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Body Dysmorphia

CRITICAL LOOKS: AN ANALYSIS OF BODY DYSMORPHIC DISORDER

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This paper sets out a framework for a comprehensive theory of Body Dysmorphic Disorder (BDD), based on interview data and theoretical reading. It combines psychoanalytic, cultural and political insights. It develops the author's earlier work on body hatred (Parker, 2003). The role of the other – actual, imagined or fantasized – is central, and ambivalence about the body, inflated by shame, is key to this dynamic. Any part of the body may be involved, and checking is compulsive, betraying an omnipotent struggle for acceptability and normality. The author suggests that BDD sufferers are especially sensitive to the power, pleasure and pain of looking and being looked at, with the objective sense of self dominating any subjective sense. Object relations provides explanations of individual differences in susceptibility to BDD, through failures of maternal mirroring. Lacan's theory of the mirror stage explains the origin of the ambivalent relation of the subject to his/her own image, rivalry with self and other, shame and desire, as well as the enduring power of cultural norms of appearance. Freud's ideas on taboo and ambivalence, and their dynamics in changing cultural forms, are illustrated and linked to Douglas's ideas of pollution and taboo.

KEY WORDS: BODY DYSMORPHIC DISORDER (BDD), AMBIVALENCE, SHAME, GAZE, MIRROR STAGE, MATERNAL MIRRORING, TABOO, CULTURAL NORMS

I was frequently subject to moments of despair. I imagined that there was no happiness on earth for a man with such a wide nose, such thick lips, and such tiny grey eyes as mine . . . Nothing has such a striking impact on a man's development as his appearance, and not so much his actual appearance as a conviction that he is either attractive or unattractive.

(Leo Tolstoy, 1855)

I am overdetermined from without, I am the slave not of the 'idea' that others have of me but of my own appearance.

(Frantz Fanon, 1967)

She's definitely got her own look. She is completely fearless.
(Madonna on her daughter Lourdes, *Grazia*, 2009)

INTRODUCTION

These three quotations together take me to the heart of the issues that arise when working clinically with those suffering from Body Dysmorphic Disorder. Tolstoy highlights the torment induced by the conviction of ugliness. Fanon confirms that when working with body image the political, cultural and social dimension forming and informing the suffering must be taken into account. The quotation from Madonna raises the question of why 'having her own look' demands complete fearlessness of her daughter.

My research into Body Dysmorphic Disorder (BDD) focuses on the links between individual lived experience and cultural formations in the development of negative body image. My range of reference is wide, ranging from psychoanalytic theory to moments of contemporary culture. My aim is to clarify individual difference in the experience of body image, and to gain greater understanding of the incredible tenacity of BDD. This paper, a mapping of the territory, is an attempt to draw together an overarching theory.

I will begin by describing the symptoms of BDD. I will then delineate the psychoanalytic understanding of the origins of shame which I shall link to the aetiology of BDD. Finally, I will look at the cultural workings of shame in relation to the body and attempt to map together the emergence of individual shame with the deployment of shame as a cultural disciplinary force. Bruna Seu (2006) has demonstrated the critical importance of bringing together Foucauldian ideas of self-surveillance and positioning in discourse, with a psychodynamic theorization in order to grasp the full significance of shame.

The divisions I am creating in the ordering of this paper echo the splits in the literature on body image disorder. When I published a paper on the subject in the *British Journal of Psychotherapy* in 2003, I could find next to nothing written on the subject from a psychodynamic perspective (Parker, 2003). This is in part because acute cases of body hatred are unlikely to reach the psychotherapist's consulting room. People suffering from acute BDD are frequently housebound, sometimes suicidal and, if they manage to leave home, more often than not it is to seek help from plastic surgeons or dermatologists. Hence BDD has been the province of psychiatry with Katherine Phillips writing on the subject in the USA and David Veale in this country (Phillips, 1986; Veale *et al*., 1996a, 1996b). Recently, however, with the recognition of the ubiquity of the condition, there has been a burgeoning of interest in the subject from within psychoanalysis. The psychoanalytic approach focuses on individual psychopathology, identifying the aetiology within specific developmental patterns of the mother–child dyad (Lemma, 2009). The sociological/philosophical approach focuses on cultural determinants (Bordo, 1993), while within psychology the emphasis is on the psychology of perception (Grogan, 2008). In addition there is a feminist perspective on BDD that believes it to be a diagnosis

which pathologizes women (Chen & Moglan, 2006). While BDD, in its most serious manifestation, in fact afflicts both sexes equally, mild BDD is predominantly the province of women; preoccupation and manipulation of the body surface is considered a 'normal' gendered activity for women. A point to which I shall return.

Before looking in detail at the symptoms or manifestations of BDD, I want to bring in a few general points. The role of the other in constructing the subject has become central to developments in contemporary psychoanalysis, in social theory and its attendant philosophies. Nowhere is this more evident than in body image, formed through identification, projection and introjection. Yet the other – 'the neighbour' – who plays such a crucial part in the construction of body image remains inscrutable. 'I exist for myself as a body known by others,' observed Sartre (1943). We can never know precisely how we are seen. And for those with powerful body-shame this is unbearable.

For those working on the body, the problem is how to avoid too much flesh on the one hand and too much society on the other – and how to avoid falling back into Cartesian dualism. Virginia Blum in her interesting book on cosmetic surgery summarizes the issue as 'I am my body yet I own my body' (2003, p. 5). All my interviewees split body and mind, speaking in terms of an object relationship with a 'rogue body part', declaring 'I hate my nose' or 'I hate my blotchy skin'. Merleau-Ponty suggests a slippage is inevitable: 'Even if I live . . . a true melange of mind and body – this does not take away my right to distinguish absolutely between my mind and body which is denied by the fact of their union' (1984, p. 54). Elizabeth Grosz offers a helpful way of thinking about the problem with her concept of 'interaction', which she considers resists both dualism and monism. She invokes Freud, claiming that a clear interaction of the biological and the psychological is forged in his writing (Grosz, 1994). My focus, however, is specifically on appearance – which requires the interaction of mind and body, as well as literally exposing the individual to social inscription.

MANIFESTATIONS

While the other, and the external web of cultural relations, constructs the body image – defined as the internal representation of physical appearance – not all of us succumb to full-blown BDD. Most of us live with what psychologists term 'normative discontent'. I shall suggest that the key affect in our 'relationship' with our bodies is ambivalence – we love and hate our bodies. This is evident in the concept of 'the good photo of me' versus 'the bad photo of me'. Elsewhere I have distinguished between manageable and unmanageable ambivalence (Parker, 1995). When manageable – when love for the body balances hatred of the body – it prompts bodily care and appropriate concern for the social functioning of appearance. When hatred significantly exceeds love, ambivalence becomes unmanageable and symptoms erupt.

Body hatred is never total. If it were, BDD would not be characterized by the struggle to control and conceal supposed bodily defects. The question is what inflates manageable ambivalence to unmanageable proportions. I shall suggest that shame inflates body hatred to the point of outweighing body love. In my view, the development of the symptoms of BDD is dependent on the degree of shame present in the

individual in their encounter with a culture which mobilizes shame as a disciplinary force in relation to the body. We adhere to cultural appearance strictures to defend against shame. Yet these very strictures threaten shame if we fail to adhere to them. I shall suggest that Western culture does not precisely cause BDD but provides a matrix in which it can flourish.

I am extending the term to cover both mild and acute BDD without suggesting that the degree of distress between a 'bad hair day' and acute BDD is remotely comparable. But there are connections, a continuum.

Body Dysmorphic Disorder was initially identified and termed Dysmorphophobia by an Italian psychiatrist, Enriquo Morselli, in 1886. Today the diagnostic criteria (DSM–IV) involves 'preoccupation with some imagined defect in appearance; if a slight anomaly is present, the person's concern is markedly excessive'. The term 'imagined' is problematic. The supposed defect is rarely imaginary but rather imagined to be more prominent than it would seem to be to an observer. Veale *et al*. suggest that the term be replaced by 'perceived defect'. Studying the condition from a cognitive perspective in relation to the perception of body image, Veale *et al*. (1996a) hypothesize that BDD patients have a magnified selective attention to their perceived defect because of their greater preoccupation with body image in terms of perfectionism or symmetry. They cite evidence that 'animals and humans seek symmetry perhaps because it advertises biological quality . . .' (p. 3). To my mind, seeking symmetry has more to do with a horror of anomaly, a point to which I will return. I would suggest that, at an individual level, the homogenous, symmetrical body is a symptom of the desire for the fantasy of an internal sense of unity – a defence against internal, conflicting divergent forces and desires, which are experienced as shameful. A homogenous surface serves to deny the heterogeneity of the self. Central to the experience of shame is a sense of incongruity or inappropriateness. Hence, the need for the homogenized body is a powerful need to expunge shame.

The mechanics of perception are, however, very important. As perceivers, we select from all the stimuli falling on our senses only those which interest us, and our interests are governed by pattern-making tendencies, known as schema (Douglas, 1966). Psychologists have developed the concept of self-schema – a person's representation of those elements that make her/him distinctive from others – to explain body image. Self-schemas influence how new, incoming information is processed through organizing and guiding the new information (Grogan, 2008).

An intense sense of shame is common to all sufferers. Shame generates the condition and shame maintains the secrecy that surrounds it. Any part of the body can become the focus for despairing shame. The desire driving the selection of the body part is categorically not for beauty but overwhelmingly for 'normality'. Writing from a psychoanalytic perspective, Alessandra Lemma (2009) believes that the declared desire for 'normality' is a defence against perfectionism. In other words, 'normal' is an intensely powerful concept, not simply a defence. The following quotation from a patient of Katherine Phillips is quite typical:

> I'm the one who looks ugly. It started with my nose. One of my nostrils stuck out more than the other. I remember catching a view of myself in the mirror one day and panicking. I thought: 'Is this what you look like?' You look a terrible freak . . . My nostrils don't bother me any more. My skin took over from them. Now all I can think about is how bad my skin looks. (Phillips, 1986, p. 10)

Phillips surveyed the frequency with which body parts are selected for shame and hatred. She found skin to be the most common, followed in order of frequency by hair, nose, eyes, legs/knees, chin/jaw, breast/chest/nipples, stomach/waist, lips, face, penis, weight, cheeks. The specific symbolic meaning of a physical attribute is, of course, in part culturally determined and in part particular to the individual.

Preoccupation with skin can precipitate one of the compulsive rituals associated with BDD: picking. People pick their skin for hours drawing blood and leaving scars. Phillips's patient cited above described her picking as follows:

> Sometimes I'd pick and pick with pins dipped in alcohol . . . I'd pick at all kind of things – little bumps, blackheads, any mark of imperfection. Sometimes I'd be up doing this at 1.00am and 2.00am in the morning. (Phillips, 1986, p. 11)

As in other forms of self-harm, the perpetrator feels powerless to stop the struggle to control the surface of the body, obsessively eliminating any discernible imperfection in a fervent, omnipotent struggle for acceptability. The search seems to be for a smooth, uniform surface. A woman described to me how she picks her feet: 'The picking feels purposive,' she says. 'I'm doing something about myself. It fills the void, answers the anxiety. I have to strip away any bit of loose skin. I know it'll hurt but I can't stop.' Shame is a powerfully motivating force. Her picking, fired with an erotic, aggressive energy, finally immobilizes her as walking becomes painful.

A patient of mine arrived for her session with a large scab on her face. She had picked a spot. She told me that even while knowing she was wrecking her face she compulsively continued with her picking, 'to make a good job of it'. She was exposing the scab rather than concealing it with make-up because she believed she would be viewed not critically, but sympathetically. It could be the mark of illness; hence she would be seen as blameless rather than shamefully blemished.

The British survey of 50 cases of BDD found the nose and hair to be more frequent sites of concern than skin (Veale *et al*., 1996b). Hair is seen as too thin, too plentiful, too full, too flat, too asymmetrical. Hours and hours are spent grooming, snipping, flattening or fluffing and a great deal of money and time is devoted to acquiring hair products, which seem briefly to offer solution and solace. Constant manipulation of the body surface has been considered a gendered activity specific to women, but men are catching up. Since the mid-1980s the cosmetic/fashion industry has increasingly targeted men. Youthful looks, lean yet muscled, are *de rigueur*. When the current recession began, it was reported that men, after losing their jobs in the City, felt compelled to seek cosmetic surgery to look younger for job hunting. The term 'Adonis complex' has been coined to describe the obsessional pursuit of the properly muscled body.

A patient with BDD is obsessively concerned to conceal the preoccupying defect – in part to protect both themselves and their therapist from the pain of an encounter with the aspect of the body felt to be so shamefully monstrous. Camouflage and concealment are central to the condition, only breached by the powerful need for reassurance. Baggy or padded clothing, hats or make-up are all employed to hide the hated body part. And a person's day is structured by the availability of mirrors (Veale & Riley, 2001). Any reflective surface will be employed as a mirror, from car doors to toasters, to ascertain whether the perceived defect is adequately concealed. Sometimes a little reassurance is obtained, asymmetry is seen to be disguised, roughness smoothed, size concealed or exaggerated.

Repeated mirror checking is motivated by the determination never to be taken by surprise, to keep a constant eye on the appearance, which could betray. But betray what? Unconsciously, the compulsion to conceal may relate to a number of shame-provoking scenarios. For example, Phil Mollon (2002) suggests that: 'Shame and false self-developments are intimately entwined' (p. 15). The mirror is scrutinized to ensure that no untoward, uncontrolled or embarrassing aspects of the person are in evidence. On the other hand, for those who feel concealment is impossible, mirrors exacerbate the sense of helplessness and worthlessness, and are hence avoided. Another ritual involves repeatedly touching the perceived defect: touching can fulfil a similar function to mirror checking or can be an act of concealment. At a deeper level it relates to the struggle to feel contained.

Inevitably, the other is engaged as a mirror and many times a day is besieged with pleas for reassurance. Reassurance is received as patronizing, trivializing or dishonest. Reassurance withheld is interpreted as unspoken condemnation, while any attempt at an honest or measured response is heard as veiled criticism. Given that the person with BDD can appear unblemished and even beautiful to the eye of the other, the search for reassurance more often than not simply provokes ridicule and exasperation.

An individual in the grip of BDD interprets difference negatively, as inappropriate and incongruous. 'To be different is to smell,' commented a young woman with BDD. The perceived defect marks them out as different with all that implies. They feel set apart and with shame set themselves apart, literally isolating themselves and their perceived defect from the eyes of the other.

Although BDD can and does develop at any age, the most usual time of onset is, predictably, adolescence, the years dominated by a simultaneous drive towards integration and fragmentation. Turning against the body is, of course, a common response to puberty and the changes set in train. The body is experienced as the enemy responsible for the sense of abnormality and worthlessness that dogs the adolescent. Writing of acute BDD in adolescence, Moses Laufer (1995) considers it a possible indication of the onset of 'serious psychological trouble' (p. 18). One adolescent with acne may react just with awkwardness, while another may withdraw from the world, convinced that their face condemns them to ridicule and rejection.

Once established, BDD is often chronic. Ageing offers no respite, and can worsen the condition. It seals loss of hope – the belief that the self can be improved, the perceived defect eradicated – and institutes mourning for a life spent locked into

disparagement of the body. Phillips (1986) describes a woman of 70 who said: 'I still think about how awful my back looks after all these years. I keep to myself because I don't want to draw attention to it' (p. 167). She spends approximately eight hours a day performing BDD-related behaviours: selecting her clothes each morning, changing them during the day, mirror checking, asking her husband for reassurance and checking other people's backs.

People I have seen with BDD, as with Anorexia Nervosa and Bulimia, usually identify a retrospectively constructed triggering moment, an event which turns their attention to the perceived defect. A characteristic of shame is that it is evoked precipitously, in an awful moment of recognition, and experienced as overwhelming and involuntary. Often a sense of shameful discrepancy or dislocation between who they believed themselves to be (how they believed themselves to be seen) and who they are told they are (how they are told they look) is evoked by a trifling comment, a trivial incident. Indeed, the apparent triviality of the incident is often experienced as shameful in itself. A patient whom I will call Carol developed BDD unusually early, and described the triggering moment as follows:

> I was five years old and playing naked in the garden with a few other children. I looked down and saw that only my tummy stuck out. The others all had flat bodies. I can remember the feeling of twigs beneath my feet and the sudden conviction of being different and somehow less good.

A protruding stomach must have been fraught with meaning for the child. Her mother had recently been pregnant with a stillborn child. Protruding stomachs may well have evoked her complex, contradictory response to the death of the sibling – loss, loneliness, a sense of failure and guilt. Moreover, in the wake of the loss of her baby, Carol's mother seems understandably to have become increasingly concerned with the body of her living child; perhaps in identification with her bereaved mother, Carol kept a close eye on her body – and found it wanting. But for the child, and indeed for the woman who became my patient, the tummy was itself overwhelmingly the reason for her unhappiness and self-hatred. Recounting the triggering moment, what mattered was that her life and her relationships had been determined by chronic, unrelenting hatred of her protruding stomach, in a culture that prizes smoothness and flatness.

PSYCHOANALYTIC FORMATIONS

I will now consider the aetiology of BDD in the context of the development of self-consciousness as understood by Object-relations theorists, and from a Lacanian perspective. I am not a Lacanian but I have found his thinking on the specular image suggestive and helpful in considering the dynamics of body hatred.

Object-relations theorists, drawing on Winnicott's theory of the mirror phase, trace the aetiology of BDD to narcissistic injury sustained through the manner of early mirroring. Very briefly, according to Winnicott, during the mirror phase, the baby sees itself mirrored in the mother's face: 'The mother is looking at the baby and what she looks like is related to what she sees there' (Winnicott, 1971, p. 131).

Alessandra Lemma (2009) attributes the evolution of body hatred to the specific qualities of the mother-as-mirror. She distinguishes three major modes of mirroring determining Body Dysmorphic Disorder. A mother, unable to take pleasure in the baby's body, may provide a one-way or blank mirror, contributing to a deficit in the early libidinal cathexis of the body, with the baby experiencing her or his body as undesirable. Or a mother may look at the baby with rejecting, hostile eyes: the baby's body is not only undesired but it also becomes the receptacle of her projections. This later leads to a deficit in symbolic thinking, making it more likely that undigested projections become concretely located in the body. Or she may be inappropriately narcissistically invested in the appearance of the child. Lemma suggests that the search for absolute certainty in relation to what the other 'sees' when looking at the self subsequently leads to desperate attempts to create the ideal body that will guarantee the other's loving gaze.

Peter Fonagy brings together relational thinking about the body with Winnicott's theory of mirroring. With the theory of mentalization Fonagy seeks to explain the factors that inhibit the development of a strong sense of self as subject, which is so central to the evolution of shame and hence of BDD. He defines mentalization as a process by which we realize that having a mind mediates our own and others' experience of the world. He suggests that the establishment of mentalization is dependent on mirroring. The image of the caregiver mirroring the internal experience of the infant organizes the child's emotional experience, facilitating the process of becoming psychologically minded. The sense of self as a regulatory agency, in other words, the subjective sense of self, is provided by a feeling of control over the parent's mirroring. The child finds in the caregiver's mind an image of himself as motivated by beliefs, feelings and intentions. When psychic reality is poorly integrated through inadequate mirroring, the self tends to be experienced as a physical being without psychological meaning. Hence, physical attributes come to reflect states such as internal well-being, control, and self-worth. And not having a clear sense of oneself from within means an individual needs other people to react to them. Fonagy *et al*. (2002) have coined the term 'unmentalized shame' for shame which remains unmediated by any sense of distance between feelings and objective realities, describing the intensity of humiliation experienced when trauma cannot be processed and attenuated via mentalization. They suggest that: 'The ability to mentalize would mitigate this process, permitting the individual to continue to conceive of himself as a meaningful, intentional subject in spite of lack of recognition from the attachment figure' (p. 425).

Winnicott compared his theorizing of a mirror phase to Lacan's mirror stage in the constitution of selfhood. Both envision the formation of the ego precipitated by a visual image. Both emphasize that an actual mirror is not a prerequisite for the maturational processes of mirroring. Both stress the importance of horizontal family relationships – siblings – in the processes of mirroring. But where they differ is in the significance accorded to the mother. Winnicott notes: 'Lacan does not think of the mirror in terms of the mother's face in the way I wish to do' (1971, p. 130). Lacan asserts that the crucial formative identification occurs only between the self and its *semblable*. Winnicott evokes the potential for growth and self-enrichment as a result

of maternal mirroring. By contrast, Lacan (1949) describes a short-lived moment of jubilation. A sense of radical, unalterable alienation pervades his account. Hence, his account offers an understanding of 'normative discontent' in relation to body image while Winnicott's account, as evidenced by Lemma, can be utilized clinically to explain different intensities of body hatred, though deriving entirely from the maternal eye.

Lacan's mirror stage has a two-fold significance for the study of BDD. Firstly, it marks a decisive turning point in the child's development and, secondly, it ushers in a permanent structure of subjectivity. The mirror stage, to my mind, foregrounds the affects that drive BDD: ambivalence in relation to appearance, rivalry with self and with the other, shame and desire. From the mid-1940s, Lacan conceived of the visuality of the eye as the primary psycho-physical organ in the formation of the I. The mirror stage directs the child's libidinal and aggressive energies towards the specular image. However, as Shuli Barzilai puts it: 'The essence of the relationship of the encounter with a specular counterpart is that it precipitates the bipolarity of identification/alienation' (Barzilai, 1999, p. 2). The subject is left split and alienated from him/herself. To know oneself through an external image is to be defined through self-alienation.

Perhaps, above all, the significance of the mirror stage lies in the overwhelming importance accorded to the visual. Lacan describes the 'capture–captivation' by the specular image – the 'enchainment and enchantment' that creates the almost hypnotic power of the specular image (Evans, 1996), which can disable the 'talking cure' and seal the grip of appearance preoccupation.

The identification is, however, precarious. Between 6 to 18 months the baby can recognize itself in the mirror before attaining control over its bodily movements. The self-recognition is hence misrecognition: the subject apprehends itself only by means of a fictional construct whose defining characteristics – focus, co-ordination – it does not share (Silverman, 1983). The wholeness of the image threatens the subject with fragmentation – and the mirror thereby gives rise to an aggressive tension between the subject and the image. In order to resolves this tension, the subject identifies with the image; this primary identification with the counterpart is what forms the ego. The moment of identification is a moment of jubilation and imaginary mastery but there may also be a depressive reaction when the child compares her or his sense of mastery with the omnipotence of the mother (Evans, 1996). The stability of the unified body image is always precarious, caught between retrospective fantasies of incompleteness and lack, and anticipatory fantasies of unity and wholeness. The mirror stage thus forms the basis of an imaginary anatomy or body phantom with an anticipatory ideal of unity to which the ego will always aspire (Grosz, 1994). Thinking in a different register, this suggests that the huge profits of the fashion/beauty industry are built on aspiration towards an impossible ideal.

Lacan believed Freud's concept of ambivalence to be one of the fundamental discoveries of psychoanalysis (Evans, 1996). The identification with the specular image creates an ambivalent relationship with the counterpart involving both eroticism and aggression. As a consequence of the irreducible distance which separates the

subject from its ideal reflection, the baby entertains a deeply ambivalent relationship with its reflection.

The sufferer from BDD, driven by the early onset of the dynamics of shame, is always struggling towards an impossible ideal. Initial jubilant identification and depressive reaction are re-experienced daily in relation to the visual media. A woman I interviewed expressed the experience of identification and disillusion in relation to fashion images as follows: 'For a second I *merge* with the photo of the model then almost at once I know I could never achieve that look.'

The presence of ambivalence, as discussed above, is evident in the evaluation of photographs of the self. The concept of 'a bad photograph of me' is predicated on the existence of a 'good photograph of me'. Unmanageable ambivalence is evidenced by the distance between the two self-images. While most of my interviewees were able to identify body hatred, body love was harder to acknowledge, in part because Western culture itself is steeped in ambivalence in relation to the body. Beauty is admired yet its pursuit is denigrated as vanity and diagnosed as narcissism. An acknowledgement of body love is also dangerous in the context of rivalry. Indeed, the very concept of 'vanity' could be viewed as a weapon in appearance rivalry, denigrating the other's self-care as 'sinful' pride and self-inflation.

Rivalry with both self and other is constellated by the mirror stage. Dylan Evans writes that: 'The constitution of the ego by identification with something which is outside (and even against) the subject is what structures the subject as rival with himself' (1996, p. 81). Someone suffering from BDD is embattled with their own appearance. Driven by bodily ambivalence, they fight the perceived defect. The declared aim is 'normality' manifested by the other. Yet, at the same time, the other is experienced as constellating an ideal – a wholeness – for which they strive with the help of cosmetics, surgery and diet. Rivalry with the specular 'fraternal' image is lived out in actual sibling rivalry experienced at the level of body image. Amongst people I interviewed, when I asked them to reflect on their childhood, their memories were dominated, almost without exception, by the formative experience of having a sibling believed to be more attractive or less attractive than themselves. The dynamic is not limited to same-sex siblings. One woman described her brother as blond, beautiful, angelic-looking, which left her feeling forever second in her parents' affection and, in later life, locked in rivalry with the appearance of the other: 'I compare myself with every other woman I meet, checking whose double chin is the biggest.' Another dwelt on the guilt and ambivalence she experienced at surpassing her sister, who was 'mousy and plain'. Often siblings disagree as to who was selected as 'the beauty', each insisting that the other was the object of parental admiration. Rivalry, of course, is experienced in both lateral and vertical relationships. A young man commented: 'My father always said: "You'll be taller than me." He wanted me to reflect his power and success but he didn't really want me to surpass him. And I didn't. We are the same height.' His tone conveyed both relief and ambivalence.

The mirror stage points not only to the formative significance of identification, ambivalence and rivalry in the establishment of body image, but, marking the onset of objective self-awareness, it ushers in desire and shame. The child grasps that she/he is

visible to others in the same way that others are visible to her/him, that she/he has an exterior which others can observe. Yet the observation of the other is uncontrollable and essentially unknowable. But while there is fear there is also joy. On the one hand, there is the child silenced by shyness, and on the other, there is the child standing on the topmost rung of the climbing frame, shouting: 'Mum, look at me!' The mirror stage establishes desire as desire of the other's desire which means desire to be the object of another's desire, and desire for recognition by another (Evans, 1996). Whether the gaze of the other activates an experience of agency, excitement and pleasure, or primarily one of passivity, terror of rejection and imperfection, is dependent on the degree of shame-proneness of the individual.

THE MAKINGS OF SHAME

I want briefly to sketch in the pivotal importance of shame in the formation of BDD from a psychoanalytic perspective. For Lacan, the shame-inducing ideal ego originates in the specular image of the mirror stage 'as a promise of future synthesis towards which the ego tends – the illusion of unity on which the ego is built' (Evans, 1996, p. 52). The ambivalence – the co-existence and conflict between body love and body hatred derived from the mirror stage – is productive of shame, and shame in turn magnifies ambivalence.

Shame is categorized as one of the self-conscious emotions. Shame is a global affect encompassing the sense of identity. Shame is a response to fantasy or evidence of personal failure. Shame is directly related to visual imagery. To see oneself or to be seen by others is an essential and invariable component of feeling ashamed, hence the significance of the body in shame dynamics. A fear underlying shame is loss of the object and loss of love.

Since Lacan's time, two developmental lines have been identified in the growth of shame: one involving narcissism and the other, following Freud, concerning instincts and control. The latter has become somewhat unfashionable, but I found that Freud's thinking on shame contributes usefully towards an understanding of BDD because he discusses the vicissitudes of looking and being looked at in the development of shame. Freud viewed shame as a servant of morality: 'Shame, disgust and morality are like watchmen who maintain repressions, dams that direct the flow of sexual excitation into normal channels instead of reactivating earlier forms of expression' (Freud, 1909, p. 45). In sum, Freud considered shame to be a reaction formation designed to maintain the repression of forbidden exhibitionistic instincts. The link Freud makes between the pleasure of looking, the pleasure of being looked at, and the working of shame is important for an understanding of BDD.

Freud (1915) discusses scopophilia (sexual gazing) and exhibitionism (self-display) in the context of the defensive turning round of an instinct upon the subject's own self. The reversal 'affects only the aims of the instinct' (p. 127). Hence the active aim (to look at) is replaced by the passive aim (to be looked at). Freud considered scopophilia to be the earlier instinct and comments that: 'It should be remarked that their transformation by a reversal from activity to passivity and by a turning round upon the

subject never in fact involves the whole quota of the instinctual impulse' (1915, p. 130). He concludes that the instinct in its primary form may be observed side by side with its (passive) opposite and 'deserves to be marked by the very apt term introduced by Bleuler: "ambivalence" ' (p. 131). He had considered the subject of scopophilia and exhibitionism in *Three Essays on Sexuality* (Freud, 1905). There he distinguished between the normal manifestation of the instincts in art practice – theatre and the visual arts – and their abnormal manifestation as perversions. He concluded that: '[The] force which opposes scopophilia, but which may be overidden by it . . . is *shame*' (Freud, 1905, p. 157).

Cultural studies have employed Freud's thinking around scopophilia and exhibitionism, particularly in film theory, while the burgeoning psychoanalytic literature on shame since the 1980s has focused rather on an understanding of shame based on narcissism. I think, however, that conflicts around exhibitionism and scopophilia offer useful ways of thinking about BDD. Freud directs us to the particular shaming power of the gaze and hence the fear, experienced in BDD, of being looked at.

Following Freud, one way of thinking about BDD is that it is driven by the conflict of ambivalence – between the desire to look and the desire to be looked at. In Freud's words, both carry 'a sexual tinge', due to the sexual origins of the instincts and both are hence damned by shame. My hypothesis is that people suffering from BDD are particularly sensitive to the power, pleasure and pain afforded by looking and being looked at.

Object-relations theorists, rather than focusing on the meaning of the act of looking, have concentrated instead on the meaning of the mother's look. The aetiology of shame-proneness in the psychoanalytic literature, as indicated above, is understood to lie with early mirroring. Infant observation has identified shame in babies. The 'still face' experience demonstrates the manner in which babies avert their eyes when mothers do not respond as expected. Shame develops in response to an empathic break between the mirroring object and the self. The experience can construct a primary, internal shaming eye focused on the depleted, fragmented self with its believed failures and inadequacies (Ayers, 2003). In adulthood, social isolation becomes preferable to the struggle to beautify the body, concealing supposed defects with the hope of eliciting an affirming and loving response from the other.

The substantial literature on shame since the 1980s understands adult shame to be a failure of the ego to achieve a narcissistic ideal. The conviction of ugliness and the declared desire for normality are determined by the sense of failing to live up to the ego ideal, which is built upon positive identification with parental images stimulating an awareness of potential and a wish for competence, progress and achievement. Juliet Mitchell (2003) suggests siblings may also be a crucial source of the ego ideal: 'Isn't it also likely that the original model (for ego ideal) may be another child, a heroic or critical older sibling?' (p. 6). She suggests that the voice of our conscience, putting us down and making us feel inferior, is reminiscent of the tauntings not of adults but of other children. The importance of lateral relationships in the aetiology of shame is highlighted by the dynamics of Lacan's mirror stage discussed above.

Appearance is undoubtedly often the focus of childhood teasing and those with both mild and acute BDD frequently recall a triggering moment of peer-group teasing. Appearance is, nevertheless, a painfully contested area between generations, precisely because appearance is a major signifier of generational difference. Separation from the parents demands visual nonconformity and adherence to peer-group norms. All those I have interviewed on body image, even those with the most benign connection with their parents, vividly recalled a moment with their parents which can be summed up as 'You are not going out looking like that'. Parents invariably employ shame to induce appearance conformity to maintain family status. For the shame-sensitive child, taking control of their own appearance is a fraught, fearful and uncertain process that continues into adulthood.

Of course, it may be not so much the actual childhood experience that makes for shame-proneness, but how it was understood. Ana-Maria Rizzuto refers to the body of the pathologically ashamed as a shame metaphor. The ashamed person believes him/herself to be repulsive in bodily appearance, foul smelling, monstrously horrifying. These metaphors reveal an anatomy that, as with hysterics, does not coincide with bodily anatomy. The *fantasy* of the hideous body is an unconscious organizer of painful experience for patients suffering from a pathological disposition to feelings of shame. The physical reality used for shame metaphors is not that of the actual body as a physical reality, but a mental construct of that physical reality as it was experienced in reality and in fantasy in the libidinal, aggressive and communicative experiences with the parental objects (Rizzuto, 2008).

A mismatch of attunement with the emergence of shame is, moreover, an inevitable and a necessary aspect of development. Shame and embarrassment in response to failures of communication and expectation are thought to be hard-wired in the human brain (Mollon, 2002). It is through the mirroring look of the mother, and the equally necessary shifting away of her gaze, that the awareness of self is brought into being. Shame is a potentially positive affect, establishing boundaries and indicating concern. Sociologist Elspeth Probyn, drawing on the work of Sylvan Tompkins, holds a particularly positive image of the workings of shame, claiming that shame illuminates our intense attachment to the world, our desire to be connected to others and the knowledge that we will sometimes fail in our attempts to maintain these connections (Probyn, 2005). As Lynd puts it: 'Experiences of shame confronted full in the face may throw an unexpected light on who one is and point the way to who one may become' (1958, p. 20). But 'unexpected light' is intolerable for someone suffering from body disparagement determined by pathological shame.

The recent development of Relational Psychoanalysis has made an important contribution to understandings of shame and hence BDD. Two different experiences of the self are understood to be involved in the relational experience of the body: a subjective sense of self and an objective sense of self, as expressed in Fonagy *et al*.'s theory of mentalization, and the American relational tradition in psychoanalysis with its concept of self-reflexivity.

An important aspect of the shame experience is that it entails the dominance of the objective sense of self. The capacity to experience shame first appears in connection

with the realization that the self can be seen from the outside: 'the thinking about others thinking about us . . . excites a blush' (Probyn, 2005, p. 45). The tension between a view of self as object and a view of self as subject is stalled in shame situations. Ideally, we are able to move flexibly back and forth between the two different experiences of the self – between experiencing the self as subject with agency, judgement and desire; and experiencing the self as an object in the eyes of others (Aron & Sommer Anderson, 1998; Fonagy *et al*., 2002). Within a psychoanalytic framework we can think of the dialectic in terms of narcissism. When self as subject dominates we encounter grandiosity and an impaired ability to experience self as object among other selves. When self as object dominates we encounter a lack of sense of agency, vitality or entitlement.

Defences against bodily shame entail a struggle to offset the experience of self as object with a strengthened self as subject. Defences include rage, concealment of the body, transformational body practices (for example, cosmetic surgery), and projection of shame into the other who is subsequently treated with contempt or ridicule. And, paradoxically, defence against shame utilizes the pursuit of bodily objectification, which is itself productive of shame.

The sense of self as object is associated with the construction of femininity. In 1972 John Berger memorably declared: 'Men act and women appear. Men look at women. This determines not only most relations between men and women but also the relation of women to themselves' (Berger, 1972).

Second-wave feminism highlighted the objectification of women's bodies, challenging the construction of women's bodies as objects to be watched and evaluated, with girls early learning the constant self-surveillance which magnifies body shame and body dissatisfaction.

Yet it is through the objectification of the body that many women seek to achieve an enhanced subjective sense of self. Susie Orbach (1986) commented that women transform their bodies in the attempt to deal with the perceived requirements of their role – expressing rebellion and accommodation with the striving for invisibility versus the wish to be seen. This has been viewed positively by some as 'self making', as resistance, as harnessing the power inherent in glamour, and as a way of inhabiting the body with defiant femininity. Kathy Davis (1995), for example, claims cosmetic surgery to be a practice of personal choice and individual empowerment.

This may be true for some, but it underestimates the power of both the psychological and the cultural processes underlying transformational practices. For someone suffering from body-image disparagement who is prompted to seek transformational practices, how others perceive her or him is all important, and, as discussed above, inevitably fraught with uncertainty and the potential to trigger shame. I have coined the term 'pathology of judgement' for the state of affairs that pertains when flexibility between the subjective and objective experiences of the self is stalled and judgement is placed overwhelmingly in the eyes of the other. Moreover, the dynamics of the mirror stage undermine transformational practices. Each change can be subverted by bodily ambivalence firing the pursuit of an impossible 'ideal unity' while the fashion/cosmetic/beauty complex harnesses these psychological processes, employing

graphic means (airbrushing and photo shopping) to ensure an ever-changing, unobtainable ideal.

SOCIAL CONSTRUCTIONS

I want now to consider the implications for BDD of some recent work on the body from a cultural perspective. The sense of shame that finds expression in body hatred is undoubtedly a transgenerational phenomenon, rooted in both psychological and social experience across time. Racism, sexism, immigration, class shifts and the condition of parenthood have all to be taken into account in understanding the unconscious transmission of transgenerational shame and its intrapsychic and interpersonal enactment in body hated.

After decades of perceived neglect, the body is at the forefront of academic discourse with the new subdiscipline, 'the sociology of the body'. The focus on the implication of the body in social relations of power is particularly relevant to a study of body image. In Judith Butler's words:

> The recasting of the matter of bodies as the effect of the dynamic of power [is] such that the matter of bodies will be indissociable from the regulatory norms that govern their materialization and the signification of those material effects. (cited in Fraser & Greco, 2005, p. 63)

The power of regulatory norms is dependent upon the inculcation of body-shame. We succumb to surveillance, discipline and normativity applied to the body precisely because, in Freud's words, 'the ego is first and foremost a bodily ego'. The ego ideal is hence indissolubly bound up with our success or failure to achieve appearance norms which, following Lacan, will remain forever out of reach.

Many column inches have been devoted to the supposedly new, virulent, persecutory body ideals. There is, however, nothing new in regulatory norms applied to bodies. What has changed is the new power and ubiquity of the image in a society oriented towards visual media. As Susan Sontag (1973) commented: 'So successful has been the camera in beautifying the world that photographs rather than the world have become the standard of the beautiful' (p. 85). The pre-eminence of the photograph and of sight is accompanied by the ability, with cosmetic surgery, to replicate the photographic image, creating a timeless, airbrushed look. Current representations of the body deny physical diversity. Writing of the negative workings of difference, art historian Griselda Pollock (1988) observed that: 'The peculiarities of anatomical structure only matter within a cultural order which makes variety signify difference "a" and "not a".'

We are surrounded by airbrushed and computer-enhanced images as the technical capacity to visually homogenize and symmetricize the body grows. The bodies on billboards, magazines, on Barbie dolls and in computer games have predominantly white, smooth, monochrome, uniform, young skin. Take, for example, the advertisement for the Dior perfume, *J'adore*. Symmetry and homogeneity are taken to new heights. The entire image, hair, skin and clothing are washed in gold with a caption

reading 'absolute femininity'. It is an ironic yet compelling image, associating the perfume with gender certainty, wealth, desire and the current ideal of the totally smooth, uniform unchanging surface.

Of course, the physicality of the body changes constantly. The body ages, and the body image – though labile – rarely keeps pace with physical change. Hence, corporeal conformity to standards of normality is precarious and 'everyone must fear becoming a member of the subordinate group. Everyone who does not die suddenly will become a member of the subordinate group' (Wendell, cited in Shildrick & Price, 1998, p. 236).

Susan Bordo (1993) explores the emotional cost of an insistence on corporeal conformity, providing a social constructionist reading of Anorexia Nervosa. She focuses on Foucauldian analysis of the production of 'docile bodies'. She comments that preoccupation with fat, diet and slenderness functions as one of the most powerful normalizing strategies, ensuring the production of self-monitoring bodies, sensitive to any departure from social norms, and habituated to self-improvement and transformation in the service of these norms.

The disciplinary power is everywhere yet nowhere, in everyone and yet in no one (Bartky, 1990). The secondary gain of submitting to disciplinary power lies in the sense of agency provided. The young woman with BDD who spends two hours preparing her face to 'face' the world seeks in disciplinary practices a strengthened subjective sense of self to offset the objective sense of self which leaves her vulnerable to shame. Yet alienation from her body, evident in these practices, undermines the attempt and body hatred soon triumphs.

From the perspective of some of those working on specific body conditions, a social–constructionist analysis of the body, ordered by power relations, has been criticized for failing to engage deeply with how the body could be a source of the social and with the lived experience of embodied action (Shildrick & Price, 1998). A feminist phenomenological approach foregrounds the lived experience of the body. Drawing on Merleau-Ponty and Simone de Beauvoir, the emphasis is on the determining rather than the determined nature of embodiment (Bartky, 1990; Moi, 2005; Young, 2005). What is needed for the study of BDD is a route between social-constructionist theories of governmentality and phenomenological accounts of lived experience and self-making.

For the purposes of this paper socio-cultural anthropology provides a particularly useful approach to linking the lived experience of body shame and cultural shaming. Freud's understanding of taboo and Mary Douglas's theories of pollution and taboo are particularly useful (Douglas, 1966). Central to the experience of body shame is the intersection of a personal shame history with cultural taboo. Simone de Beauvoir (1949) writes:

> It is not merely as a body, but rather as a body subject to taboos, to laws, that the subject is conscious of himself and attains fulfilment – and it is with reference to certain values that he evaluates himself . . . (p. 68)

In his essay 'Taboo and emotional ambivalence', Freud (1913) defines taboos as prohibitions and restrictions intended to manage ambivalence. Taboos 'constitute a

symptom of ambivalence and a compromise between two conflicting impulses' (p. 66). The intensity of affect surrounding taboo is due to the fact that prohibitions concern activities towards which there is 'a strong inclination'. I have suggested that our relationship to our bodies is driven by ambivalence. We love and hate our bodies. Appearance strictures contain disgust and delight, scopophilia and exhibitionism.

Freud highlights the complexity of the dynamics surrounding taboo, pointing out that the violation of taboo renders the offenders themselves taboo – shunned and unclean. A woman writing in *Elle* magazine commented tellingly: 'In my mind bad skin is worse than having a big nose or a dominant chin. Why? Because it looks dirty.' Similarly, patients with BDD, looking back at adolescence, characterize it as the time when they became 'dirty' and started to 'smell'. Focusing on a perceived defect they become unclean in their own eyes.

Commenting not on BDD but on OCD, Freud (1913) observes that: 'People who have created for themselves individual taboo prohibitions . . . obey them just as strictly as savages obey communal taboos of their tribe or society' (p. 26). However, the violation of taboo can be made good by atonement, expiation and purification, restriction and obedience to taboos. Feeling tabooed, the sufferer retreats into isolation and pursues purification with transformational body practices ranging from picking to full-scale cosmetic surgery.

TV makeover programmes are constructed around the dynamics of taboo. An individual is exposed as having violated a bodily taboo. Instead of managing bodily ambivalence, they have 'let themselves go'. The 'priest' (Gok Wan, for example, or Trinny and Susannah) exposes and shames them before the masses and then imposes atonement, expiation and re-education in appearance strictures, before revealing them to an audience who applaud wildly at the sight of taboo once more successfully in place.

Fashion journalism is driven by the excitement generated by the instability of taboos which contain and control forbidden desires. Freud (1913) observed that in the unconscious there is nothing people want more than to violate taboos, yet 'they are afraid to do so; they are afraid precisely because they would like to, and the fear is stronger than the desire' (p. 31). We can see ambivalence at work in fashion through conformity and non-conformity, modesty and display, desire and disgust, dress and undress. Consider the following directive issued by the *Observer* newspaper:

> Animal print is a difficult proposition. Get it right and you'll look ineffably glamorous. Get it wrong and look ineffably trollopy. Why should you care? Because animal print is big news this season, and it's set to endure well into the next.

Because animal print is 'big news', the desire of the other's desire demands the donning of leopard or tiger print. Fashion is synonymous with the superficial – hence the mandatory ironic tone – but the word 'trollopy' casts horror to the heart of the shame-prone reader and illustrates Freud's thesis that taboos 'constitute the symptom of ambivalence and a compromise between two conflicting impulses'. The reader both longs to look trollopy (seductively sexual) and dreads looking trollopy (seductively

sexual). The shame constellated by ambivalence renders the reader vulnerable to the commercial tie-in which the journalist soon provides. The article continues:

> Having made some disastrous leopard print errors over the years, the *Observer Woman* desk concluded that the easiest way to do animal right is to go expensive. Mulberry, Peter Jensen, Sass and Bide know what we mean.

The shame-prone obey the dictates of fashion and shell out for top-of-the-market animal prints because, as discussed above, an important aspect of shame is the dominance of the objective sense of self with the centre of judgement 'placed' overwhelmingly in the other.

However, as Freud emphasizes, the objects of taboo are split into 'veneration and horror' and violating prohibition is also associated with sanctity. I think we can see the modern equivalent of sanctity in celebrity. Select individuals are permitted to break appearance strictures, which has the effect paradoxically of strengthening the taboo. Consider Beth Ditto, the lead singer with the band *Gossip*. She is very fat, seemingly confident and she rejects heteronormativity. At an individual level, she has the shamelessness or the sufficiently strong subjective sense-of-self to break taboos; at a cultural level, she stimulates both excitement and horror, thus maintaining the taboo she breaks. And, as we know, celebrity appearance is precarious. The paparazzi are dedicated to revealing the unclean concealed in those we sanctify. Freud observed of 'the privileged person' – the person permitted to break taboos – that, alongside the veneration, and indeed idolization, 'there is the unconscious opposing current of intense hostility'.

Freud usefully points to the workings of taboo and ambivalence. The anthropologist, Mary Douglas (1966), elucidates the structural dynamics of pollution and taboo. Her book, *Purity and Danger: An Analysis of Concepts of Pollution and Taboo*, remains as persuasive today as it was when published in 1966. Douglas defines taboo as 'a spontaneous coding practice which sets up a vocabulary of spatial limits and physical and verbal signals to hedge round vulnerable relations' (p. xiii). Behaviour that blurs classification is considered polluting and hence tabooed. Douglas discusses the concept of dirt, observing that 'where there is dirt there is system. Dirt is the by-product of a systematic ordering and classification of matter, in so far as ordering involves rejecting inappropriate elements' (1966, p. 44). Hence, dirt is matter out of place. Fur is acceptable on the cat but unacceptable on the sofa. In other words, the image and experience of anomaly drive pollution behaviour.

Veale *et al*. cited above, suggest that bodily symmetry is desired because it advertises biological quality (1996a, 1996b). I would suggest, rather, that symmetry is desired because asymmetry is experienced as anomaly. Body hatred and disgust can be understood as driven by pollution behaviours constructed by the visual norm that surrounds us. The current technical ability to visually homogenize and symmetricize the body means that any deviation from the smooth, firm and uniform is experienced as anomaly – as matter out of place – and hence taboo.

The concept of pollution and taboo experience and behaviour can explain the extreme disgust and horror occasioned by minor skin defects or slight physical

asymmetry or by changes wrought through age – the seemingly anomalous arrival of lines on a previously smooth skin. Similarly, loose or wiggly areas of the body signify formlessness. The marginal, the transitional, the formless are experienced as indefinable and hence vulnerable and dangerous. According to current fashion dictates, 'curves' are permitted but bulges are taboo. The ideal body, ever more costly to attain, is no longer simply thin but absolutely tight, contained and, to cite Susan Bordo, 'bolted down'. To return to Beth Ditto, her fat is sanctified because her silhouette is firm and solid.

Douglas observes that:

> Ideas about separating, purifying, demarcating and punishing transgressions have as their main functions to impose system on an inherently untidy experience. It is only by exaggerating the difference between within and without, above and below, male and female, with and against, that a semblance of order is created. (1966, p. 5)

She emphasizes that: 'No particular set of classifying symbols can be understood in isolation, but there can be hope of making sense of them in relation to the total structure of the classifications in the culture in question' (p. vii). Turning to the Biblical Israelites she writes that:

> The Israelites were always in their history a hard-pressed minority. In their beliefs, all the bodily issues were polluting . . . The threatened boundary of their body politic would be well mirrored in their care for integrity, unity and purity of the physical body. (p. 153)

We can speculate on what is being mirrored or protected by our culture's contemporary concern with the hard, smooth, firm body boundary. As recession deepened, changes in the ideal norm became evident. A feature in the *Observer* in April 2009, entitled 'Return of the Beefcake', notes the change in the shape required of male models. The male waif is out, 'strong masculine looks are the ones that designers and consumers prefer in times of economic crisis. We seem to need them.' Douglas would say we need them because they focus and control experience.

Considering the sanctions that keep taboos in place returns us to the issue of shame. Douglas comments: 'With us pollution is a matter of aesthetic hygiene or etiquette, which only becomes grave in so far as it may create social embarrassment' (p. 92). The sanctions are social sanctions – contempt, ostracism or gossip. Douglas instances pollution behaviour provoked by underclothing appearing where over-clothing should be – the peeping bra strap. Today, of course, the taboo has shifted and bras are almost revealed with impunity. A feature on Spring/Summer 2010 fashion is entitled 'Show us our Knickers! No, really, do'.

Freud emphasized the changing content of taboo: 'Obsessional prohibitions are extremely liable to displacement. They extend from one object to another . . .' (1913, p. 27). This is vividly illustrated by the shape-shifting of breasts over the last two centuries. In the mid-19th century a bra was introduced called 'The Divorce', and was ridiculed for creating 'a sort of fleshy shelf disgusting to the beholder' (cited in Ribera,

1986, p. 120). Soon, however, anything short of a fleshy shelf was deemed matter out of place. My younger female interviewees describe the horror manifested by young men, reared on Internet pornography, when they first encounter the fall of the bra-less breast. Pornographic imagery may be similarly responsible for labia being considered as matter out of place, heralding, over the last two years, a 70% increase in genital 'cosmetic' surgery – labiaplasty for women on the NHS. There were 1,118 operations in 2008 compared to 404 in 2006 with more in the private sector. Young women consider the labia minora to be matter out of place. 'They want the inner labia to be level and inside the outer labia,' commented a surgeon (*Guardian*, 20 November 2009). The compulsion to correct matter out of place is powerful enough for them to risk the pain and possible complications of the surgery.

And yet the desire to push the boundaries, to flaunt the rules, to attract attention, recognition and desire, echoes down the centuries with fashion journalists telling us how to manage taboos without incurring shame. Take the following advice from the *Observer* in 2009 on how to negotiate the boundary between masculinity and femininity:

> It's a guy thing. This season's take on the masculine/feminine look is simple but devastatingly sexy. Combine rugged fabrics . . . tweed, houndstooth and sharp tailoring and make a dashing, boyish silhouette.

The key to keeping shame at bay and classifications in place lies with the word 'boyish'. To be mannish is tabooed. Yet the boundaries controlling androgyny are complex. In 2009, 'boyfriend jeans' were advocated for women (baggy and low-waisted) but there was no masculine equivalent; 'girlfriend jeans' were not on the menu.

Julia Kristeva's theory of abjection develops Douglas's ideas in relation to pollution, and suggests why 'girlfriend jeans' are taboo. She argues that the function of taboo 'is to ward off the subject's fear of his own identity sinking irretrievably into the mother' (Kristeva, 1980). In other words, the abject is the feminine. Where does this leave men? As Frosh (1994) has written: 'One central attribute of masculinity . . . is to oppose "the body" . . . and the emotion associated with it to perpetuate domination – and to maintain obsessional structures of control' (p. 104). He suggests that the body, linked to sex, nature, women and the fear of femininity, is 'constantly threatening to break up the tangled yet fragile structures of masculinity'. But body matters are changing for men. As mentioned above, the male body has, since the mid-1980s, been increasingly commodified and objectified in advertising and the media. When male employment shifted from manufacture, where strength mattered, to the service industry where appearance counts, the clothing/cosmetic industry began targeting men. Recently, men are turning to cosmetic surgery in large numbers, pursuing, in particular, breast augmentation to swell the pectoral muscles. As with women, amongst the young men I interviewed, self-esteem is determined by the intensity of conflict they experience between body love and body hatred – often expressed through their photos posted on social networking sites. During interviews they complained that girls were critical of their bodies: 'She hugged me and then said: "Ugh! you've got a hairy

back".' Just as feminine perception is informed by a devastatingly fierce visual acuity turned against themselves and other women, so young men – of all sexual orientations – now anxiously compare themselves not only to David Beckham on billboards in his pants, but also to the bodies of their male friends.

Dutton (1995) has suggested that recent 'legitimation of women as observers of male bodies has radically altered patterns of . . . awareness' (p. 14). Nevertheless, he points out that the use of the commercial employment of the male body is significantly different from the representation of women's bodies. The images of men highlight control, with states of emotional and physical equilibrium, rational, cool, laid back. And crucially the subjective sense of self is foregrounded. The model is often named. It is not just a man in his pants. It is David Beckham.

For young men this renders the image of the body – hairless, six-packed and well-oiled – ever more desirable and unobtainable. Amongst the men I interviewed, the size of their muscles was a source of anxious preoccupation; thin 'weedy' arms were reiterated as an area of concern. To be weedy is to be feminine.

I headed this paper with a quote, in *Grazia* magazine, from Madonna, who supposedly said of her daughter, Lourdes: 'She's definitely got her own look. She is completely fearless' (*Grazia*, 2009). I hope by now it is evident why having her own look requires fearlessness. To be different, to be individual requires a strong subjective sense of self, lacking in the shame-prone. The 'look' in question, according to *Grazia*, was 'glamour/grunge'. Mixing clothing categorizations and classification risks creating matter out of place and evoking disciplinary shame. But by naming the look *Grazia* ironed out the particular, the different, the subversive; 'the look' became not a source of shame but of aspiration. Glamour/grunge will, however, long remain beyond those with unmanageable bodily ambivalence. For those in the grip of powerful, conflicting love and hate for the body, the marginal, contradictory overtones threaten ridicule, contempt and shame with intimations of loss of the object and loss of love.

In conclusion, working clinically with BDD is fraught indeed. Focusing on the perceived defect simply strengthens the objective sense of self, constructing the therapist as the judge and patient as the judged (Parker, 2003). However, the processes of psychotherapy can, of themselves, strengthen, extend and render robust the subjective sense of self, offsetting the shame that fosters BDD.

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