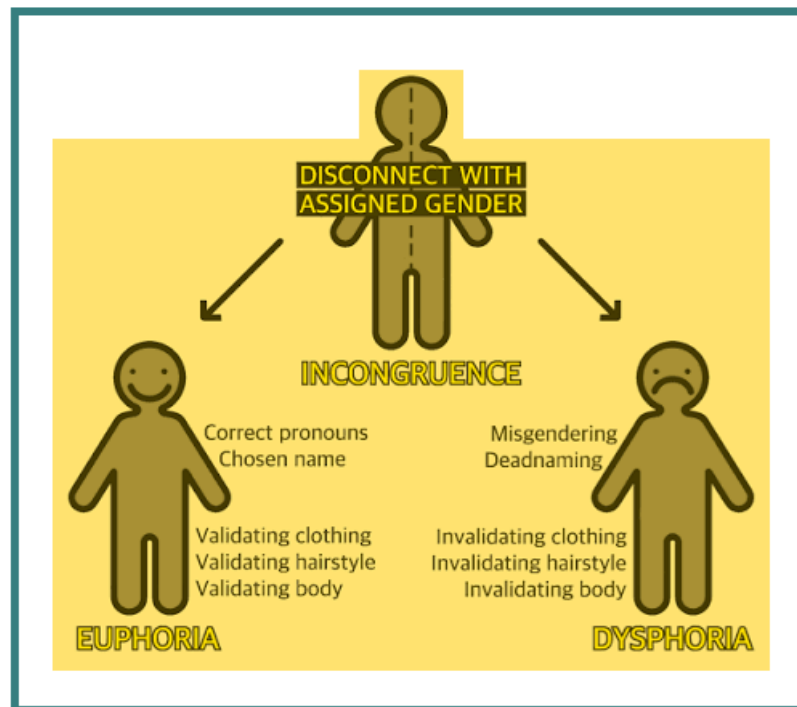


Gender incongruence: biological and social/cultural explanations.

Incongruence means to be 'in conflict with', suggesting differences in gender development.

The ICD-11 classification from the World Health Organisation defines gender incongruence as a sexual health condition rather than a mental disorder, removing old stigmatising labels.

Gender incongruence is simply the difference in identity, whereas gender dysphoria refers to the emotional distress or discomfort that can accompany that difference. Not everyone with gender incongruence experiences distress.



Incongruence could be due to abnormal chromosomes and/or abnormal hormone exposure in the womb, which results in a mismatch between gender identity and biological sex. Such conditions are referred to as intersex. Major health organisations have moved away from older terms like "gender identity disorder." The World Health Organisation now uses **gender incongruence**, shifting the focus from a mental illness to a matter of sexual health and personal identity.

Gender dysphoria (GD) is the distress a person feels due to a mismatch between their **gender** identity and their sex assigned at birth. People with **gender dysphoria** are typically **transgender**.

Gender dysphoria is the feeling of **discomfort or distress** that might occur in people whose gender identity differs from their sex assigned at birth or sex-related physical characteristics. Transgender and gender-diverse people might experience gender dysphoria at some point in their lives.

Biological & Social/ Cultural Explanations

Biological

One biological explanation for gender dysphoria has a basis in brain structure, in particular with the size of the bed nucleus of the stria terminalis (BNST). The bed nucleus of the stria terminalis (BNST) is a structure in the brain involved in emotional responses. There is some suggestion that the bed nucleus of the stria terminalis (BNST) is implicated in the biological explanation of gender dysphoria. It is believed that people with gender dysphoria have a BNST which is the size of the gender they identify with, not their biological sex.

Zhou et al (1995) suggested problems with the BNST fits with reports made by people who are transgender that feel from an early age they are born the wrong sex.

Kruijver et al (2000) found the BNST area of the brain to be larger in men than women and suggest it has been found to be female sized in transgender women.

However, Hulshoff Pol et al (2006) studied changes in transgender individuals' brains using MRI scans taken during hormone treatment. The scans showed the size of the BNST changed significantly over a period of time.

In contrast, some research evidence suggests there may be other brain differences associated with gender dysphoria. Rametti et al (2011) studied the white matter in the brains of males and females. This is the deeper tissue of the brain. They found that the amount and distribution of white matter corresponded more closely to the gender individuals identified as, rather than their biological sex.

Some psychologists suggest there may be a genetic prevalence to gender identity disorder. The genetic explanation for gender dysphoria looks for inherited characteristics that run in families or in the concordance rate of twins studies.

Coolidge et al (2002) assessed 157 twin pairs for evidence of gender dysphoria. They found that 62% of the variance could be accounted for by genetic factors, suggesting a strong heritable component.

Heylens et al (2012) compared 23 MZ twins with 21 DZ twins where one of each pair was diagnosed with gender dysphoria. They found 39% of the MZ twins were concordant for gender dysphoria compared to none of the DZ twins.

Social and Cultural

Social explanations for gender identity disorder centre on maladaptive learning experiences and dysfunctional cognitive processes. Some psychologists claim the gender identity disorder can be explained by social factors such as reinforcement and role models.

Some psychologists argue that gender identity disorder could be the result of a lack of suitable same-sex role models. This idea supports the Social Learning Theory (SLT). Rekers (1995) found a common feature associated with gender dysphoria in a group of 70 young boys was that they had a lack of male role models. However, correlational studies do not necessarily imply that the absence of a male role model in early life causes gender identity disorder.

For individuals who experience gender dysphoria, the gender 'confusion' arises because society forces people to be either a man or a woman, and people must act accordingly.

According to the idea of social construction gender dysphoria is not a pathological condition but more a social phenomenon. Not all cultures have two genders, Samoa recognises a 3rd gender; fa'afafine, these people have fluid gender roles that move between male and female ideals.

Many Indigenous and global cultures have long recognised three, four, or more distinct gender roles, viewing gender fluidity as natural rather than disordered. Colonisation by Western powers often imposed strict binary gender rules (male/ female only), stigmatising traditional fluid identities and causing lasting social and psychological friction. In cultures with rigid gender boundaries, individuals stepping outside traditional norms face higher risks of anxiety, depression, and social rejection.

Other research has suggested that issues with gender identity could be related to attachment between a mother and child. Stoller (1973) reported that, in interviews, biological males with gender dysphoria displayed overly close relationships with their mother. This suggests a stronger female identification and more conflicted gender identity in the long term.

Coates & Person (1985) suggest when a severe form of separation anxiety is found in males, who remain psychologically attached to their mother, they can develop a gender identity to replace the mother. According to Coates & Person (1985) to reduce the anxiety associated with gender dysphoria children may imitate their mother by cross-gender behaviour. A significant proportion of people who experienced gender dysphoria in childhood do not do so as adults. Drummond et al (2008) followed a sample of 25 girls who were all diagnosed with gender dysphoria in childhood, only 12% were still classified when followed up at age 24.

There is no single, conclusive explanation for why people are transgendered or experience some sense of gender incongruence. Some hypotheses suggest biological factors such as genetics, or prenatal hormone levels, as well as social and cultural factors, such as childhood and adulthood experiences. Most experts believe that all of these factors contribute to a person's overall gender identity (American Psychological Association, 2008).

