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Review Article

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Reconsidering Body Integrity Identity Disorder: Nosological Reflections and Ethical Challenges of Elective Amputation

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Abstract

Body Integrity Identity Disorder (BIID) is a condition in which individuals experience a persistent mismatch between their bodily self-image and their intact physical body, leading to a desire for limb amputation. Surgical amputation in BIID is usually rejected on ethical grounds, particularly on appeals to non-maleficence and the claim that removal of a healthy limb necessarily creates disability and therefore constitutes serious harm. This article critically examines that assumption. It argues that much of the ethical opposition to amputation in BIID rests on an unexamined conflation of physical impairment with disability. Using the social model of disability, the paper distinguishes the immediate surgical harms of amputation from the longer-term harms commonly attributed to disability, many of which arise from social and environmental factors rather than from impairment itself. Once this distinction is made, the claim that elective amputation is intrinsically harmful becomes less secure. The article does not offer an unqualified endorsement of surgical intervention but instead reframes the ethical debate by clarifying what kinds of harm are at stake and where they originate. It concludes that, in carefully selected cases, where decisional capacity is intact, suffering is substantial, alternatives have failed, and safeguards are in place, elective amputation in BIID cannot be dismissed as inherently unethical and deserves a more nuanced ethical appraisal.

Keywords: Body Integrity Identity Disorder; ICD-11; Bioethics; Apotemnophilia; Amputation; Identity

Abbreviations

BIID: Body Integrity Identity Disorder; SSRIs: Selective Serotonin Reuptake Inhibitors; rTMS: Repetitive Transcranial Magnetic Stimulation; DSM: Diagnostic and Statistical Manual of Mental Disorders.

Introduction

In 1997, whereas most people feel significant distress at the loss of a limb, a surgeon was approached by an apparently able-bodied individual to amputate his apparently healthy left leg. The patient, a married male lecturer, showed

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no abnormalities on psychiatric evaluation. In a similar case, another person underwent surgery to remove a fully functional limb before such procedures were prohibited by the hospital administration. These individuals were found to be suffering from what is now termed "Body Integrity Identity Disorder" (BIID) [1]. BIID, otherwise known as "Amputee Identity Disorder", "Body Incongruence Disorder", "Xenomelia", or "transability (transableism)" is an "intense feeling of a discrepancy between a real intact body and the mental image of a disabled body (e.g. amputation)" [2]. The affected individual feels a sense of completeness only after the amputation of a limb [2,3]. Apart from amputation the desire to become deaf, blind, or achieve the status of a eunuch may also be present [3].

No empirical study has yet determined the prevalence of BIID, and reporting is limited to a few case reports, with more reports coming from western countries than Asian ones. The vast majority of the cases are men, especially in those who desire for limb amputation, but this gender gap is less pronounced in those desiring blindness or deafness. These individuals typically have a higher education status. Non-heterosexuality is much higher amongst those with BIID, however, the basis of the association between BIID and sexual orientation is not known [3].

Despite increasing clinical interest, BIID remains a rare and diagnostically contested condition for which evidence-based treatment strategies are lacking. Although reports of elective amputation in BIID are confined to a handful case of reports, they have generated ethical debate disproportionate to their prevalence. BIID as a separate psychiatric entity and its distinction from other conditions involving disturbances of body representation, identity, or motivation also remains contested. The present article therefore seeks to re-examine BIID through an integrated nosological and ethical framework, critically evaluating psychiatric differentials before undertaking an ethical analysis of elective amputation, with the aim of elucidating the underlying moral tensions. This article presents a narrative review and conceptual ethical analysis of Body Integrity Identity Disorder, integrating psychiatric, neuroscientific, and bioethical perspectives. As this article is a narrative and conceptual analysis based exclusively on previously published literature, it did not involve human participants or animals and therefore did not require approval under the Declaration of Helsinki.

Historical Context

The earliest documented case dates back to 1785, when an Englishman offered a French surgeon 100 guineas to amputate his healthy leg. After the surgeon declined, the man coerced him at gunpoint to carry out the procedure. Sometime later, the surgeon received 250 guineas by mail, accompanied by a letter stating: "You have made me the happiest of all men...by taking away from me a limb which put an invincible obstacle to my happiness [4]". Money et al in 1977 [5] described two male cases who both pursued elective above-knee amputations. They noted that five years earlier, a series of letters published in Penthouse magazine had brought attention to a paraphilia involving attraction to amputees or a desire for self-amputation. This condition was labelled "apotemnophilia" (amputation love) or "acrotomophilia" (attraction to amputees). The two men were identified as having apotemnophilia, with their desire for self-amputation characterized as an idée fixe; a predominant thought rather than a delusional belief. Two decades later, Bruno in 1997 [6] introduced an alternative psychological interpretation for similar cases, suggesting the term "factitious disability disorder". He observed the growing presence of online forums and discussion groups, wherein individuals seeking sexual relationships with amputees were referred to as devotees. Additional categories also emerged: pretenders; those who simulated having a disability by using aids like crutches or wheelchairs, and; wannabees; individuals who wished to become disabled themselves, typically through limb amputation. Bruno theorized that this condition might fulfil a psychological need for love or attention, whether the disability was genuine or feigned, and whether it involved oneself or another person. More recently, Brugger P, et al. [7] in 2013 introduced the term "xenomelia" as a more fitting label for the condition, emphasizing its central characteristic; feeling alienated from one's own limb(s).

Phenomenology

Under typical conditions, the body is perceived in two ways: as a physical object like any other, and simultaneously as a living, vital part of our personal identity. These dual aspects are captured by the German terms; Körper and Leib. Körper refers to the body as a tangible, inert object with measurable dimensions that resists physical interference. In contrast, Leib represents the lived, subjective body, the sensing, perceiving self that is alive and rooted in time and space [8].

BIID suggests that a disconnect may exist between the internal body schema and the actual physical body. It also brings forth the question of how strong the drive can be to resolve this mismatch by modifying the physical body to align it with one's internal sense of bodily identity [8]. Hilti and Brugger [9] in 2010 proposed that dysmelia/ amelia represents the inverse of BIID, where amelia involves the presence of a sense of limb (animation) without an actual limb (incarnation), while BIID involves having a physical limb (incarnation) without a corresponding sense of ownership or connection (animation).

Psychodynamic explanation: About half of individuals with BIID report that their desire for amputation was first triggered by seeing an amputee. Such observations merit closer examination. It has been suggested that a hyper-empathetic response may predispose some individuals to incorporate observed bodily deficits into their own body schema. This speculation was based on the phenomena of mirror-touch synaesthesia in healthy individuals and the experience of phantom limbs in people with congenital limb aplasia. Xenomelia may therefore be conceptualized as the mirror image of phantom limb in aplasia: just as being born without a limb can mean that seeing a limb in motion evokes the feeling of having a corresponding limb, in xenomelia, observing the absence of another person's limb may reveal a congenital under-representation of one's own existing limb [3]. Other theories include BIID as an attempt to gain attention from cold and unloving parents, or the desire being a manifestation of an unresolved internal conflict [10].

Ethical Discussion about Elective Amputations

For those suffering from BIID, the urge to remove a limb is not a passing fantasy but a persistent desire to eliminate an appendage being experienced as alien. These persistent desires cause marked distress, disrupt social functioning, and impair performance at work. In severe cases, the situation can be life-threatening: individuals unable to obtain medical amputation may attempt self-mutilation; by shooting a limb, sawing off digits, placing the limb in front of a train, or using dry ice to induce irreversible tissue damage [11]. The intense longing to align the body schema with the lived physical body raises several questions: can it ever be justified to amputate a healthy limb?; what boundaries exist for individual autonomy in medical decision-making?; and does a patient's informed consent take precedence over a physician's moral refusal to operate on a healthy body part? In the following sections, we examine the ethical arguments for and against elective amputation through the lens of Beauchamp and Childress's widely endorsed medical ethics framework, namely autonomy, non-maleficence, beneficence, and justice.

Autonomy

Decision-Making Capacity and Psychiatric Compulsion: A central question in the ethical analysis of BIID is whether the request for amputation can ever represent a truly autonomous decision. To address this, both psychiatric evidence and philosophical theories of free will must be considered together.

Respect for autonomy does not apply when a patient cannot make a fully informed and rational decision, because either they are immature, incapacitated, ignorant, coerced, or exploited. Examples of such patients include the mentally sick, delusional, and drug-dependent persons [12]. In such cases, the principles of beneficence and non-maleficence prevail. Consequently, every BIID case should be assessed by psychiatric specialists to show that the amputation wish arises from an obsessive drive/ autonomous reasoning, and not from a monothematic delusional belief. Surgeons, therefore, cannot solely on their own, accept a BIID patient's request for amputation as a valid exercise of autonomy [11,12].

From an autonomy perspective, individuals seeking amputation can be broadly divided into three groups: (a) those with BIID, whose desire arises from a neuropsychological disturbance in limb ownership; (b) apotemnophiles, who seek amputation for paraphilic reasons; and (c) individuals motivated by anticipated financial or social gain, such as insurance benefits or increased attention. Although respect for autonomy theoretically allows individuals to make decisions about their own bodies, including the extreme choice to undergo an elective amputation, this principle cannot be applied uncritically. Each request must be assessed to determine whether it reflects a genuinely autonomous choice or whether it is shaped by an underlying neuropsychological condition. Interestingly, it is contested that since the drive for amputation in BIID stems from a disorder of body identity, therefore the autonomous decision-making in such individuals is potentially compromised. In contrast, those pursuing amputation for sexual gratification or secondary gain do not demonstrate such neuropsychological impairments, and their choices can therefore be considered fully voluntary, even if ethically contentious [11].

Philosophical Accounts of Free will and Higher-order Volitions: Beyond psychiatry, analytic philosophy also distinguishes between genuinely free choices and choices produced by obsession. A will is free only when it follows one's rational judgment, ie when a person could choose otherwise if they thought otherwise. A will is unfree when a person feels compelled to want something that their own judgment advises against. States such as compulsion, obsession, addiction, loss of self-control, conformity, or indoctrination are all examples of an unfree will [11,13].

To distinguish autonomous choice from pathological compulsion, Harry Frankfurt's framework of higher-order volitions is particularly illuminating. First-order volitions refer to immediate wants or desires, while second-order volitions represent a person's reflective stance toward those desires. For instance, a smoker's craving for a cigarette is a first-order volition, whereas the wish to no longer have that craving reflects a second-order volition. According to Frankfurt, a will is autonomous only when these two levels of volition are in harmony [11,14]. In the context of BIID, the wish for amputation constitutes a first-

order volition, whereas the desire to be free of this urge, expressed by many patients as “I wish I did not feel this way”, functions as a second-order volition. This higher-order desire could theoretically be satisfied either by amputating the limb or by eliminating the pathological drive itself. If the patient is convinced that only surgery can extinguish the unwanted desire, the second-order volition reinforces the first-order volition, producing a powerful internal push toward amputation. Conversely, if the patient believes the urge might resolve through psychological or neurological intervention, the second-order volition introduces resistance to the amputation wish and motivates treatment-seeking instead, much like a smoker who adopts nicotine replacement to counteract cravings. Crucially, the amputation desire in BIID also conflicts with other stable and rational volitions the patient simultaneously holds, such as the wish to remain healthy, avoid pain, preserve mobility, and maintain social acceptance. This intrapsychic conflict demonstrates that the amputation wish does not represent a unified, reflective, or fully autonomous will; rather, it behaves like an obsessive or monothematic pathological desire that overrides the individual’s broader values and rational judgment. It is precisely this fragmentation of volition, and the dominance of a compulsive drive over self-governance, that underlies the conclusion that BIID-related amputation requests cannot be ethically classified as autonomous decisions [11,14].

Limits of Autonomy in Medical Practice: According to the principle of autonomy, patients may choose among medically accepted treatment options, weighing their risks, benefits, and personal values. If amputation were an established treatment for BIID, patients could legitimately select it alongside psychotherapy, medication, neurorehabilitation, or neuromodulation techniques such as TMS. However, determining whether amputation qualifies as a valid therapy is not governed by a patient’s autonomy. Patients have no entitlement to interventions that conflict with professional ethical standards [11,12].

Some authors promote amputation as a therapeutic option for BIID, framing it as a surgical form of psychotherapy, others, base their argument on unrestricted personal liberty, claiming that individuals should be free to modify their bodies without clinical justification. They place elective amputations on a continuum with cosmetic surgeries, arguing that just as cosmetic patients pursue beauty, persons with BIID pursue disability as a form of authenticity [11].

Clinical Autonomy and Arguments in Favor of Amputation: A contrasting argument posits that elective amputation can be ethically permissible in a subset of BIID patients when autonomy is interpreted according to standards used in clinical medicine rather than philosophical idealism. Swindell distinguishes between philosophical autonomy, which demands reflective endorsement of one’s desires, and clinical autonomy, which serves primarily to protect patients from unjustified paternalism. In the medical context, a patient’s choice must simply meet four criteria: (a) the patient understands the nature of their condition and the risks and benefits of the proposed treatment; (b) the patient appreciates that this information applies to them personally; (c) the patient can reason with this information and weigh alternatives; (d) the patient can communicate a stable and voluntary decision [15]. Earlier studies have consistently described BIID patients as well-educated, articulate, and cognitively intact. Many have lived with the desire for decades, researched surgical techniques and prosthetics, rehearsed life as an amputee, and articulated clear expectations of postoperative disability [10]. Smith also notes that BIID sufferers are “among the most well-informed patients encountered,” often possessing a deeper understanding of amputation rehabilitation than typical surgical candidates [10]. Their decision-making is typically stable across years and persists despite presence of shame, secrecy, and social stigma; features which are generally absent in delusional disorders [10,16,17].

Moreover, the desire for amputation in BIID is identity-constituting rather than impulsive. Patients frequently describe a mismatch between their bodily anatomy and their “true self,” paralleling the phenomenology of gender dysphoria [10,17]. Brugger and colleagues argue that in these individuals, amputation is not a rejection of bodily integrity but an affirmation of it and the amputation should not be considered as self-harm but as self-realization [3].

Autonomy-based justification further strengthens when considering the absence of effective alternatives. Psychotherapy, Selective Serotonin Reuptake Inhibitors (SSRIs), hypnosis, behavioural interventions, and neuromodulation have not produced sustained improvement in BIID. Meanwhile, elective surgical amputation, though radical, has been consistently associated with durable relief of dysphoria and a significant reduction in psychiatric morbidity [10]. From the standpoint of autonomy, the availability of a treatment that alleviates suffering and has been repeatedly chosen by well-informed, competent individuals supports a presumption in favour of respecting their choice.

Autonomy and Patient Safety: Finally, the autonomy argument gains practical force when viewed against the backdrop of patient safety. Denial of surgical amputation has driven many BIID patients to attempt dangerous self-amputation using firearms, trains, or dry ice, often resulting in catastrophic injury or death [10,11]. Respecting autonomy in a clinical setting may therefore not only honor patient

agency but also avert greater harm than the controlled surgical alternative.

Taken together, these perspectives illustrate that while autonomy is central to medical ethics, it cannot be invoked uncritically in BIID. The underlying pathology may compromise rational self-governance in some individuals, yet a subset of patients may still meet clinical standards of autonomy and request amputation as a well-informed, identity-affirming choice. The challenge lies in distinguishing between these groups and ensuring that surgical intervention is not grounded in an impaired or non-autonomous will.

Non-maleficence

Irreversibility and Surgical Harm: Under the principle of non-maleficence, physicians must not perform amputations without a valid medical indication, as the procedure carries substantial risks, including infection, thrombosis, paralysis, necrosis, and chronic phantom pain, apart from the resulting disability. The existence of other elective body modifying surgeries, such as cosmetic breast enlargement, does not justify undertaking an even more injurious procedure. Moreover, amputation inflicts irreversible harm that cannot be undone, even if future treatments were able to normalize the patient's disturbed body image [11].

Harm Reduction and Prevention of Self-injury: A contrary view to the above argument is put forth by clinical observations indicating that untreated BIID may itself generate substantial risk and morbidity. Individuals with BIID experience severe and persistent distress that may lead to self-inflicted amputation attempts, sometimes with fatal consequences. Within this context, amputation can be understood as consistent with medicine's goals where it reduces suffering associated with a discordance between bodily form and body identity. Patients with BIID typically demonstrate intact decision-making capacity, pursue change through informed consent, and seek improvement in functional and psychological wellbeing. For some individuals, surgical intervention appears to alleviate distress more reliably than the traumatic and medically uncontrolled amputations. In non-delusional patients, amputation is therefore compatible with the principle of non-maleficence since it reduces psychological suffering without introducing disproportionate harm [18].

Beneficence

Evidence for Benefit and its Limitations: Under the principle of beneficence, amputation could only be justified if its benefits clearly outweighed its harms, which requires evidence of effectiveness, lasting benefit, and the absence of safer alternatives. Although some authors argue that these criteria are met, they provide only anecdotal reports from a small sample, mostly self-selected individuals who were satisfied with their amputations [16,19-21]. The durability of benefit is also questionable, as symptom substitution has been reported, with some patients seeking further mutilation after the initial procedure [22-24]. However, the principle of beneficence could justify amputations if they could prevent even worse consequences, since some of the patients are so obsessed with amputations that they take matter in their own hands, by crushing a leg under weights or placing the affected limb in the way of an oncoming train. While medically performed amputation could theoretically avert such outcomes, this reasoning, however, presumes that amputation is inevitable and simply shifts the question to who performs it. Moreover, many BIID patients do not attempt self-harm and might instead be influenced toward surgery if a clinical option were made available [11,12]. Psychotherapy and medication have shown limited but occasional benefits, and it is incorrect to assume that amputation is the only way to align bodily experience with bodily form; non-invasive approaches such as movement therapy, Repetitive Transcranial Magnetic Stimulation (rTMS), or targeted brain stimulation may offer alternative avenues. Thus, the requirements for beneficence are unproven or unmet [11].

Identity-based Accounts of Benefit: Some authors have proposed a beneficence-based justification for elective amputation by drawing two arguments. Firstly, in individuals with BIID, the desire for disability represents a set of stable, deeply internalised values that are central to the person's identity rather than transient or impulsive preferences. From this perspective, endorsing the patient's request is viewed as an affirmation of bodily integrity rather than a violation of it, because the intact limb is experienced as incongruent with the person's authentic bodily self. Secondly, the way that amputations in conditions such as ischemia alleviate pain, restore function, and enhance quality of life, amputation in BIID can yield an improvement in psychological wellbeing by resolving the chronic dysphoria arising from a mismatch between the physical body and the internal sense of embodiment. Accordingly, they claim that the net benefit, measured in terms of sustained relief, restored psychological coherence, and improved global functioning, may be sufficient to satisfy the principle of beneficence [25].

Justice

Resource Allocation and Collective Responsibility: From a justice perspective, amputation in BIID may appear defensible at the individual level but problematic when viewed in terms of collective responsibility. Amputation is commonly associated with dependency on societal resources, including modified housing, financial compensation, and supported transport, in addition to the direct costs of surgery. These, along with the costs of rehabilitation, early

retirement, and lost productivity, place significant strain on public health systems. From this standpoint, permitting elective amputation of a healthy limb may be seen as imposing avoidable economic and social burdens on the community, thereby raising concerns about the fair allocation of shared healthcare resources. Public funding is ethically justifiable only when an amputation is medically necessary to treat a serious illness, not when it is requested for aesthetic, erotic, or financial motives. Because amputation cannot be defended as a legitimate medical treatment for BIID, it should not qualify for public financing under the principle of justice [10,11].

Societal Benefit and the Cost of withholding Treatment: Conversely, justice-based arguments can also be advanced against denying surgical intervention to individuals with BIID. Evidence suggests that, for affected individuals, amputation is an enabling experience, often leading to improved functioning, increased productivity, and a reduction in the use of psychiatric services. Moreover, elective amputation may be safer and cost-effective than managing the consequences of self-attempted amputations. On this account, withholding surgery may paradoxically generate greater societal burden, thereby constituting an injustice both to the individual and to the healthcare system [10].

Is Surgery Really Therapeutic? Empirical Evidence

Significant reservations have been expressed regarding whether surgical intervention in BIID should be prioritized over non-surgical approaches (antidepressants, behavioural therapy). Critics of surgical management further assume the possibility of "looping effect," wherein the relief obtained from one procedure reinforces desires for additional interventions. This concern is often articulated by drawing parallels with conditions such as Body Dysmorphic Disorder (BDD) or mania operativa [26].

To empirically address these concerns, Noll and Kasten [26] conducted one of the first follow-up studies of individuals with BIID who had achieved their desired impairment. The sample comprised twenty-one participants, the majority of whom had obtained amputation either through physician-performed surgery, or through deliberate self-injury when surgical access was denied. Notably, none of the participants reported regret following amputation. Post-operative assessments demonstrated marked improvements in body satisfaction, perceived identity congruence, and multiple domains of quality of life. Participants reported having reached their ideal body image and experiencing a sense of bodily completeness. Furthermore, the majority did not express a desire for additional surgical interventions, thereby challenging analogies drawn with BDD. The study also noted that apart from counselling, no other non-surgical intervention had any significant effect on improving BIID symptoms and consequently, amputation be considered as a viable option of treatment in BIID. [26]

Patrone [27] has termed this as a "master argument", which follows that: (a) BIID patients present with suffering; (b) amputation leads to lasting relief and; (c) no effective alternate treatment exists except amputation, therefore; (d) the preferences and treatment requests of individuals with BIID should be evaluated according to the same clinical standards, and accorded the same level of respect, as those of patients presenting with more conventional conditions. Patrone [27], however, also adds an exception that the "master argument" does not hold true if the desire for amputation stems from other psychiatric disorders such as depression with suicidal ideation or amputation of genitals done in response to command hallucinations in schizophrenia or delusions of guilt over perceived sexual transgressions. Sexual arousal as the drive for amputation or desire for amputation due to BDD are also excluded from the argument.

Dissecting BIID from other Psychiatric Diagnoses

Even though the concept has been introduced as early as 1977, only about 100 cases have been documented, which have been investigated by a handful of researchers. Its inclusion into International Classification of Diseases, Eleventh Revision (ICD-11) has been criticized, since its incorporation into ICD-11 as a separate diagnosis was largely due to the influence of a single expert who authored much of the limited literature on the condition. This represents a striking instance of disproportionate impact by an individual on diagnostic classification. Endorsing BIID as an official diagnosis carries its own risks, as it may be invoked to justify harmful amputation procedures and could precipitate a rise in imitative symptom presentations [28]. Apart from having a disputed nosological validity, BIID has also been earlier compared with other psychiatric diagnoses, which may also have a desire for amputation as their presenting feature. Here we have briefly delineate BIID from other such diagnoses.

Psychotic Disorders

The unusual nature of the preoccupation observed in individuals with BIID raises the question of whether the condition should be conceptualized as delusional. However, the phenomenology of BIID does not meet criteria for delusional belief formation. Individuals with BIID do not hold false beliefs about external reality in relation to their desire for disability; rather, they report an internally generated sense that their body would feel "right" only if configured in a particular disabled form. For instance, an individual who

experiences a persistent conviction that he should have been born without his left lower limb fully recognizes that the limb is anatomically a part of his body and understands that his experience arises from within himself rather than from an external cause. In contrast, psychotic disorders are characterized by externalized, reality-distorting explanations. A psychotic individual might, for example, believe that an external force has attached another person's limb to their body or engage in self-amputation in response to command hallucinations or delusional guilt [29].

The aspect of BIID that most closely approaches the appearance of false belief concerns the expectation that acquiring the desired disability (limb amputation or paraplegia), would alleviate the dysphoric experience. Nonetheless, this expectation should not be construed as delusional for two principal reasons. First, earlier reports describe substantial or complete resolution of distress following amputation, suggesting that such expectations may not be inherently false or based on incorrect inferences about external reality, as required by the Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of delusion. Second, individuals with BIID typically retain insight and acknowledge the possibility that surgical intervention may fail to relieve their distress; their belief, is therefore not held with delusional conviction. At most, such beliefs may be characterized as overvalued ideas rather than delusions [29].

Body Dysmorphic Disorder (BDD)

When comparing BIID to BDD, the two conditions prima facie show a preoccupation with a specific part of the body, however, persons with BIID do not hold delusional convictions regarding bodily defects. Instead, they acknowledge the affected limb as anatomically normal and functionally intact [30]. In BDD, where there is a preoccupation with perceived defect in physical appearance, individuals with BIID do not typically regard the affected limb as aesthetically unattractive; rather not being consistent with their inner body image [10,18]. Even when aesthetic concerns are reported, they rarely constitute the primary impetus for the desire for amputation [18].

Gender Dysphoria

Similarities between BIID and transsexualism include deep discomfort with one's physical embodiment, sexual arousal from simulating the desired state (such as pretending to be an amputee or cross-dressing), and sexual attraction to individuals who possess the body type the person wishes for themselves (acrotomophilia). This latter trait is especially notable in non-homosexual male-to-female transsexuals; those not exclusively attracted to men and is explained by a phenomenon known as "erotic target location error". This mechanism is believed to be relevant in certain cases of BIID [31]. According to this theory, individuals who long for amputation are often also sexually drawn to amputees, partially because their sexual aesthetic preferences are shaped by how their own body is represented in the brain's cortical map [32]. Other commonalities and differences between the two disorders is summarized in table 1 [3]. Differences include focus upon gender rather than upon a limb in gender dysphoria; intensity of rejection of body parts, which may reach upto the point of hatred towards genitals in gender dysphoria, whereas in BIID individuals try to remain indifferent [33].

Characteristic	BIID	Gender dysphoria
Marked distress due to body morphology	Yes	Yes
Typical age of onset	Early (before adolescence)	Early in FtM, both early and late in MtF
Sex ratio (biological)	More common in men than women	More common in men than women
Elevated prevalence of non-right-handedness	Yes	Yes
Simulation of desired state	Frequent (pretending)	Frequent (crossdressing)
Sexual arousal associated with simulation	Frequent	Frequent in gynephilic MtF
Psychotherapy an effective treatment?	No	No
Surgery an effective treatment?	Yes (illegally available in some non-Western countries)	Yes (legally available in many countries)
Secondary psychiatric disorders	Frequent	Frequent
Co-occurrence described?	Yes	Yes

Table 1: Comparative Overview of Core Features of BIID and Gender Dysphoria.
MtF=male-to-female transsexuals.
FtM=female-to-male transsexuals.

Anorexia Nervosa (AN)

BIID has often been compared with AN, both of which involve surgical interventions (eg stomach stapling in persons with AN). However, unlike AN, BIID is not associated with false beliefs. Persons with AN believe that they are overweight despite the evidence to contrary. In contrast, individuals with BIID realise that their bodies are healthy; and that amputation is a means to align with their idealized internal self-image. It is this mismatch that causes a BIID patient to suffer, not an alleged false belief [30].

Factitious Disorder

Some individuals with BIID report engaging in behaviors that resemble disability simulation or illness feigning. For example, individuals with a longstanding desire for paraplegia may spend substantial periods using a wheelchair and behaving as though they were paraplegic. Other individuals have described simulating medical conditions in an attempt to persuade surgeons that an elective amputation is medically indicated; for instance, one reported case involved feigning a chronic pain disorder affecting a lower limb in the hope that amputation would ultimately be proposed as a therapeutic option. The occurrence of such behaviors raises the question of whether BIID should be conceptualized as a variant of factitious disorder, which is defined by the intentional production or feigning of physical or psychological symptoms. However, the critical distinction between factitious disorder and BIID lies in the underlying motivation for the feigning behavior. In factitious disorder, the primary aim is to assume the sick role in order to obtain care/ attention. In contrast, the desired impairments in BIID, such as amputation, paraplegia, or blindness, are not sought to secure caregiving or social support. Rather, they are experienced as necessary for restoring the body to an internally experienced, intended, and subjectively “correct” configuration. Moreover, individuals with BIID frequently conceptualize the prospect of living with their desired impairment as an expression of personal strength and resilience rather than dependency. Consistent with this orientation, many actively strive for maximal independence following attainment of the desired bodily state, a pattern that stands in marked contrast to the motivational structure characteristic of factitious disorder [29].

Conclusion

Some questions remain unanswered. So far, no comprehensive model has been developed that fully explains the cause of BIID. The existing theories fail to address several fundamental questions: (a) why do individuals with BIID only feel a sense of wholeness or completeness after undergoing an amputation?; (b) why is it that the desire for amputation can shift from one side of the body to the other, yet almost never changes from one specific limb or body part to a different one?; (c) why doesn’t the desired site of amputation correspond to neuro-anatomical boundaries like dermatomes, but instead aligns more with the commonly seen patterns of amputation in everyday life; (d) why do many individuals with BIID exhibit a sexual attraction toward partners who have similar physical disabilities?, and; (e) why does BIID typically manifest itself from childhood? [2].

Ethical opposition to surgical intervention in BIID often rests on the assumption that amputation of a healthy limb is intrinsically mutilating and therefore impermissible. However, as Song [34] argues, the moral meaning of bodily alteration cannot be determined solely by the physical status of the limb, but must be evaluated in relation to the welfare of the person as a whole. Drawing on the ethics of mutilation and historical precedents of surgical interventions for psychiatric conditions, Song suggests that irreversible procedures may be ethically defensible in rare and carefully circumscribed circumstances, particularly when suffering is severe, persistent, and resistant to all reasonable alternatives. At the same time, it cautions against grounding such interventions solely in claims of autonomy or identity fulfilment, as this risks reducing medicine to a consumer enterprise and eroding principled limits on bodily intervention. Taken together, these considerations underscore the need for a nuanced, case-by-case ethical framework that resists both reflexive prohibition and uncritical endorsement of amputation in BIID.

Taken together, the available evidence does not support elective amputation as a standard or routine therapeutic option for BIID. Nor, however, does it justify an unqualified ethical rejection grounded solely in intuitions about bodily integrity or normality. Rather, BIID occupies a narrow and ethically precarious space in which irreversible surgical interventions, if considered at all, demand exceptionally stringent diagnostic assessment, exhaustion of non-surgical alternatives, and careful consideration of proportionality, long-term consequences, and broader social implications.

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