Gender Incongruence as a Distinct Clinical Construct: Restoring Differential Diagnosis in Gender-Related Care

Abstract

Contemporary diagnostic frameworks in both the DSM and ICD define gender-related conditions primarily through presenting states—distress ("gender dysphoria") or self-reported incongruence ("gender incongruence")—while remaining intentionally agnostic about underlying mechanisms. This approach, adopted to reduce stigma and preserve access to care, has produced an unintended clinical consequence: heterogeneous phenomena with distinct etiologies are collapsed into a single diagnostic category. Symptoms become diagnoses, and differential inquiry is truncated.

This article proposes *Gender Incongruence* as a distinct clinical construct characterized by a persistent, internally anchored perception that one's sexed body is incongruent with one's experienced self. It distinguishes this condition from gender nonconformity in roles or expression, distress arising primarily from social conflict or stigma, trauma-related alienation from the body, body image disturbance unrelated to sexed anatomy, developmental identity exploration, and psychotic or dissociative states. Within this framework, "gender dysphoria" is reconceptualized as a response state—a clinically significant form of distress that may arise from multiple sources—rather than as a diagnosis in itself.

Developmentally sensitive diagnostic criteria are presented for children/adolescents and for adults. The criteria anchor diagnosis in internal self–body incongruence, require persistence across time and context, and include explicit exclusion rules. Distress and functional impairment are retained as specifiers rather than definitional features, preserving access while restoring diagnostic clarity.

Reintroducing etiology-sensitive classification strengthens clinical care by aligning intervention with underlying condition. It enables appropriate treatment sequencing—addressing trauma, depression, anxiety, neurodevelopmental factors, or social conflict when these are primary, and reserving medical transition pathways for cases in which a stable self–body mismatch is demonstrable. The proposed framework does not re-pathologize identity; it restores psychiatry's obligation to discriminate among causes. A symptom-centered model may justify services, but it cannot substitute for diagnosis. This construct generates testable predictions: that internally anchored self–body incongruence

will show greater temporal stability, discriminant validity from trauma, mood, and body dysmorphic presentations, and differential response to intervention compared with other sources of gender-related distress.

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1. Introduction: When Symptoms Become Diagnoses

Over the past half-century, diagnostic frameworks addressing sex- and gender-related distress have undergone a steady conceptual shift. Earlier formulations treated transsexualism and later gender identity disorder as conditions defined by an internal mismatch between self and body. Subsequent revisions replaced this etiological orientation with increasingly symptom-centered models. In DSM-5, the diagnosis became "gender dysphoria," foregrounding distress rather than underlying condition. In ICD-11, "gender incongruence" was removed from the chapter on mental disorders and reframed as a non-pathologizing classification within sexual health. These changes were motivated by legitimate ethical aims: reducing stigma, avoiding the medicalization of identity, and preserving access to care.

Yet the cost of this shift has been a progressive retreat from diagnosis as discrimination among causes. Contemporary frameworks define the clinical object by what is experienced—distress or incongruence—while remaining intentionally agnostic about why it is present. The clinician's task becomes one of confirmation rather than inquiry. Heterogeneous presentations that share a surface phenotype are treated as if they represent a single condition.

As currently used, *gender dysphoria* 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.

In medicine more broadly, symptoms are entry points, not endpoints. Fever signals infection, inflammation, or malignancy; chest pain prompts evaluation for cardiac, pulmonary, musculoskeletal, or psychological causes. The role of diagnosis is to determine

what kind of condition is present, because treatment depends on mechanism. When a presenting state becomes the diagnosis itself, inquiry is foreclosed and care becomes palliative rather than investigative.

The current gender framework represents a rare exception to this principle. Distress over sexed embodiment, social role, or identity is treated as the condition, rather than as a signal requiring differential diagnosis. This article argues that psychiatry cannot sustain such an exception without abandoning its own clinical standards. The aim is not to re-pathologize identity or restrict care, but to restore the distinction between symptom and condition.

To that end, this paper proposes *Gender Incongruence* as a distinct clinical construct: a narrowly defined condition characterized by a persistent, internally anchored perception that one's sexed body is incongruent with one's experienced self. By separating this phenomenon from socially mediated distress, trauma-related alienation, body dysmorphia, neurodevelopmental rigidity, and developmental exploration, diagnostic classification can again perform its primary function—discriminating among causes in order to align intervention with need.

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2. Diagnostic Evolution in Gender-Related Nosology

- **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.

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3. DSM-5 and ICD-11 as Convergent Models

Although DSM-5 and ICD-11 differ in placement, language, and institutional framing, they converge on a shared diagnostic philosophy. Both systems define gender-related conditions by *presenting states* rather than by underlying mechanism. In DSM-5, the object of diagnosis is distress—*gender dysphoria*. In ICD-11, it is experienced incongruence—*gender incongruence*—explicitly detached from mental disorder status. The surface

divergence conceals a deeper unity: in both systems, the experienced state itself becomes the condition.

This convergence is intentional. Each framework was shaped by ethical and policy goals: depathologization, stigma reduction, and preservation of access to care. ICD-11's relocation of gender incongruence from the mental disorders chapter to sexual health exemplifies this orientation. The intent was explicitly to decouple gender variance from psychopathology while maintaining a classification that enables care. DSM-5's reframing of the diagnosis around distress rather than identity reflects the same ethical settlement within a psychiatric taxonomy. To achieve these ends, both systems bracket etiology. They do not ask *what kind of condition this is*; they ask only whether a person experiences distress or incongruence of sufficient persistence to warrant classification. Heterogeneous pathways are collapsed into a single diagnostic container so that services may be accessed without adjudicating cause.

The clinical consequences of this shift are already visible in practice. The original Dutch protocol—the empirical foundation for pediatric medical transition—was built on a narrowly defined cohort: children with early-onset, persistent gender incongruence and otherwise relative mental stability. Within this constrained population, outcomes following puberty suppression and subsequent medical transition were largely positive. The protocol's success depended on *phenomenological specificity* and *etiological coherence*. This does not imply that early Dutch cohorts were homogeneous or that outcomes were uniformly positive, nor does it settle debates about long-term effects. It does, however, demonstrate that pathway design was originally tethered to a narrow and explicitly defined phenotype.

As diagnostic frameworks broadened, however, inclusion criteria loosened. Contemporary cohorts increasingly include adolescents with later-onset presentations, complex psychiatric comorbidities, trauma histories, neurodevelopmental differences, and socially mediated distress. These heterogeneous populations are now classified under the same diagnostic umbrella. Notably, outcome data in these expanded cohorts show greater variability and a higher incidence of regret, persistence of distress, and psychiatric morbidity. What was once a treatment pathway for a specific condition has become a default response to a surface phenotype.

This evolution mirrors the DSM–ICD convergence: a move from mechanism-sensitive selection to symptom-based inclusion. The clinician's role shifts from identifying *which patients resemble the original Dutch cohort* to confirming that distress or incongruence is present. The diagnostic category no longer discriminates among pathways; it authorizes access.

The proposed framework departs from this settlement while preserving its ethical aims. It does not reintroduce identity as pathology, nor does it make distress a prerequisite for care. Instead, it restores the classical medical distinction between *symptom* and *condition*. "Gender dysphoria" is reconceptualized as a response state—clinically significant and in need of care, but non-specific in origin. "Gender incongruence" is narrowed to a distinct construct: a persistent, internally anchored perception that one's sexed body is incongruent with one's experienced self.

This distinction resolves the core problem created by the DSM–ICD convergence. Rather than collapsing heterogeneous phenomena for the sake of access, the proposed model separates them for the sake of care. Trauma-related alienation from the body, socially mediated conflict, body dysmorphia unrelated to sexed anatomy, neurodevelopmental rigidity, psychotic belief, and developmental exploration remain legitimate clinical concerns—but they are no longer presumed to be the same condition.

Crucially, this framework preserves what DSM-5 and ICD-11 sought to protect. Distress and impairment remain specifiers, not gatekeepers. Access is not denied; it is sequenced. Individuals whose primary difficulty lies in trauma, depression, anxiety, autism-related rigidity, or social conflict receive care directed at those mechanisms. Individuals who meet criteria for a stable self–body mismatch—those who most closely resemble the original Dutch cohort—are identified as such, allowing medical transition to be considered in alignment with etiology rather than as a default response to a surface phenotype.

In this way, the proposal does not reject the DSM–ICD project; it completes its unfinished clinical work. Depathologization need not entail diagnostic abdication. A classification system can reduce stigma while still asking what kind of condition it is treating. By restoring etiology-sensitive discrimination within a non-pathologizing frame, the proposed model reconciles access with accuracy—and returns diagnosis to its proper role: understanding before intervention.

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4. The Problem of Heterogeneity

Under current DSM-5 and ICD-11 frameworks, a wide range of clinically distinct phenomena are subsumed under a single diagnostic heading. Distress related to gender, or the experience of incongruence, is treated as a unitary condition regardless of its origin. This heterogeneity is not incidental; it is structural. By design, contemporary classification

brackets etiology in favor of access and depathologization. The diagnostic category becomes a broad container for any presentation that appears "gender-related."

In practice, this container now includes individuals whose difficulties arise from fundamentally different mechanisms:

- Trauma-related alienation from the body or self
- Depressive or anxiety-driven collapse of self-concept
- Neurodevelopmental rigidity and concretization (e.g., in autism spectrum conditions)
- Body image disturbance unrelated to sexed anatomy
- Psychotic or dissociative states in which identity or embodiment is episodic or state-dependent
- Transient developmental exploration during adolescence
- Socially mediated distress arising from role conflict, stigma, or rejection
- A smaller cohort characterized by a stable, internally anchored self–body mismatch

These presentations may converge phenomenologically. Each can produce discomfort with sexed embodiment, preoccupation with gendered identity, or a desire for change. Yet they are not the same condition. They differ in developmental course, prognosis, and optimal treatment. When classification treats them as equivalent, clinical reasoning is flattened. The same label authorizes the same pathway, regardless of whether the underlying driver is trauma, mood disorder, neurodevelopmental difference, or a persistent internal incongruence.

The proposed framework addresses this collapse directly by embedding exclusion as a core diagnostic function. Gender Incongruence is not defined by what it resembles, but by what it is *not*. A diagnosis requires the presence of a stable, self-referential self–body mismatch *and* the absence of more plausible alternative explanations. The presentation must not be better accounted for by:

- Gender nonconformity in interests, roles, or expression
- Distress arising solely from social rejection, role pressure, or cultural conflict
- Transient identity exploration without persistence across time and context
- Body image dissatisfaction unrelated to sexed anatomy

- Psychotic, dissociative, or mood states in which incongruence is episodic or state-dependent
- Trauma-related self-alienation not specifically centered on sexed embodiment

These exclusions do not deny the reality or seriousness of these conditions. On the contrary, they insist that each deserves to be understood and treated on its own terms. Trauma requires trauma-focused care. Depression and anxiety require psychiatric treatment. Neurodevelopmental rigidity requires developmental and behavioral intervention. Social conflict requires family, school, and community-level response. None of these are "less real" than gender incongruence; they are simply different.

Heterogeneity becomes a problem only when it is misrecognized as unity. A classification system that cannot distinguish among causes cannot guide treatment. It can only authorize pathways. The result is a default sequence in which surface similarity substitutes for diagnosis, and intervention precedes understanding.

By reintroducing explicit exclusions, the proposed framework restores the clinician's responsibility to discriminate. It converts "gender-related distress" from a terminal category into a starting point for inquiry. Only those individuals whose presentation cannot be better explained by these alternative pathways—and who demonstrate a persistent, internally anchored self–body mismatch—meet criteria for Gender Incongruence. In doing so, the framework preserves access while preventing category error, aligning care with mechanism rather than appearance.

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5. Gender Dysphoria as a Response State

A central conceptual move in the proposed framework is the separation of *distress* from *condition*. In the current diagnostic landscape, "gender dysphoria" functions as both symptom and diagnosis. Distress becomes the disease. This conflation obscures the clinical task: to determine *what kind of condition* is generating the distress.

Within the proposed model, dysphoria is reconceptualized as a **response state**—a clinically significant form of suffering that may arise from multiple underlying mechanisms. It is analogous to pain or fever: meaningful, urgent, and deserving of care, but non-specific in origin. Dysphoria may emerge from internal self–body incongruence, from social rejection, from trauma, from depression or anxiety, from neurodevelopmental rigidity, or

from developmental identity exploration. Its presence signals that something is wrong; it does not, by itself, specify what that something is.

This distinction resolves a persistent ambiguity in both DSM-5 and ICD-11. When distress is treated as the diagnosis, clinical inquiry ends where it should begin. The proposed framework restores the classical medical sequence: symptom → differential diagnosis → condition → treatment. Dysphoria initiates evaluation rather than terminating it.

The Conceptual Notes of the proposal formalize this shift:

- *Gender incongruence is a clinical condition, not an identity and not a mental disorder.*
- *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.*

These statements serve three functions. First, they prevent the diagnosis from collapsing into identity. A person may adopt a transgender identity without meeting criteria for gender incongruence; conversely, a person may meet criteria without adopting any identity label. The diagnosis concerns an internal self–body relationship, not social affiliation or self-description.

Second, they prevent distress from substituting for mechanism. Dysphoria remains clinically central—it is often what brings individuals into care—but it no longer defines the condition. Distress becomes a *specifier*, allowing clinicians to describe severity and impairment without erasing etiological differences.

Third, they protect normative variation. Gender nonconformity in interests, roles, or expression is explicitly excluded from pathology. The framework does not medicalize difference; it medicalizes a specific form of internal incongruence when it cannot be better explained by other conditions.

This reconceptualization addresses a core failure of the convergent DSM–ICD model. By collapsing all gender-related distress into a single category, current systems treat suffering as self-explanatory. The proposed framework restores explanatory discipline. Dysphoria becomes a signal rather than a verdict.

Clinically, this change has immediate consequences. An adolescent presenting with intense distress about sexed embodiment is no longer presumed to have the same

condition as a peer whose distress is driven by trauma, depression, or social conflict. Both are taken seriously. Both receive care. But they are not assumed to share the same diagnosis or pathway.

By disentangling response from condition, the framework preserves the ethical aims of depathologization while restoring diagnostic integrity. It affirms that suffering is real without presuming that all suffering of a similar form arises from the same cause. In doing so, it re-establishes psychiatry's fundamental obligation: to understand before it acts.

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6. Defining Gender Incongruence

The proposed framework does not introduce a novel phenomenon; it clarifies one that has long been clinically recognized but conceptually diluted. Within the draft, *gender incongruence* is defined not by identity, role, or expression, and not by distress, but by a specific internal experience: a persistent perception that one's sexed body is incongruent with one's experienced self.

This definition is developed in three interlocking layers. First, the conceptual framing distinguishes a cohort whose distress does not arise from social misrecognition or role conflict, but from an internally experienced self–body mismatch. These individuals do not claim that society is mistaken about who they are; they claim that *their body is*. The body is medically typical, in the absence of disorders of sex development, yet is experienced as wrong. The incongruence is not interpersonal; it is intrapersonal.

Second, this conceptual core is operationalized in the diagnostic criteria. Both the child/adolescent and adult criteria sets begin with the same anchor:

A marked and persistent internal incongruence between the individual's experienced gender and their sexed body.

This is made explicit in Criterion A1:

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

All additional features—discomfort with sex characteristics, desire to alter or prevent their development, desire for other sex traits, and internal identification not reducible to roles or

style—are subordinate to this core. They are supportive, not defining. Without evidence of an internally anchored self–body mismatch, the condition is not present.

Third, the construct is bounded by the Conceptual Notes and exclusion criteria. Gender incongruence is specified as:

- A *clinical condition*, not an identity and not a mental disorder.
- Independent of identity labels; adoption of a "transgender" identity is neither necessary nor sufficient.
- Distinct from gender dysphoria, which is a response state that may arise from multiple sources.
- Exclusive of gender nonconformity, which is a normal human variation.

The exclusions complete the definition by contrast. The presentation must not be better explained by gender role nonconformity, socially mediated distress, transient developmental exploration, body image disturbance unrelated to sexed anatomy, trauma-related self-alienation, or psychotic or dissociative states in which incongruence is episodic or state-dependent. These phenomena may resemble gender incongruence in outward form, but they are not the same condition.

Taken together, these elements define gender incongruence as:

A distinct clinical condition characterized by a persistent, internally anchored perception that one's sexed body is incongruent with one's experienced self, in the absence of disorders of sex development and not better explained by alternative psychological, developmental, or social mechanisms.

This definition accomplishes what current frameworks avoid. It specifies what kind of thing gender incongruence is. It distinguishes mechanism from appearance, condition from response, and internal experience from social position. It allows clinicians to say not merely that a person is distressed about gender, but *why*—and whether that distress arises from this particular condition or from another pathway that requires a different form of care. The construct is empirically falsifiable. If gender incongruence, as defined here, is a coherent clinical entity, it should demonstrate longitudinal stability, discriminant validity from trauma-related alienation, affective disturbance, and body dysmorphic disorder, and differential treatment response compared with these conditions. Failure on these dimensions would argue against its nosological independence.

By making the construct explicit, the proposal restores diagnostic meaning without re-pathologizing identity. It preserves the ethical commitments of contemporary systems

while reestablishing psychiatry's central task: to discriminate among causes so that treatment can be aligned with what is actually present.

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7. Developmentally Distinct Criteria: Children, Adolescents, and Adults

Gender incongruence does not present identically across the lifespan. The proposed framework therefore provides separate criteria sets for children and for adolescents/adults, not to imply different conditions, but to reflect developmental realities in how the same core phenomenon is experienced, expressed, and detected.

In adults, access to the internal state is direct. The clinician can evaluate a stable, self-referential conviction of self–body mismatch through narrative coherence, temporal persistence, and reflective capacity. Adults typically articulate incongruence as an internal truth about the self that precedes and exceeds social roles or identity labels. The adult criteria therefore emphasize phenomenology: a persistent internal conviction (A1) supported by body-focused discomfort or desires (A2–A4) and an identification not reducible to role preference or affiliation (A5). The task is differential—distinguishing a stable self–body mismatch from trauma-related alienation, body dysmorphia, psychosis, or mood-state–dependent identity disturbance.

In children and younger adolescents, the same core phenomenon exists, but access to it is indirect and developmentally mediated. Minors do not self-refer to clinical services. Presentation is filtered through parental awareness, cultural expectations, school environments, and family norms. Some children experience internal incongruence long before they possess the language to articulate it. Others become aware of mismatch only when external interactions make it salient. In supportive environments, distress may be minimal; in restrictive ones, it may be acute. Parental concern alone, however, does not constitute diagnosis.

For this reason, the child/adolescent criteria are anchored in the same core feature—internal self–body incongruence—but allow it to be inferred through stable cross-context patterns and consistent self-statements. Play style, peer affiliation, and gender-nonconforming interests are explicitly excluded as sufficient evidence. They may coexist with incongruence, but they do not define it. The diagnosis requires evidence that the child's experience is not merely expressive or exploratory, but internally referential and persistent.

Developmental timing further differentiates presentations. In prepubertal children, incongruence often emerges as statements about being "really" another sex or distress about anticipated bodily change. In early adolescence, pubertal development intensifies awareness of the body and may rapidly amplify distress. These changes unfold on compressed timescales. A rigid, multi-year persistence requirement risks converting caution into neglect. The proposed six-month threshold is therefore paired with phenomenological specificity: persistence across time and context, internal self-reference, and body-focused features. The safeguard is not elapsed time alone, but the structure of the experience.

The distinction between child/adolescent and adult criteria thus reflects two realities:

1. The same condition is present across development, but
2. The means of identifying it differ because cognitive capacity, language, and social mediation differ.

In adults, diagnosis relies primarily on direct phenomenological report. In children and adolescents, it relies on convergent evidence: self-statements, cross-context stability, and body-focused concern, interpreted within a developmental and familial context. In both groups, the clinician's task remains the same—to determine whether a persistent, internally anchored self–body mismatch is present and not better explained by alternative mechanisms.

By separating criteria sets while preserving a single construct, the framework avoids two common errors. It prevents the over-diagnosis of children based on gender nonconformity or parental anxiety, and it prevents the under-recognition of genuine incongruence in minors who lack the language or safety to articulate it. The result is a developmentally literate diagnostic model that respects both the continuity of the condition and the realities of how it emerges across the lifespan.

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8. Differential Diagnosis

The clinical value of the proposed framework lies in its capacity to discriminate among presentations that converge at the level of appearance but diverge in mechanism. Under current DSM-5 and ICD-11 models, gender-related distress functions as a terminal

category. In contrast, the present approach treats such distress as an entry point into differential diagnosis. The task is not to determine whether a person is suffering, but *why*.

At minimum, assessment must determine whether the presentation reflects a persistent, internally anchored self–body mismatch, or whether it is better explained by another primary condition. The proposed exclusions formalize this task.

Trauma-Related Self-Alienation

Individuals with histories of abuse, neglect, or chronic invalidation may experience their bodies as foreign, unsafe, or "not mine." This alienation may become focused on sexed anatomy, especially when trauma is sexual in nature. The resulting distress can resemble incongruence in form—disgust toward body parts, desire for removal, fantasies of being "other"—but the mechanism is defensive rather than constitutive. The self is not experienced as belonging to another sex; it is experienced as fractured or endangered. Treatment priorities center on trauma integration and safety, not on altering the body.

Affective and Self-Concept Disturbance

In some adolescents and adults, gender-related distress arises within a broader collapse of self-coherence associated with major depression, severe anxiety, or emerging personality pathology. These individuals often experience pervasive uncertainty about identity ("I don't know who I am"), intense dissatisfaction with the body, and a desire for categorical transformation as a solution to diffuse psychic pain. Gender becomes the organizing symbol for a more global disturbance of self.

The phenomenology may resemble incongruence: urgent desire for change, alienation from the body, and conviction that becoming "other" will resolve suffering. Yet the core experience is not a stable self–body mismatch but an unstable or fragmented sense of self. Identity claims may shift rapidly; distress waxes and wanes with mood; meaning is retroactively imposed on affect.

In such cases, gender-focused intervention risks mistaking a structural vulnerability for a specific condition. Treatment priorities center on affect regulation, identity integration, and stabilization. The proposed framework captures this pathway through exclusion of mood- or state-dependent presentations and of self-alienation not specifically centered on sexed embodiment.

Body Dysmorphic Disorder

In body dysmorphic disorder, preoccupation is with a body part believed to be malformed or ugly. The goal is correction of defect. In gender incongruence, the problem is not defect but category: the body part is experienced as wrong *because it is sexed*. Distinguishing these requires careful phenomenology. “I hate my chest because it is deformed” is not equivalent to “I hate my chest because it makes me female.” When appearance concerns are better explained by dysmorphia and are not organized around sexed identity, the diagnosis is not gender incongruence.

Neurodevelopmental Rigidity (e.g., Autism Spectrum Conditions)

Some individuals with autism spectrum conditions exhibit literal or rigid reasoning about gender categories, social rules, and self-definition. A child who reasons, “I like X, and X is for girls, therefore I am a girl,” may present with conviction and distress when contradicted. The form resembles incongruence, but the driver is cognitive style rather than an internally anchored self–body mismatch. Longitudinal assessment, narrative depth, and body-focused phenomenology are essential. Treatment often centers on cognitive flexibility, social understanding, and emotional regulation.

Psychotic and Dissociative States

In psychotic disorders, individuals may develop delusional beliefs about transformation, identity, or bodily change. In dissociative conditions, identity states may shift episodically. These experiences can include gendered content, but they fluctuate with illness state and lack the stable, self-referential continuity of gender incongruence. The clinician must assess temporal stability, coherence across mental states, and responsiveness to treatment of the primary disorder.

Developmental Exploration

Adolescence is a period of identity experimentation. Many youths explore gendered aesthetics, names, pronouns, or social roles without a fixed internal self–body mismatch. Such exploration may be intense and emotionally charged, particularly in peer-mediated environments. The proposed framework requires persistence across time and context and anchors diagnosis in internal conviction rather than in exploratory behavior. This preserves normative developmental variance.

Socially Mediated Distress

A young person may be distressed because their temperament, interests, or relationships conflict with gendered expectations. The distress may become framed as "gender dysphoria" in a cultural context that offers that language. The suffering is genuine, but the driver is external constraint rather than internal mismatch. Intervention targets family systems, school climate, and self-acceptance rather than the body.

Each of these pathways can produce discomfort with sexed embodiment, preoccupation with gendered identity, or desire for change. Yet each differs in mechanism, prognosis, and optimal treatment. Without explicit differential rules, surface similarity substitutes for diagnosis. The proposed exclusions ensure that only those presentations characterized by a persistent, internally anchored self–body mismatch—and not better explained by these alternative mechanisms—meet criteria for Gender Incongruence. Exclusion here does not deny care; it redirects it. Each alternative pathway remains clinically actionable and ethically urgent. In doing so, the framework converts gender-related distress from a terminal label into a clinically meaningful starting point.

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9. From Pathway Authorization to Mechanism-Aligned Sequencing

Diagnostic categories do more than name conditions; they shape clinical trajectories. Under the convergent DSM–ICD model, gender-related distress or self-reported incongruence functions as a sufficient endpoint. Once the label is applied, a familiar arc tends to follow: affirmation, social transition, and consideration of medical intervention. This is not a failure of individual clinicians. It is the structural consequence of a system in which the diagnosis itself carries an implicit pathway logic.

The proposed framework breaks that coupling. By separating presenting state from underlying condition, it reintroduces a staged clinical logic:

1. **Presenting state:** gender-related distress or concern.

2. **Differential phase:** determine whether a persistent, internally anchored self–body mismatch is present, or whether another mechanism better explains the presentation.
3. **Primary intervention:**
    - Trauma → trauma-focused treatment
    - Affective/self-concept disturbance → psychiatric stabilization and identity integration
    - Neurodevelopmental rigidity → developmental and cognitive support
    - Social conflict → family, school, and systemic intervention
    - Gender incongruence → consideration of gender-affirming pathways
4. **Secondary interventions:** address residual distress, comorbidity, and functional impairment.

This is not restriction; it is alignment. No one is denied care. Care is sequenced according to cause.

The empirical stakes of this shift are already visible in the history of pediatric gender medicine. The original Dutch protocol—the foundation for puberty suppression and subsequent medical transition—was built on a narrowly defined cohort: children with early-onset, persistent gender incongruence and otherwise relative mental stability. Within this constrained population, outcomes were largely positive. The protocol's success depended on phenomenological specificity and etiological coherence. It was not designed for all forms of gender-related distress.

As diagnostic frameworks broadened, inclusion criteria loosened. Contemporary cohorts increasingly include adolescents with later-onset presentations, complex psychiatric comorbidities, trauma histories, neurodevelopmental differences, and socially mediated distress. These heterogeneous presentations are now classified under the same diagnostic umbrella. Outcome data in these expanded cohorts show greater variability, higher rates of persistent distress, and a growing incidence of regret and detransition. Whether these trends reflect changes in referral patterns, sociocultural context, clinical practice, or underlying epidemiology remains contested. What is not contested is that the treated population has diversified. A model that does not discriminate among pathways cannot account for that diversification. What was once a treatment pathway for a specific condition has become a default response to a surface phenotype.

This evolution mirrors the DSM–ICD convergence: a move from mechanism-sensitive selection to symptom-based inclusion. The diagnostic category no longer discriminates among pathways; it authorizes access. The result is not simply broader care—it is altered sequencing. Interventions designed for a specific phenotype are applied to a mixed population whose needs are not uniform.

The proposed framework restores the original clinical logic without abandoning ethical commitments. Distress and impairment remain central and actionable, but they no longer substitute for diagnosis. Individuals whose primary difficulty lies in trauma, mood disorder, neurodevelopmental rigidity, or social conflict receive care directed at those mechanisms first. Individuals who meet criteria for a stable self–body mismatch—those who most closely resemble the original Dutch cohort—are identified as such, allowing medical transition to be considered in alignment with etiology rather than as a default response to distress.

In this model, nosology changes outcomes by changing order. It replaces pathway authorization with mechanism-aligned sequencing. The question is no longer "Does this person experience gender-related distress?" but "What kind of condition is generating this distress, and what should be treated first?" That is not a political stance. It is the most traditional medical principle: intervene in accordance with cause.

By restoring this principle, the framework preserves access while protecting patients from category error. It honors the lesson embedded in the Dutch protocol—that outcomes depend on matching pathway to phenotype—and extends it to a clinical landscape that has outgrown its original assumptions.

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10. Integrating Diagnosis, Ethics, and Practice

The proposed framework reshapes gender-related care by restoring the distinction between symptom and condition while preserving the ethical aims that motivated recent diagnostic reforms. It does not return to identity-based pathology, nor does it deny the reality of suffering. Instead, it clarifies what kind of clinical object psychiatry is addressing.

By reconceptualizing gender dysphoria as a response state, the framework treats distress as a signal rather than a verdict. Dysphoria remains urgent and actionable, but it no longer defines the condition. This restores the classical medical sequence: presenting state →

differential diagnosis → condition → treatment. Gender-related suffering becomes the beginning of inquiry rather than its end.

The operational definition of gender incongruence completes this shift. Diagnosis is anchored in a persistent, internally anchored self–body mismatch, supported by body-focused features and bounded by explicit exclusions. Identity labels, community affiliation, and expressive style are decoupled from diagnosis. Gender nonconformity is explicitly protected as normal human variation. Distress and impairment are retained as specifiers, allowing clinicians to describe severity without erasing etiological differences.

This structure produces three clinical consequences.

First, it re-centers differential diagnosis. Presentations that resemble gender incongruence in form but differ in mechanism—trauma-related self-alienation, affective instability, neurodevelopmental rigidity, body dysmorphia, psychotic or dissociative states, developmental exploration, and socially mediated distress—are no longer presumed equivalent. Each pathway becomes visible as a distinct clinical problem requiring its own form of care.

Second, it restores coherent treatment sequencing. Care is no longer organized around a surface phenotype. Instead, intervention follows cause. Trauma is treated as trauma. Mood disturbance is stabilized as mood disturbance. Developmental rigidity is addressed developmentally. Social conflict is met systemically. Gender incongruence, when present, becomes one pathway among others—distinct, identifiable, and aligned with interventions designed for it.

Third, it reconciles precision with access. The model does not gate care behind distress thresholds or identity claims. Individuals with gender-related suffering are not turned away; they are assessed. Distress remains actionable. Impairment remains urgent. What changes is not whether care is offered, but what kind of care is offered first.

Ethically, this approach avoids both historical errors. It neither pathologizes identity nor abdicates diagnosis. It affirms that difference is not disease while insisting that disease must still be named. It recognizes that suffering is real without presuming that all suffering of similar form arises from the same cause.

In this way, the framework restores psychiatry's core obligation: to discriminate among causes so that intervention can be aligned with what is actually present. It replaces a post-nosological model—where experience becomes diagnosis—with a clinically grounded one, where experience initiates understanding.

What is proposed is not restriction but restoration: of diagnostic meaning, of clinical reasoning, and of medicine's responsibility to understand before it acts.

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11. Conclusion

Contemporary diagnostic frameworks in both the DSM and ICD define gender-related conditions by presenting states—distress or experienced incongruence—while remaining intentionally agnostic about underlying mechanisms. This shift was motivated by ethical imperatives: to reduce stigma, avoid pathologizing identity, and preserve access to care. Yet it has produced an unintended clinical consequence. Heterogeneous phenomena with distinct etiologies are collapsed into a single diagnostic category. Symptoms become diagnoses, and differential inquiry is truncated.

This paper has argued that such a model cannot sustain psychiatry's core function. In medicine, symptoms initiate inquiry; they do not end it. Fever is not a disease. Pain is not an etiology. When distress or incongruence becomes the condition itself, clinical reasoning is foreclosed and care becomes palliative rather than investigative.

The proposed framework restores that distinction. *Gender dysphoria* is reconceptualized as a response state—clinically significant, urgent, and deserving of care, but non-specific in origin. *Gender incongruence* is defined as a distinct clinical construct: a persistent, internally anchored perception that one's sexed body is incongruent with one's experienced self. Developmentally sensitive criteria operationalize this construct for children, adolescents, and adults, while explicit exclusions enforce differential diagnosis across trauma, affective and self-concept disturbance, neurodevelopmental rigidity, body dysmorphia, psychotic and dissociative states, developmental exploration, and socially mediated distress.

This approach does not re-pathologize identity. It does not deny access. Distress and impairment remain clinically central, retained as specifiers rather than gatekeepers. What changes is not whether care is offered, but how it is conceptualized and sequenced. Intervention becomes aligned with mechanism. Trauma is treated as trauma. Mood disturbance is stabilized as mood disturbance. Social conflict is addressed systemically. Gender incongruence, when present, is identified as such and may proceed along pathways designed for it.

In this way, the framework reconciles depathologization with diagnostic integrity. It affirms that difference is not disease while insisting that disease must still be named. It preserves the ethical achievements of recent reforms while restoring medicine's obligation to understand before it acts.

A symptom-centered model may justify services; it cannot substitute for diagnosis. Clinical classification requires continued inquiry into underlying mechanisms. What is proposed is not restriction, but restoration: of conceptual clarity, of differential reasoning, and of psychiatry's fundamental task—to determine what kind of condition is present so that care can be aligned with what is actually occurring.

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Selected References and Contextual Literature

Diagnostic History and Nosology

- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 3rd–5th eds.
- World Health Organization. *International Classification of Diseases, 11th Revision (ICD-11)*.
- Drescher, J. (2015). Out of DSM: Depathologizing homosexuality. *Behavioral Sciences*.
- Zucker, K. J., et al. (2013). DSM-5 gender dysphoria diagnosis. *Archives of Sexual Behavior*.
- Reed, G. M., et al. (2016). Disorders related to sexuality and gender identity in ICD-11. *World Psychiatry*.

ICD-11 Rationale and Depathologization

- Reed, G. M., et al. (2016). Innovations and changes in the ICD-11 classification of mental, behavioural and neurodevelopmental disorders. *World Psychiatry*.
- Drescher, J., et al. (2012). Minding the body: Situating gender diagnoses in ICD-11. *International Review of Psychiatry*.
- WHO Working Group on Sexual Disorders and Sexual Health (2014–2018) background papers.

Developmental Trajectories and the Dutch Cohorts

- Cohen-Kettenis, P. T., & Pfäfflin, F. (2003). Transgenderism and intersexuality in childhood and adolescence.
- Steensma, T. D., et al. (2011). Desisting and persisting gender dysphoria after childhood. *Journal of the American Academy of Child & Adolescent Psychiatry*.
- de Vries, A. L. C., et al. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*.
- Wiepjes, C. M., et al. (2018). The Amsterdam cohort of gender dysphoria study. *Journal of Sexual Medicine*.

- Zucker, K. J. (2019). Adolescents with gender dysphoria: Reflections on some contemporary clinical and research issues. *Archives of Sexual Behavior*.

Comorbidity and Heterogeneity

- Strang, J. F., et al. (2018). Increased gender variance in autism spectrum disorders. *Journal of Autism and Developmental Disorders*.
- Skagerberg, E., et al. (2013). Gender dysphoria in adolescents: A review of co-occurring psychopathology. *Clinical Child Psychology and Psychiatry*.
- Dhejne, C., et al. (2011). Long-term follow-up of transsexual persons. *PLoS ONE*.
- Kaltiala-Heino, R., et al. (2015). Two years of referrals of children and adolescents to a gender identity service. *Archives of Sexual Behavior*.

Differential Diagnosis Domains

- Phillips, K. A. (2005). *The Broken Mirror: Understanding and Treating Body Dysmorphic Disorder*.
- van der Kolk, B. (2014). *The Body Keeps the Score*.
- Paris, J. (2015). *The Intelligent Clinician's Guide to Personality Disorders*.
- Morrison, A. P., et al. (2014). *Psychosis: A Clinical Guide*.
- American Psychiatric Association. DSM-5-TR differential diagnosis sections.

Conceptual and Ethical Analyses

- Sadler, J. Z. (2005). *Values and Psychiatric Diagnosis*.
- Hacking, I. (1995). *Rewriting the Soul*.
- Conrad, P. (2007). *The Medicalization of Society*.
- Wakefield, J. C. (1992). The concept of mental disorder. *American Psychologist*.