Diagnosing Culture: Body Dysmorphic Disorder and Cosmetic Surgery

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Abstract A recent clinical literature on the psychology of cosmetic surgery patients is concerned with distinguishing good from bad candidates. Body Dysmorphic Disorder (BDD) – a mental disorder marked by a pathological aversion to some aspect(s) of one's appearance – is typically understood in this context as a contra-indication for cosmetic surgery, as it marks those with inappropriate motivation who are unlikely to be satisfied by the surgery's outcomes. This article uses Foucault's genealogical work to argue that both the attempt to provide diagnostic conditions for BDD itself, and the broader attempt to demarcate normal and psychopathological concern with appearance are, in part, effects of disciplinary power. Although often presented as a way of making cosmetic surgery more ethical and restrained, this epistemic project inadvertently defends cosmetic surgical interests. Specifically, it contributes to legitimizing the image of an ethically suspect sub-specialty of medicine, and supports its commercial expansion and effective profit-making by displacing its negative sequelae onto patient psyches.

Keywords biomedical ethics, disciplinary power, Foucault, mental disorder, psychiatric diagnosis

In her germinal article on anorexia nervosa, Susan Bordo famously describes psychopathology as 'the crystallization of culture' (Bordo, 2003: 139–64). This phrase, she suggests, hopes to capture the reality that so-called mental disorders, far from being aberrant and idiosyncratic features of pathological individuals, offer instead a window into a culture's pressures, incitements, history and structures of power. In other words, we should read normalcy through abnormalcy, with no bright line between the two. This is, of course, also a familiarly Foucauldian project, and one that has been extended to a variety of mental disorders since

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Vol. 15(4): 73–93; DOI: 10.1177/1357034X09347222

Foucault's death, including schizophrenia, Multiple Personality Disorder, Gender Identity Disorder and depression.[1] Furthermore, at the same time as we examine the psychology of the abnormal *patient* as a symptom of culture, such projects often argue, we must theorize her subjectivity as, in part, constituted through the technologies of the self distinctive to her milieu: we cannot understand Gender Identity Disorder without a critical genealogy of sex reassignment surgery, or contemporary depression without Prozac, for example.

Against this backdrop, consider the following case study: imagine a woman who is very unhappy about some aspect of her body. Her breasts are too small, perhaps, or her wrinkles too prominent. Her nose is misshapen, or her thighs are fat. She is preoccupied with this fault; she tries to hide it, but feels constantly surveyed and self-conscious. Other people tell her she looks OK – even good – but she persists with the feeling that they are just being kind (or duplicitous) – for she looks terrible to herself. She constantly checks her reflection in the mirror and worries at the offending body part, or alternatively avoids mirrors like the plague. She imagines herself without the flaw, and feels sure that her life would be much improved. Perhaps other people would respond more positively to her body, while if the blemish were fixed, most importantly, she would be able to live with her own looks. If she had cosmetic surgery, she reasons, her problem would be solved.

What interests me about this hypothetical phenomenology is that, with only a difference in inflection, it can be made to describe two allegedly very different types of person. First, imagine this woman's preoccupation with the bodily flaw is hugely upsetting and distracting, and is thereby holding her back from going to social gatherings, say, or doing part of her job. Imagine she simply can't stop thinking about it, even if she wants to. Imagine that her coping habits have become completely necessary to her functioning, and that her behaviour is obsessive. Katharine Phillips describes a number of such (real) individuals in her book *The Broken Mirror*; for example:

> Carrie, who worried about slight facial blemishes and her 'small' breasts, was sometimes late for work because she got stuck in the mirror checking her face. And she missed parties because she thought she looked so bad she didn't want people to see her. (2005 [1996]: 3)

Or, to give a more extreme case:

> Jane was so tormented by her 'huge' nose, 'crooked' lip, 'big' jaw, 'fat and round' buttocks, and 'tiny' breasts that she dropped out of school and couldn't keep a job. She stopped dating and seeing her friends. Because she thought she looked so monstrously ugly, she locked herself up in her house for five years, finally even trying to kill herself'. (2005 [1996]: 4)[2]

Any of these individuals might well be diagnosed as suffering from Body Dysmorphic Disorder (BDD) – a mental disorder on which there is now a substantial

clinical literature, and which is catalogued in the World Health Organization's (WHO) *International Classification of Diseases*, and the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual*. BDD is diagnosed as preoccupation with a defect in appearance that causes significant distress and/or impairs normal work or social functioning. 'The defect is either imagined, or, if a slight physical anomaly is present, the individual's concern is markedly excessive' (APA, 2000: §300.7). The individual experiences intrusive thoughts about her appearance flaws that are difficult or impossible to resist or control. Anxiety over appearance is managed by repetitive behaviours such as mirror checking, or trying to mask the flaw, and by avoidance behaviours such as refusing to look in mirrors or refusing to attend social events. Hair, skin and facial flaws are the most common objects of anxiety, although weight, body contours, breasts or genitals can also preoccupy sufferers (Crerand et al., 2006: 171), who may pick at their skin, pull out their hair, or obsessively apply cosmetics, as well as diet or exercise compulsively, for example. BDD sufferers typically persist in the belief that their defect is real and striking even in the face of repeated reassurance from others, which they will often rationalize as falsely kind, deceitful or patronizing (Phillips, 2005: 103–6). For this reason, if they seek help it will often be surgical, rather than psychiatric. Thus the desire for cosmetic surgery is in this case read as a part of the problem: falsely believing that the fault lies in her body, not in her mind, the sufferer of BDD attempts to draw the cosmetic surgeon into her delusion in the same way that the anorectic might try to get her doctor to prescribe diet pills. Increasingly, self-described ethically responsible (and legally prudent) commentators on the psychology of cosmetic surgery urge surgeons *not* to operate on those who meet the clinical criteria for BDD since, such critics suggest, they are unlikely to experience relief of their psychological suffering as a result (see Crerand et al., 2006: 174–5).

Then again, my original description is a familiar enough lived experience. Perhaps it even describes a certain norm of femininity. The woman who has a long-standing dissatisfaction with a particular body part, who keeps the flaws of her body always at the front of her mind, and who receives reassurance from others that she finds iteratively disappointing ('Are you *sure* I don't look fat in this?') is a trope of mainstream culture (think: Bridget Jones). And qualitative research with ostensibly mentally healthy women reveals that a painful preoccupation with one's own defective appearance is commonplace (e.g. Davis, 1995; Gimlin, 2006). Debra Gimlin interviewed English women who had had cosmetic surgery about their motivations; although from her descriptions they do not consistently meet the criteria for BDD, she does say that 'my respondents explained that prior to having cosmetic surgery, their physical "flaws" regularly encroached

upon their thoughts, blocking out other concerns, involvements and interests'. She provides an example:

> Michelle, a 23-year-old graphic artist, said that before having rhinoplasty, sudden self-consciousness about her nose regularly drew her attention inward. She said, 'It was like, my nose would just get really, sort of, *hot* and I'd be like, I've got to get to a mirror' (her emphasis). Such bodily demands distracted Michelle from other activities: 'My boyfriend and I would be having a meal out and I wouldn't be thinking, y'know, about enjoying myself. I'd be worrying, does my nose look huge in this light.' (Gimlin, 2006: 706)

Phillips' book includes a section entitled '"My Problem Isn't Very Severe": Do I Even Have Body Dysmorphic Disorder?', in which 'Sarah' admits that:

> I don't like my thighs . . . They're flabby. They have this rippling look, and the skin isn't taut. I also worry a lot about varicose veins on my legs and ankles. I think they look *really* bad. They're dark purple, and some of them bulge out of my legs. They bother me a lot. I get very upset when I think about these things – very nervous and anxious. It causes me a lot of emotional turmoil. It's worse on some days than on other days; some days aren't so bad, but it can be very upsetting. (2005: 21–2)

Although Sarah is also significantly preoccupied with her hair (too flat, not symmetrical) and her weight (she is 'always on a diet'), her anxiety about her legs interferes most with her lifestyle: she turns down invitations to the beach, doesn't wear shorts, and has avoided dating. As Phillips' description of Sarah progresses, her case comes to seem more severe – and, neatly enough, closer to the diagnostic criteria for BDD – but the difference between Sarah and a person on the other side of the diagnostic line seems to be mainly one of genre (this is a clinical self-help book, while Bridget Jones is a character of chick-comedy) and inflection (our sympathy for Sarah is gradually drawn out, but Bridget's pathos makes us laugh).

The woman who organizes her life to a significant degree around disciplining and managing her body, and who feels strongly that taking action to change it would make her feel better about herself, is in many ways the cosmetic surgeon's ideal candidate. The body on which cosmetic surgery is performed may well have no symptoms of physical illness, and experience no physical pain that surgery aspires to cure; probably no future physical health risk is managed by surgical intervention, and this body likely has an appearance that falls within most ideas of 'normal' parameters, even if it is not 'ideal'. Since cosmetic surgery cannot be said to directly improve physical health, it has throughout its history drawn on psychological justifications and their indirect effects on overall well-being: the benefits of altering the body's appearance, advocates contend, may include increased self-esteem, more physical self-confidence, or overcoming shyness or anxiety (see Haiken, 1997: esp. 108–30). On this account, cosmetic surgery both relieves suffering and enhances quality of life – not *prima facie* unreasonable

goals for a medical enterprise. Change the degree of severity of symptoms in my original description, then, and you can come up with either an individual for whom cosmetic surgery is contra-indicated due to psychopathology, or who is precisely cosmetic surgery's anticipated patient.

Because cosmetic surgery is quickly becoming very much more common, at the same time as techniques and procedures are proliferating, health professional interest in the psychology of cosmetic surgery has also burgeoned. There is now a large set of studies – almost all published since the mid-1990s – by psychologists and psychiatrists, nurses, and (to a lesser extent) cosmetic surgeons, that seek to psychologically profile the cosmetic surgical candidate.[3] An epistemological mandate implicit in almost all of this literature is to examine the demographic and psychological characteristics of different patient and control populations in order more precisely to distinguish between abnormal and normal concern with appearance (see also Pitts-Taylor, 2007: 124). More specifically, one key goal is to discover who is a 'good' candidate for cosmetic surgery, psychologically speaking, and who is a 'bad' candidate (e.g. Veale et al., 2003). In my research on commercial weight loss organizations (Heyes, 2006), I showed how the disciplinary practices at play in the structured diet programme require a particularly fine-grained and increasingly absurd regulation of food and exercise habits that is very much like the obsessive behaviours commonly associated with eating *disorders*. The psychology cultivated by the practices of the commercial diet, I suggested, blurs the line between pathology and 'normal' eating, even as it attempts to shore it up with the rhetoric of improving one's health. In an analogous way, I want to argue here, the cosmetic surgery industry contributes to the production of a subjectivity that it then pathologizes if enacted too convincingly. Although I don't dispute the psychological anguish associated with the symptoms of BDD, I do want to draw attention to some tacit, unquestioned premises that structure this research, and, more broadly, tend to inflect many projects that draw qualitative lines between a pathological and a normal experience of one's own subjectivity. To put it more boldly, I want to defend the thesis that, at least in the context of the literature on the psychology of cosmetic surgery, both the attempt to provide diagnostic conditions for BDD itself and the broader attempt to demarcate normal and psychopathological concern with appearance constitute instances of the crystallization of culture.

Which particular parts of the culture 'crystallize out', so to speak, in these moments? I'll argue that a BDD-like relation to one's own embodied subjectivity might form part of a larger historical picture of how we typically experience our bodies, even as magnified versions of this experience may be labelled psychopathological. By challenging the terms of the project of demarcating the abnormal,

my method opens up (as Foucault's also did) the possibility that this labelling serves other purposes than simply identifying the mentally ill so that they may better be helped. In this way it contributes to a larger critical literature that offers genealogical analysis of medicine, where 'genealogical' signals both a certain attitude to history as well as the contingency of current self-understandings. Although it is not the goal of this article to delve into the history of BDD (and its precursors), I take it that my project is part of a scholarly trend that aims both to historicize psychiatry's more essentialist claims (see e.g. Metzl, 2003) and to challenge the contemporary pathologization of individuals and the de-politicization of medical practice (see e.g. Blackman, 2001). Here I argue that the psychological profiling of cosmetic surgery candidates functions (although this is not all it does) as a tool for shoring up and normalizing cosmetic surgery, and providing a rhetoric for defending cosmetic surgical interests. Specifically, it contributes to legitimizing the image of an ethically suspect sub-specialty of medicine, and supports its commercial expansion and effective profit-making by displacing its negative sequelae onto patient psyches. When much of this literature represents itself as identifying patients who should be *excluded* from the pool of prospective cosmetic surgery recipients – in ways that sometimes run afoul of existing laissez-faire practices and would, in theory, limit some surgeons' income – this is tremendously paradoxical.

Developing Dysmorphia: Foucault, BDD and Cosmetic Surgery

In *Discipline and Punish*, volume 1 of *The History of Sexuality*, and some of his concurrent lectures at the Collège de France, Foucault famously develops a genealogy of a novel form of power that operates on bodies – indeed, that (re)constitutes the body as the object and product of developmental processes that can be measured and managed – and creates new subjectivities as well as new ways of relating to oneself. This analysis (and its evolution in a post-disciplinary world) has a number of key features, although I won't rehearse Foucault's larger argument in any detail here.[4] Let me, instead, just assemble three reminders, before showing how each insight can be applied to the psychology of cosmetic surgery: in brief, I'll show how cosmetic surgery generates the psychological states it then diagnoses; uses and increases the power of visibility in the post-disciplinary world; and cultivates an ambivalent relation to the will.

First, a central tactic of disciplinary power, Foucault demonstrates, is to create the effects that it then manages, at the same time alleging they are prior to its exercise. In *Discipline and Punish*, for example, he shows how new institutions such as the prison do not just punish those who are already wrongdoers; they

also contribute to the production of the type of individual who comes to be known as 'the criminal'. By spatially bringing together those who have committed crimes, by constituting them as subjects within an institutional regime with its own norms and practices, and by inducting them into a regime of truth within which their criminal characters must be made known in order to be corrected, the prison system actually constitutes and perpetuates criminal subjectivity. This system, however, organizes its dominant self-understanding around the belief that already existing criminals are properly the objects of retributive and rehabilitative justice within the institution of the prison (Foucault, 1979: esp. part IV). The subjectivities disciplinary power (and, in Foucault's later work, bio-power) cultivates are not only to do with character, but are also somatic. To give an example that post-dates Foucault, a child whose attention wanders in ways unacceptable to those around him, for example, is now diagnosed as a child 'with Attention Deficit/Hyperactivity Disorder', treatable with certain pharmaceuticals. Yet the development and promotion of the drugs themselves may lead to the back-formation of types of child – those who respond to the drug must 'have' the disease, the marketing of which encourages identification with the syndromes it purports to cure (Rose, 2007: esp. 209–15). These effects of power on the body thus become the locus of further action: make a person into someone with these characteristics and then further manage them to achieve disciplinary goals – all the time acting as if the body being managed has an origin both chronologically and ontologically prior to this mechanism.

Plastic surgeons performing cosmetic procedures, unlike physicians in other medical sub-specialties, must advertise their skills and actively recruit patients. This recruitment process necessarily involves representing the flawed bodies that surgeons will then improve. These bodily defects are not only described but also created through this visual repertoire, which constantly draws attention to parts of the body previously relatively immune to surgical intervention (for example, the genital labia), to finer details of body parts already colonized by surgical possibility (such as the 'thread' facelift, marketed to younger women who 'need' less lifting), and to novel possibilities for physical transformation through new medical techniques or materials (like 'fillers' such as Restylane or Sculptra).

In addition to colonizing the body for negative aesthetic evaluation, the visual economy of advertising and marketing cosmetic surgery is also pedagogical, teaching ways of reacting negatively to one's own embodiment. This is done indirectly, through the still image, and especially the popular 'before and after' photo set, a 'mode of representation where cosmetic surgery's labour and pain is hidden' (Jones, 2008: 16). In addition to erasing the work of surgery, such images teach negative evaluation: looking at photos of body parts that seem perfectly

typical of what one might see any day in the park or the gym locker room, one learns that these are the 'befores'. Often the 'after' effects a change that the viewer had not previously identified as desirable, or effects a very minor change. In both cases the viewer is educated into the visual lexicon of bodily defects. Although before-and-afters that do not seem all that different are cautionary – a way of encouraging prospective patients to lower their expectations, as cosmetic surgeons often have cause to do – they also teach closer negative reading. These lessons are not universally or consistently learned, but the ubiquity of before-and-after pictures provides a text clearly organized around worse-and-better in which the pre-surgical individual lives before the hyphen, while her future holds the promise of a rather amorphous but always possible 'improvement' that makes clear there is something wrong with the now.

Increasingly, however, as Meredith Jones implies, before-and-after photos are perceived as simplistic or *passé* in their representation of cosmetic surgery's benefits (2008: 20). I have suggested elsewhere that contemporary cosmetic surgery derives its appeal more and more through *narrative* representations of self-transformation, which represent the phenomenology of embodied dissatisfaction seamlessly with a psychological cure through surgery (Heyes, 2007: esp. 89–110). The cosmetic surgery industry plays an active role in TV makeovers, for example, with barely disguised shilling for particular practitioners a central component of their marketing. Nonetheless, many surgeons strongly disapprove of them as offering unrealistic and overly dramatic portrayals of what cosmetic revision can achieve (see Turner, 2004). Across the board, however, the cosmetic surgical industry relies not just on pictures but also on narratives – namely, the first-person accounts of satisfied customers whose lives as well as their looks have been improved.

To go to a cosmetic surgeon, then, and say that because of one's body flaws one lacks self-esteem, is shy or anxious about social events, or is excessively preoccupied with negative self-judgements is in many ways to accept a walk-on part in the script that the industry has already written. As Virginia Blum says:

> One patient told me that what she liked best about her surgeon was his confirmation of her own obsessive but guilty concern with her face: 'He acknowledged that it wasn't in my head.' . . . The surgeon is in many ways the legitimator of our otherwise embarrassing preoccupation with physical appearance. In the plastic surgeon's office, you are in the place of unsuppressed narcissism – the place where your otherwise absurd concern with the angle of your chin will feel entirely 'normal'. It will feel scientific even, as the surgeon measures and evaluates the arrangement of your features. He will make you feel that all your trivial little obsessions are absolutely justifiable – like any therapist, he's there to support you. (2003: 274–5)

Many prospective patients – including Blum herself – report that surgeons go further, and point out flaws the candidate was herself not even aware of (Blum,

2003: e.g. 6–8; see also Bordo, 1997: 52–7; Spitzack, 1988: 45–8). It takes a tough-minded individual to walk out of a consultation having refused a procedure that an 'expert' on bodily aesthetics thinks is warranted, without any further psychological consequence. And once one 'knows' that cosmetic surgeons can evaluate a body in a way that exceeds one's own aesthetic judgements, it's possible to develop yet more paranoia about the possible flaws with which one is not yet preoccupied. Thus many practices internal to the industry of cosmetic surgery – including the advertising strategies and consulting gambits of cosmetic surgeons themselves – foster ways of reading one's body as flawed, and cosmetic surgery as the fix. This partly explains why BDD symptoms are typically exacerbated (or even initiated) by consulting about or having cosmetic surgery, although cosmetic surgery is typically represented as an autonomous technology that is merely 'not effective' for those with pre-existing BDD (e.g. Phillips, 2005: 302–8), rather than causing the symptoms themselves.

Here is a second reminder of the consequences and significance of Foucault's middle work: for political theorists sympathetic to Foucault's analysis modern power is itself often invisible yet renders its subjects hyper-visible in order to tighten its grip: 'it is the fact of being constantly seen, of being able always to be seen, that maintains the disciplined individual in his subjection' (Foucault, 1979: 187). The display of power, Foucault argues, thus moves from overt expression of potency (in which the *apparatus* of power must be made visible) to the ceremonial presentation of subjects, in which power is only a gaze (Foucault, 1979: 187–8). The literature on BDD is striking for its emphasis on the intensely visual nature of the disorder. Sufferers are described as either obsessively preoccupied with looking in the mirror to check their appearance, or with obsessively avoiding mirrors and other reflecting surfaces for fear of what they might see. Indeed, the best-known monograph on BDD (from which earlier reference to case studies was taken) is entitled *The Broken Mirror* (Phillips, 2005 [1996]). Other symptoms include constantly examining a body part, attempting to disguise one's flawed appearance when in public, and a tortured sense of being always on display – whether or not there is an actual observer. The main phenomenological difference between BDD sufferers and others in their relation to the gaze appears to be primarily the amount of 'distress' they feel in imagining or witnessing (parts of) their own body, symptomatically manifested by a troubled relation to using or avoiding mirrors. The only study on mirror-gazing and BDD, by David Veale and Susan Riley (2001), understandably treats this suffering exclusively as an individual psychopathology that can be mitigated with cognitive-behavioural techniques.[5] The enhanced distress an individual may experience when mirror-gazing, however, only has meaning if we understand looking in order to construct one's embodied subjectivity as a learned practice. The individual's learning,

moreover, takes place against the backdrop of a general cultural education in *how* to look at bodies, where the disciplinary power of the gaze is omnipresent but rarely visible. Although they don't exactly see it like this, Veale and Riley's advice to BDD sufferers recognizes and tries to undermine this learning:

> BDD patients tend to assume that 'What You See Is What You Get' in front of a mirror. We have found it helpful to engage our BDD patients in a model of 'What You See Is What You Construct' as a result of selective attention to specific aspects of their appearance and on an internal representation of their body image. (2001: 1391)

Their specific guidelines are useful (for BDD sufferers, and, if I am correct, for all of us), but if we understand the ways power functions through ocularcentrism we may need to inflect them with the insights of political philosophy in order to unseat the cultural overdetermination of the gaze.

Interestingly, Veale and Riley describe one motivation for mirror-gazing among some BDD patients as an attempt 'to change their internal body image to see something different. This might be regarded as a type of *mental cosmetic surgery*' (2001: 1390, emphasis in original). Performing 'mental cosmetic surgery' is a very familiar form of perceptual training in contemporary Western cultures: from invitations to 'imagine yourself . . .' in women's magazines to the increasingly popular morphing computer programs that cosmetic surgeons themselves use to represent the 'after' you may become, the cultural imaginary here intersects with individual imaginative projection to make constructing a different aesthetic self-image commonplace. There remains a considerable gap between a large political theoretical analysis of ocularcentrism and the symptoms of individual sufferers of BDD that this brief discussion cannot fill; however, I hope to have indicated that one's own gaze, even – perhaps especially – when turned against oneself, can be thought of as a historical construction that individuals learn to practise in quite specific and detailed ways, including through the techniques provided by the cosmetic surgery industry.

The third impact of Foucault's work comes from the 1973 Collège de France lectures, published in English as *Abnormal* (2004), where he examines normalizing judgement and its relation to the emergence of psychiatric power more specifically. He argues that in the middle of the 19th century the locus of madness shifts. The proto-psychiatrist J.G.F. Baillarger exemplifies this key reversal when he compares being in a dream state and being mad, suggesting that the analogy is apt because in a dream (as in madness) one is not in control of one's will: 'the dream functions as a model of all mental illness as the seat of involuntary processes'.[6] As Foucault interprets Baillarger, 'a person who is mad is someone in whom the demarcation, interplay, or hierarchy of the voluntary and involuntary

is disturbed', and 'this disturbance . . . is the basis for the development of all the other phenomena of madness' (Foucault, 2004: 157–8). This 'epistemological thaw', according to Foucault, marks the beginning of psychiatry proper, and moves it away from the identification of delirium – 'the traditional core of mental illness' (2004: 311).

Foucault argues that this shift is part of a larger emerging picture in psychiatry that has two key features: first, any behaviours that deviate from norms of conduct can be classified as symptoms. Because the need to identify a core of madness qua overt displays of delirium disappears in favour of something as intangible as a problem of the will: 'there is nothing in human conduct that cannot, in one way or another, be questioned by psychiatry' (2004: 160). Second, a closer union between organic medicine and psychiatry develops. The focus on deviation from norms of voluntary conduct – when people really are acting without will – enables medicine and psychiatry to communicate through the domain of enquiry concerned with the disintegration of self-control, for which the archetypal case is hystero-epilepsy. The 'liminal discipline' of neurology can thus bridge physical medicine and psychiatric medicine, with the latter becoming both a real medical science (because founded in neurology) and a discipline concerned with *all* of human behaviour. Confounding two senses of 'norm' – as rule of conduct (social norm) and as marker of proper functioning (medical norm) – psychiatry both legitimizes itself and spreads its net. Thus normalizing judgement writ large creates ways of being a kind of person at the same historical moment as, according to Foucault, psychiatric power extends itself to investigate what Mariana Valverde (1998) has labelled 'diseases of the will'.

Assume that Foucault has correctly identified something important in the history of psychiatry, where the spread of psychiatric power and the pathologization of human experience entails a troubled relation between the voluntary and involuntary. This relation is, in fact, central to the diagnosis of BDD, in which a key feature is that the preoccupation is 'difficult to control'. Thoughts of one's own ugliness are intrusive and relentless; BDD is often classified (not without controversy) as part of the spectrum of obsessive-compulsive disorders (see Phillips et al., 1995). Thus the failure of the will in this case is one key criterion demarcating normal anxiety about one's appearance from the pathological. Those who can exert a greater degree of voluntarism with regard to their own anxiety are less disordered, reflecting in part the conflation Foucault describes of a culturally specific rule of conduct (be in charge of your own desires) with a medical marker (those whose mental landscape is marked by the involuntary are mad). BDD is characterized by *uncontrollable* anxiety and critical self-visualization; whereas normal anxiety or internalization of the gaze can be managed in ways

that do not impair 'functioning'. (This last also reminds us that in capitalism being *ill* is so often defined as being *unable to work*.)[7]

Gimlin's interviews with women who have had cosmetic surgery describe the struggle that surrounds this phenomenology, in which the body intrudes into consciousness only as an object of distaste and repulsion.[8] Gimlin draws on Drew Leder's account of the lived experiential bases of Cartesian dualism, and in particular his account of the normal 'disappearance' of the body from consciousness, as contrasted with the 'dys-appearance' of the body at times of illness, pain, disability or under the Other's gaze. Without making any reference to BDD, Gimlin argues that cosmetic surgery may be undertaken as a response to this 'dys-appearance' of the body and a desire for a more normal (or normalized) 'dis-appearance':

> Although notions of normalcy – like those of beauty – are undoubtedly shaped by processes of inequality, many of the respondents in this study described normalcy as the ability to either ignore or attend to the body at one's own behest. Accordingly, many of these women decided to have cosmetic surgery because they hoped to gain control over how and when they focus on the body. That is, they wanted to eliminate the compulsive character of bodily dys-appearance in favour of a more volitional experience of embodiment. (2006: 711)

Thus a deeper analysis of BDD's psychopathology 'as the crystallization of culture' would require an investigation of the role of the will in defining psychological normalcy. It seems not unreasonable to suggest that the more one is overwhelmed by intrusive thoughts of one's own physical inadequacies, the more one might want psychiatric help. However, in the context of cosmetic surgery, those identifying BDD sufferers in order to distinguish them from Gimlin's interviewees will have to take into account a paradox:[9] those prospective patients who can fully control their bodily dys-appearance, keeping less than ideal body parts absent from consciousness and allowing their bodies to disappear whenever they threaten to disturb mental equilibrium, are hardly candidates for cosmetic surgery at all. Thus, again, definition of the suitable cosmetic surgical candidate requires the ability to manage and control one's will (keeping one out of the realm of madness) but not so much that one doesn't actually *want* cosmetic surgery, versus lacking such ability to the extent one becomes a psychiatric case and thus a potentially unsuitable candidate for surgical cure. We can see here a playing out of the historical dynamic Foucault identifies: deviation from norms of self-governance that themselves shift can be understood as symptoms (here, of BDD), while the simultaneous invocation of the physiological basis of BDD solidifies its classification as a mental disorder. In short, candidates for cosmetic surgery must be psychologically resilient, realistic and have good self-esteem. Yet, as the remediation of psychological distress is cosmetic surgery's major stated function, they

must also, paradoxically, have some psychic struggles that surgery can ameliorate. The rhetorical battle to isolate appropriate and treatable dissatisfaction with appearance is mutually constitutive, I am suggesting, of the battle to identify psychopathological obsession (see also Pitts-Taylor, 2007: esp. 125–7).

The Function of BDD for Cosmetic Surgery

The analysis I have been developing so far raises the question: if psychopathological diagnoses are ways of taxonomizing a domain of experience while simultaneously creating it, what political purposes do such diagnoses serve? What does examination of the abnormal here tell us about normal practice and its repressive and enabling aspects? Let me very briefly suggest (based on an archive of cosmetic surgery textbooks and bioethical advisories, studies of prospective and actual cosmetic surgery recipients, and the literature on BDD as it relates to cosmetic surgery), two tacit functions that diagnoses of the psychopathological cosmetic surgery patient may serve. These are intended to be both speculative and provocative – ways of cracking open the assumptions in a discourse that sometimes represents itself as occupying a critical position with regard to the more blatantly consumerist practices of the cosmetic surgery industry but that in fact may be tacitly complicit with them. They are not intended to be clinical or even phenomenological – describing how actual patients experience their symptoms or are treated in any detailed way. This would make a complementary article, but it is work that is not central to this argument. BDD is at a stage of historical development where it is a well-known yet relatively amorphous diagnosis. Victoria Pitts-Taylor points out that cosmetic surgeons actually use the label rather loosely – sometimes to describe anyone who has had 'too many' surgeries, or who disputes the surgeon's judgement in a variety of context-relative ways: 'whatever the reality, the term has become a readily available code for any surgery or patient considered crazy or disturbing' (2007: 112). This was also apparent in the textual archive I surveyed: as I'll show, whatever its reality, BDD functions as a useful place-holder for a variety of paradoxes that those involved in cosmetic surgery would rather not confront. Sustaining these paradoxes often requires projection of psychological responsibility onto patients without serious phenomenological attention being paid to the lived experience of diverse cosmetic surgery recipients.

First, clinical debate over who is a psychologically good or bad candidate for cosmetic surgery may function to make cosmetic surgery seem both medically serious and ethically responsible. In their critical analysis 'Cosmetic Surgery and the Internal Morality of Medicine', Miller et al. suggest that cosmetic surgery violates the internal morality of medicine: 'a professional practice governed by a

moral framework consisting of goals proper to medicine, role-specific duties, and clinical virtues' (2000: 353–4). Although 'the relief of pain and suffering caused by maladies' is part of medicine's legitimate purview, this does not extend to all pain and suffering, not all of which is caused by a 'malady'. They reject the suggestion that the suffering caused by a negative body image might qualify as in need of surgical remediation, arguing that: '"malady" in the medical context suggests an objectively diagnosable condition calling for medical treatment; and this is precisely what is lacking in the case of cosmetic surgery. The "need" for cosmetic surgery is a function entirely of subjective preference' (2000: 358). Later, they bluntly state that: 'to give an aura of standard medical legitimacy to cosmetic surgery, cosmetic surgeons have concocted diagnostic categories warranting cosmetic surgical intervention, most notably, the "inferiority complex"' (2000: 358). Comparing the psychiatric apparatus that accompanies evaluation for sex reassignment surgery with the lack of such evaluation in the case of cosmetic surgeries, they argue that:

> If cosmetic surgeons truly believed that they were treating 'real' psychiatric 'maladies', then in order to provide minimally competent care, they ought to be working in tandem with mental health teams . . . and offering nonsurgical options to at least some of their patients. To our knowledge, very few if any cosmetic surgery offices and clinics are run in this fashion, which tends to suggest that cosmetic surgeons themselves do not take very seriously the claim that their practices are legitimated by the reality of psychiatric disease. (2000: 359)

Miller et al.'s article is one of very few articles to situate cosmetic surgery in an ethical and medical frame and to be unabashedly critical of cosmetic surgeons' standards of practice. However, their argument hinges on the absence of psychiatric diagnosis (with a mental disorder that is not simply 'concocted') in cosmetic surgery practice. There is no substantive research on the proportion of cosmetic surgeons who perform psychological testing, or patients who are turned away, although anecdotal evidence suggests that surgeons consider it important to be an amateur psychologist (testing for the candidate who is unlikely to be satisfied with the procedure, even if the outcome is technically satisfactory), and all think it important sometimes to turn down a request (although examples of would-be recipients who actually have been turned down by a surgeon seem to be far rarer than the claims warrant). This scepticism notwithstanding, there does seem to be a growth in the literature on cosmetic surgery and mental health, including policy recommendations for cosmetic surgeons. If this literature had consequences for practice, then, following Miller et al.'s line of reasoning, in some quarters at least cosmetic surgery would be made more legitimate. Indeed, this seems to be an outcome of Miller et al.'s argument that they likely did not intend: introduce a 'mental health evaluation' and automatically legitimate your cosmetic surgery practice as ethical because more closely allied to internal norms of medical prac-

tice. Introducing psychiatric screening for the unsuitable patient also reinforces the notion that those who *do* receive surgery are mentally stable, and thus likely to benefit from it – indeed, mental health comes almost to be defined, in a thoroughly circular fashion, through patient satisfaction or dissatisfaction with outcomes (see also Pitts-Taylor, 2007: 119–23).

A second function of psychiatric diagnosis is to make cosmetic surgeons more able to pathologize the dissatisfied patient. The psychological literature aimed at cosmetic surgeons in particular is striking for its willingness to classify patients who have almost any negative emotional reaction to surgery as mentally disordered. The diagnosis of BDD may thus help to crystallize the larger process of the back-formation of *kinds* of patient from surgical sequelae. For example, in a short chapter of a cosmetic surgery textbook, 'Guidelines for Preoperative Screening of Patients', Mark Gorney explicitly classifies patients into 'types' for the purposes of screening out those unlikely to benefit from surgery: patients may be 'demanding', 'indecisive', 'the VIP', 'secretive' and 'immature'. The VIP, for example, makes: 'a constant, conscious effort to impress the surgeon with professional or community status'. They are 'likely to have a weak ego structure, needing constant bolstering, and are prone to forget financial obligations' (1989: 50). At the end of reading this literature one is left with the clear impression that the ideal, psychologically appropriate candidate for cosmetic surgery expects little of the surgeon. She interacts deferentially and asks minimal questions, is willing to be satisfied with any outcome that also satisfies the surgeon, has moderate, normative expectations for her change of appearance, is not excessively anxious about her bodily flaws but nonetheless expects to have a reasonable number of future surgeries, pays her bill promptly and doesn't sue. Clearly this profile suits surgeons, and also picks out a distinctively feminine comportment; thus, as cosmetic surgery normalizes feminine bodies, so the discourse of mental health with regard to cosmetic surgery normalizes feminine psychology. That men are so often described as less likely to be psychologically appropriate candidates for cosmetic surgery because, among other things, they are 'too demanding' merely confirms the point.

If this psychological profiling is in general of most interest to self-styled medically responsible cosmetic surgeons, however, one particular aspect of it has a broader appeal. Certain kinds of cosmetic surgery patients are increasingly described in risk management terms. For example, a short article in the journal *Healthcare Risk Management* says:

> . . . new research suggests that patients seeking cosmetic surgery are much more prone to have personality disorders such as narcissism. The findings could have important implications for risk managers, however, because it also appears that cosmetic surgery patients with personality disorders are much more likely to sue for malpractice. (Gaborian, 1999: 83)

Within this discourse, even the most profit-driven, consumer-oriented cosmetic surgeon will have reason to be interested in psychological profiling because it can increase his profits and decrease his chances of being caught up in litigation. The BDD sufferer again appears here as one 'type' among others who may be contra-indicated for cosmetic surgery because her dissatisfaction will have negative consequences for surgeons.

Diagnosing Culture

I hope to have shown here that the cosmetic surgery industry contributes to the cultivation of a culturally recognizable psychology that is different from the symptoms of Body Dysmorphic Disorder in degree rather than in kind – a point of course conceded by some clinical commentators (see discussion in Phillips, 2005: 187–91). In this case the widespread clinical practice of drawing the line between the psychologically normal and the mentally ill, however, does not only function as a way of predicting who will 'benefit' from cosmetic surgery and who will be further damaged. The cosmetic surgery industry needs us to be distressed about our aesthetically inadequate bodies and works to develop this distress – creating surgical subjectivity at the same time as it tries to control the less manageable, profitable or normative consequences of this subjectivity. Indeed, I've gone further, to suggest that the diagnosis of BDD may implicitly serve the interests of the cosmetic surgery industry by adding to the repertoire of pathologies that disappointed consumers can be labelled with. This tension leads to extraordinary paradoxes: that potential patients must be both recruited and rejected, that we must be educated about our bodily flaws while surgeons claim only to be responding to demand, that cosmetic surgery's only viable rationale is making one feel better about oneself but only if one doesn't feel too bad to begin with, and that the scene of address in which the demand for cosmetic surgery is generated is back-formed into the patient's psyche itself.

Those who have applied Foucault's genealogies of normal and abnormal to such problems are often accused of lacking compassion for the afflicted. Indeed, Bordo includes discussion of how her work on anorexia was initially charged with just such hard-heartedness toward the individual anorectic for its failure to mark the unique psychopathological status of the disorder (2003 [1993]: 60–1). If we are all part of an anorexic culture, critics alleged, then there is no room for the special suffering of the anorectic, no distinction between the ordinary dieting woman and the starving waif in a hospital bed. This is clearly a reductive accusation, but I fear my own analysis may provoke a similar response: if BDD is interpreted as an effect of power continuous with and constituted by normal

experience, aren't I trivializing a serious and agonizing psychological syndrome? To be clear: investigating why some people feel so bad about their normal bodies that they refuse to leave the house, destroy their own flesh with obsessive behaviours or self-attempted surgeries or commit suicide, is not a project my analysis precludes. Nor am I suggesting that representations of cosmetic surgery are the sole cause of BDD. However, I am arguing that a clearer sense of how the cosmetic surgical industry – including in its relation to mental health discourse – constructs the normal and abnormal patient might reveal the conditions of possibility for BDD. This in turn will permit genealogical critique that may enable interventions into the psychic life of cosmetic surgery, which at the moment is almost entirely closed off from humanistic analysis. This project should be of general concern to theorists undertaking cultural critique, because the psy disciplines increasingly dominate popular understandings of subjectivity, and are increasingly oriented toward essentialist understandings of identity that render both phenomenological and political analysis irrelevant. This is a kind of intellectual domination that, as I have argued in more detail elsewhere, closes down our possibilities for thinking ourselves differently, and hence our capacity for self-government (Heyes, 2007: esp. 15–37).

Such analysis might also have consequences for therapeutic practice – as indeed it already has with more recognizably 'political' disorders such as depression and Gender Identity Disorder. The ways we are urged to take on the 'unbearable' weight of cultural imperatives as a part of our own essential selves is, I would argue, not only a political problem but also a factor in psychological stress. Clinicians regularly emphasize that accepting a biomedical disease model for mental illness diminishes stigma and absolves the individual of responsibility while providing a simple and accessible explanation for her woes. The reverse can sometimes be true, however: if the problem lies within one's self, then motivation to act to change one's environment, or even to reach out as an agent to others, can be diminished. Studies of BDD sufferers who take SRIs (serotonin reuptake inhibitors, such as fluoxetine [Prozac]), have shown positive results in improving symptoms (Phillips et al., 2002; Phillips and Rasmussen, 2004). While I don't dispute that SRIs may work for some, from the fact that they may alleviate the symptoms of BDD one cannot infer that low levels of serotonin cause it, any more than one can infer from the fact that a stiff drink at the end of the day helps me to relax means that my stress is caused by alcohol deficiency.[10] The effect of much of the medical research on BDD is to make the patient's physiological identity into the privileged object of analysis. Within this paradigm, commentary on the conditions of possibility for BDD – including the role of cosmetic surgery or other institutions in cultivating a BDD-like phenomenology

– is either non-existent, or a casual footnote to the main business of investigating the individual (Pitts-Taylor, 2007: 123–7).

As our cultures become ever-more preoccupied with appearance, and cosmetic surgery continues to grow exponentially in popularity, we can expect (if my theory is correct) to see a concomitant growth in BDD that cannot be attributed to 'better' diagnostic practices or increased public awareness per se. The criteria for BDD require that the defect that is the object of one's obsession be 'imagined' ('or, if a slight physical anomaly is present, the individual's concern is markedly excessive') (APA, 2000: §300.7). Just as it is a complex epistemological task to distinguish between a normal relationship to a mirror and a pathological one, so it is hard to mark what should count as an 'imagined' defect or 'excessive' concern about it. This seems uncontroversially to vary by place: what counts as ugly in southern California might be thought perfectly unremarkable in rural Manitoba. The diagnostic criteria for BDD thus cannot claim to have much cultural or even geographic consistency. More interestingly, perhaps, even a cursory knowledge of the history of appearance norms and cosmetic surgery reveals that what it means to have a normal body has changed: cosmetic surgical candidates who might have found it hard only ten years ago to get a surgeon to take their aesthetic concern seriously can now easily qualify as in need of fixing. So the threshold for what counts as an intersubjectively real body flaw has dropped, and more and more people have, in effect, physical defects, as well as a level of concern about them that can find more and more justification in cultural standards. The threshold for BDD has therefore effectively shifted, too. If body flaws are real, then being distressed about them is justified; if they are delusions, then it's a mental illness. As what counts as a real flaw moves, it both relocates and narrows the definition of psychopathology. So, again if my theory is correct, it predicts not only that more and more people will develop BDD, but that (if current trends continue) more and more people will become highly anxious and dissatisfied with their appearance but fail to meet the diagnostic standard because their distress has cultural validation. At this point, there are limits on what Prozac can do for any one of us, let alone 'us' writ large.

Thus, finally, rather than interpreting my argument as trivializing BDD, we might understand it as making the everyday awfulness of many people's lived experience more explicit. Those working with BDD sufferers (and, to the extent they speak publicly, those sufferers themselves) are motivated to stress the seriousness of the disorder, and its distinctive abnormality when compared with commonplace body image dissatisfaction. Not unreasonably, they want recognition of their distress and its negative consequences, and funding for their research and for treatment regimens. The critical perspective on psychiatry my analysis

both draws on and implies, however, shows that hiving off the mentally ill as a distinct category of person will often function to depoliticize the context that provides conditions of possibility for their subjectivity. I hope to have shown here that the way BDD is interpellated in cosmetic surgery discourse sustains a surgical industry that is invested in cultivating its symptoms, even as BDD is represented as an indicator of when surgical expansion should be checked. Far from standing in the way of providing care to the afflicted, this argument ought to motivate complementary challenges to a cultural trend that threatens to relocate 'normalcy' to a place of tremendous suffering.

Notes

1. On schizophrenia see Sass (1998), on Multiple Personality Disorder see Hacking (1995), on Gender Identity Disorder see Feder (2007) and on depression see Leder (2005).

2. For more, and more extensively documented, case studies, including patients' letters, see Phillips, esp. chapter 2, 'Patients Speak' (2005: 7–20).

3. Indeed, this literature is now so extensive that I cannot provide a complete bibliography here. Representative key articles and books that effectively review the rest of the literature, including the relationship between cosmetic surgery and BDD, include: Crerand et al. (2006), Honigman et al. (2004), Sarwer and Crerand (2008), Sarwer et al. (1998, 2006).

4. For the original argument, see Foucault (1979: esp. 135–228); for my exegesis and interpretation of Foucault's account as it relates to normalization and bodies, see Heyes (2007: esp. 28–37).

5. Veale and Riley's mirror guidelines for BDD sufferers are:

> 1. To use mirrors at a slight distance or ones that are large enough to incorporate most of their body; 2. To deliberately focus attention on their reflection in the mirror rather than an internal impression of how they feel; 3. To only use a mirror for an agreed function (e.g. shaving, putting on make-up) for a limited period of time; 4. To use a variety of different mirrors and lights rather sticking to one which they 'trust'; 5. To focus attention on the whole of their face or body rather than a specific area; 6. To suspend judgement about one's appearance and distance oneself from automatic thoughts about being ugly or defective; 7. Not to use mirrors that magnify their reflection; 8. Not to use ambiguous reflections (for example windows, the backs of CDs or cutlery or mirrors that are dusty or cracked); 9. Not to use a mirror when they feel they have the urge but to try and delay the response and do other activities until the urge has diminished. (2001: 1391)

6. Jules Gabriel François Baillarger (1809–90) was a French neurologist and psychiatrist. He studied medicine at the University of Paris under Esquirol (1772–1840), and while a student worked as an intern at the Charenton mental institution. In 1840 he accepted a position at the Salpêtrière, and soon after became director of a mental asylum in Ivry.

7. This aside is drawn from a talk given by Lauren Berlant in 2007 at the University of Alberta.

8. Understanding the phenomenology of self-objectification and self-hating is a much larger feminist project than I can fully explore here, albeit one that would, in my view, usefully complement Foucauldian analyses that tend to take a larger historical picture as their scope, and, as Linda Alcoff argues, eclipse phenomenology within feminist theory in favour of a discursive analysis that cannot account for embodied subjectivity in a Merleau-Pontian sense (Alcoff, 2000; see also Alcoff, 2006: esp. chs 4 and 7, for a constructive appropriation of Merleau-Ponty's view for political purposes).

9. Of course another possibility is that Gimlin's interviewees *are* in fact sufferers of BDD. Certainly some of them – inferring from the brief quotes and descriptions that paint pictures of individuals – seem to meet some of the clinical criteria. They don't meet others, however: they are all 'normal functioning' and (if I may participate in the circularity of this whole discourse) they seem to have found some relief for their symptoms via cosmetic surgery.

10. This analogy is borrowed from Radden (2003: 45).

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