GENDER DYSPHORIA

Gender Dysphoria

GD

DSM-5-TR 302.85 (ADOL/ADULT), 302.6 (CHILD) | ICD-10-CM F64.0, F64.2

Clinically significant distress from incongruence between experienced gender and sex assigned at birth; the distress, not the identity, is diagnosed.

TRANSGENDER ADULTS (US)	TYPICAL ONSET	CARE STANDARD	LIFETIME SUICIDE ATTEMPT
~0.5-0.6% of adults	Childhood or at puberty	WPATH SOC-8 (2022)	~40% (2015 US survey)

CLINICAL PICTURE

- Marked incongruence between experienced gender and assigned sex, present at least 6 months and expressed with consistency and insistence.
- Distress commonly localizes to specific sex characteristics: chest, voice, facial and body hair, menses, genitals, and body habitus.
- Puberty frequently intensifies dysphoria sharply, converting tolerable discomfort into acute distress and functional collapse.
- Presentation may be masked by depression, anxiety, self-harm, substance use, or eating pathology aimed at altering body shape.
- Being transgender or gender diverse is not a mental disorder; distress and impairment, not identity, define this diagnosis.
- Many gender diverse people never meet criteria, and dysphoria often resolves substantially with social and medical affirmation.

DIAGNOSTIC CRITERIA AT A GLANCE

- Adolescents and adults require at least 2 of 6 indicators over at least 6 months, with clinically significant distress or impairment.
- Adult indicators include incongruence with one's sex characteristics, wanting to be rid of or to acquire them, and wanting to be treated as another gender.
- Children require at least 6 of 8 indicators over 6 months, and a strong stated desire to be another gender is mandatory among them.
- Child indicators cover cross-gender role play, toy and playmate preferences, rejection of assigned-gender clothing, and dislike of one's anatomy.
- Specifiers note a co-occurring disorder of sex development and posttransition status when affirming treatment is established.

NEUROBIOLOGY & PHYSIOLOGY

- Gender identity has partly biological determinants; twin studies estimate heritability of gender incongruence at roughly **30-60%**.
- Prenatal androgen exposure influences gendered behavior, seen in elevated rates of gender variance in congenital adrenal hyperplasia.
- Reported differences in the bed nucleus of the stria terminalis and INAH3 exist but are not diagnostic or clinically usable.
- No biological test establishes or refutes gender identity; diagnosis rests entirely on the person's self-reported experience.
- Gender-affirming hormone therapy produces the expected somatic changes and, in cohort studies, marked reductions in dysphoria and depression.
- Monitoring targets bone density, lipids, hematocrit on testosterone, and venous thromboembolism risk on estrogen therapy.

PSYCHOLOGICAL MECHANISMS

- Minority stress explains most excess psychiatric morbidity: discrimination, rejection, concealment, and internalized transphobia.
- Family acceptance is the strongest modifiable protective factor, reducing rates of depression and suicide attempt severalfold.
- Chest binding, tucking, restrictive eating, and body avoidance manage dysphoria short term at real physical and functional cost.
- Use of the affirmed name and pronouns in even one setting is associated with substantially lower suicidal ideation in youth.
- Conversion or reparative efforts to change gender identity are ineffective and harmful and are rejected by every major professional body.

DIFFERENTIAL & COMORBIDITY

- Distinguish from gender nonconformity without distress, transvestic disorder, body dysmorphic disorder, and psychosis-driven beliefs.
- Depression, anxiety, PTSD, and substance use disorders are elevated and largely reflect stigma and victimization, not the identity.
- **Autism spectrum disorder** co-occurs at several times the base rate; it does not invalidate gender identity or preclude affirming care.
- Screen actively for suicidality, self-harm, homelessness, survival sex work, and violence victimization at every encounter.
- Eating disorders are common and may serve gender goals such as suppressing menses or altering curves; ask about motive directly.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- **GnRH agonists** such as leuprolide or histrelin pause puberty from Tanner stage 2 and are largely reversible, per Endocrine Society guidance.
- Feminizing therapy uses **estradiol** with an antiandrogen such as **spironolactone**; monitor estradiol, potassium, and VTE risk.
- Masculinizing therapy uses **testosterone** by injection or gel; monitor hematocrit, lipids, blood pressure, and menstrual cessation.
- Discuss fertility preservation before starting blockers or hormones, since gonadal function may not fully recover afterward.
- Treat comorbid depression and anxiety on their own merits; affirming care itself often reduces symptom burden substantially.

PSYCHOTHERAPY

- Gender-affirming psychotherapy explores identity without a predetermined destination and never aims to change gender identity.
- **WPATH SOC-8** replaces gatekeeping with assessment of capacity for informed consent and management of coexisting conditions.
- **CBT** and **DBT** address depression, anxiety, and self-harm and build distress tolerance around body-related triggers.
- Family therapy that moves caregivers from rejection toward acceptance is among the highest-yield interventions available.
- Peer and group support reduces isolation and internalized stigma; refer to vetted local and online community resources.

ADJUNCT & SUPPORTIVE

- Social transition covers name, pronouns, clothing, hair, voice, and documents, is reversible, and typically comes first.
- Surgical options include chest, genital, facial, and voice procedures, coordinated under **SOC-8** readiness criteria.
- Voice and communication therapy, hair removal, and prosthetics address dysphoria that hormones alone do not resolve.
- **ICD-11** renamed the construct gender incongruence and moved it out of the mental disorders chapter to reduce stigma.
- The DSM diagnosis is retained largely to secure insurance coverage and access to medically necessary gender-affirming care.

CLINICAL PEARLS

- The identity is not the disorder; the distress is, and affirming care usually relieves it.
- Family acceptance and affirmed name use are the strongest protective factors for youth.
- Conversion efforts are harmful, ineffective, and condemned by every major medical body.

References

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist*, *70*(9), 832-864. https://doi.org/10.1037/a0039906

Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., de Vries, A. L. C., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M., Green, J., Hancock, A. B., Johnson, T. W., Karasic, D. H., Knudson, G. A., Leibowitz, S. F., Meyer-Bahlburg, H. F. L., Monstrey, S. J., Motmans, J., Nahata, L., … Arcelus, J. (2022). Standards of care for the health of transgender and gender diverse people, version 8. *International Journal of Transgender Health*, *23*(Suppl. 1), S1-S259. https://doi.org/10.1080/26895269.2022.2100644

Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., Rosenthal, S. M., Safer, J. D., Tangpricha, V., & T'Sjoen, G. G. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *The Journal of Clinical Endocrinology & Metabolism*, *102*(11), 3869-3903. https://doi.org/10.1210/jc.2017-01658

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*(5), 674-697. https://doi.org/10.1037/0033-2909.129.5.674

Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*, *145*(2), e20191725. https://doi.org/10.1542/peds.2019-1725

World Health Organization. (2019). *International classification of diseases for mortality and morbidity statistics* (11th rev.). https://icd.who.int/browse11

NOTE

References are formatted in APA 7th edition style with hanging indents. Diagnostic terminology, criteria structure, and coding follow the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; APA, 2022); criteria are paraphrased for instructional use and are not reproduced verbatim. Verify all citations against the original sources before use in academic work, and confirm medication dosing against current prescribing information.