ScieniQ Publishers

Archives of Clinical Case Studies and Case Reports

Case Report

Case reports of 6 patients who were able to relieve or end the pressure caused by Body Integrity Dysphoria

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Received: 10 August 2025
Accepted: 16 August 2025
Published: 10 September 2025

Abstract

Background: Body Integrity Dysphoria (BID) is a strange disorder in which the external body does not match with the mental image of the body. Those affected usually feel that a body part (e.g., a leg, a foot, an arm, or a hand) is not part of their body. They perceive this limb as foreign and not belonging to them.

Methods: The article describes the fate of six patients who found different ways to escape the mental pressure caused by BID.

Results: The first patient was able to have an amputation in a clinic; afterward, he felt well and was extremely satisfied with his new physical condition. The second patient suffered a serious road traffic accident with multiple fractures of one leg; his life was saved, and he spent a long time in a rehabilitation clinic. Due to the pain and difficulty walking, he realized that life is easier with two healthy legs, and he was able to abandon the need for amputation. The third individual case described here survived the pressure of BID by pretending; he couldn't afford an expensive amputation abroad. He then met a disabled woman with a double thigh amputation. He found that being able to love her in her disabled state was enough for him and his own desire for an amputation faded into the background. The fourths patient suffered from the comorbidity of being transgender (male to female) and the urge to amputate his/her right leg. Since gender reassignment was easier to achieve than surgical removal of the leg, the patient initially decided to undergo gender reassignment. However, afterward, she felt much more at home in her body and no longer considered the leg surgery necessary. The fifth case described here was able to convince the authorities that he suffered from a severe neurological disorder. He then lived in a wheelchair for some time with the status of severely disabled. However, he eventually became bored with not being able to do anything independently and ended his disability. The last patient made numerous attempts to cope with the pressure of BID. He ultimately died in a motorcycle accident, and it is unclear whether he deliberately caused the accident to cause the loss of a leg.

Conclusions: Most of the six case studies probably do not contain a general solution for all BID sufferers, but they show that BID is also a psychological phenomenon and that focusing on other aspects can reduce the need for acquiring a disability. Ultimately, there are many different forms and degrees of severity of BID and each affected person will likely have to find his/her own solution.

Keywords: Body Integrity Dysphoria, Body Integrity Identity Disorder, Identity disorder, Xenomelia, Amputee Identity Disorder, Acrotomophilia, Mancophilia

Introduction

Around the 12th century the Arabian historian Usama ibn Munqidh described in his book "Kitab al-I'tibar" a Frankish doctor who tried to amputate a man's leg simply because of his wish [29]. An 18th-century anecdote tells of a doctor who was forced at gunpoint by a man to amputate his perfectly healthy and functional leg (quoted from: [20]). The need to amputate a limb therefore appears to be more than just a feature of modern, affluent societies, where social systems care for the disabled and even amputees can survive without problems and rely on assistive devices in most countries around the world. In the past 50 years this syndrome was termed as e.g.: Apotemnophilia, Xenomelia, Amputee Identity Disorder and Body Integrity Identity Disorder (BIID). In the ICD-11 it is renamed as "Body Integrity Dysphoria" (BID).

Body Integrity Dysphoria (BID) is a strange disorder in which the external body does not match the mental image of the body. Those affected usually feel that a body part (e.g., a leg, a foot, an arm, or a hand) is not part of their body. They perceive this limb as foreign and not belonging to them. Others seek paralysis, sometimes they want to reach the state of a patient with paraplegia in both legs. Often, they actually attempt to achieve the desired disability. First [14] and First & Fisher [13] have found that many BID sufferers have undergone surgery to adjust their real body to their mental body image. The condition usually begins in childhood or early adolescence [32], the need to be amputated then covers the patient's entire lifespan [22, 23]. The predominant focus of this desire for disability is the removal of limbs [39]. However, it may also involve wishing for a loss of sensory capabilities, such as blindness, deafness or paralysis [18, 41]. The sufferer does not perceive the body part that is the focus of the dysphoria

as belonging to his or her body; some BID sufferers even describe a feeling of being "overcomplete" [4]. The constant focus on their bodies that ensue from the condition may impact sufferers' friendships, intimate relationships and careers [34, 39].

The urge for a disability may be so intense that those affected try to achieve an approximation to their desired body image, by, for example, binding up the undesired part of their bodies (e.g. the lower leg), or by the use of crutches or a wheelchair [22, 39]. Dissatisfaction with the body can increase to the extent that sufferers resort to radical methods, such as putting a limb in dry ice to freeze the tissue, triggering infections, or even lying down on railway tracks (14, 22, 39]. Alternatively, sufferers may seek surgery abroad, which may be illegal and costs more than $ 20,000 for an amputation. After surgery, due to the shame, the sufferer use excuses to others, ascribing their state to a car accident or a serious infection.

A legal amputation in a hospital raises a host of ethical questions: Are doctors allowed to amputate a healthy limb? However, there is a psychological indication due to the mental suffering [3, 9, 34].

Over the last three decades there has been increased attention among researchers to BID, predominantly where amputation was the focal desire. In 1997, Bruno [11] reported the case of a woman who had no desire for an amputation, but used a wheelchair on a permanent basis. Similarly, of the 52 sufferers interviewed by First [14], two did not desire amputation, but rather paraplegia. Although numerous studies speak of the existence of a deep desire for various other disabilities (e.g.: [5, 7, 15, 24, 33, 38]), these conditions have received little attention thus far. A further aspect of the condition relating to the type of desired disability emerges in the finding of Aner and colleagues [1] who found that those with BID gave higher attractiveness ratings to drawings depicting people with disabilities.

Most cases refer to a specific body part [6]. The primarily affected body part is the leg; individuals with BIID report being able to feel the exact line for amputation [[9]. BIID is life-defining and not the result of physical or psychiatric morbidity [7, 14].

The true cause is unknown, but most current scientific studies indicate that BID has a (presumably congenital) neurological basis. Initial studies suggest damage to the parietal lobe, while more recent research suggests a malfunction in a complex network responsible for body image, which extends across multiple nodes throughout the brain [2, 6, 8, 10, 15, 17, 19, 27, 36].

To date, there is little knowledge about how to effectively treat individuals with BIID [40]. However, the development of an effective treatment requires clarification of the aetiology [37], which has not yet been conclusively clarified. The combination of psychotropic medications, cognitive behavioral therapy, and psychodynamic psychotherapy has not yet brought a cure. Only some relief is found in dealing with the desire for amputation [39, 40]. This finding is also confirmed by Kröger et al. [40], who analysed that a reduction in emotional pressure can be achieved through therapy, but the desire for amputation can be reinforced by all forms of therapy. This is further complicated by the fact that many therapists are unfamiliar with the disorder [30].

The following section presents the fate of six patients who managed to completely or largely relieve the pressure caused by BID. These are individual case studies, and generalization to all affected individuals is difficult.

Case#1

Case#1 wrote that he has been living with Body Integrity Dysphoria (BID) for 40 years now, and that the suffering has become increasingly severe. He feels the urge to have his right leg amputated below the knee. There were times when the unfulfilled desire to not be the way he felt "right" was unbearable. In his twenties he reached a phase in his life where he finally wants to be "complete." He wrote that his right lower leg does not belong to him and has been disturbing his body image for decades. Case#1 often mimicked the state of living with only one leg in his free time, but this only gave his mind a brief moment of peace. Whenever he looked down at himself, he saws a thing that in his opinion don't really belong there. This problem affected his life, and his thoughts mostly revolve around how he could finally be happy and achieve a state of inner peace.

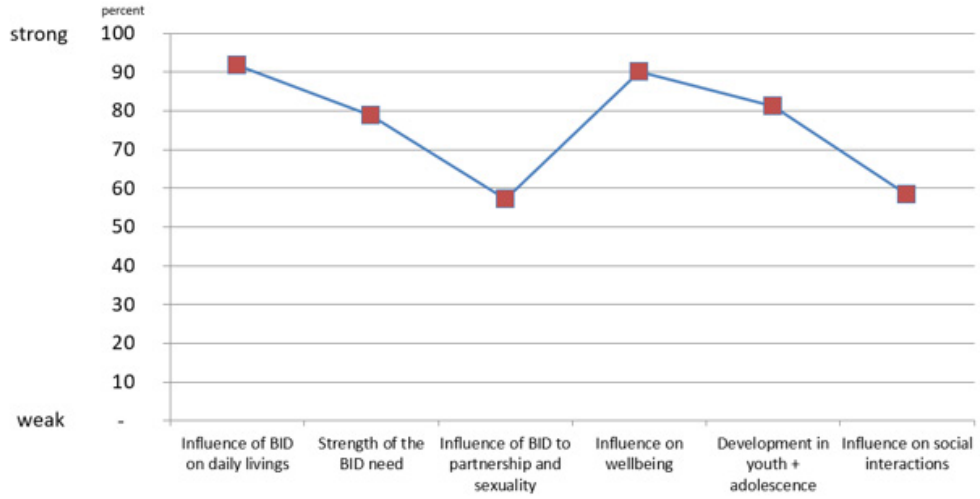
He reports that when he was about ten years old, he saw a woman with an amputation on his way home from school, and that's when something clicked inside him. He was fascinated and since then, he hasn't been able to get the thought of wanting to be like that out of his head. When asked what he had done about it so far, Case#1 wrote that he had practiced breathing techniques, Qi Gong, and relaxation exercises to calm these thoughts, as well as doing a lot of exercise. He tried to have pleasant experiences to fill his head with positive thoughts.

His long-term goal was to achieve the amputation of his right lower leg from the lower edge of the calf. Case#1 wrote that from this position, his body ceased to exist for him.

In a questionnaire regarding the distress caused by the desire for amputation, Case#1 scored 25 out of 39 points. This indicates a high level of distress caused by the feeling of living in the wrong body. He stated, for example, that it is a great burden to constantly keep the need for a disability secret. The mental pressure caused by BID robs him of his joy in life, makes him desperate, and reduces his concentration and performance.

In the BID questionnaire according to Garbos et al [16 see Fig. 1], Case#1 wrote that this need has tormented him for nearly 40 years, but that the trend was increasing and became increasingly difficult to bear. Especially since his children had left home and he had more time for himself, the need for amputation had become increasingly severe. He tried to pretend the disability almost daily and was essentially mentally preoccupied all day long with what it would be like to achieve the desired state. He told his current partner about BID. After initial skepticism and complete disbelief, understanding, but also sadness, emerged. Ultimately, she was able to understand that this was bothering him deeply and that he must have been leading a secret life for a long time, or actually lived two lives.

Figure. 1: Results of the BID-Test oft Case#1



Case#1 cites the following arguments in favour of amputation: "*Peace of mind, satisfaction with one's inner body image, simply being happy, no longer feeling sadness or inner restlessness, no more lies." The only argument against this was: "No longer being able to shower long time while standing.*"

Case#1 was ultimately able to obtain an amputation in a distant clinic abroad. He had to pay well over $20,000 plus travel expenses for this; he had been saving for it for a long time. But finally, being the way his mental body image dictated, was worth the money to him.

A month after this amputation, he wrote: "*I wanted to get in touch with you again. It's been almost four weeks since I was able to experience healing. I'm doing very well, and I no longer have any thoughts of BID. It's simply gone, and I feel free and full of inner peace and strength. Of course, everything is a little different now, but I always have a smile on my face.*"

Later, in another message, he added: "*Although I must confess that I no longer have any thoughts of amputation. It's all gone from my mind, and there's plenty of room for good thoughts.*" A telephone conversation was held with Case#1 in June 2025, and he continued to state that he was not only satisfied with his decision, but even happy.

Case#2

The second case is more peculiar. This patient also suffered his entire life from the urge to have one of his legs amputated. He was one of the first participants in our studies, and we continued to exchange emails over more than 20 years. At that time, he was urgently looking for addresses or possibilities for a surgical solution to his problem.

He always wished to lose a leg, always the left one – until December 2005. Up until that point, his 'dark' feelings had lain dormant for years; in the meantime, he had fulfilled his desire for piercings. But sometime in December 2005, he saw a magazine drawing of an athlete with a sports prosthesis – and he was (once again) electrified. After that, the desire became stronger than ever – but this time it was for the right leg. For the first time, he browsed the internet and was fascinated and relieved that he wasn't the only person with this wish, indeed, that there were even people who had fulfilled it. He visited several forums every day to get more information, although his expectations were only partially fulfilled. He had also naively and, of course, unsuccessfully tried to contact Smith in Scotland, who had made such an amputation. He discussed BID with his family doctor, whom he has known for a long time and who was non-dogmatic, but for years they made no progress.

If someone had told him, "*You can go to the hospital and wake up tomorrow without a leg,*" he would have done it immediately. But he wrote at that time, that will remain a wish; he will have to wait for a chance or take action himself. He went to sleep with the desire for amputation and woke up with it—which significantly limits his quality of life because it was simply too gnawing at him. Case#2 said that he was too rational and realistic to completely lose himself in these thoughts, but the successful examples simply wouldn't leave him alone.

He often thought about where this wish comes from, but it was clearly just there. Just like someone is homosexual or heterosexual. Superficially, one would associate this with an unconscious desire for limitations, but that's not the case – he saw it as an expansion of his body's capabilities and the way he interacts with it. He said that, as an amputee, he would definitely want a prosthesis because he didn't want to appear 'disabled' to others, as he wouldn't feel that way himself. And here he (sometimes) couldn't figure it out himself: why would he want – indirectly – a condition he already has?

For various reasons, however, he spent his entire life trying to cope with the pressure caused by BID as best he could. Shortly before retirement, in his mid-60s, he was involved in a serious traffic accident. He was hit by a car traveling at 70 km/h. He suffered multiple fractures of his right leg, broke his left arm, and cracked a cervical vertebra. He had to be taken by ambulance to a hospital emergency room and spent time in the intensive care unit. Afterward, he underwent several weeks of inpatient rehabilitation at a specialized clinic. What helped him survive the accident at all was that he was relatively fit and not overweight. He wrote that the accident turned his life upside down; even today, his arm and leg aren't quite as functional as they once were. Fortunately, his head only suffered a concussion and is still functioning well.

Strangely, the accident also largely eliminated his need for amputation. He wrote, among other things: "*But I do feel what it means when something doesn't work or doesn't work well. And since I'm a passionate driver (using manual transmission), I simply need two feet (...) There were many amputees in rehab – all of this made me realize that a complete, functional body is a value in itself... I realize that now, when it's not exactly the case ... Perhaps it also has something to do with age. Anyway – I don't know what BID is: an obsession? For me – without knowing why – it no longer plays a role. I recently threw away all my BID documents. That chapter seems to be closed – for me.*"

He believes his "spontaneous healing" was triggered by the shock of the

accident, coupled with the insights and observations from rehab. Strangely, he hadn't thought about BID at all between the accident and the end of rehab. On the other hand, as Case #2 wrote, he doesn't know how he would have reacted if he had really lost his leg. Would he have been happy and relieved? If that had been the case, he would have had to come to terms with it. However, it apparently wouldn't have been unbridled joy at first (which should have been the case). In the clinic, he saw many amputees in wheelchairs and thought that wasn't what he had imagined; however, many were already old and overweight. On the other hand, he was using a wheelchair himself at the time, which he found quite comfortable in the situation, but somehow didn't want to use for his entire life.

Case#2 also asked that his email address be removed from the mailing list. It had always been important to him to participate in research about the phenomenon, but now it no longer seemed OK to him to participate in studies on BID, as he no longer felt like he was affected.

Case#3

Case#3 first wrote to me in February 2020, and we've been in casual email correspondence ever since. He wrote that he'd wished he could wear a wooden leg since childhood. As a teenager, around 14, he observed a school janitor who was an amputee and had a wooden leg. It was precisely this very special gait that fascinated him. Whenever he saw the school janitor in his cargo work pants and prosthetic leg, he would discreetly follow him, trailing a few steps behind. He did it again and again, following the janitor; it was like an addiction. This was in first grade; he watched the amputee janitor's every move and mimicked his typical prosthetic gait. One day, Case#3 was supposed to fetch props from the school basement. As he walked past the janitor's metal cabinet, he saw his prosthetic leg. The janitor always walked home without a prosthetic leg, using crutches—no one knows why. Case#3 looked around to see if anyone was coming, sat down on a chair, took the prosthesis, and placed it next to him, and it actually looked as if he were wearing it.

Case#3 remembers that after this, i.e. between the ages of 6 and 12 years, he began experimenting. For example, he took two equally long round wooden poles from his father's basement and placed them on either side of his right leg. He then wrapped a long, thin rope around it and put his jogging pants back on. His right leg was now completely stiff, and he started walking like that. This feeling was indescribable, and he did it every day after school when he was alone. From then on, the thought of living with only one leg forever, and ideally immediately, never left him. He wrote, among other things, that he wished nothing more than to have his right leg amputated.

He made a prosthesis for his right leg from an old pair of fishing boots he found in the dump. To do this, he cut the boot open from the thigh down to the calf and made holes in it on the right and left sides. This allowed him to overlap the two sides by about 15 cm and lace them up with a rope threaded through them. He then put on the right boot and laced it tightly. The thick rubber was very tight on his leg, like a prosthesis, and he was fascinated, seeing himself like that and walking with the completely immobile part. He wanted to go upstairs from the basement of his parents' house to look in the mirror, but discovered that he could no longer climb the stairs. This only worked after several attempts, and he was extremely excited and happy when he finally saw himself in the mirror. He ran through the entire house, got his diary, and wrote in it in large letters with a red felt-tip pen: "*Dear God, I wish my leg had to be amputated! Please do it quickly, I just want one leg forever!" From that day, this wish grew ever stronger; there was only one thought: "How can I get rid of my leg as quickly as possible*!"

One day, his parents found this entry in his diary stating that he wanted nothing more in the world than to have a leg amputated. As a result, he ended up in a child and adolescent psychiatric clinic. There, he was asked to explain why he was having such thoughts. He began to cry and wanted to die because he couldn't explain it.

At 18, he saw a girl his own age at the beach. She had a double leg amputation and walked past him with both prosthetic limbs. He felt a jolt of lustful shock. He considered himself abnormal; he was embarrassed to have such thoughts; he thought he was crazy for wanting a leg amputated. A few days later, he attempted suicide in his parents' apartment with sleeping pills. In the morning, his mother came into the room, tried to wake him, and realized something was wrong. She called his father, and as a firefighter, he knew what to do. He called his colleagues, and Case#3 had his stomach pumped. When the doctors at the hospital asked him why he had done that, he didn't reveal the real reason.

He then began to mimic his disability more and more often, using crutches and tying up his lower legs with straps. Asking peoples on the street with a prosthetic leg excites him in a very special way.

At the age of 40, he was once again walking down the street with his pretender prosthetic leg, and at a traffic light, he accidentally met a real amputee who looked at him, smiled, tapped his prosthetic leg with his cane, and said, "*Well, we have something in common!*" The sound of tapping the prosthetic leg went right through him. Case#3 felt hot and his heart pounding like crazy; he was bright red as he said that one leg was nothing to be ashamed of.

Sometimes he went to a nearby rehabilitation clinic or simply to a hospital where leg amputees and patients with prosthetics could be seen in the cafeteria.

Case#3 had been striving for amputation for decades and wanted a typical, old-style wooden leg. He wrote that if he had a wooden leg after amputation, he would be the happiest person in the world. The decades of enormous, indescribable suffering, he wrote, were almost unbearable and also affected his health. He wrote that from childhood to the present day, he had lived a life of extreme emotional stress, one that outsiders could not even begin to understand. Only immediate amputation could bring him absolute healing from this suffering and from BID, so that he could then spend the rest of his life happily and in contentment, with inner peace and harmony, and live an active life. He claimed that there was no alternative therapy other than immediate amputation! It was vital to him! He believed that this entire condition was also the trigger for his multiple sclerosis, as well as the restless legs disease that subsequently developed. Then he suddenly developed "crippled toes" and deformities on his foot, and, precisely at the spot where the incision for the amputation was supposed to be made, a kind of mole. He wondered if it was all a coincidence? In his opinion, there might be things between heaven and earth that we humans don't understand and perhaps don't even want to acknowledge.

Then, at the age of about 60, he happened to meet a woman who had a double leg amputation. It took two years before they could get to know each other properly. She has two leg stumps, about 25 cm long. After a long search, he found an orthopaedic technician who still makes real, old wooden legs as prostheses. He had her made what he actually wanted for himself: varnished wooden leg. He realized that seeing her with her wooden legs was actually enough for him. His own desire for amputation has faded considerably since he began a relationship with this woman.

Case#4

The fourth case presented here is perhaps even more peculiar. BID shows a disproportionate incidence among transgender individuals [28, 26, 35]. People who desire gender reassignment surgery are significantly more common in the BID patient group than in the general population. The individual presented here desired a male-to-female gender reassignment

surgery and also wanted to be one-legged.

Case#4 is still married to a woman today. Coincidentally, in the summer of 2014, his wife saw pictures of her husband depicting himself as a one-legged woman. Case #4 had to admit both that he wanted to be a woman and one-legged. His relationship with his wife was strained at the time, and her knowledge was an absolute disaster. Fortunately, she sought advice from a psychologist, which led to her showing some understanding.

Case#4 was never typically boyish or masculine as a child. While he didn't play with dolls, he never enjoyed boyish wrestling. It may be important to note that his mother always wanted a girl but gave birth to only boys. Apart from his transgender tendencies, the patient had a normal childhood and adolescence with a normal circle of friends. He played a lot of sports and was a member of a sports club, among other things. He said he can't see any typical girlish behavior or appearance in his childhood photos, but he often observes a typically feminine posture in some of the old snapshots. Case#4 still has a rather feminine-looking face today.

He has no memories of a change in his gender identity during childhood. Case#4 only felt the desire to live in a female body as a teenager and can remember dressing up as a woman during puberty. When no one was home, he would sneak into his mother's bedroom and dress in female clothing. He remembers that his mother had relatively little physical contact with her children and also with his father. His mother also seemed quite insecure in character.

He took the normal path and lived with a woman for over 30 years, whom he married in 2011. The relationship remained childless. As woman, he initially only lived in his far away second home mostly after work.

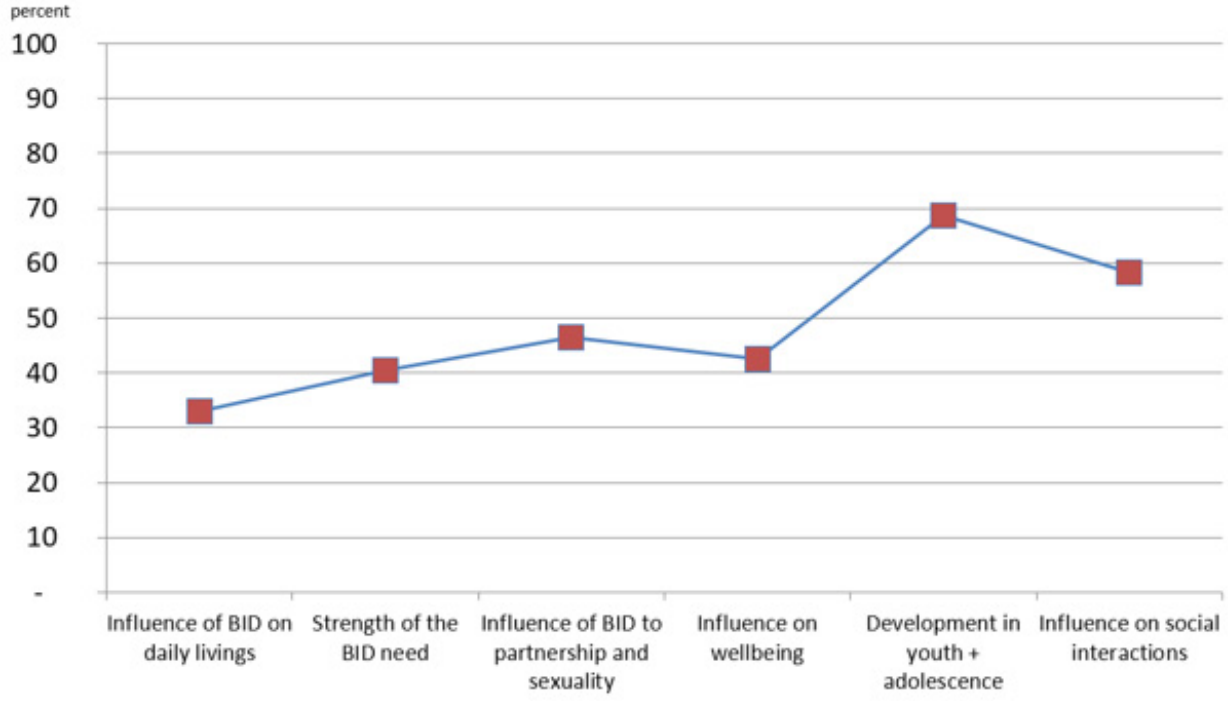
After his coming-out as transgender, initial shock, and threats of separation, his wife accepted the gender reassignment. As a first step, female clothing, makeup, and a wig were purchased, and most of the male body hair was removed. The patient felt "right" in the role of a woman. Case#4 first underwent hormone therapy, then total genital surgery, later breast augmentation, and had her first name changed. Later, she still had to attend certain professional appointments in a male role, but felt strange and inappropriate doing so.

At the same time, Case#4 suffered from another identity disorder. Since around the age of 7 or 8, she loved to imitate a one-legged child when playing with other children and would fall asleep at night with one leg bent. She initially dismissed this as a "fancy," but from around the age of 12, the feeling grew stronger. Back then in her youth, there were still many war-wounded veterans, and she was always fascinated by seeing a one-legged person. Distraction and imitating the disability eventually no longer helped. When she looked in the mirror, she imagined what she would look like with one leg. At times, this was downright obsessive; she brooded too much about BID and was therefore unable to accomplish many things. She felt the urge to have her right leg amputated above the knee. To get closer to the ideal image, she drew pictures of one-legged women. At times, she mimicked the monopodial state, tying up one leg and hobbling around the apartment when no one was there. Later, she had an orthosis made that felt like a prosthetic leg; this helped her to cope with the pressure for a while. She then joined an association for people with BID and attended meetings. On one trip, she saw a female athletic one-legged basketball player, which reawakened BID, because this woman precisely matched the ideal image.

For him, the decision between amputation and gender reassignment was difficult, especially since he worked in a predominantly male profession. Increasingly venturing out into public as a woman took a lot of courage. In his desires, he was a woman first, and only then one-legged. He couldn't imagine himself as a one-legged man. He forbid himself from having a relationship with a leg amputee due to the suspicion of sexual fetishism. From today's perspective, that would have been merely a projection, and finding someone who would have consensually entered into such a relationship seemed impossible.

However, on the Garbos questionnaire for BID [16 ses Fig. 2], Case#4 scored primarily low to moderate. The onset in childhood and adolescence is typical, but the strength of the need for a disability is in the lower half, the impact on the profession is less than in other affected individuals, only the area of social interactions is more affected.

Figure. 2: Results of the BID-test of Case#4



After the gender reassignment surgery had progressed, Case#4 observed with her own astonishment that the desire for amputation increasingly faded into the background. She became less depressed and more mentally cheerful; mood swings lessened, and she also became more resilient professionally. She mimicked the one-legged condition less and less, eventually abandoning it altogether. For a long time, BID was not even discussed in therapy. Years later, during a move to another town, she found crutches and a wheelchair in the basement. She hasn't thrown them all in the trash yet and she hasn't completely forgotten them; they were a part of her, like someone recovering from a serious injury who doesn't quite trust their recovery yet. At her new place of residence, she realized that she was happy to walk with two legs through the garden, which is on a slope, this would have been difficult with only one leg. There had previously been phases when she couldn't imagine continuing to have two legs, but since the gender reassignment surgery, things had improved considerably. Being transgender, she said, had completely pushed the pressure of BID into the background.

Case#5

The 5. patient reported that in childhood his mother did not care for him at all; her career was more important to her than her child. He had essentially grown up with his father, who worked in a school for mentally and physically disabled children. From an early age, he identified with disabled children and looked at them with envy, as he had the impression that, because of their disability, they received all the maternal love that he lacked. During puberty, he tended to self-harm. By being with disabled children at his father's school, he had the feeling that these children were doing well, that they were protected by their disability and were not confronted with the hardships of life.

From an early age, he suffered from depression, anxiety, panic attacks, and feelings of burnout and was treated with antidepressants. He subsequently tried using a wheelchair himself and experienced a soothing sense of calm there. Especially in situations of overload and burnout, Case#5 increasingly sought refuge in the world of disability, which suggested relaxation to him.

In order to officially live out his need for disability, he gave up his job and moved to a distant city. He told there that at times he was barely able to move and required care for up to 24 hours a day. He allegedly suffered from urinary and bowel incontinence, and food and fluids had to be given to him. He was unable to stand or walk independently; he spent most of the day in a wheelchair or lying in bed. He also suffered from anxiety attacks and panic attacks. Case #5 was primarily cared for by his girlfriend. Based on his description of his symptoms, a healthcare provider suspected multiple sclerosis (disseminated encephalomyelitis). He was given an official disability rating, and care was provided for him.

After nine months in the desired physical state of a severely disabled wheelchair user, an inner disillusionment set in. Outwardly, "everything was fine": He had arranged his environment and his life according to the image of a severely disabled person. However, he increasingly missed his professional life, which stood in stark contrast to his disability. The initial euphoria of having achieved a state that corresponded to his mental self-image faded. He then returned to work and presented himself to the outside world as a normal, independent entrepreneur.

This was not so easy, since he had been officially recognized as disabled by the authorities. In this situation, the relevant authorities were questioned as to whether the patient was truly suffering from a neurological disorder. Due to the significant fluctuations in the extent of possible movements, the suspicion was raised that it might not be multiple sclerosis, but rather a conversion disorder or dissociative disorder, which can, in principle, be cured through therapy. Of course, Case #5 improved rapidly during the course of treatment, the claim for medical care could be withdrawn, and Case #5 has since returned to social life on two feet and is professionally active.

But shortly after returning to a seemingly "normal" life, however, the patient once again developed a hidden double life. To the outside world, he appears to be a functioning, independent entrepreneur—socially integrated, mobile, and professionally active. In his private life, however, he continues to live in the self-chosen role of a severely disabled person.

He set up his own "playroom" in his house, equipped with a wide variety of medical and nursing aids: including several wheelchairs of various designs, a padded intensive care bed with restraint straps, therapy chairs, tear-resistant nursing overalls, epilepsy helmets, orthopedic shoes, as well as various therapy devices and special furniture from residential homes for the disabled. This environment allows him to continue living the life of a person with severe physical (and mental) disabilities in a protected space – completely controlled, yet highly realistic.

This is thus a persistent manifestation of Body Integrity Dysphoria (BID). The patient is able to largely conceal his tendency in social and professional contexts. Despite his successful reintegration into working life, the mental disorder persists and continues to significantly influence his private behavior and social contacts.

Case#6

The sixth patient reported here was a tall, handsome, broad-shouldered, and strong man who preferred to be an amputee.

He has a younger sister. His father was often away from home due to his job. As a child, Case#6 moved several times with his parents to other cities. He was interested in cycling. His childhood friendships were balanced. At school, he experienced bullying; he was referred to as the "bigwig's son." However, he always avoided arguments or fights. Even at that age, he felt that something was wrong with his body. He had different sensations in his legs and the feeling that one leg didn't belong to him. This seemed strange to him, so he distracted himself from it, thinking that it would go away as he continued to develop, perhaps related to growth.

Case#6 graduated from high school with average grades. His parents separated when he was 18, and Case#6 moved out of home the same year.

After leaving a job as a retail salesperson at a men's clothing store, he trained as a stonemason. He worked for the same company for two years after completing his training, but left due to the poor working environment. Then he worked as a stonemason at a sewer concrete pipe company, where he was promoted to foreman within three years. The patient stated that he quickly felt disadvantaged, noticing that another foreman was receiving preferential treatment. He was also dissatisfied with the working hours. He ultimately simply stayed away from work.

After this, he was unemployed, only occasionally tinkering in a private workshop. For some years he worked as a newspaper and letter delivery driver. After a bicycle accident, resulting in a severe injury to his right shoulder, the patient was completely unable to work for two years. Case#6 subsequently reported pain in his right shoulder when exerting stress.

In addition, he experienced gastrointestinal bleeding due to oesophageal varices. After a stay at a spa, the patient was granted early retirement with a 50% disability. Since then, he has been receiving a low-income pension. Case #6 reported having had no prior psychiatric or psychotherapeutic inpatient or outpatient treatment. His development has been unremarkable. The Minnesota Personality Inventory (MMPI, short form) was administered for diagnostic purposes. The results are average; the control and lie

scales show no abnormal results. The personality profile lies exclusively in the average range of 40 to 60 T-scores. A psychiatric or psychopathological disorder cannot be inferred from this.

The patient reported excessive alcohol consumption for several years, and suffered from gastrointestinal bleeding, requiring subsequent inpatient treatment. Oesophageal varices were also diagnosed. Due to these health conditions, he has not consumed any alcohol since then; he stopped drinking alcohol on his own at that time, without inpatient detoxification treatment.

Suicide attempts and self-harm were denied. No evidence of body dysmorphic disorder was found.

Case #6 expressed a gynephilic sexual orientation. He reported a four-week relationship with a girl at the age of 18, which, however, did not "work out" and was perceived as deficient. No further relationships developed in the following years. He then lived in a partnership with a woman for several years. They met in a music park. In this relationship, they supported each other. His partner was going through a divorce; her ex-husband was an alcoholic.

Unfortunately, his partner then passed away. After a long period of mourning, Case #6 tried to meet a new partner, but despite all his efforts, he was unsuccessful. Most women weren't interested in him. He became increasingly lonely, despite his repeated efforts to establish contacts and hanging out in relevant bars. Life was unsatisfying. As a result of intestinal and liver disease, he was unemployed and single, living in isolation in an apartment. He wrote in an email: "Nobody comes to visit me anymore anyway. I'm always very sad and cry a lot. I have no friends anymore, even though I even lent them money. None of my motorcycle friends are here anymore." In this situation, the pressure of BID returned. Since his youth he was dissatisfied with his lower body and felt a strong desire to have a leg amputated. He tried simulating the amputation, but in the long run, this brought him little satisfaction. He looked for a job to escape the loneliness and the mental pressure of the need to lose a leg. He drove disabled patients to doctors or dialysis in the mornings and picked them up again at lunch or in the afternoon. This provided him with some money and distraction: "Hi, I'm just getting home from hours of driving a taxi. I'm fairly comfortable with being distracted and working. It blocks my thoughts a bit. Best regards."

But the job was only twice a day for about one or two hours, and at other times of the day, especially on weekends, he sat alone in his apartment, thoughts of the amputation racking his brain: "Without friends and with these new worldviews, the world has crushed me, so to speak. I'm just the taxi driver in my dreams. Nothing more. We all dream our lives, so to speak."

He then got a cat, which provided him with a long distraction. Unfortunately, the cat somehow managed to leave the apartment and was run over by a car on the street. Case #6 searched for his cat for days until he found the dead carcass on the side of the road.

After that, Case#6's mental decline began, becoming increasingly desperate. He repeatedly saw a woman with a missing arm, which triggered his need: "Here, when I'm shopping, I always see a woman with half her forearm missing. It's so fascinating to me, it's like a curse."

He then tried an orthosis, like Case #3, hoping that it would reduce the pressure from BID, but that didn't work: "Oh, I tried it. The knee orthosis isn't what I need. And it's unsuitable for the job anyway. Glad to hear from you."

He then sought treatment from a psychologist and also received medication from a psychiatrist, but neither of these efforts alleviated the pressure of BID: "The world has overwhelmed me. All I can think about is being amputated. That eases the pressure in my head somewhat. The thoughts just keep coming back. Sometimes I take up to five Tavor tablets a day to keep from going crazy."

Ultimately, the pressure of wanting amputation became so intense that he cut off the little finger on his left hand with garden shears. He claimed it was an accident while pruning roses, which the hospital believed, even though he didn't have a rose garden. The wound was treated, and Case #6 was discharged. However, he was unable to drive any more ambulances for a long time until the wound healed; this made him even more lonely at home, and his thoughts about how to get rid of her leg grew ever stronger: "Good morning, dear world. The BID thoughts are getting me down again. I don't have to go to work until this afternoon, and I'm trying to stay normal. Best wishes."

He had saved some money through his work, and to treat himself to something positive, he bought a used motorcycle: "Maybe I'll buy a used motorcycle on Friday. I think that will do me better than anything else. On the internet, everyone is just talking about amputations. I don't pay much attention to the internet anymore. I'll just wish you a pleasant day. It's snowed a bit here and is frozen solid. Best wishes."

Maintaining the old motorcycle and riding around on it gave him some freedom and partially restored his zest for life. Nevertheless, he became increasingly isolated and felt pushed out of the world and abandoned. He couldn't afford an illegal leg amputation abroad: "Hello Dr. Kasten. They're trying to destroy me psychologically. The world has overwhelmed me, and I have no option for an amputation abroad. So, my fate is already sealed. In the European Union, especially in Germany, you can only imagine an amputation in your head until the end of your life, or you can kill yourself beforehand in such a big world. And I haven't even been officially assisted in using a wheelchair. I'm standing there like a complete idiot."

The idea of deliberately inducing a motorcycle accident to damage his leg so badly that doctors would have to amputate it, began to take shape in his mind. He was strongly advised against it, because you never know what will happen in such accidents, not to mention that other traumatic injuries could occur and the amputation stump would never look good. He was persuaded not to do it, but continued to complain about loneliness and the mental pressure of finally wanting to be amputated.

In the spring of 2025, contact was lost. Through indirect means, it was discovered that Case #6 had died as a result of a serious motorcycle accident.

Discussion

Amputation of the affected limbs is considered by the majority of BID sufferers to be the only way to establish their body identity [6]. Indeed, those who have undergone amputation report a regression of BID, Blom et al. [7] concluded that amputation significantly improves the quality of life of BID sufferers and therefore appears to be beneficial for BIID sufferers. On the Sheehan Disability Scale used by Blom et al. [7], which measures a person's perceived disability, BIID sufferers with amputation reported significantly lower scores than those without surgery. Thus, BIID sufferers prefer a state consistent with their perceived body identity, even if this means being mentally disabled. There are practically no case reports in which the desire for amputation shifted to a new limb after surgery [21].

It is therefore logical that the first case presented here is satisfied after the amputation; it is certainly important here that no regrets arose even some time after the operation. Case #1 is still convinced today that this was the right decision. This is consistent with the data from the study by Noll et al.[31], which surveyed a group of successful amputees about their satisfaction. A much larger study by Saricicek has unfortunately remained

unpublished. In her study, Buket Saricicek examined a sample of 119 BID sufferers (98 disability not achieved; 21 had the disability achieved). The author conducted an interindividual comparison of BID severity, general well-being as well as depression, anxiety, and stress symptoms of the subsamples. Saricicek stated: "BID sufferers who had already reached their desired state of physical disability showed a significantly higher sense of well-being. Finally, in the course of the intraindividual examinations, a significant and, above all, sustainable improvement in psychological condition after the implementation of the BID-related procedure could be shown." In her work, the author comes to the conclusion: "Thus, the achievement of a physical disability can be assessed as promising for the BID-affected."

Essentially, many people with BID experience, through imitation, how complicated it can be to live as a disabled person in our environment. They repeatedly encounter situations that are unsuitable for amputees or wheelchair users. Even many offices are often not geared towards this. Case #2 experienced what it is like to be severely disabled through an accident. The ideal of BID and the reality of actually being unable to walk due to an accident suddenly diverged.

For most affected individuals, mimicking the desired disability is a way to release pressure. Since the need for an amputation is usually associated with shame, it is done either secretly in one's own home or outside at night. Many also travel to distant cities, where they then spend a weekend or a vacation on crutches or in a wheelchair. This releases the pressure and leads to a catharsis that lasts for days or even weeks. However, there are also opposing voices who say that mimicking does not bring them any relief, as it is not the real condition, but merely a game in which one pretends to be disabled. Many affected individuals who initially benefited from pretending behavior also report that after years they lost interest in it and it no longer brings them any relief. This is where Case #3 becomes interesting, as there are apparently individuals with BID who are satisfied with wearing an orthosis and desire nothing more. Apparently, there is a subgroup of sufferers for whom simulating the disability or wearing a prosthesis or orthosis is completely sufficient to keep them satisfied; they do not want a real amputation, even in the long term. However, it should also be mentioned here that the subgroup of BID sufferers who desire paraplegia have no other option than to constantly pretend. Doctors worldwide do not injure the spine to cause paralysis of the legs. However, if you spend your life solely in a wheelchair, the leg muscles atrophy, and at some point, your legs become so weak that you can no longer actually stand or walk. Nevertheless, this condition is still far from that of a true paraplegic, as the legs retain sensitivity.

What is most interesting about this case is that Case #3 was happier after meeting a disabled woman. Perhaps this is a vicarious transference. It is also possible that this is more of a case of mancophilia, i.e. a deformation fetishism, which the patient initially related to his own body, but then realized that it is much more satisfying to have a disabled partner. On the other hand, it is clear from the patient's life and suffering that he himself wanted an amputation and a prosthesis. He did not display (or was not really aware of) any Mancophilic interests. While Case #4 avoided a relationship with a disabled woman, as it seemed like a mere projection of their own needs and desires onto their partner, Case #3 is apparently satisfied with this solution [12]. This teaches us once again that BID is not the same as BID. Every person is different.

Transgender and BID often coexist [35], i.e. the proportion of people with a need to adjust their gender is significantly higher than in the rest of the population. Case #4 was satisfied with her appearance after the change in her externally visible genitals, and the urge to be disabled completely faded into the background, Case #4 subsequently led a happy and professionally successful life as a woman. This suggests that transgender and BID are actually related identity disorders. Case #4 had a mental image of a disabled woman, but when she reached 50% of that, she felt enough body satisfaction to stop further procedures.

Case #5 is perhaps the most important case presented here. He lived for years as a severely disabled patient in a wheelchair and even achieved an official disability rating. But at some point, his condition became tiresome and boring, and he consciously decided to give up BID, leave the wheelchair, and return to leading a normal life on two legs. Clearly, it is possible, at least in some cases, to push BID aside with a rational decision, which contradicts a purely neurological cause. Even if he still shows pretending behavior at home, Case #5 can therefore be compared well with Case #2, who also reached the same state after an accident.

The last case is the saddest and shows how our society's ignorance towards BID can drive a person to death. Du to the unfulfilled need for amputation Case #6 sank deeper into depression, became lonely, and found it increasingly difficult to live his life. Case #6 struggled for many years to cope with this pressure; he acquired a brace, tried to distract himself with a cat, a small job, and a motorcycle; but ultimately, the pressure was too great. He sought psychotherapy and medical treatment. Unfortunately, the pressure from BID ultimately couldn't be alleviated. Whether the accident was truly an attempt to get rid of the leg or simply fate, we'll never know. Ultimately, however, Case #6 ended the suffering caused by BID in his own way.

These case studies are not suitable as therapy for those affected, but there is a suspicion that many people with BID have not really considered the limitations that come with living with one leg or in a wheelchair. Having a nice, round leg stump is glorified (see [1]), but everyday problems are perhaps often not sufficiently focused on.

These case reports suggest that BID is not simply a congenital neurological malfunction, but can be influenced by many psychological factors. The above-cited study by Kasten & Stirn [21], which describes cases in which the desire for amputation shifted from one side of the body to the other for rational reasons, already suggested the involvement of psychological processes. Besides successful amputation, as described in Case #1, there are apparently other ways to cope with BID.

Conclusions

Unfortunately, the case studies described here do not represent a general therapy for all those affected by BID, but they do shed light on some specific perspectives. The donkey in Buridan's fable shows that no one tool is suitable for all purposes. A real amputation seems to help all those affected; at least, no case is known of them later regretting it. A clear understanding of the true everyday consequences of amputation can help those affected to decide, on a rational level, whether or not they want to pursue this path. It is known that mimicking the disability has a relieving effect, but there are no studies on whether living with a disabled partner also reduces the pressure of BID. For the relatively small number of people affected by BID and who are transgender, it appears that resolving one half of their identity problem can reduce the pressure. The most tragic case is certainly the last one presented here, which was ultimately driven to death by BID, as this world offers no real help for the suffering of those affected.

Institutional Review Board Statement

The study was conducted in accordance with the Declaration of Helsinki, and approved by the Ethics Committee of the Medical School Hamburg.

Informed Consent Statement

Informed consent has been obtained from all participants to publish this paper.

Data Availability Statement

The original data can be obtained from the author upon request.

Conflicts of Interest

The author declares no conflict of interest.

Funding

No funding.

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Cite this article: Erich Kasten. (2025) Case reports of 6 patients who were able to relieve or end the pressure caused by Body Integrity Dysphoria. Archives of Clinical Case Studies and Case Reports 5(2): 351-360.