

Grounding of the Proposed Addition to DSM

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This is an independent proposal, without institutional adoption or endorsement.

This companion organizes the principal clinical propositions and descriptive claims in the proposal. Claims below are paraphrased unless identified otherwise.

The purpose is to make the basis of the proposal inspectable. Clinical observation, professional guidance, historical classification and empirical research contribute different kinds of grounding. A proposal can reasonably emerge from clinical experience without already having been validated as a new diagnostic construct. The categories describe that distinction; they are not a numerical evidence hierarchy.

Category	Meaning in this review
E Empirical research	Published observational, field or follow-up findings bear on the claim. Applicability to the proposed population must still be examined.
G Published clinical guidance	A classification or professional guideline recognizes the principle or practice. Recognition is not itself experimental validation.
H Historical precedent	Earlier diagnostic or clinical formulations used a related distinction or requirement. Precedent does not establish superiority.
P Proposed modification	The author selects, combines, narrows or explains features in a way requiring professional evaluation and, where feasible, empirical testing.

Reading the annotations

Each entry gives the proposal location, category, grounding and boundary of support. More than one category may apply. P does not mean unsupported or unsuitable; it identifies where the proposal goes beyond the referents. Sources are selective anchors, not exhaustive citations for every sentence. This is a preliminary interpretive register, not a systematic review or institutional endorsement.

Annotated clinical claims

1 Incongruence and distress are distinguishable

Location: Definitions and conceptual notes | Categories: E G P

Grounding. ICD-11 recognizes gender incongruence without requiring clinically significant distress or functional impairment. Robles and colleagues examined related ICD-11 and DSM-5 categories in 649 treatment-seeking adults across six countries [1,3].

Relevance and limits. The proposal distinguishes the identification of incongruence from assessment of its clinical consequences, recording distress and impairment as specifiers rather than diagnostic prerequisites. Diagnosis alone does not establish a need for medical intervention. The accompanying proposed Standards of Care require a separate assessment of clinical indication, anticipated benefits and risks, and suitability for the particular intervention. The cited research supports the distinction between incongruence and distress, but does not validate the exact cohort defined by the proposed criteria.

2 Persistent internal self–body incongruence

Location: Core Condition and A1 | Categories: G E P

Grounding. APA and WHO diagnostic descriptions recognize incongruence between experienced gender and assigned sex or sex characteristics. Related classification field studies examine the clinical usefulness of identifying that presentation [1–4].

Relevance and limits. A1 identifies the patient’s persistent, self-referential experience of bodily incongruence, distinguished from preferences concerning roles, appearance, or social positioning. It operates together with the bodily concerns and physical-change goals required by A2 and A3, and the listed exclusions. These features define the proposed clinical presentation without establishing its biological cause. Whether medical intervention is indicated remains a separate determination under the accompanying Standards of Care.

3 Primary bodily concern and desire for change

Location: Mandatory A2 and A3 | Categories: G H P

Grounding. Existing diagnostic descriptions include discomfort with sex characteristics and desires to remove, alter, or acquire them [1,2]. Earlier transsexualism formulations provide historical precedent for identifying a presentation involving a desire for bodily change [5].

Relevance and limits. The proposal requires both persistent discomfort with primary sex characteristics, or preoccupation with their incongruence, and a persistent desire for primary bodily change. Secondary sex characteristics are included where applicable. Together, A2 and A3 distinguish the proposed presentation from internal identification alone and connect the bodily concern to the patient’s treatment goals. Making these features jointly mandatory is the author’s proposed narrowing of the diagnostic criteria. It identifies the presentation and desired change; the accompanying Standards of Care separately determine whether a particular intervention is clinically indicated.

Annotated clinical claims continued

4 Two years and all three criteria

Location: Core Condition in both age groups | Categories: H P

Grounding. As a historical diagnostic comparator, ICD-10 required two years of persistence for adolescent/adult transsexualism. Related ICD-11 childhood field work examined a two-year duration requirement and a formulation requiring all specified features [5,6]. These provide precedent for duration and combined-feature requirements, rather than validation of the exact criteria proposed here.

Relevance and limits. The proposal requires the presentation defined by A1–A3 to have persisted for at least two years. This combines a historical duration safeguard with the author’s proposed diagnostic formulation, requiring evidence of sustained internal incongruence, bodily concerns, and corresponding physical-change goals. The diagnostic duration is distinct from the therapeutic and assessment periods specified in the accompanying Standards of Care; those periods may overlap where their respective requirements are met. Neither elapsed time nor diagnostic persistence alone establishes eligibility for intervention. The exact duration and combination proposed here have not been established as optimal by the cited referents.

5 Expression and labels do not establish the condition

Location: Exclusions and conceptual notes | Categories: G

Grounding. WHO states that gender-variant behavior and preferences alone do not establish gender incongruence. APA likewise distinguishes gender nonconformity from gender dysphoria [1,2].

Relevance and limits. The proposal applies this distinction by requiring the persistent internal incongruence, bodily concerns, and physical-change goals specified in A1–A3. Clothing, interests, social roles, identity labels, or community affiliation cannot substitute for those features. Such expression or affiliation may accompany the condition, but neither establishes nor excludes it. Diagnosis requires the positive criteria to be met and alternative explanations to be assessed; exclusion alone is insufficient.

6 Differential assessment of alternative explanations

Location: Exclusions and Differential Diagnosis | Categories: G P

Grounding. Endocrine Society guidance requires diagnostic competence, differentiation from conditions with similar presenting features, and assessment of relevant mental health and social circumstances [7].

Relevance and limits. The proposal applies this principle by requiring assessment of whether another condition or circumstance better explains the presentation. The presence of a coexisting condition does not, by itself, establish that it explains the incongruence or exclude the diagnosis. Conversely, meeting the positive criteria does not remove the obligation to investigate plausible alternative explanations. The specific exclusions are the author’s proposed formulation. The accompanying Standards of Care address how coexisting conditions affect treatment suitability, sequencing, and supervision.

Annotated clinical claims continued

7 Distress and impairment as specifiers

Location: Specifiers in both age groups | Categories: E G P

Grounding. ICD-11 and related classification field studies distinguish gender incongruence from associated distress or functional impairment and recognize the presentation without requiring either [1,3,4]. This provides a clinical comparator for the proposed distinction.

Relevance and limits. The proposal records clinically significant distress and functional impairment as specifiers rather than prerequisites for identifying incongruence. This allows clinicians to document the condition's presence separately from its consequences, including impairment confined to a single important area of life. Their absence does not establish a need for intervention, and their presence does not determine which intervention is appropriate. Those decisions require the additional clinical assessment specified in the accompanying Standards of Care. Use of these specifiers within a DSM addition is the author's proposed implementation; its placement within DSM requires professional consideration.

8 Developmental history and puberty matter

Location: Clinical Context and Development and Course | Categories: E G P

Grounding. Steensma and colleagues examined developmental trajectories in childhood clinic referrals. The Dutch clinical account describes assessment attentive to developmental history, persistence, and changes associated with puberty [8–10].

Relevance and limits. These referents support examining when incongruence became apparent, how it was experienced and expressed over time, and how bodily development affected the presentation. The proposal uses developmental history to interpret the required criteria and document onset, rather than treating age at referral as equivalent to age at onset. Earlier experiences may not have been disclosed or recognized when they occurred. The cited populations were defined under other diagnostic formulations; their findings inform developmental assessment but do not establish the course or outcomes of the precise construct proposed here.

The studies' limitations for establishing treatment effects should be distinguished from their contribution to describing developmental histories and clinical presentations. Their relevance to the proposed construct requires examination of the original selection criteria and assessments, rather than assuming either equivalence or inapplicability.

9 Heterogeneity warrants clinical differentiation

Location: Introduction and recommendation | Categories: E G P

Grounding. Clinical guidance and follow-up studies recognize differences in developmental histories, presenting concerns, coexisting conditions, and clinical course among patients presenting for gender-related care [7–10].

Annotated clinical claims continued

9 Heterogeneity warrants clinical differentiation (cont.)

Relevance and limits. These differences provide a clinical rationale for examining a more specifically defined presentation rather than assuming that everyone within a broader diagnostic or referral category has equivalent needs. The proposal identifies that presentation through the combined requirements of A1–A3 and assessment of alternative explanations. The accompanying Standards of Care address individual treatment suitability and consistency of clinical assessment and supervision. Findings from broader populations require examination for their applicability to this proposed cohort; findings from selected cohorts likewise require care before wider application. Whether the proposed distinctions improve diagnostic reliability or treatment decisions remains to be evaluated.

10 Social adversity can contribute to distress

Location: Clinical Context and Functional Consequences | Categories: E

Grounding. The Mexican ICD-11 field study and related classification research examined relationships among social rejection, violence, distress, and functional impairment in the populations studied [3,4].

Relevance and limits. These findings support assessing how social circumstances interact with an existing experience of incongruence. Difficulties may arise through bodily discomfort, concealment, anticipated reactions, or strained interactions, as well as overt rejection. Awareness of incongruence may precede disclosure or recognition by others. The proposal excludes presentations explained solely by external rejection, role pressure, or cultural conflict; it does not exclude independently established incongruence accompanied by socially mediated distress. The cited findings do not determine the source or relative contribution of these factors in an individual patient.

11 Comorbidity requires assessment

Location: Introduction Comorbidity and exclusions | Categories: E G P

Grounding. A Dutch adolescent study documented psychiatric comorbidity in a gender-dysphoric referral population. Endocrine Society guidance requires assessment and appropriate management of coexisting mental health concerns [7,11].

Relevance and limits. The proposal requires clinicians to distinguish a coexisting condition from an alternative explanation for the presentation. Anxiety, depression, trauma-related symptoms, or other conditions may coexist with incongruence, contribute to distress, or require care in their own right. Their presence neither establishes nor automatically excludes the proposed diagnosis. The accompanying Standards of Care address their implications for treatment suitability, sequencing, and supervision. Comorbidity rates in broader referral populations cannot be assumed to describe this proposed cohort; neither a low rate nor an elevated rate has been established for the exact construct.

Annotated clinical claims continued

12 Population estimates require cohort caution

Location: Prevalence and referral patterns | Categories: E

Grounding. Nota, den Heijer, and Gooren's *Endotext* chapter reports Dutch medical-treatment-based prevalence estimates of approximately 1 in 2,800 transwomen and 1 in 5,200 transmen, drawing on the Amsterdam cohort [12].

Relevance and limits. These estimates describe people accessing medical treatment, rather than specifically those seeking surgery or everyone experiencing incongruence. They provide context for historical treatment utilization but do not establish the prevalence of the distinct construct proposed here. The transwomen estimate differs between the cited chapter and the underlying study's journal abstract; the figures should therefore remain explicitly attributed to *Endotext*. They are approximate estimates, not upper bounds. Changes in referral numbers or ratios alone cannot establish whether the underlying prevalence has changed.

13 Sex differentiated developmental coupling

Location: Adult conceptual notes and physiological discussion | Categories: P

Grounding. The proposal offers a developmental interpretation of the relationship between sexed embodiment and the internal experience of self. It describes incongruence as a divergence in that relationship, rather than a departure from socially expected roles or behavior.

Relevance and limits. The proposed developmental coupling is an explanatory hypothesis informed by research on hormonal influences on development. Direct confirmation of the full developmental sequence would require observations not presently available; individual links and predictions may nevertheless be examined through related research [13–16]. The hypothesis is not established as the mechanism underlying this specific clinical presentation. Diagnosis rests on A1–A3 and assessment of alternative explanations, rather than demonstration of a particular hormonal history.

14 Diagnosis must inform individualized care

Location: Overall rationale and relation to SOC | Categories: G P

Grounding. The Dutch clinical account and Endocrine Society guidance connect diagnostic assessment with individualized consideration of treatment eligibility, informed consent, and coordinated care [7,10].

Relevance and limits. The proposal identifies a distinct clinical presentation to inform further assessment, rather than prescribing treatment from the diagnosis alone. The accompanying Standards of Care require an individualized clinical indication, consideration of anticipated benefits and risks, and assessment of suitability for the proposed intervention. This division distinguishes identifying the condition from establishing how it should be treated [17]. Neither diagnostic classification nor treatment justification depends on first demonstrating a biological cause. The cited guidance supports this assessment-based approach, but does not validate the precise diagnostic criteria or treatment requirements proposed here.

Annotated clinical claims continued

15 Historical evolution of classifications

Location: Historically section | Categories: H P

Grounding. Successive DSM editions changed the terminology and diagnostic requirements applied to these presentations, including transsexualism, gender identity disorder, and gender dysphoria [18–22]. APA descriptions and classification comparison studies provide context for these changes [2,3,5].

Relevance and limits. The historical discussion explains the author’s rationale for proposing a distinct construct rather than revising the existing Gender Dysphoria diagnosis. Changes in emphasis among bodily concerns, identification, distress, and impairment provide context for the proposed distinction. The interpretation that these changes obscured a clinically important presentation is the author’s critique; historical terminology alone does not establish that earlier classifications identified a known biological cause or a uniform patient population. Specific descriptions of earlier diagnostic requirements should be grounded in the corresponding original editions.

16 Narrower criteria may improve usefulness

Location: Recommendation and submission rationale | Categories: P with related E

Grounding. Classification field studies and longitudinal clinical research provide precedents for evaluating diagnostic usefulness, developmental course, and outcomes in defined patient populations [3,6,8,9].

Relevance and limits. The proposal makes a specific clinical presentation explicit so that its identification, assessment, and outcomes can be examined systematically. Used with the accompanying Standards of Care, it provides a basis for evaluating both diagnostic distinctions and the consistency of treatment pathways. Whether these criteria improve diagnostic reliability, distinguish clinically meaningful groups, or better inform treatment decisions remains to be established. The proposal supplies a framework for that evaluation, rather than presuming its results.

Selected referents

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- [11] de Vries, A. L. C., Doreleijers, T. A. H., Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Psychiatric comorbidity in gender dysphoric adolescents. *Journal of Child Psychology and Psychiatry*, 52(11), 1195–1202.
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- Earlier DSM editions are catalogued through APA’s PsychiatryOnline archive:
<https://psychiatryonline.org/dsm/dsmPreviousEditions>

Source boundaries

These referents identify the clinical, empirical, historical, and conceptual grounding of the proposal. They are selective rather than exhaustive. Classification descriptions and professional guidance are distinguished from

observational findings, and studies of diagnostic acceptability or clinical utility are distinguished from treatment-outcome research.

The behavioral endocrinology sources [13–16] provide background concerning hormonal influences on neural and behavioral development. Hooven supplies the author's principal synthesis; the accompanying research supplies related experimental and developmental foundations. These sources do not establish the proposed developmental coupling as the mechanism underlying this specific clinical construct.

The DSM editions [18–22] provide primary historical reference points. The proposal's interpretation of changes in diagnostic emphasis remains the author's analysis. APA's discussion of diagnosis and treatment [17] supports their separation without endorsing the proposed criteria or Standards of Care.