Bodily Integrity in Body Dysmorphic Disorder

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Abstract: Body dysmorphic disorder (BDD) poses a significant challenge to an individual's mental well-being. The obsessive preoccupation with perceived defects in one's appearance affects individuals' daily functioning and can result in serious risks, including suicidal ideation and self-surgery. While treatments such as cognitive behavioural therapy and serotonin reuptake inhibitors can provide relief, they do not achieve complete remission. It has been suggested that therapy should not only interrupt the harmful behaviour, but should also address their sense of self, and that after addressing their internalised values, individuals with BDD will be able to incorporate their perceived defect in a manner similar to how individuals with real deformities often do. Phenomenology of psychopathology analyses subjectivity in cases of pathology, and analyses of BDD show that the perceived defect has become a locus of shame. This implies that individuals with BDD have permanently incorporated the gaze of the Other and constantly experience their body as a body-for-others. This paper further explores the sense of self in individuals with BDD through Jenny Slatman's interpretation of bodily integrity: bodily integrity as a never-ending process of identification. By comparing the experiences of individuals with BDD to those with real deformities and to those who have undergone cosmetic surgery, I will show that re-identification does not occur in individuals with BDD. This suggests that their bodily integrity is fundamentally disturbed and that addressing their internalised values alone will probably not be sufficient for the disorder to go into remission.

Keywords: Philosophy, Phenomenology, Shame, Disfigurement, Gaze of the Other

Introduction

Body dysmorphic disorder (BDD) is a severe and debilitating condition characterised by an excessive preoccupation with perceived defects in one's appearance, which are often invisible or negligible to others. Due to the repetitive behaviours associated with the disorder, such as mirror gazing and excessive grooming, the condition can significantly impair many aspects of an individual's life. The disorder is also frequently accompanied by intense feelings of shame, which, in turn, can lead to social phobia or, in the most extreme cases, to individuals becoming housebound (American Psychiatric Association 2013, 242-247). The phenomenon of mirror gazing is particularly distressing as it perpetuates the cycle of obsession and dissatisfaction (Veale and Riley 2001). Cognitive-behavioural therapy and selective serotonin reuptake inhibitors are the primary treatments for this condition (Phillips and Hollander 2008). Nevertheless, BDD is often chronic, with symptoms persisting or returning despite these treatments (American Psychiatric Association 2013, 244). Regardless of the fact that its prevalence is higher than that of other body image disorders such as anorexia nervosa (Veale et al. 2016), BDD remains less understood. The high incidence of suicidal ideation among individuals with BDD (American Psychiatric Association 2013, 245), however, highlights the necessity for a deeper understanding of the disorder.

The phenomenology of psychopathology analyses subjectivity in cases of pathology and it can assist in forming testable hypotheses regarding the underlying neurobiological mechanism (Fuchs 2009, 547). Previous phenomenological analyses have already provided valuable insights into the lived experiences of individuals with BDD, particularly regarding the concepts of shame and self-perception. Thomas Fuchs' (2002) analysis suggests that the perceived defects symbolise a deeper insecurity, and that due to an inability to neutralise the gaze of the Other, these individuals are stuck in a constant state of self-scrutiny and shame. David Veale's (2004a) proposition further extends this understanding, suggesting that addressing the idealised values held by individuals with BDD might help them accept their perceived defects, akin to how individuals with real deformities learn to integrate their physical changes.

In this paper I will further explore the phenomenological aspects of BDD, with a particular focus on the impact of the disorder on the individual's sense of self and bodily integrity. By comparing the experiences of individuals with BDD to the experiences of individuals who have physical deformities or have undergone cosmetic surgery, I aim to deepen our understanding of the disorder's underlying existential dimensions. I will start with a clinical psychological perspective and eventually present a phenomenological critique to Veale's proposition. This will be achieved by applying Jenny Slatman's (2012) definition of bodily integrity as a never-ending process of identification. This will show that in individuals with BDD, their bodily integrity is fundamentally disturbed and that solely addressing their internalised values will probably be insufficient.

The initial paragraph will provide a more detailed account of the nature of BDD, including its classification, etiology, and treatment. The following paragraph will present the phenomenology of BDD, with a phenomenological analysis of shame by Thomas Fuchs, and the findings of interpretive phenomenological analyses. In the third paragraph, I will present Jenny Slatman's analysis of bodily integrity in individuals with scars and demonstrate how this leads to a new interpretation of bodily integrity. In the final paragraph, I will compare the bodily integrity of individuals with real deformities and women who have undergone cosmetic surgery to that of individuals with BDD. This comparison will be used to argue that bodily integrity in individuals with BDD is disturbed because re-identification does not take place.

Body Dysmorphic Disorder[1]

Body dysmorphic disorder (BDD) is defined as a preoccupation with perceived defects in one's physical appearance, which are often invisible or only slightly visible to others. The preoccupation gives rise to repetitive behaviour, in the form of safety behaviour and compulsions, which significantly impairs the patient's life on a social, professional and relational level. Repetitive behaviour encompasses activities such as mirror gazing, excessive grooming and seeking reassurance. BDD occurs among women as well as among men and the prevalence

[1] In this paper, I start from a clinical perspective on BDD, which means I adopt the definition of BDD as outlined in the DSM-V. I am aware that the DSM has been subject to a great deal of criticism over the years, particularly from those working within the field of phenomenology. Nevertheless, the objective of this paper is not to provide a direct critique of the DSM-V. Instead, it seeks to examine the subjective experience of BDD and its implications for currently employed therapies. Individuals who receive therapy for BDD do so based on recommendations from the DSM-V, which is why I will not offer a direct critique. For those interested in critiques of the DSM-V, please see: Andreasen, 2007; Pickersgill, 2014; Mishara and Schwartz, 2013.

among adults in the United States is 2.4% with a lower prevalence observed outside the United States, at approximately 1.7% (American Psychiatric Association 2013, 242-244). This indicates that the prevalence of BDD is higher than that of other body image disorders, such as anorexia nervosa which occurs at approximately 1% among the adult population (Veale et al. 2016). Suicide idealisation and suicide attempts are highly prevalent among individuals with BDD (American Psychiatric Association 2013, 245; Brohede et al. 2016).

Individuals with BDD may possess an accurate understanding of their disorder, recognizing that the perceived defect is likely not actual. However, almost a third of the individuals with BDD do not have this insight and hold a delusional belief that their perceived defect truly exists. The majority of individuals with BDD perceive a defect in their face or on their skin. However, defects can be perceived in any area of the body, and individuals with BDD frequently perceive more than one defect (American Psychiatric Association 2013, 243-244). Consequently, individuals with BDD often describe themselves as "ugly" or "abnormal" (American Psychiatric Association 2013, 243; Brohede et al. 2016). They frequently experience feelings of shame regarding their appearance, which may result in the adoption of excessive grooming practices. This, in turn, can give rise to severe social phobia, leading to a situation in which some individuals with BDD become housebound and too afraid to leave their homes. An important aspect of the disorder is 'mirror gazing', whereby individuals with BDD can spend hours looking in the mirror and checking their physical appearance. They are drawn to the mirror in the hope that their mental representation of how they look is incorrect or that their appearance may change. However, looking in the mirror makes them feel worse afterwards as the images they see are confusing (Veale and Riley 2001; Brohede et al. 2016). Individuals with BDD have reported seeing one or more faces in the mirror, depending on the position of the body and the intensity of light (Veale and Riley 2001).

Although little is known about the causes of BDD, researchers have proposed a diathesis-stress model, wherein predisposed factors, such as genetics and brain structures, together with environmental factors, can lead to the development of BDD. The most common triggering events are bullying, and experiences that instilled a particular beauty standard (Weingarden et al. 2017). It is possible that these beauty standards may be culturally determined, given that although BDD occurs in many different cultures, the specific symptoms vary depending on the specific beauty standard in question (American Psychiatric Association 2013, 245; Singh and Veale 2019). A cognitive model has also been proposed which describes how BDD symptoms are maintained. This model begins with an external representation, such as looking in the mirror, as a triggering event. From here individuals with BDD form a negative appraisal of their appearance which causes safety behaviours such as excessive grooming and seeking reassurance (Veale 2004a). Cognitive behavioural therapy (CBT) is employed to interrupt this cycle and alleviate BDD symptoms (Veale 2004b). Selective serotonin reuptake inhibitors (SSRI's) may also be prescribed to alleviate the compulsive and repetitive behaviour. Although both treatments have been demonstrated to be effective (Phillips and Hollander 2008), BDD is a chronic disorder whose symptoms may be managed but will not completely disappear (American Psychiatric Association 2013, 244). Furthermore, discontinuation of SSRI's often leads to a recurrence in symptoms (Phillips and Hollander 2008). Effective treatment is also challenging due to a reluctance to seek therapy, often due to feelings of shame and a fear of being perceived as vain and narcissistic. Even if individuals with BDD are seeking help, they frequently consult dermatologists or cosmetic surgeons as they believe that their physical defect is the root cause of their distressing feelings (Phillips et al. 2001). If individuals with BDD are not able to receive cosmetic surgery, for example because they are turned down or do not have the financial funds for it, they sometimes resort to doing it themselves (American Psychiatric Association, 2013, 244).

Phenomenology of BDD

Phenomenology is a descriptive philosophical method aimed at examining and articulating the form and structure of conscious experience. It emerged in the early 20th century, primarily through the work of philosophers such as Edmund Husserl, Martin Heidegger, and Maurice Merleau-Ponty. The objective of phenomenology is to describe and understand the structures, meanings, and essences of subjective experiences without presupposing any theoretical frameworks or interpretations (Smith 2013). Similarly, the phenomenology of psychopathology is not concerned with causality, but rather analyses subjectivity in cases of pathology. These analyses can assist in the formation of testable hypotheses regarding underlying neurobiological mechanisms (Fuchs 2009, 547). A number of phenomenological analyses have already been conducted on BDD, with the majority focusing on the role of shame and the impact of mirror gazing.

Phenomenology differentiates between the minimal self and the extended self. The minimal self is a pre-reflective form of self-awareness that is always present, regardless of whether or not the individual is engaged in

introspection. It is sometimes equated with a sense of mineness, in that the individual is always aware that they are the one experiencing. The extended self is the self that is embedded in the world and is constituted through our relationships with others. This is also referred to as the narrative self, through which we can develop a concept of ourselves and a unique identity (Fuchs 2009, 549-551; Messas et al. 2018). It is also the extended self that enables the experience of shame. Usually when we do something unusual, like stumbling, our body, which is typically perceived as being in the background of our experience, becomes the focal point of attention. Our body is no longer experienced as transparent, but rather as a corporeal thing. This allows us to see our body from the perspective of an outsider. By incorporating this gaze of the Other, the body is transformed into a body-for-others and thereby leaving it exposed to potential rejection (Fuchs 2009, 550-552). It is important to note that the gaze of the Other as an outsider's perspective is not an real outsider's perception of us, but rather our perception of ourselves through their eyes. Individuals without BDD are able to regain some self-esteem after leaving the shameful situation by adopting a self-other metaperspective. They are able to disengage from the immediate situation, adopt a perspective that considers both themselves and others, and in doing so, they neutralise the incorporated gaze of the Other, thereby reducing the intensity of their shame. For example, they may acknowledge that the stares of others are not always directed at them, thus overcoming the sense of being trapped in a shameful situation (Fuchs 2002). In contrast, individuals with BDD are unable to put their appearance concerns into perspective (Brohede et al. 2016), and therefore remain trapped in feelings of embarrassment. Because individuals with BDD are overly focused on themselves and how they believe others perceive them, they cannot convince themselves that others are not constantly judging them. This egocentric way of perceiving themselves results in a constant reinforcement of shame. The perceived defect becomes the locus of shame, and renders the body a constant object of attention. The inability to neutralise the gaze of the Other means the gaze of the Other is permanently incorporated, so that individuals with BDD experience their body only as a body-for-others; they thus remain stuck in a corporeal experience of their body (Fuchs 2002; Fuchs 2009, 556).

In his phenomenological analyses of shame, Thomas Fuchs situates BDD within the realm of the extended self, thereby identifying it as a disturbance of social relationships. He also proposes that the corporealization of the body conceals a deeper insecurity, which is symbolised by the perceived defect (Fuchs 2002; Fuchs 2009, 555-556). These suggestions have been supported by recent interpretative phenomenological and other qualitative analyses. When individuals with BDD describe what they see in the mirror, they often use descriptions of internal feelings rather than simply describing their physical features. This implies that individuals with BDD might attend to a mental representation of their body image while looking in the mirror (Veale and Riley 2001). Additionally, individuals described being fearful that others would perceive their flawed inner qualities by noticing their perceived physical defect (Brennan et al. 2021), and expressed that only they could perceive their true self through their perceived defect (Silver and Farrants 2016). Numerous individuals with BDD also report general feelings of inferiority or inadequacy, a sense of not feeling good enough and feelings of unequalness to others (Silver and Farrants 2016; Craythorne et al. 2022; Phillips et al. 2008). It is suggested that these general feelings of inadequateness exist due to the exceptional high standards they set for themselves (Brohede et al. 2016; Veale 2004a; Silver and Reavey 2010).

It is important to note that the above observations do not fully capture the complexity of BDD and that further nuances need to be considered. Because while it might seem that BDD is solely constituted by an internal negative belief that is projected on the body, this is not entirely accurate. As Brennan et al. (2021) observed, individuals with BDD may actually experience an unstable sense of self. The reason individuals with BDD are drawn to the mirror is that they often hope or believe that their physical appearance has changed or will change (Silver and Farrants 2016; Brennan et al. 2021; Veale and Riley 2001). Individuals with BDD sometimes describe their reflection as a picture, and the necessity to come to terms with this picture, indicating a disconnection from the self (Silver and Farrants 2016). This results in uncertainty, and individuals with BDD – particularly in those who still have a certain level of insight into the disorder – express that they find it challenging to trust their perceptual experiences (Brennan et al. 2021). For these reasons, Brennan et al. have recommended that psychotherapeutic approaches should not solely focus on the modification of maladaptive behaviour, but should also address the sense of self that individuals with BDD possess. David Veale (2004a) also proposed that addressing idealised values – such as symmetry, youth or social acceptance – might enable individuals to accept their perceived defect in a manner similar to how individuals with a real deformity[2] are often able to do. This claim is mentioned quite offhandedly without much elaboration but is incorporated into the recommended CBT scheme.

[2] The concept of 'real deformity' is solely used to be able to discern between individuals who have a perceived defect that is usually not noticeable to others, and individuals that have bodies that deviate from the norm of physical intactness. Nowhere is it meant to include a normative statement.

About its efficacy nothing significant is mentioned, but the claim is interesting nonetheless. It suggests that an understanding of phenomenology of scars and deformities may offer insights into the underlying mechanisms of BDD.

In the next two paragraphs I will delve deeper into the sense of self experiences by individuals with BDD in comparison to individuals with scars and other real deformities, with a particular focus on the experience of bodily integrity. This will demonstrate that there is a fundamental disturbance in the bodily integrity of individuals with BDD that is might not be solved by solely addressing their idealised values.

Bodily integrity in deformed bodies

The preceding paragraph revealed that individuals with BDD experience an inability to neutralize the gaze of the Other, as well as experience an unstable sense of self, signified by general feelings of wrongness and a detachment from the self. Additionally, the perceived defect often symbolises idealised values that individuals with BDD feel they are unable to fulfil. Jenny Slatman observed similar phenomena in individuals who have experienced scarring after a mastectomy.

The term "integrity" is derived from the Latin word *integrum* which translates to "wholeness". Consequently, bodily integrity is defined as bodily wholeness (Slatman 2012). Slatman identifies three interpretations of bodily integrity (Slatman and Widdershoven 2015, 87-88). The first interpretation is one that is frequently discussed in ethical and feminist literature, and which is linked to the concept of autonomy. In this interpretation the body is seen as something we posses, and the concept of bodily integrity is used to determine who can alter this body. This form of integrity cannot be identified within the body itself; rather, it is conceived by Slatman as an 'ethical fiction' (Slatman 2012). However, upon the examination of the subjective experience of bodily integrity, a second form emerges. Bodily integrity as a phenomenological concept is inextricably linked to the lived body. This lived body is a pre-intentional and pre-objective non-thing through which we are able to perceive the world (Slatman and Widdershoven 2015, 94). It is through this body that we react to the possibilities embedded in the world, and it is therefore often described as an "I can". In contrast to the first interpretation of bodily integrity, the body is no longer regarded as the body one *has*, but rather as the body one *is* (Slatman and Widdershoven 2015, 88-90). The physicality of the body constrains the lived body's capacity to respond to the possibilities in the world. Usually this is not an issue as we are accustomed to what our body is able to do. But if the physicality of the body suddenly changes – for instance due to an amputation – then this is no longer the case. Bodily integrity is affected, or no longer intact, when our engagement with world is inhibited (Slatman 2012). Our "I can" has become an "I cannot".

This phenomenological concept of bodily integrity is frequently used to describe the effects of disease and impairment. But it is insufficient to describe the impact of scars, as the concept depends upon a physical alteration that affects the mobility of the physical body. Individuals with scars or other deformities may experience a disturbance in bodily integrity even if their "I can" is not directly impacted. In light of this, Slatman identifies a third interpretation of bodily integrity that is based on embodied self-identification. The core aspect of this form of bodily integrity is that it not only focuses on the lived body, but also includes the body as a corporeal thing. Slatman uses Husserl's illustration of our two hands touching to exemplify this stance. The right hand is experienced by the left hand as a corporeal thing, yet the right hand simultaneously experiences being touched by the left hand. The experience of the lived body in the right hand is only possible because the right hand is also experienced as a corporeal thing by the left hand. The lived body can therefore only be experienced because it is a corporeal thing as well, which implies that there is no true separation between the lived body and the body as a corporeal thing. This implies that any experience of the self necessarily includes the self as a corporeal thing and thus also experiences of strangeness. A concept of bodily integrity that incorporates both these aspects would be as follows: I am the body I have. In this third interpretation of bodily integrity, bodily integrity is a never-ending process of identification. By defining bodily integrity as the possibility of being one's body, the strangeness of the body is acknowledged, and bodily integrity is experienced when someone is able to identify with the strangeness of their own body. This signifies that bodily integrity is an ongoing process which enables constant ex-corporation and incorporation. However, in instances where incorporation of an altered body part is unsuccessful, as is the case in those who are unable to identify themselves with their deformities, a disruption in bodily integrity may be experienced. Even if their "I can" remains unaffected, the inability to re-identify with their deformities causes them to experience their body as a corporeal thing, preventing them from being the body they have (Slatman 2012; Slatman and Widdershoven 2015, 93-101).

An interesting consequence of this is that bodily integrity may be experienced even if the physical body itself is not intact. It is possible for individuals to experience a sense of wholeness despite the fact that, technically speaking, their body is not “whole”. This is the case in individuals who, following a mastectomy, have been able to re-identify with their one-breasted body. These individuals, Jenny Slatman suggests, are unlikely to derive significant benefit from reconstructive surgery, given that they have already re-established a sense of bodily wholeness. Conversely, individuals may experience a disruption to their bodily integrity even when their bodies are intact and not deformed. Those who suffer from Body Integrity Identity Disorder (BIID), sometimes desire the amputation of a healthy limb. They experience such strangeness in their bodies, that they can only experience their body as a corporeal thing. Individuals who suffer from this condition have stated that they only felt "whole" again after the amputation of their healthy limb. There appears to be a mismatch between their real body and how these individuals experience their body. As a result, they are unable to identify themselves with their body, which leads to a disruption in their bodily integrity (Slatman 2012). To summarise, by including both the lived body and the aspects of strangeness that accompany the experience of the body as a corporeal thing into one definition of bodily integrity, we are able to examine disturbances of bodily integrity that do not depend on the intactness or the mobility of the physical body. This interpretation views bodily integrity as a never-ending process of identification, in which bodily integrity is experienced if there is identification with the strangeness of the body.

By discerning this third interpretation of bodily integrity, Slatman also offers a critique on the second interpretation of bodily integrity. She argues that in literature on the phenomenology of illness and impairment, authors excessively focus on the lived body. By not incorporating the corporeal experience of the body into the experience of disease and impairments, effects of how the body is perceived by others are often overlooked. By incorporating both the lived body and the body as an object in a single definition, bodily integrity can be analysed through both a bodily and a sociological analysis. When we do this, it also becomes clear that although a disturbance in bodily integrity in the third sense may not always affect an individual's “I can”, it is definitely possible. Phenomenological analyses of scars and deformities demonstrate that the “I can” can be disrupted even when the physical mobility of the body remains unimpaired. An important source for our agency and “I can” is that our body is in the background of our experience, and we do not have to consciously think about our movements all the time (Slatman 2016). But as previously discussed, the gaze of the Other can prompt the body to come to the foreground of our experience and become a body-for-others. Individuals that are focused on how they look and how they are perceived by others, are often unable to completely focus on the project at hand because their bodies remain the focal point of attention. This incorporation of the gaze of the Other may result in an inhibited “I can” or an “I cannot” (Yaron et al 2017). An individual may, for instance, be continually aware of the position of their head in order to conceal a scar. This implies that the project of grocery shopping needs to be done with the body as a main focus point. The “I can” is then inhibited even in the absence of a physical defect that limits the mobility of the body as might be the case after, for example, an amputation. The “I can” is therefore also dependent on how we believe others perceive us (Slatman 2014).

Bodily integrity in individuals with BDD

The third interpretation of bodily integrity is most applicable to individuals with BDD in order to describe their experience. Not only is the disturbance of their bodily integrity independent from the intactness of their body, but similar to individuals with real deformities, individuals with BDD have also permanently incorporated the gaze of the Other and experience an inhibited “I can”; despite the fact that there is no impairment to their mobility. In BDD, this inhibited “I can” is exemplified by excessive grooming behaviour prior to leaving the house, or even an “I cannot” if the individual is housebound. The fact that the perceived defect is not real, is not necessarily relevant for the experience of bodily integrity, because for individuals with BDD the perceived defect often *is* real. In the remainder of this paper, the term "bodily integrity" will be used to refer to the third interpretation as described by Jenny Slatman.

As bodily integrity is a never-ending process of identification, habituation of a scar – or other real deformity – is sometimes possible. One of the key elements of this process is de-signifying the scar. In cases where an individual is unable to re-identify with their body following scarring, this is frequently due to the fact that they do not solely perceive the scar itself, but also the loss that the scar signifies. The scar has gained a meaning beyond its given materiality. In such instances, individuals often look through their scar instead of simply at the scar. By confronting the physical reality of the scar, for instance by encouraging oneself to occasionally look at and interact with the scar, the scar can cease to symbolise its original meaning and become an inherent aspect of the body's physicality. It is not accurate to state that the scar itself has become invisible; rather, it has simply become a scar,

and nothing more. Once de-signifying is achieved, the body may recede to the background once more. An illustration of this can be observed in individuals who have undergone a mastectomy and have chosen not to wear a prosthesis. By observing and interacting with the scar, a shift may occur. A body lacking a breast – where the loss of the breast is symbolised by the scar – becomes a one-breasted body with a scar. The scar is not invisible or forgotten, but the absent breast is. The scar has been de-signified, and what remains is only the physical reality of the scar, which has become part of the body (Slatman 2016). For individuals with BDD, CBT can be viewed as an attempt to de-signify their defect. CBT treatment challenges patients to face their assumptions about being defective, thereby modifying their idealised values in order to reduce the importance of their appearance (Veale 20114a). The efficacy of CBT in individuals with BDD is yet to be fully established, although initial findings indicate that CBT can alleviate BDD symptoms and enhance individuals' understanding of the disorder. Nevertheless, CBT does not seem to result in the remission of BDD, as symptoms may not completely disappear. In the cases symptoms do disappear, they can return at any time. For these reasons, BDD is considered a chronic disease by the DSM-V.

Let us return to the statement made by Veale, in which he suggested that individuals with BDD who address their idealised values might be able to incorporate their perceived defect. Although it is true that research suggests that individuals with BDD have higher aesthetic values (Silver and Reavey 2010; Veale 2004a), the preceding analysis demonstrates that Veale's statement does not fully address the issue at hand. While CBT may result in a reduction of symptoms, it usually does not eliminate them entirely. Consequently, it cannot be asserted that CBT leads to a fully incorporated defect. Slatman also acknowledges that not all individuals with scars are able to habituate to their new body. For those who are unable to re-identify with their scar, reconstructive surgery could be an option to help them restore their bodily integrity (Slatman 2012). In order to understand why individuals with BDD are unable to habituate to their perceived defect, it is necessary to consider another group of people who display similar characteristics: women who have undergone cosmetic surgery.

In *The Absent Body Project: Cosmetic Surgery as a Response to Bodily Dys-appearance* (2006), Debra Gimlin examined the lived experiences of women who have undergone cosmetic surgery. Similar to individuals with scars, this group of women show similar symptoms to those with BDD. Gimlin's research demonstrates that women who wanted cosmetic surgery were similarly constrained by the experience of their bodies. All of the women were healthy, able-bodied individuals who nevertheless described experiencing their body as a body-for-others due an increased awareness of the gaze of the Other. The women also exhibited similar behaviour patterns to those observed in individuals with BDD; for example, camouflaging the disliked body part and avoiding specific outside locations. The defects that these women perceived included noses and breasts that they considered to be too large. These frequently symbolised an internalised beauty standard that the women believed they did not fulfil, and they often described how they felt that their body did not represent how they felt inside[3]. Additionally, the women who wanted to have cosmetic surgery were frequently told by those close to them that the surgery was unnecessary (Gimlin 2006). However, similar to individuals with BDD, these comments did not help and sometimes only aggravated their symptoms (Gimlin 2006; Brohede et al. 2016). In a sense, their physical defect was also only perceived by themselves. Following cosmetic surgery, these women were able to re-identify with their body. The women describe how the surgery had silenced their body, meaning that their bodies had effectively receded into the background of their experience (Gimlin 2006). Another literature review on the psychosocial outcomes of cosmetic surgery, also shows that most patients are satisfied with the outcome and experience a higher self-esteem after the surgery (Honigman et al. 2004).

Despite the similarities between individuals with BDD and women who have undergone cosmetic surgery, the positive result of the latter stands in stark contrast to individuals with BDD. In cases of BDD, cosmetic surgery is rarely successful (Veale et al. 2016; Hostiuc et al. 2022; Phillips et al. 2001). In fact, the greater the conviction that their defect is real, the more dissatisfied they tend to be (Hostiuc et al. 2022). Even if individuals with BDD are satisfied with the result of their cosmetic surgery, this does not diminish their BDD symptoms. Instead, they often perceive a new defect on another body part (Tignol et al. 2007; Brohede et al. 2016; Veale 2004a).

In individuals with BDD, restoring bodily integrity is not achieved by de-signifying their bodies or altering perceived defects to match their idealised values. In comparison, these approaches often succeed for other groups of people with similar symptoms. However, individuals with BDD differ from women who have undergone

[3] I would like to include an example from Gimlin's study. One woman thought her breasts were too large. She expressed she hated the sexual comments she frequently received, which caused her to ensure she was fully covered whenever she left the house. The comments led to a heightened awareness of the gaze of the Other, which in turn led to a perception of her body as a body-for-others. She expressed she believed that people around her often perceived her to be more sexual than she actually was, something she felt she should not be, which is why she thought that her body did not accurately represent who she felt she was on the inside.

cosmetic surgery in one important aspect: they do not only perceive themselves as failing their internalised values, but they also experience a general sense of 'wrongness'. They feel trapped in a body that feels inherently wrong. Sometimes, individuals with BDD even seek to identify a physical flaw as this is something that can be fixed (Brennan et al. 2021). The perceived defect thus serves as a scapegoat for a body that can only be experienced as wrong or abnormal.

De-signifying the body and the success of cosmetic surgery rely on a never-ending process of identification that maintains bodily integrity. However, both these interventions are ineffective for those with BDD, which indicates that re-identification with their bodies does not take place. They have a body, but they cannot be that body, leading to dissatisfaction with cosmetic surgery results or a new pre-occupation with another body part. Brennan et al. correctly assert that psychotherapeutic approaches should not only focus on modifying maladaptive behaviours but should also address the individual's sense of self. However, solely addressing their idealised values, as Veale proposed, is likely insufficient for the disorder to go into remission. It fails to address the fundamental disruption in bodily integrity that individuals with BDD experience – namely the inability to identify with their bodies.

Conclusion

Body dysmorphic disorder (BDD) is a significant challenge to an individual's psychological well-being. The obsessive preoccupation with perceived defects in one's appearance affects daily functioning and can lead to serious risks, including suicidal ideation and self-surgery. While treatments such as cognitive behavioural therapy (CBT) and serotonin reuptake inhibitors may provide relief, they fail to achieve complete remission.

Phenomenological analyses show that the perceived defects often symbolise a deeper insecurity and that the perceived defect has become a locus of shame. This means that individuals with BDD have permanently incorporated of the gaze of the Other and view their bodies only from an outsider's perspective, causing them to constantly experience their body as a corporeal thing. However, David Veale proposed that individuals with BDD might be able to incorporate their perceived defect in similar ways as individuals with real deformities, after addressing their internalised values. In this paper I attempted to further explore this proposal and the sense of self in individuals with BDD, by applying Jenny Slatman's interpretation of bodily integrity.

Slatman identifies an interpretation of bodily integrity that not only focuses on the lived body, but also includes the experience of the body as a corporeal thing, and by extension our beliefs about how others perceive us. Bodily integrity in this interpretation can be defined as a never-ending process of identification, or in other words: being the body one has. By comparing the experience of bodily integrity in individuals with BDD to those with real deformities and to those who underwent cosmetic surgery, I have shown that re-identification might not occur in individuals with BDD after therapeutic interventions that have shown to be successful for similar groups of people. Individuals with BDD seem to be unable to be the body they have and are trapped in a body that feels inherently wrong. They seem to be unable to identify with their bodies. This not only shows that Veale's proposal will probably be insufficient, but also explains why CBT does not result in remission and why cosmetic surgery is almost never successful in individuals with BDD.

As previously stated in the first footnote, the purpose of this paper was not to provide a direct critique of the DSM-V. Instead, I started from the clinical perspective and proceeded to construct a phenomenological analysis. It must, however, be acknowledged that this analysis is not without limitations. Despite the value of the BDSM-V as a tool for measuring the severity of BDD symptoms it often fails to address the complex interplay of psychic structures and processes, societal structures and globalised beauty standards that may all contribute to BDD. Similarly, the focus of phenomenology on the conscious experience and the way in which phenomena appear to the subject excludes the influence of the unconscious mind on these experiences. Although a phenomenological analysis of BDD offers a rich descriptive account of how individuals with BDD perceive and engage in the world, it does not seek to transform the underlying structures that contribute to BDD. It is therefore my belief that further investigation into these matters is required if we are to develop a more efficient treatment for individuals with BDD.

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