Clinician Checklist: Differentiating Gender Dysphoria and Body Dysmorphic Disorder

This checklist is designed to help clinicians consider whether a person may be experiencing body dysmorphic disorder, gender dysphoria, both, or another related form of body-based distress. It is not a substitute for a full clinical assessment and cannot be used to make a formal diagnosis.

Clinician stance

Tick all before proceeding:

- ☐ Start from the premise that being trans is not a pathology.
- ☐ Use affirming language and avoid framing requested gender-affirming care as cosmetic, superficial, or clinically irrelevant.
- ☐ Take a curious, collaborative stance rather than assuming that all body distress has the same meaning.

Go to **Step 1**.

Step 1. Immediate safety

Tick any that apply:

- ☐ Current suicidal thoughts, intent, plan, or recent attempt.
- ☐ Current self-harm or escalating urges.
- ☐ High risk environment (e.g., abuse, coercion, homelessness, or immediate threat to safety).

If **any** are endorsed, go to **Step 6.1 Acute Risk Support**. Return to **Step 2** when safe.

If **none** are endorsed, go to **Step 2**.

Step 2. Core appearance or body concern

What is the feared outcome?

- ☐ A: Defect (e.g., being "ugly", "abnormal", "disgusting", "defective", judged).
- ☐ B: Misrecognition (e.g., being seen as the wrong gender, misgendered).
- ☐ C: Both.

Which language fits best?

- ☐ A: Defect language (e.g., ugly, deformed, disgusting, abnormal, hideous).
- ☐ B: Incongruence language (e.g., not me, not right, wrong for me, does not belong, alien).
- ☐ C: Both.

What reliably reduces distress, even briefly?

- ☐ A: Ritual relief (e.g., checking, camouflaging, reassurance seeking, comparing, avoidance, rumination)
- ☐ B: Gender affirmation and recognition (e.g., correct name and pronouns, being perceived correctly, gender congruent presentation, desired gender-affirming medical care, community validation)
- ☐ C: Both

What happens after relief occurs?

- ☐ A: The person’s life becomes narrower, with more checking, avoidance, reassurance seeking, comparison, rumination, or restriction.
- ☐ B: The person’s life becomes broader, safer, more connected, or more congruent.
- ☐ C: Both patterns occur.

If responses are **predominantly A**, go to **Step 3**.

If responses are **mixed or both**, complete both **Step 3** and **Step 4**.

If responses are **mostly B**, skip to **Step 4**.

Step 3. Body dysmorphic disorder

Appearance preoccupation

Is there an appearance preoccupation framed as a defect or flaw (e.g., ugly, deformed, abnormal, disgusting, defective, or unacceptable)?

- ☐ Yes.
- ☐ No.

If **yes**, **continue**.

If **no**, go to **Step 4**.

Repetitive behaviours or mental rituals

Are there repetitive behaviours or mental rituals driven by the appearance concern? Tick any that apply:

- ☐ Mirror checking or reflective surface checking.
- ☐ Excessive grooming.
- ☐ Skin picking.
- ☐ Camouflaging.
- ☐ Reassurance seeking.
- ☐ Comparing with others.
- ☐ Repeated photo checking.
- ☐ Rumination, mental checking, or scanning.
- ☐ Avoidance of mirrors, photos, social situations, intimacy, school, work, or other valued activities.

If **any** are endorsed, **continue**.

If **none** are endorsed, go to **Step 4**.

Distress or impairment

Does the preoccupation or ritual cycle cause significant distress or impairment (e.g., marked anxiety, shame, avoidance, relationship disruption, work or study impact, or restriction of valued activities)?

- ☐ Yes.
- ☐ No.

Eating disorder differential

Consider whether the appearance concern is better explained by an eating disorder, including concerns about weight, shape, fatness, muscularity, food intake, exercise, fear of weight gain, or attempts to change body size or composition.

- ☐ Eating disorder concerns are not the primary explanation.
- ☐ Eating disorder concerns may be present and require assessment.
- ☐ Eating disorder concerns appear to be the primary explanation.

If the appearance concern is primarily related to weight, shape, fatness, muscularity, food, exercise, or fear of weight gain, assess and treat the eating disorder formulation alongside any BDD or gender dysphoria formulation.

If there is an appearance preoccupation, repetitive behaviours or mental rituals, significant distress or impairment, and the concern is not better explained by an eating disorder alone, BDD may be present and warrants further diagnostic assessment.

Continue to **Step 4**.

Step 4. Gender dysphoria

Focus of bodily distress

Does bodily distress focus predominantly on gender, gendered features, gendered embodiment, or gendered social recognition?

- ☐ Yes.
- ☐ No.

If **yes**, **continue**.

If **no**, go to **Step 5**.

Gendered meaning or social reading

Is distress strongly linked to gendered meaning or gendered social perception (e.g., distress increases with misgendering, gendered expectations, puberty-related changes, gendered milestones, sexual development, reproductive expectations, or being treated as the wrong gender)?

- ☐ Yes.
- ☐ No.

Dysphoria presentations

Tick all that apply:

- ☐ **Social dysphoria**: distress about being read, addressed, named, grouped, or treated incorrectly.
- ☐ **Physical dysphoria**: distress about sexed features, puberty-related changes, reproductive features, voice, body shape, hair, chest, genitals, or other gendered bodily features.
- ☐ **Existential dysphoria**: distress about life trajectory, future, ageing, roles, relationships, or being imagined in a gendered future that feels wrong.
- ☐ **Dissociative dysphoria**: disconnection, numbness, depersonalisation, derealisation, or avoidance around gendered embodiment.
- ☐ **Sensory or interoceptive dysphoria**: visceral wrongness, distress in bodily sensations linked to gender, or discomfort with internal bodily processes that carry gendered meaning.
- ☐ **Social or relational dysphoria**: distress connected to family roles, intimacy, sexuality, public space, peer groups, or community belonging.

If these experiences are persistent, distressing, impairing, and linked to gender incongruence or gendered social recognition, gender dysphoria may be present and should be assessed further.

Go to **Step 6**.

Step 5. Broader clinical assessment if unclear

If neither BDD nor gender dysphoria is clearly indicated, pause the checklist and complete a broader clinical assessment.

Consider:

- ☐ Eating disorders or disordered eating.
- ☐ General body image distress.
- ☐ Obsessive-compulsive symptoms.
- ☐ Trauma-related body distress.
- ☐ Dissociation.
- ☐ Sensory distress.
- ☐ Interoceptive distress.
- ☐ Psychosis or unusual perceptual experiences.
- ☐ Medical concerns.
- ☐ Pain, gastrointestinal symptoms, fatigue, or other bodily symptoms.
- ☐ Minority stress.
- ☐ Family, peer, cultural, or social pressures.
- ☐ Bullying, harassment, discrimination, or coercion.

It is important not to force the formulation into BDD or gender dysphoria if the person's distress is better explained by another pathway.

Go to **Step 6** only once the most relevant formulation has been clarified.

Step 6. Treatment and support

6.1 Acute risk support

- ☐ Complete an immediate risk assessment that covers suicidal ideation, intent, plan, access to means, recent self-harm, acute intoxication, psychosis, risk of violence from others, risk of harm to others where relevant, and environmental safety.
- ☐ Develop a collaborative, written safety plan with the person. Include warning signs, internal coping strategies, supportive people, professional contacts, emergency contacts, and clear steps for reducing access to means.
- ☐ If necessary, engage your local emergency pathway (e.g., crisis team, emergency department, urgent mental health service, or other appropriate local pathway).

Continue the checklist only when it is safe to do so.

6.2 Gender dysphoria

- ☐ Provide gender-affirming care as the baseline standard.
- ☐ Use the person's correct name and pronouns.
- ☐ Take a collaborative stance that understands distress in context rather than treating it as evidence of pathology.
- ☐ Clarify the person's goals for gendered embodiment, comfort, safety, expression, and social recognition.
- ☐ Revisit goals over time, as they can evolve.
- ☐ Support steps towards embodiment goals. This may include social transition, support with coming out where relevant, and practical assistance navigating school, workplace, family, peer, or healthcare contexts.
- ☐ Support access to gender-affirming items and strategies when desired, such as chest binders, packing, tucking garments, hair changes, clothing changes, voice work, or other presentation-related strategies. Provide harm reduction guidance when relevant, such as safer binding or tucking practices.
- ☐ Facilitate access to gender-affirming medical care when desired.
- ☐ Address minority stressors, such as discrimination, misgendering, rejection, internalised shame, internalised burdensomeness, and barriers to care.
- ☐ Strengthen protective factors, such as community connection, social support, family support where available, peer connection, identity pride, and access to affirming services.
- ☐ Explore and support gender euphoria and other positive gender emotions, not only for distress reduction.

6.3 Body dysmorphic disorder

- ☐ Provide CBT tailored to body dysmorphic disorder. Core components typically include exposure and response prevention, behavioural experiments, and interventions targeting distorted appearance beliefs, attentional biases, and appearance-related safety behaviours.
- ☐ Include a plan for reducing checking, camouflaging, reassurance seeking, comparing, avoidance, rumination, and other rituals.
- ☐ Support the person to expand valued activities that have been restricted by appearance preoccupation.
- ☐ When indicated, pharmacotherapy may be considered in line with age, severity, comorbidity, prior treatment response, and prescribing guidance. For adults with moderate to severe BDD, SSRIs may be considered alone or alongside CBT. For children and young people, CBT is usually first-line, and SSRIs require careful monitoring.
- ☐ Routinely assess suicidality and comorbid depression, anxiety, obsessive-compulsive symptoms, eating disorder symptoms, trauma, and substance use. Integrate safety planning when indicated.

6.4 Co-occurring body dysmorphic disorder and gender dysphoria

- ☐ Clarify which distress is related to gender dysphoria and which is related to perceived defectiveness of appearance. Useful tools include curious questions, body mapping, timelines, trigger mapping, and tracking shifts over time.
- ☐ Identify repetitive behaviours, degree of conviction, functional impairment, avoidance patterns, reassurance seeking, and the impact of each concern on daily life.
- ☐ Prioritise immediate safety and the sources of distress that most interfere with functioning and treatment engagement.
- ☐ Where gender dysphoria is preventing engagement in BDD treatment tasks, begin with gender-affirming support and stabilisation, while planning BDD treatment collaboratively.
- ☐ Use gender-affirming support to reduce gender dysphoria enough that the person can safely and meaningfully engage in BDD treatment tasks.
- ☐ Use BDD treatment to target BDD mechanisms, including defect-based beliefs, appearance preoccupation, checking, camouflaging, reassurance seeking, comparison, avoidance, and rumination.