117 - 6C21 Body integrity dysphoria

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435 Disorders of bodily distress or bodily experience Boundary with hypochondriasis (health anxiety disorder) Unlike individuals with hypochondriasis, who are preoccupied with the possibility of having one or more serious, progressive or life-threatening illnesses, individuals with bodily distress disorder are typically preoccupied by the symptoms themselves and the impact of the symptoms on their lives. Individuals with hypochondriasis may also seek medical attention, but their primary purpose is to obtain reassurance that they do not have the feared serious medical condition. Individuals with bodily distress disorder typically seek medical attention in order to get relief from their symptoms, not to disconfirm the belief that they have a serious medical illness. Boundary with factitious disorder imposed on self Individuals with factitious disorder imposed on self may also present bodily symptoms. If the presented symptoms have been feigned, falsified or intentionally induced or aggravated, factitious disorder imposed on self rather than bodily distress disorder is the appropriate diagnosis. Body integrity dysphoria Essential (required) features • An intense and persistent desire to become physically disabled in a significant way (e.g. a major limb amputation, paraplegia, blindness) accompanied by persistent discomfort or intense negative feelings about one’s current body configuration or functioning, is required for diagnosis. • The desire to be disabled results in harmful consequences, manifested in either or both of the following: • attempts to actually become disabled through self-injury, which have resulted in the person putting their health or life in significant jeopardy; • preoccupation with the desire to be disabled, resulting in significant impairment in personal, family, social, educational, occupational or other important areas of functioning (e.g. avoidance of close relationships, interference with work productivity). • Onset of the persistent desire to be disabled occurs by early adolescence. • The disturbance is not better accounted for by another mental disorder (e.g. schizophrenia or another primary psychotic disorder – in which, for example, a delusional conviction that the limb belongs to another person may be present – or factitious disorder) or by malingering. • The symptoms or behaviours are not better accounted for by gender incongruence, by a disease of the nervous system or by another medical condition. 6C21 Disorders of bodily distress or bodily experience | Body integrity dysphoria

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders Additional clinical features • It is common for individuals to describe their discomfort in terms of feeling like they should have been born with the desired disability (e.g. missing a leg). • Most individuals with this condition exhibit associated “pretending” or simulation behaviour (e.g. binding one’s leg to simulate being a person with a limb amputation, or using a wheelchair or crutches), which is often the first manifestation of the condition. These behaviours are usually done in secret. The need for secrecy may result in avoidance or termination of intimate relationships that would interfere with opportunities for simulation. • Some individuals who attempt to make themselves disabled through self-injury try to cover up the self-inflicted nature of the attempt by making it look like an accident. • Many individuals with body integrity dysphoria have a sexual component to their desire – either being sexually attracted to individuals with certain disabilities or being intensely sexually aroused at the thought of being disabled. • Shame about the desire to be disabled is common in individuals with body integrity dysphoria, and most individuals keep this desire a closely guarded secret because of a fear of being rejected or thought to be “crazy” by others. It is common for the family, friends, co-workers and even their partners or spouses of individuals with body integrity dysphoria to be unaware of their desire. Some may seek treatment for associated depressive or other symptoms and yet not share their desire to be disabled with their health-care provider. • It is assumed that most individuals with body integrity dysphoria never come to clinical attention. When they do, it is generally as adults – often when they seek the assistance of a health-care professional to relieve their distress, to help them actualize their desired disability, or because they have injured themselves in an attempt to become disabled. Boundary with normality (threshold) • Some individuals, especially children and adolescents, may have time-limited periods in which they pretend to have a disability such as blindness out of curiosity about what it is like to live as a disabled person. Such individuals do not experience a persistent desire to become disabled or the harmful consequences associated with body integrity dysphoria. Course features • The typical course is for the intensity of the desire to become disabled and consequent functional impairment to wax and wane. There may be periods of time where the intensity of the desire and the accompanying dysphoria is so great that the individual can think of Disorders of bodily distress or bodily experience | Body integrity dysphoria

 nothing else, and may make plans or take action to become disabled. At other times, the desire to become disabled and the associated intense negative feelings abate, although at no time does it completely cease to be present. Developmental presentations • The onset of body integrity dysphoria is most commonly in early to mid-childhood, although some cases have their onset in adolescence. The first manifestation is typically the child pretending to have the desired disability, often in secret. Culture-related features • Although apparently quite rare, cases have been reported in many different countries and cultures. Sex- and/or gender-related features • Among those who come to clinical attention, prevalence appears to be higher among males. Boundaries with other disorders and conditions (differential diagnosis) Boundary with schizophrenia, other primary psychotic disorders, and other mental disorders with psychotic symptoms Somatic delusions may involve the conviction that a part of the person’s body does not belong to them. In such cases, a diagnosis of schizophrenia or another primary psychotic disorder, or a mood disorder with psychotic symptoms should be considered. Individuals with body integrity dysphoria do not harbour false beliefs about external reality related to their desire to be disabled, and thus are not considered to be delusional. Instead, they experience an internal feeling that they would be “right” only if they were disabled. Boundary

with obsessive-compulsive disorder Obsessive-compulsive disorder is characterized by repetitive and persistent thoughts, images or urges that are experienced as intrusive and unwanted (ego-dystonic). In contrast, the repetitive Disorders of bodily distress or bodily experience | Body integrity dysphoria

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders thoughts, images and impulses related to the desire to become disabled in body integrity dysphoria (e.g. fantasies of being disabled) are ego-syntonic, and are not experienced as intrusive, unwanted or distressing. Distress in body integrity dysphoria is typically related to not being able to actualize the disability, or to fear of the negative judgements of others. Boundary with body dysmorphic disorder Individuals with body dysmorphic disorder have persistent preoccupations about a part of their body that they believe is defective, or a perception that their appearance overall is ugly. In contrast, individuals with body integrity dysphoria are persistently preoccupied with a sense that the way their body is configured (e.g. for those who desire an amputation) or functions (e.g. for those who want to be paraplegic or blind) is wrong, unnatural and not as it should be. Boundary with paraphilic disorder involving solitary behaviour or consenting individual Some individuals have a paraphilic focus of intense sexual arousal involving the fantasy of having a serious disability, which may be associated with transient periods of wanting to acquire the disability that is the source of arousal. If the desire to acquire a disability occurs solely in connection with sexual arousal, body integrity dysphoria should not be diagnosed. A diagnosis of paraphilic disorder involved solitary behaviour or consenting individuals may be appropriate in such cases, if the individual is markedly distressed about this arousal pattern or if they have injured themselves as a part of enacting sexual fantasies related to it. Boundary with factitious disorder and malingering Individuals with body integrity disorder often simulate their desired disability as a way of reducing their negative feelings (e.g. a person who desires to be paraplegic may spend part or all of their time using a wheelchair). Moreover, they typically shun medical attention. In contrast, individuals with factitious disorder feign medical or psychological signs or symptoms in order to seek attention – especially from health-care providers – and to assume the sick role. Malingering is characterized by feigning of medical or psychological signs or symptoms for obvious external incentives (e.g. disability payments). Boundary with diseases of the nervous system Some diseases of the nervous system may cause symptoms that involve profound changes in the person’s attitude towards and experience of their own bodies (e.g. somatoparaphrenia, in which a paralysed body part is experienced as alien or as belonging to someone else.) If the persistent discomfort about the individual’s body configuration is better accounted for by a disease of the nervous system, then body integrity dysphoria should not be diagnosed. Disorders of bodily distress or bodily experience | Body integrity dysphoria

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