Body dysmorphic disorder and gender dysphoria: differential diagnosis in adolescents

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Body dysmorphic disorder (BDD) and gender dysphoria (GD) share body dissatisfaction as a core feature and are often associated with a strong desire to alter body features through cosmetic and medical procedures [1]. As recently highlighted, there are overlaps and important differences in behavioural and psychological features between the two conditions, which are important to consider when contemplating treatment options, including body modification [1]. However, there is a striking lack of research on the intersection between BDD and GD, and no guidance on how the two conditions can be differentiated should a clinician feel unsure when assessing worries about appearance [1]. Since the genesis and clinical management of BDD and GD differ substantially, accurate diagnosis is essential. The recommended treatments for BDD are cognitive behaviour therapy (CBT), with or without selective serotonin reuptake inhibitors (SSRIs) medication [2]. In contrast, support for GD is multi-modal and typically includes therapeutic exploration, psychosocial support and, for some, staged medical intervention [3]. Medical body modification may be indicated in GD; puberty blockers and gender affirming hormones have been used among adolescents, although this is a topic of current debate, and gender surgery may be considered after the age of 18 years [3]. In contrast, medical body modifications (cosmetic procedures) are generally viewed as contraindicated in BDD, although it should be noted that in both BDD and GD medical body modification is a focus of much ongoing debate [1]. The aim of the current article is to provide, for the first time, criteria for differentiating BDD and GD in young people, enabling appropriate care planning.

BDD is characterised by preoccupation with perceived flaw(s) in appearance that appear minimal or are unobservable to others, as well as repetitive behaviours aimed at hiding, checking, or fixing the perceived flaw(s) [4]. BDD typically develops during adolescence, with a mean age at onset of 12 -13 years [5] and has a point prevalence of approximately 2% in community samples of adolescents [6]. Among young people, BDD has

a female preponderance [6], and approximately 80% of adolescents seen in BDD services are female as assigned at birth [5]. GD is characterized by significant distress or impairment associated with incongruence between the individual's experienced gender and their sex assigned at birth [4]. The population prevalence of GD among adolescents is unknown, but a steep increase in referrals to gender services has been reported over the last decade [7]. Compared to BDD, a younger mean/median age of onset is likely given the average age at assessment is 7-8 years in child samples [8]. However, the range of age at assessment has been reported to be between 1 to 17 years across child and adolescent samples [8]. The distress and impairment may be exacerbated by the onset of puberty and development of secondary sexual characteristics. Historically, males assigned at birth were more likely to present to gender services, but recently there has been a sharp increase in females assigned at birth being referred (e.g. [9]). The rate of co-occurrence of BDD and GD are currently unknown, but according to DSM-5 diagnostic criteria the two can co-occur (i.e. DSM-5 does not take a hierarchical position; neither diagnosis 'trumps' the other) [4].

Table 1 outlines some of the key clinical features that can help to differentiate BDD and GD. A case example in supplementary section is included to highlight some of these differentiating features. In BDD, appearance concerns can relate to any body part but commonly involve facial features, with sufferers typically worrying that they appear 'ugly', 'abnormal' or 'disgusting'. Many young people with BDD report multiple areas of concern (10.5 reported on average) with the most common being skin, nose, hair, face and stomach [5]. Interestingly, just under half report being unhappy with their breasts/chest and a fifth report appearance concerns about their genitals [5]. In GD, body dissatisfaction is focused on sex signifiers. Though most commonly the focus will be chest and genitalia, a broad range of features can cause discomfort, such as face, frame, feet and hands. Individuals typically describe that these body parts 'do not feel right' and are incongruent with their gender

identity. Given this overlap in concerns about sex signifiers, it is important to consider other aspects of presentations to help distinguish the two conditions.

In BDD, sufferers see the source of their difficulties being their physical appearance, rather than a psychological condition, and they often wish to alter their appearance to fix their perceived flaw(s), with just over half reporting a desire for cosmetic surgery [5]. In GD, the issue is not perceived flaws but rather a feeling of incongruence, and medical treatments, including hormones and surgery, may be desired to specifically improve the congruence of the body with the felt gender. Typically, BDD focuses on the outward aspects of appearance, whereas gender distress can centre upon both external and internal sex signifiers, plus their symbolic meaning. For example, a 14-year-old birth assigned female may be very preoccupied and distressed by their ovaries and uterus, and the thought of menstruation or oestrogen in their body, despite its private nature.

Fear of judgement by others is common in both conditions but may differ in terms of underlying concerns. For example, a 17-year-old with BDD who worries that his nose is crooked may be concerned others will detect this 'flaw' and reject him due to his ugly appearance. In GD, the concerns are typically about others' misperception of their gender (misgendering), and associated expectations placed upon them regarding gender. For example, a 15-year-old assigned female at birth identifying as male may find attending an all-girls school challenging or when they are expected to wear a gendered uniform.

An additional differentiating feature of body-focused concerns in BDD versus GD is their temporality. In BDD, the focus of appearance anxiety is around how the body *currently* looks, whereas in GD they may also worry how the body will be in the *future* as they develop. For example, a 10-year-old birth-assigned female identifying as male can worry about developing breasts and menstrual cycles later in adolescence.

Additionally, the experience of BDD and GD can differ in terms of relating to others. BDD sufferers often report feeling isolated and different to others. For example, a 16-year-old young person with BDD might worry about her breasts being too big, her facial features not looking 'right' and that she 'looks like an alien' and she constantly compares herself to others and believes she is 'different'. GD can be an isolating experience, but in many cases young people successfully connect with others who feel the same about their gender through online communities, organisations, and groups.

INSERT TABLE 1

In clinical assessment the aim is to come to a shared understanding of body image and any related distress, alongside a broad psychosocial assessment. Using Table 1 above as a guide, a clinician can explore some of the drivers of appearance related worries and behaviours and whether features of concern are primarily sex signifiers. A timeline of bodily concerns and gender history is often helpful in identifying in what order and contexts body dissatisfaction have been experienced. Families can helpfully provide collateral history. Body maps can elicit feelings about individual features and overall ratings of satisfaction and distress, and how features are viewed in terms of attractiveness and 'normality'. Asking how the young person feels about their body in different situations can reveal what social judgements are feared and delineate which aspects feel personal or public. Tools such as gender questionnaires and The Body Image Scale [10] can elicit gender feelings alongside body satisfaction and identify priorities for bodily gender expression and change. It is useful to explore hopes and worries for puberty and the future body. If surgeries are desired, explore what types, and the motivations and expectations. Questionnaires that explore BDD symptoms specifically can be utilised, such as the Yale-Brown Obsessive Compulsive Scale

modified for BDD, Adolescent version (BDD-YBOCS-A) [11] which includes a body map, measures distress, preoccupation and impact, and captures the repetitive safety behaviours commonly seen in BDD. In summary, there are apparent overlaps in the clinical presentation of BDD and GD, but also key distinguishing features. This paper did not aim to address all the complexities or nuances of these clinical conditions, but hopefully will assist clinicians to differentiate the two as well as identify when they occur together in routine clinical practice to appropriately direct people to the right support and treatment. BDD and GD are often distinguishable with careful assessment but can also to occur together. For example, an adolescent with GD, who has had to live with body discomfort, marginalisation, and detriments to self-esteem, could be vulnerable to developing an excessive preoccupation with appearance alongside GD. Future research could seek to improve the evidence base for the intersection of these two conditions and their clinical management. There is undoubtedly a need to improve access to appropriate treatment and support for both conditions.

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