

A Critical Examination of Bodily Distress Disorder (ICD-11 6C20): Classification, Diagnosis, Treatment, and Contemporary Debates

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Table of Contents

1. Introduction	2
2. Classification and diagnostic criteria	2
3. Treatment Approaches	3
4. Rehabilitation and Recovery	5
5. Current Discussions and Emerging Issues	5
6. Conclusion and Recommendations	7
7. References	8

1. Introduction

The classification of mental and behavioural disorders is central to modern psychiatry and serves as the basis for all diagnosis, research, and clinical work. The International Classification of Diseases (ICD-11) has Chapter 6, which contains the entire classification of mental, behavioural, and neurodevelopmental disorders, and standardises the classification and understanding of the psychopathology for the entire global health system (WHO, 2024). These systems of diagnosis allow for the guiding of clinical systems, policies, and evidence-based treatment formulation for clinical practice. The American Psychiatric Association (2013) also has the Diagnostic and Statistical Manual of Mental Disorders, as the ICD-11 classification system is still recognised. Both systems of diagnosis aim to standardise the practice of psychiatry, but the ICD-11 version is shaped more by the World Health Organisation (WHO) and its focus on global and multicultural health (Clark et al. 2017).

Among its various disorders, Bodily Distress Disorder (6C20) is a significant and controversial case. As Gureje et al. (2025) explain, BDD comprises one or more chronic bodily symptoms such as fatigue or pain, gastrointestinal symptoms, and is associated with concentrated distress or impairment and a disproportionate focal attention toward the phenomenon. This disorder captures the intricate character of psychological and somatic factors in dysfunction. Understanding the uncertainties and controversies arising from the potential diagnosis of BDD as a somatic illness raises ethical concerns about the psychologisation of bodily symptoms. Not only the absence of mind–body interfaces, but also the absence of BDD itself makes the diagnosis highly relevant in contemporary psychiatry. This assessment aims to focus on some critical aspects of the ICD-11 conceptualisation of Bodily Distress Disorder (BDD). It outlines and discusses the diagnosis and classification, comparing and contrasting these with the classification of Somatic Symptom Disorder (SSD) in the DSM-5, assesses the corresponding ICD-11 treatment approaches, and discusses the rehabilitation and recovery principles discussed in the ICD-11 in relation to BDD.

2. Classification and diagnostic criteria

The ICD-11 classifies Bodily Distress Disorder (6C20) under Mental, behavioural or neurodevelopmental disorders, which implies an understanding of the psychosocial components of the severity and chronicity of symptoms. There are three cardinal components of the diagnostic criteria, which are the symptoms sustained, excessive preoccupation with the symptoms and the associated emotional distress or dysfunction (Stein et al. 2020). Symptoms of fatigue, pain, or gastrointestinal distress are common and may exceed the available medical explanation or be

within the context of the documentation. ICD-11 distinguishes severity (mild, moderate, severe), which implies a thoughtful consideration of the degree of preoccupation and the impact of functional loss (ALHosni et al. 2023). The transition in the naming of ICD-10 “somatoform disorders” to “bodily distress” in ICD-11 captures an important conceptual shift in the understanding from a duality perspective to a biopsychosocial model.

The Somatic Symptom Disorder diagnosis in DSM-5 has considerable overlap but places different emphasis. Somatic Symptom Disorder diagnoses look more at the psychological processes of the symptoms, such as the case of going on to develop disproportionate thoughts, feelings, or behaviours in comparison to the focus on there being no relevant medical explanation (D’Souza and Hooten, 2023). Both systems seek to avoid the risk of pathologising individuals when their symptoms are unexplained. However, there are still uncertainties as to when normal concern regarding one’s health becomes excessive. Florian Seemüller (2023) argue that ICD-11’s symptom-oriented description and the DSM-5’s focus on cognitive and emotional factors are possibly two culturally influenced manifestations of the same underlying condition.

The process for BDD diagnosis includes the unique collection of documentation, which incorporates medical history and clinical interviews, along with the exclusion of identifiable organic causes. Assessing symptom severity can utilise the PHQ (Patient Health Questionnaire)-15 and Bodily Distress Disorder Scale (Türk et al. 2023). However, the complexities of diagnosis persist as certain physical conditions can resemble body dysmorphic disorder (BDD) and share overlapping characteristics with anxiety and depressive disorders, which makes distinguishing these disorders difficult. The cultural context is also important, as the non-Western population may experience psychological distress with somatic symptoms. Overdiagnosis may be considered ethically appropriate, as it may invalidate a legitimate physical illness; conversely, underdiagnosis may withhold necessary psychological treatment (Castle et al. 2021). Ethical considerations also arise from stigma and the possibility that patients may feel dismissed if told that their symptoms are psychological. Similarly, diagnostic methods must consider the balance between compassion and the desperation of the patient.

3. Treatment Approaches

BDD is best managed through a complex technique which considers the psychological and physical aspects. According to Veale and Singh (2019), Cognitive Behavioural Therapy (CBT) is the most proven method to treat BDD. CBT assists in the recognition and modification of dysfunctional beliefs regarding bodily sensations and the confronting and recalibrating of

catastrophic interpretations and avoidance behaviours, which leads to meaningful functioning and improvement of quality of life. CBT has been shown to consistently yield positive outcomes in the reduction of symptom distress (Chand et al. 2023). MBCT (Mindfulness-Based Cognitive Therapy) and ACT (Acceptance and Commitment Therapy) build on this foundation by encouraging the practitioner to encourage non-judgmental awareness and acceptance of bodily sensations rather than resistance to them. Psychoeducation and motivational interviewing assist in clarifying the sustaining mind–body symptom and in reframing the disorder in a biopsychosocial model, which improves engagement (Webb, 2023).

The role of pharmacological treatment is secondary and symptom-focused. There are no specific effective therapeutic agents for BDD. While antidepressants, particularly SSRIs (selective serotonin reuptake inhibitors), are used for comorbid anxiety or depression, and may relieve some depressive symptoms but such an approach requires caution (Hong et al. 2019). While such use may alleviate mood symptoms, it must be approached with caution. Overreliance on medication may strengthen the view of the illness as purely physical and block psychological recovery. The potential of overmedicalisation emphasises incorporating any pharmacological approach into a wider therapeutic plan. Integrated multidisciplinary care approaches are recognised as best practices. General practitioners, psychiatrists, psychologists, physiotherapists, and occupational therapists, coordinated in teams, can tackle the complex nature of the disorders. Considering that many patients with BDD first present in general medical settings, these models are particularly relevant as they comply with the WHO guidelines on integrated physical and mental health care (Ayre et al. 2023).

The structure is grounded in the biopsychosocial model, which aims to address emotional regulation, physical functioning, and social participation within the same framework. There are still notable gaps even with positive indicators. Although psychologically based interventions show meaningful effect sizes, there remain challenges about adherence, accessibility, and patient engagement (Henningsen, 2018). There will always be some patients who resist therapy, meaning any engagement with the therapy reduces their suffering, but ignores the underlying pain to be worked on (Röhrich et al. 2019). The wide variability in treatment outcomes, particularly the chronicity of severe cases, underscores the necessity for more flexible, culturally considerate solutions. Such solutions should prioritise collaborative, validating and self-management components.

4. Rehabilitation and Recovery

WHO (World Health Organisation) values on mental health rehabilitation focus on recovery, autonomy, and social integration within a community over simple symptom reduction (Saraceno and Almeida, 2022). Rehabilitation for Bodily Distress Disorder aims for psychosocial and occupational recovery. The ICD-11 defines success as improvement in daily functioning and social integration; accomplishment is warranted, despite constant physical symptoms. Activity programs, which are graded along with occupational therapy, play a key role in helping people safely and gradually increase their activities without the risk of overdoing it or relapsing (WHO, 2024). Such an approach helps limit deconditioning and avoidance cycles, promotes and encourages an individual's confidence in re-establishing a routine.

Empowerment of patients through self-management strategies, which include pacing, regulation of stress, and structured exercises. Proximal and psychoeducational support groups integrated in rehabilitation facilitate the avoidance of isolating the patient and reinforce the coping mechanisms (Stepanian et al. 2023). As part of rehabilitation, contextual barriers such as inflexibility in the workplace and lack of social support are also addressed. However, the rehabilitation of chronically and inconsistently suffering BDD is challenging. This all, together with stigma and lack of specialised services, can encourage disengagement. The separation of mental and physical health services further gap in the integration of care.

Long-term outcomes vary widely, with some individuals regaining all their functional abilities and others having continuing distress or permanent disability. Higher relapse rates are noted in individuals with more severe baseline symptoms and those with less social support (Barcutean et al. 2024). Integrating individuals back into work roles is problematic as work environments poorly accommodate changes in endurance and functionality. These elements underscore the importance of viewing recovery from BDD as complicated and nonlinear and involving a protracted collaborative undertaking involving the patient and a recovery team comprising different specialities.

5. Current Discussions and Emerging Issues

When discussing Bodily Distress Disorder, the key issues include ethics, the validity of the diagnosis, and the scope of the disorder conceptually. One key issue centres on whether the disorder overlaps with chronic fatigue syndrome, fibromyalgia, and medically unexplained symptoms (MUS). Veale and Singh (2019) claim that BDD functions as a 'catch-all' category due to its heterogeneous presentations, thereby failing to account for variant mechanisms and

prognoses. This scenario can lead to inadequate therapeutic encounters. Ryum and Kazantzis (2024) claim that the diagnosis, pragmatically, reflects the clinical reality of the overlapping cognitive-behavioural frameworks associated with other somatoform disorders, enabling research on pathways of distress that connect these conditions.

Concerns regarding medicalisation and gender biases are also complicated. Body dysmorphic disorder (BDD) and similar conditions have been recorded more among women, even considering that women are more likely to disclose distress (Smakowski et al. 2024). This may point to biases within clinical assessments and social lenses regarding women and emotionality. Regarding the risk of reinforcing stereotypes and the gendered implications of clinicalisation in the literature, scholars are concerned about the potential pathologisation of clinical distress. Under emerging narratives and the neurodiversity model, the implicit pathology in bodily distress is argued to be an adaptive response to trauma or stress (Henningssen and Bernd Löwe, 2024). This suggests that clinical recognition in some cases may be less warranted than support and acceptance, even labelled as harmful involvement, resilient distress is labelled adaptive.

Cultural and ethical considerations are vital. Somatisation is the presentation of psychological distress as physical symptoms, which differs from culture to culture (Häuser, Fitzcharles and Henningssen, 2025). For instance, in several cultures outside the Western world, somatic complaints are present as culturally appropriate idioms of distress where the overt discussion of emotional suffering is offensive. Similarly, the clinician must understand distress in the body through a biased cultural lens to avoid misdiagnosis. Ethically, the potential risk of invalidation is still present, as the suggestion of a psychological cause may be interpreted as disbelief and dismissal (Mateusz Curyło et al. 2025). As a result, clear and compassionate communication in all scenarios is essential to promote dignity and avoid depleting the therapeutic alliance.

Responses to BDD are shaped by policy and legal frameworks. Within the UK Mental Health Act (1983), amended in 2007, involuntary treatment only applies in extreme cases of risk or incapacity. BDD rarely meets such thresholds, but the inclusion of BDD within psychiatric classifications strengthens its position as a legitimate mental health condition. Within the NHS, its integration into care pathways remains irregular, although NICE has begun to recommend the biopsychosocial model for medically unexplained symptoms (Zigmond, 2017). Ongoing policy discussions focus on clinician education, the integration of services, and the funding of functional disorders. Current policy discussions continue to focus on clinician education, service integration, and functional disorder funding.

6. Conclusion and Recommendations

The inclusion of Bodily Distress Disorder (ICD-11 6C20) is a significant attempt towards the integration of the psychological and physical aspects of human suffering. The classification of distressing bodily symptoms within a single entity suggests that ICD-11 goes beyond classification and diagnostic systems disassociated with a holistic understanding of the mind and body. There are still problems of diagnostic precision and stigma, and the provision of adequate equity and person-centred care. Integrated psychological therapy, medical management, and psychosocial rehabilitation remain the most effective and most integrated pathways towards recovery and the rehabilitation of a suffering person socially. As the classification of psychiatric illnesses continues to progress, so does the need for a more compassionate and culturally attuned balance with the rest of the psychiatric science.

To deepen the comprehension and Treatment Approaches concerning the organisation and management of Body Dysmorphic Disorder (BDD), advances in definitional and systemic changes within the field are required. From a definitional perspective, it remains important to restrict the diagnosis and treatment of BDD, fibromyalgia and chronic fatigue syndrome. Educating clinicians, particularly primary-care practitioners who account for most of the BDD case load, within the biopsychosocial framework and on constructive communication, is vital. For systemic configuration, collaborative care practices should include general practice, psychiatry, psychology and rehabilitation. Subsequent research should focus on clarifying treatment pathways and evaluating the longitudinal outcomes of care. Culturally sensitive diagnostic and treatment tools will be necessary, as will the legislative prioritisation of providing psychological therapies, training clinicians, and providing clinical psychotherapy. Future advances will come from transdisciplinary research that is ethically grounded and that involves people in the care processes.

7. References

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