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Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders • Excessive attention is directed towards the symptoms, which may manifest in: • persistent preoccupation with the severity of the symptoms or their negative consequences – in individuals who have an established medical condition that may be causing or contributing to the symptoms, a degree of attention related to the symptoms that is clearly excessive in relation to the nature and severity of the medical condition; • repeated contacts with health-care providers related to the bodily symptoms that are substantially in excess of what would be considered medically necessary. • Excessive attention to the bodily symptoms persists, despite appropriate clinical examination and investigations or appropriate reassurance from health-care providers. • Bodily symptoms are persistent; that is, some symptoms are present (although not necessarily the same symptoms) on most days during a period of at least several months (e.g. 3 months or more). • The bodily symptoms and related distress and preoccupation result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. • The symptoms or the associated distress and preoccupation are not better accounted for by another mental disorder (e.g. schizophrenia or another primary psychotic disorder, a mood disorder, or an anxiety or fear-related disorder). Severity of bodily distress

disorder The severity of bodily distress disorder should be classified based on the degree of distress or preoccupation with bodily symptoms, the persistence of the disorder and the degree of impairment. The clinician should make a global determination of the appropriate rating of severity based on the overall clinical presentation, and select one of the following subcategories. Mild bodily distress disorder • All the essential features of bodily distress disorder are present. • Although there is excessive attention to distressing symptoms and their consequences, which may result in frequent medical visits, the individual spends only a limited amount of time focusing on them (e.g. no more than 1 or 2 hours per day), and is able to focus on other unrelated topics. • The bodily symptoms and related distress and preoccupation result in mild impairment in personal, family, social, educational, occupational or other important areas of functioning (e.g. strain in relationships, less effective academic or occupational functioning, abandonment of specific leisure activities). Moderate bodily distress disorder • All the essential features of bodily distress disorder are present. • Persistent preoccupation with the distressing symptoms and their consequences is typically 6C20.0 6C20.1 Disorders of bodily distress or bodily experience | Bodily distress disorder

431 Disorders of bodily distress or bodily experience associated with frequent medical visits. The individual devotes a substantial amount of time and energy to focusing on the symptoms and their consequences (e.g. several hours per day). • The bodily symptoms and related distress and preoccupation result in moderate impairment in personal, family, social, educational, occupational or other important areas of functioning (e.g. relationship conflict, performance problems at work, abandonment of a range of social and leisure activities). Severe bodily distress disorder • All the essential features of bodily distress disorder are present. • The presentation is characterized by a pervasive and persistent preoccupation with the distressing symptoms and their consequences, and a narrowing of interests such that the bodily symptoms and their consequences become the nearly exclusive focus of the individual's life, typically resulting in extensive interactions with the health-care system. • The bodily symptoms and related distress and preoccupation result in severe impairment in personal, family, social, educational, occupational or other important areas of functioning (e.g. unable to work, alienation of friends and family, abandonment of nearly all social and leisure activities). Bodily distress disorder, unspecified Additional clinical features • The most common bodily symptoms associated with bodily distress disorder include pain (e.g. musculoskeletal pain, backache, headaches), fatigue, and gastrointestinal and respiratory symptoms, although patients may be preoccupied with any bodily symptoms. The individual can generally provide a detailed description of the symptoms, but it may be difficult for clinicians to account for the symptoms in anatomical or physiological terms. • Individuals with bodily distress disorder often over-interpret or catastrophize about their bodily symptoms, and dwell on their most extreme negative consequences. For example, in more severe cases, pain or fatigue may be perceived as being so intense that they prevent normal activities, despite there being no medical basis for such a belief. This is often accompanied by fear of triggering pain or an exacerbation of other symptoms, which may lead to undue avoidance of activities; this may in turn lead to other symptoms associated with inactivity (e.g. stiffness and muscle weakness, muscle pain following minimal exertion). • Individuals with bodily distress disorder may hold a range of attributions regarding their symptoms, including psychological and physical explanations. As severity increases, affected individuals are more likely to reject psychological explanations for their symptoms. Some individuals with bodily distress disorder believe that their bodily symptoms indicate underlying physical illness or injury (i.e. disease conviction), even though this has not been detected. Insistence that the symptoms are caused by an undiagnosed illness or 6C20.2 6C20.Z

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Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders injury may result in multiple medical tests and procedures. This pattern is most common in individuals with severe bodily distress disorder, who may have long and complicated histories of contact with both primary and specialist medical services, during which many negative investigations or fruitless operations across various body systems may have been carried out. • Individuals with bodily distress disorder most often present in general medical settings rather than for mental health services. They may be reluctant to agree that there is a psychological component to their experience, and may react negatively to the suggestion of a referral to a mental health professional. • Individuals with bodily distress disorder often express dissatisfaction with the medical care they have received previously, and may change health-care providers frequently. • In communities with limited access to health care, individuals with bodily distress disorder may not have extensive interactions with the formal health-care system, but they may seek care from alternative sources. • Bodily distress disorder often occurs in the context of comorbid medical conditions and co-occurring mental disorders – especially depressive disorders and anxiety and fear-related disorders. Boundary with normality (threshold) • The experience of bodily symptoms and occasional concern about them is normal. However, people with bodily distress disorder report greater distress about their bodily symptoms than would generally be regarded as proportional to the nature of the symptoms, and their excessive attention to their symptoms is not alleviated by appropriate clinical examination and investigations, and by reassurance from health-care providers. • Individuals with bodily distress disorder who have a comorbid medical condition that may be causing or contributing to the bodily symptoms exhibit greater preoccupation with symptoms and greater functional impairment than those who have a medical condition that is similar in nature and severity without concurrent bodily distress disorder. Furthermore, the number of bodily symptoms reported often exceeds that usually associated with the comorbid medical condition. Course features • In about half of individuals diagnosed with bodily distress disorder seen in primary care settings, bodily symptoms resolve within 6–12 months. Individuals with severe disorder and those with multiple bodily symptoms tend to experience a more chronic and persistent course. The presence of multiple bodily symptoms is commonly associated with greater impairment in functioning, as well as with poorer treatment response for any co-occurring mental or medical conditions. Disorders of bodily distress or bodily experience | Bodily distress disorder

433 Disorders of bodily distress or bodily experience Developmental presentations • Bodily distress disorder can occur across the lifespan. The most common bodily symptoms in children and adolescents include recurrent gastrointestinal symptoms (e.g. abdominal pain, nausea), fatigue, headaches and musculoskeletal pain. Children are more likely to experience a single recurrent symptom rather than multiple bodily symptoms. School absences due to symptoms are common. In severe cases, children may display regression of behaviour and extreme impairment – for example, affecting self-care and mobility. • In children and adolescents, parental or caregiver responses to symptoms can affect the course and severity of bodily distress disorder, as well as whether medical attention is sought. For example, excessive parental or caregiver concern can worsen the severity or prolong the course of the disorder in children. • Older adults with bodily distress disorder are more likely than younger adults with the condition to have multiple bodily symptoms, and symptoms are more likely to be persistent. The diagnosis of bodily distress disorder in older adults

can be challenging due to the higher likelihood of medical conditions that may account for symptoms, or that are comorbid with bodily distress disorder. Culture-related features

- Somatic symptoms are common in all cultural groups, especially among people seeking health care.
- Differences in rates of bodily symptoms may be related to cultural reporting styles. Differences may also reflect the organizational culture of the health-care system, with somatic complaints more likely where clinical encounters are brief and the delivery of services is less person-centred.
- Symptoms that are common in one cultural group may be less common in other groups. For example, whereas pain symptoms are common across cultures, symptoms such as heat in the body or in the head, crawling sensations, heaviness, or complaints of “gas” or abdominal bloating are common in certain cultural group but not in others.
- Culture may influence explanatory models, with symptoms variously attributed to forms of bodily energy, humours or other ethno-physiological concepts, as well as religious, spiritual, personal, family or environmental stresses. Some specific attributions, such as symptoms being caused by semen loss or kidney weakness, are common in certain cultural group but not in others.
- Across cultural groups, people with multiple distressing bodily symptoms are likely to seek health care, including from traditional or faith healers. However, help-seeking behaviour is also substantially influenced by access to health-care services. Individuals may not have extensive interactions with the formal health-care system because of limited opportunities to access health care, which varies substantially by cultural group.

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Sex- and/or gender-related features

- Prevalence rates do not appear to differ by gender prior to puberty, after which prevalence is higher in females.
- Symptom presentation may vary by gender, with women more likely to report multiple bodily concerns.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with mood disorders

Among individuals with mood disorders, somatic symptoms may be the dominant aspects of the clinical presentation – particularly in primary care settings. In addition, some individuals with mood disorders may develop neurovegetative symptoms (e.g. weight loss, fatigue) or other associated physical symptoms (e.g. pain), about which they become preoccupied. Bodily distress disorder should be diagnosed only if the preoccupation with physical symptoms occurs outside the context of mood episodes – for example, if the preoccupation precedes a depressive episode or persists after the depressive episode has remitted.

Boundary with generalized anxiety disorder

Individuals with generalized anxiety disorder may report somatic symptoms about which they are concerned (e.g. palpitations or gastric distress), but they also report concerns about negative events occurring in several different aspects of everyday life (e.g. work, relationships, finance). Unlike individuals with bodily distress disorder, individuals with generalized anxiety disorder do not typically exhibit a preoccupation with bodily symptoms that persists despite medical evaluation and reassurance. However, co-occurrence of bodily distress disorder and anxiety and fear-related disorders is common, although individuals with bodily distress disorder are less likely to endorse the psychological components of anxiety other than distress about their bothersome symptoms.

Boundary with panic disorder

Panic disorder is characterized by recurrent, unexpected, self-limited episodes of intense fear or apprehension with prominent somatic symptoms and feelings of an impending catastrophe (e.g. fainting, having a stroke, heart attack or dying), with a sense of immediacy of the threat. Individuals with panic disorder often become preoccupied with the transient somatic symptoms they experience during panic attacks, and may express concern that they are dangerous and suggestive of imminent harm. An additional diagnosis of bodily distress disorder should not be assigned on the basis of concern about symptoms experienced during panic

attacks. However, if individuals with panic disorder are excessively attentive to or preoccupied by persistent somatic symptoms that are distinct from those typically associated with panic attacks, and all diagnostic requirements for both disorders are met, both diagnoses may be assigned.

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