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Embodied crises: cultural narratives, online social networks, and the mirror syndrome

CRISIS CORPOREIZADAS: NARRATIVAS CULTURALES, REDES SOCIALES ONLINE Y EL SÍNDROME DEL ESPEJO

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Abstract

This article addresses three interrelated phenomena: the irruption of new cultural narratives of power, the role of online social networks in the creation of embodied crises, and the emergence of the Mirror Syndrome as a new computer-mediated medical challenge. In doing so, it exposes the negative consequences that the cultural narratives of beauty canons executed by social media have, above all, for young women's health.

Keywords

Embodied crises; cultural narratives; Mirror Syndrome; online social networks

Resumen

Este artículo aborda tres fenómenos interrelacionados: la irrupción de nuevas narrativas culturales de poder, el rol de las redes sociales en la creación de crisis corporeizadas y el surgimiento del Síndrome del Espejo como un nuevo desafío médico mediado computacionalmente. De este modo, expone las consecuencias negativas que las narrativas culturales de los cánones de belleza impuestos por los medios sociales tienen, sobre todo, en la salud de las jóvenes.

Palabras Clave

Crisis corporeizadas; narrativas culturales; Síndrome del Espejo; redes sociales online

Sumario / Summary

1. Embodied Crises and Cultural Narratives / *Crisis Corporeizadas y Narrativas Culturales*
2. Online Social Networks / *Redes Sociales Online*
3. The Mirror Syndrome (BDD) / *El Síndrome del Espejo*
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1. Embodied Crises and Cultural Narratives

Over the last years, we have witnessed a growing number of academic publications in Crisis Studies that vary from sociological, economic, cultural to political and communication approaches (Castells, 2012a; 2012b; 2013; 2018; Crosthwaite, 2021; Milanovic, 2016; Wodak, 2015). However, as it occurs with any complex societal challenge, we are still missing multi-disciplinary and/or inter-disciplinary studies that contribute to addressing the interconnected nature of the technological, cultural, social, economic, and political crises that have overlapped since the start of the 21st Century marked by the terrorist attacks on the Twin Towers back in September 2001 (Valdivia, 2020).

The present article aims at partially filling such gap in the current scientific literature on Crisis Studies by deploying both a multidisciplinary approach and adding a holistic analysis not just to possibilities of human agency, key transformations in our social fabric and economic-political conjunctures of change and rupture as, for instance, epitomized by the 2008 financial crisis, the ongoing refugee crisis, and the Covid-19 pandemic; but to centering its critical focus to one of the very few elements that human beings share: the existence of a body in which such crises we experience, live, narrate, feel and reflect mutable processes of change and renewal.

The too-often logocentric academic approach to the notion of crisis either as an external agent or as a historical process has invisibilized, if not consciously left out of the spotlight, the very fact that any crises are always traumatic (Crosthwaite, 2012) and, thus, embodied to the extent that their traces and marks are both evidenced at psychological and physical levels. A crisis is, by definition, a critical moment for decision-making which result will collapse, as in quantum physics, a whole body of possibilities and potentialities before others into a new set of structures-in-the-making: new ways of understanding and representing the actual world and novel configurations of ongoing developments that might lead to incremental and/or revolutionary changes (Valdivia, 2020). Therefore, when academically discussing the notion of crisis, we argue that most critical inquiries have projected an analysis that (un)consciously left aside some actual coordinates: the embodiment, the network interconnectedness of any crises, and how these enact new cultural narratives of power.

Consequently, in this article, we will address three foundational overarching research questions: 1) how cultural narratives of power are engendered by and through the articulation of new symbolic and psychological configurations; 2) in which ways online social networks have played a vital role in the creation and regulation of recent embodied crises; 3) how the Mirror Syndrome exemplifies novel ways in which power is exercising new interactions that emerge as profoundly social and medical challenges amplified by daily technological experience. Moreover, our analysis of such complex and new paradigms requires us to overcome traditional disciplinary boundaries. This article is the product of complementary and combined qualitative methodology informed in the theoretical crossroads of cultural, communication, media, and medical studies. As a point of departure and common theoretical ground, we find it very useful to employ the recent work of Valdivia on cultural narratives and crisis studies (Valdivia 2016; 2017; 2018a; 2018b; 2019; 2020). In this vein, Valdivia defined cultural narratives as 'the moral and aesthetic coded symbolic matrix-in-the-making which orientates behavior and signifies the imaginary relationship between an individual (and/or [virtual] community) and her (his/their) material conditions of existence in a given historical-spatial context. In short, a 'cultural narrative' is a sort of 'dark matter' that establishes the cognitive and performative grounds of social interactions, attachments, expectations, rationalities, and modes of becoming. Cultural narratives operate as cognitive and performative thresholds. They create meaning and orientate behavior in multi-directional ways.' (Valdivia, 2019, p. 287).

Furthermore, Valdivia offered the following working definition of crisis as a notion that comes from the Greek verb *krinein*, and its etymology encompasses notions of 'separating' and 'deciding,' with roots in the medical discourse which are associated with a turning point in disease after which a patient is either

destined to die or will proceed to recovery (2016). Currently, it implies a moment of rupture and instability, as exemplified by the 2008 financial crisis and the ongoing refugee crisis. Crises always involve turbulence and discontent but also rethinking and innovation. They generate new ways of analyzing and engaging with the past and present while opening paths to articulating possible futures that can challenge traditional ideas' (Valdivia, 2019, p. 287). As mentioned above, in the very root of the notion of crisis, it is possible to already note the multidisciplinary intrinsic dimension of the term and how close was, since its conception, to biological processes related to the field of medicine.

However, under the advent of new technologies and the pivotal role of online social networks in collective and individual formation (especially now that we are close to the standardization of augmentative cognitive surgical procedures), it is necessary to re-think how such crises are affecting, re-orientating, and re-engineering not only the 'social body' but the 'individual body' and its relational and networked engagement with both the virtual and physical worlds.

Therefore, it is possible to argue that it is essential to not neglect nor dismiss that such crises are operationalized in biological bodies, which at this moment are configured by agents of bio-political markers and triggers insufficiently studied, more detail such is the case of the activation and spread of the Mirror Syndrome disorder (BDD) via and due to the processes of psycho-emotional retribution models under which major social networks, such Instagram, daily function and harvest data and attention from their users.

2. Online Social Networks

Within a relatively short period, social media have become prevalent in people's media diets. In the case of the United States, for instance, a recent Pew Internet and American Life survey report (N= 1,502) revealed that around seven-in-ten Americans ever use any kind of social media site and that this share has remained relatively stable over the past five years (Pew Research, 2021, p. 3). Further, the report describes social media use as ubiquitous among younger adults (e.g., YouTube is used by 95% of 18-29 young adults) and notable among older adults (e.g., YouTube is used by 49% of 65+ adults). As for the platforms, YouTube and Facebook continue to dominate, with 81% and 69% of respondents reporting ever use these sites (Pew Research, 2021, p. 3), followed by Instagram (with 40% of the adults), and Pinterest and LinkedIn (both with 30% of the adults). Despite the leading positions of YouTube and Facebook, certain apps are powerful among some population cohorts; for example, a vast majority of "18- to 29-year-olds say they use Instagram (71%) or Snapchat (65%), while roughly half say the same for TikTok" (Pew Internet, 2021, p. 4).

Among the plethora of social networking sites (Boyd & Ellison, 2007) available, Instagram has some characteristics which make this platform particularly interesting for our research. On Instagram, people can upload, view, and share pictures and videos with many or few users. Indeed, the platform allows users to edit photos, add filters, and modify their appearances (Holland & Tiggemann, 2016). Taken together—the possibility of exposing one's physical traits to several (known or unknown) users and the capacity of manipulating the portrayal of these physical characteristics—can potentially be very harmful, especially for young women's health.

Previous research has shown (Sun & Wu, 2012) that primary stimuli for sharing photos or videos is based in the psycho-emotional retribution mechanism released by the obtention of likes from, for instance, a selfie. When this validation happens, large doses of dopamine are released in the user's brain, increasing the pleasure levels. This techno-mediated communication process finds legitimacy in a new cultural narrative of power where the psycho-emotional reaction of an individual needs to function under a permanent state of crisis translated into the privilege of certain virtual and physical imaginary features. This is a very efficient process as Instagram users remain convinced that their body image is in line with (psycho-emotional) trends. Furthermore, they tend to naturalize externally conditioned effects and attachments to create a meaningful relationship with their virtual and social environment (Salim et al., 2017).

Recent medical research, albeit incipiently, have indicated a positive association between the effects of social media use among young female university students and the development of the Mirror Syndrome, i.e., a mental disorder involving individuals' distorted perception about their physical appearance. According to Grover et al. (2016), young women try to be in line with the idea of beauty promoted by social media influencers and, while doing so, naturalize the external psycho-emotional conditions to achieve a goal (e.g., having shiny white teeth; meeting certain body configurations; wearing a particular clothing size, manicure designs, amongst others) set by these social media influencers. This can, at times, end up developing several mental, emotional, and physical conditions such as depression, Body Dysmorphic Disorder (BDD), anxiety, social isolation, or loss of self-esteem. The following section explores in more detail the BDD and the permanent state of embodied crises it triggers, fuels, and reinforces.

3. The Mirror Syndrome (BDD)

As this condition is increasingly present in our society due to several of the factors already explained, this section aims to (a) conceptualize the medical definition of this medical condition, its principal features, and the consequent

behavioral re-orientation and re-engineering of the people who suffer from it; (b) indicate the role of mirrors (digital and physical) in this disorder since this is where the colloquial name of the syndrome comes from; (c) review whether this syndrome has an actual connection with eating disorders; (d) analyze what is the particular relationship among cultural narratives of power, body image, online social networks, and BDD; and (e) inquire on the consequences and treatments related to the Mirror Syndrome.

More than 100 years ago, the Italian psychiatrist Enrico Morselli was the first scholar who referred to Body Dysmorphic Disorder. He defined it as a mental disorder closely related to a person's physical appearance, making an individual unsafe and sorrowful about how s/he looks in front of a mirror. He also stated that this disorder manifests in the individuals' daily lives, to the point of getting them desperate because of the fear of being deformed or extremely ugly (Morselli in Phillips, 2004). Morselli found out that this condition affected the average performance of people in their work, social, and sentimental environment.

The Mirror Syndrome is a disorder in which individuals develop an exaggerated preoccupation about slight or unreal physical defects. Generally, it is typically lasted by compulsive behavior regarding the imaginary defect involved. This pathology affects the interpersonal relationships of those who suffer it. Moreover, it generates, in recognizing who suffers from it, a psychological complex related to their physical appearance, and the fear of being rejected for not reaching the imposed canons of beauty. In other words, people who undergo BDD think they can be an object of rejection for looking ugly and deformed which results in a permanent embodied state of crises. According to the patients' narrative enactment of this medical condition, their social and work environment would notice their ugliness and stay away from them. Thus, the fear of missing out, or not belonging to a determined social group contributes to the articulation of a cultural narrative that interferes in their lives, and manifests itself through isolation at home, without going to work, study or attend social events (Phillips, 2008; Dunai et al., 2010; Onden-Lim & Grisham, 2012; Fang et al., 2014; Singh & Veale, 2019). Furthermore, the Mirror Syndrome has been largely under-recognized and underdiagnosed. Although research on BDD has increased over the past several decades, the disorder is still understudied (Fang et al., 2014, p. 296; Singh & Veale, 2019). BDD affects approximately 2% of the general population, making it more prevalent than schizophrenia or bipolar disorder, and, worriedly, 3,3% of university students suffer from this medical condition (Arienzo et al., 2013; Schneider et al., 2019).

Due to the fact that we live in societies which reinforce the cult to the external appearance and the body, individuals who become negatively obsessed with their physical image can unconsciously be affected by the Mirror Syndrome

(Singh & Veale, 2019). Subjects living with this condition usually describe themselves as unattractive, deformed, like a monster. They are convinced of their ugliness and believe that people who surround them consider them as such. Indeed, according to the current scientific literature, their preoccupation typically lasts between 3 and 8 hours per day (Veale & Riley, 2001; Phillips, 2004; Heyes, 2009; Phillips, 2014) and they cannot control their behavior and anxiety. Therefore, individuals suffering from BDD tend to avoid interacting with other people and prefer to confine themselves (Veale & Riley, 2001; Heyes, 2009; Singh & Veale, 2019). As this disorder involves the patients' physical appearance, the most visited medical specialists are dermatologists with a 12% of cases, even though any aspect of the appearance can be the focus of concern (Uzun, 2003), cosmetic surgery consultations are related to the 15% of people who suffer from BDD (Thompson & Durrani, 2007). The medical evidence states that 66% of BDD patients have received beauty treatment, being dermatological treatments the most used (Mulken et al., 2012).

In this vein, Kollei et al. (2011) noted that BDD diagnostic criteria are not well operated. The misdiagnosis is produced, on many occasions, in subjects that just feel embarrassed about being extremely worried about their appearance. Subsequently, the Mirror Syndrome is difficult to diagnose because of social prejudice and a lack of realization of their symptoms. In some cases, subjects believe they can manage the situation or hide their problems. According to Phillips (2014), the above mentioned are the main reasons why this disorder is under-recognized; 'The Mirror Syndrome can vary from patient to patient, and any body part can be the focus of concern' (Phillips, 2009, p. 17). This variation is also related to the condition's gradualism; like any health problem, Body Dysmorphic Disorder has a spectrum, 'ranging from milder symptoms to very severe and even life-threatening symptoms' (p. 16). Hence, when patients who suffer from Mirror Syndrome that are in the middle stage, they are more manageable than those with a more advanced case.

As subjects who suffer from this disorder are convinced that their physical problem is real (Fang et al., 2014), 'it is important to take patients' appearance concerns seriously by empathizing with their suffering. We recommend neither dismissing their appearance concerns as unimportant or trivial nor agreeing that there is something wrong with how they look' (Phillips, 2008, p. 4). According to Fang et al. (2014), the subjects who experience the Mirror Syndrome can avoid people or situations that can evaluate them and their imaginary defects or exclude them from the rituals involving and prestige the dominant cultural narrative of power which functions as a mirror upon them. Most of the time, this obsessive concern is out of control and can consume many hours of the day (Phillips, 2004), thus affecting their daily routines and obligations; for example,

"lateness caused by time spent grooming or camouflaging" (Hunt et al., 2008, p. 219). In this sense, the quality of life of BDD patients is even lower than depressed patients. An example is the time-consuming beauty rituals like mirror-gazing (Veale et al., 2003); this is because "the longer that the person looks in a mirror, the more self-conscious s/he becomes, and the more than the negative image is reinforced" (Silver & Reavey, 2010, p. 1642). Thus, patients who suffer from the Mirror Syndrome enter into a permanent state of embodied crises due to the dissonance between the imaginary unreachable archetype they aim to achieve and the actual configurations of their bodies.

Along these lines, Katharine Phillips argues the obsessions that Body Dysmorphic Disorder entails about the stressful self-awareness of being socially and narratively constructed by the rest, usually diminish concentration and/or productivity of those who suffer it. Sometimes, patients do not have a social life, or it is constrained because of this condition, which seemingly reveals how Mirror Syndrome patients live in an embodied crisis (or crises) that pervasively affects their life quality (2004). In other words, according to Silver & Reavey (2010), "Social impairment seems to be universal in BDD" (p. 1642), and people who suffer from this syndrome also experience different challenging situations that involve their social environment. It becomes an impairment for speaking or writing in public, initiating a conversation, going to parties, or meeting new people (Fang & Hofmann, 2010). Despite the growing research interest in subjects that suffer from this condition, there is still an essential lack of information regarding the complex details of social issues that overwhelm BDD patients.

Mirror Syndrome can affect any part of an individual's body, even the entire body, but the most common is the obsession with the face or the head. For example, hair, nose, skin color, or imperfections (Phillips, 2004; Singh & Veale, 2019). People suffering from this disorder compare their imagined ugliness with an ideal appearance that is external and socially conditioned, which is impossible to reach for them: "reactions to their perceived image and maladaptive thoughts may invoke disgust and lead an individual to engage in ritualistic safety behaviors, such as camouflaging to alter the appearance, avoiding social situations, skin-picking, reassurance-seeking, or escaping uncomfortable situations" (Fang et al., 2014, p. 290). This entails the excessive conviction that people who surround the individual affected notice and judge the several defects that s/he imagines (Singh & Veale, 2019). This condition is so severe that patients can present affective delusions; for example, they may think that people around them laugh or notice their unreal defects (Phillips in Fang & Hofmann, 2010). People with BDD collect, compulsively, images of their favorite celebrities or people they consider attractive, compare themselves with their appearance, and convince themselves about their ugliness. Thus, they live in a permanent state of ongoing

embodied crisis(es). In this line, Katharine Phillips (2009) mentions that “it makes sense that comparing oneself with beautiful people (...) would make a person feel worse about their looks” (p. 74) for the reason that they do not look similar to them even if they put an enormous effort on it. This is promoted and reinforced by the dominant cultural narrative that commodifies and monetizes bodies which is very especially emphasized in online social media.

Additionally, there is a gender perspective with the Mirror Syndrome, which we should consider: “about 40% of people with BDD are men, and about 60% are women” (Phillips, n.d.). Due to the imposition of strict cultural narratives of power and beauty standards, women tend to be more obsessive about several aspects and parts of their body, and “gender may be an important moderator of BDD symptoms and clinical presentation” (Phillips in Fang et al., 2014, p. 291). Consequently, “patients are often reluctant or ashamed to admit the problem or seek help for it” (Hunt et al., 2008, p. 219) because they tend to believe that their situation is not real or as pervasive as it is.

The evidence presented by Phillips (2006) shows that there is not a significant difference among adolescents and adults suffering from the mirror syndrome, and this is because most of the times, BDD begins during adolescence: “Among the adolescents, 94.3% reported moderate, severe, or extreme distress due to BDD, 80.6% had a history of suicidal ideation, and 44.4% had attempted suicide” (Phillips, 2006, p. 305). Unfortunately, adolescents have a higher rate of suicide attempts due to the intense pressure imposed over their bodies and their physical changes.

In this regard, mirrors operate here both as a symbol and artifact when addressing Body Dysmorphic Disorder. According to Veale & Riley (2001), many patients are hopeful that the image they will see through the mirror will be different. They will feel comfortable with their appearance, but sometimes it only creates more confusion among those who suffer from this medical condition. In their minds, patients can create and imagine different images about themselves each time they gaze at their reflection in a mirror. About 80% of people diagnosed with Mirror Syndrome have this behavior with mirrors and are told to avoid them because of the risk to their health and the actual time they waste looking at their images.

This repeated behavior consists of excessively checking mirrors, grooming, skin picking, tanning to darken the skin when it is too pale, camouflaging with make-up the defects perceived and touching it regularly, and an exaggerated change of clothing. They can also spend many hours in front of a mirror, just looking at it. Sometimes, people develop excessive slowness for beauty rituals (Veale & Riley, 2001; Phillips, 2008; Dunai et al., 2010; Phillips, 2014). This behavior submits patients into a vicious circle, directly related to their appearance and imaginary defects, increasing their symptoms and getting gradually worse in their condition.

People affected tend to compare themselves to their idealized reflection in the mirror (Veale & Riley, 2001) In this case; there are two extreme possibilities to their attitude towards a mirror: "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" (Heyes, 2009, p. 81). In other words, there are people with the Mirror Syndrome who spend hours in front of any element that reflects their image, and there are other people that avoid mirrors above all things. For that reason, psychological support is a fundamental part of the treatment of this disorder, and to note that not all individuals feel and react in the same manner, since people may have not only BDD but also they can have other diseases too because some patients are not aware that this condition is mainly a mental disorder and not a physical one. It is then possible to have patients with eating disorders as a parallel condition of BDD.

Individuals with BDD report more short mirror sessions of about 5 minutes and significantly longer gazing sessions per day up to 170 minutes. This ritual can consume time and make individuals feel worse about their appearance after looking at them in the mirror every time (Möllmann et al., 2020). For that reason, they are told to avoid some activities that produce negative feelings about themselves, such as the amount of time that they gaze themselves in the mirror (Onden-Lim & Grisham, 2012). This action can help the patients to diminish their negative emotions, acting like behavioral treatment.

Mirror Syndrome is closely related to eating disorders, but limited research has investigated both diseases' relationships. It is only known that in both cases, there is a body image distortion and dissatisfaction in a first instance (Fang & Hofmann, 2010). The scholars mentioned above established that the only similarity between Mirror Syndrome and eating disorders is that gender distribution among people who suffer from this disorder is equal. Patients with Body Dysmorphic Disorder usually have more localized physical parts that they have an issue with; meanwhile, people with an eating disorder are focused on weight (Fang & Hofmann, 2010). Another difference they mentioned is related to the quality of life; people who have problems with their appearance have a more negative evaluation of themselves than people suffering from eating disorders. Lastly, people with Mirror Syndrome do not necessarily have eating disorders. Still, people who suffer from eating disorders may have some degree of BDD; for instance, individuals with a BDD diagnosis found that 32.5% of them had at least a period of eating disorder in their lives (Fang & Hofmann, 2010). So, people who have eating disorders may also have Body Dysmorphic Disorder (Hunt et al., 2008), but they need to be treated for the two diseases separately.

When individuals talk about body image, they refer to how people perceive their physical appearance, which is closely related to self-esteem. If someone

is not in conformity with their appearance, self-esteem will be lower (Mulken et al., 2012) as people who suffer from the mirror syndrome imagine their defects. They have delusionality episodes, and depart from the assumption that people will evaluate them negatively for being defective; they think that their weaknesses are physical and not psychological (Fang & Hofmann, 2010). It is known that Mirror Syndrome is closely related to body image, defined as “the picture of our body that we have in our mind” (Phillips, 2009, p. 18). Patients suffering from Mirror Syndrome do not have clarity about how their body looks in reality. Still, they are continually seeking to know about it (Veale & Riley, 2001); for that reason, the obsession about their body image triggers the conduct attitude and behavior mentioned above. Katharine Phillips (2006) adds that, in general, adolescent girls present more dissatisfaction with their body image than boys. Individuals suffering from this disorder fight every day to change their body image and reflect what they have idealized in the mirror. It is known that people who suffer from the mirror syndrome compare their appearance, or beauty, to others. This action usually convinces them that the other people are evaluating how they look. People with BDD develop social phobias and hallucinations, being particularly sensitive about what people are thinking about their appearance (Buhlmann, 2004). The emotional system produces acute stimuli to the brain, making it perceive and process emotional information; this information triggers an individual’s behavioral responses. In this regard, some particular disorders are influenced and developed by the images viewed and how they produce emotional information in the brain; in the same line, imagery can also be confused with reality, as people who suffer from the mirror syndrome, since they imagine distorted their physical appearance. As mental images can influence the behavior of a person, patients of BDD may overreact in terms of what they are processing in the relation of physical features and getting obsessed with their imaginary defects. For that reason, mental imagery is like an amplifier of emotions and can direct many emotional disorders (Holmes & Mathew, 2010).

Concerning genetics and brain function, it can be said that, according to Dong et al. (2019), the pathophysiology of body dysmorphic syndrome is contributed by the genetic of a person; in other words, it has a pattern that may be heritability and people could suffer from this syndrome just for their genetic load and not for being dissatisfied with their physical appearance. According to the evidence, 8% of individuals with BDD have a first-degree family member with a lifetime diagnosis of BDD (Feusner et al., 2010). In that sense, Dunai et al. (2010) express that brain function and organization involve frontal-striatal dysfunction in both cases. In concordance, patients who suffer from the mirror syndrome experiment deficits in thinking speed and spatial working memory. Besides, these scholars mentioned that people who suffer from BDD have standard short-term memory

and visual memory; over and above, the spatial working memory and cognitive memory at the moment of planning tasks show significant deficits. In the same vein, Arienzo et al. (2013) stipulate that "individuals with BDD perceive detailed imperfections and flaws and are unable to contextualize them as minor relative to their whole appearance" (p. 1136); this is because for them, the reality is distorted in respect of what they are looking at the mirror and the evidence mentioned shows that the connectivity in regions involved in interhemispheric visual information transfer; those interested in lower/ higher-order visual and emotional processing is abnormal as well as information processing and also they exhibit peculiar white matter brain network organization; and not only that, people with the mirror syndrome demonstrate higher edge betweenness centrality for connections between anterior temporal and occipital regions, just as well between bilateral occipital poles (Arienzo et al., 2013). Consequently, it can produce a distorted perception of their physical appearance, worsening the symptoms and condition of those who have this mental disorder.

4. Psychiatric disorder, comorbidity, treatment and suicide

Katharine Phillips (2004) assesses that the problem is that this disorder "usually goes undiagnosed in clinical settings" (p. 15) and this is due to Body Dysmorphic Disorder is a psychiatric disorder that may be more common than thought. According to Hunt et al. (2008), there could be a possibility that a person has a genetic predisposition to anxiety and, with that, the chances of developing Mirror Syndrome increases solidly. It is also mentioned that "the predominant view of BDD is that it may be an obsessive-compulsive spectrum disorder" (Fang & Hofmann, 2010, p. 2), and that could be the answer for the behavior that people with Body Dysmorphic Disorder have because they also manifest that "preoccupations trigger feelings of depression, anxiety, distress, shame, or other painful emotions" (Phillips, 2014, p. 325). Likewise, they can experience different symptoms such as hallucinations, listening to voices that criticize the patients for being ugly, or giving them instructions to kill themselves due to their ugliness (Fang & Hofmann in Phillips, 2004).

Mistakenly, some people think that a surgical operation is a suitable solution for correcting and fixing the defects that patients imagine they have because it seems to be an aesthetic illness. In this regard, it should be noted that "BDD is a brain-based disorder - not vanity" (Phillips, 2014, p. 326). The plastic surgery industry has contributed to this cultural syndrome: most of the time, they proceed and operate their patients without evaluating their minds (Heyes, 2009). According to Lai et al. (2010), 26-40% of patients who suffer from the Mirror

Syndrome have at least one cosmetic surgery, and around 20% of people who request a rhinoplasty have a possibility of benign diagnosis with BDD (Veale et al., 2003). It concerns that there are an immense amount of people who feel emotionally worse after cosmetic surgery, and the possibility that their symptoms get increased high (Silver & Reavey, 2010). The evidence of Veale et al. (2003), shows that almost 83% of patients reported that their symptoms were even worse after the cosmetic surgery they ask to have. Therefore, having cosmetic surgery is not the solution for BDD.

The Mirror Syndrome arises with comorbidities such as depression, phobias, anxiety, personality disorders, and suicidality. According to a study developed by Coles et al. (2006), almost 34% of people diagnosed with BDD showed the features of having a social phobia. They also found that comorbidity with social phobia is more common than with obsessive-compulsive disorder. It is also mentioned, by Fang & Hofmann (2010), that BDD and social anxiety disorder have pathological aspects in common because 12% of people who suffer from mirror syndrome also suffer from a social anxiety disorder. It can even be a detonator and develop BDD symptoms.

As Body Dysmorphic Disorder is comorbid with other psychological illnesses, a study tried to elucidate whether there is a relationship between schizophrenia and BDD at the level of how their brain works. In that sense, Silverstein et al. (2015) explain that, as well as schizophrenia, people who suffer from mirror syndrome have difficulties processing visual information, called perceptual organization, regarding the problem. According to the study previously mentioned, the reduction of perceptual organization in people with schizophrenia is not the same as people with BDD. In the second case, it comes from different perceptual troubles, possibly related to emotional factors. In concordance with the aforementioned, patients with mirror syndrome present low spatial frequency information and demonstrate hypoactivity in occipital regions during processing information from oneself or other different stimuli (Feusner et al., 2007 in Silverstein et al., 2015).

About comorbidity, it is frequently mentioned that BDD is comorbid with obsessive-compulsive disorder. Both disorders have several features in common; one similarity is the obsession and preoccupation about the defect making them feel uncomfortable (Dunai et al., 2010). In the quoted study, it is also mentioned that compulsions in obsessive-compulsive disorder are similar to, for example, mirror checking and hair grooming; this is why it is said that BDD has a spectrum of obsessive-compulsive disorder. Unfortunately, the mirror syndrome has an essential association with suicidal ideation and suicidal behaviors. Patients who suffer from it are very likely susceptible to suicidal behavior and ideation (Snorrason et al., 2019) which means that patients are vulnerable to any stimuli

that promote the idea of attempting against their integrity if they do not have access to the appropriate treatment.

There is no evidence about definitive treatment for BDD and, as a significant number of factors develops the Mirror Syndrome, "patients are unlikely to receive the treatment they require and continue to suffer" (Singh & Veale, 2019, p. 134); for that reason, there are two possible areas for the treatment of Body Dysmorphic Disorder. The first one is related to the change of appearance. As some people consider that they have one or more physical 'defects,' it is possible to repair this imaginary flaw through a dermatologist treatment, i.e., a plastic surgeon, among other procedures. According to Hunt et al. (2008), cosmetic procedures are unsuccessful in patients that suffer from Mirror Syndrome. It is inappropriate to treat this disorder through cosmetic procedures because the symptoms can worsen; it can also generate violent behavior in patients against in more detail re they were treated (Sewer in Phillips, 2014). The second option of treatment is through "cognitive behavioral therapy" and antidepressants, which function is to increase serotonin levels in the brain, and which category corresponds to the "serotonin reuptake inhibitor (SRI) medication" (Singh & Veale, 2019, p. 133), it consists of therapy sessions in which patients are taught to live with and overcome their obsessions related to their appearance through psychological and psychiatric therapy so that they can deal appropriately with their social and personal environment; besides the prescription of psychiatric medications that will help them in the recovery process during the time that the professionals consider appropriate. Even though it seems complicated to treat, "most patients can be treated successfully" (Phillips, 2008, p. 2). By being constant and persevering, patients can get ahead and recover once they have assumed their health condition.

Everyone hopes, after a treatment, to get remission. Remission is to be recovered after an illness; it can be complete or partial. In BDD, there is no consistent evidence about how patients react to the specialists' treatment for being recovered from the mirror syndrome (De la Cruz et al., 2019). The results are subjective, and there is no specific and concrete evidence about how people can recover from this mental illness; the only hope is to keep them alive.

Compared to other, and more common, mental disorders, such as depression, bipolar disorder, or eating disorders, the Mirror Syndrome has a higher death rate (Phillips & Menard in Fang & Hofmann, 2010; Phillips et al., 2006). This is since when people have "negative feelings, experiences, and perceptions, especially when linked with social isolation, are risk factors for the triggering, and maintenance, of suicidal thoughts, behaviors, and acts" (Angelakis et al., 2016, p. 56). If somebody with BDD does not have social support or has low self-esteem, it increases anxiety and depression. Hence, a patient that suffers from

this disorder has many suicide risk factors (Phillips & Menard, 2006). It is a matter of concern that around 80% of individuals with the Mirror Syndrome present a record of suicidal ideation, and approximately 25% of them committed suicide (Phillips et al., 2006; Phillips, 2008; Fang & Hofmann, 2010; Fang et al., 2014). There is an inadequacy of consciousness about the danger of self-murder in BDD patients; as a consequence, people who suffer from Mirror Syndrome “might not be appropriately assessed for suicide risk” (Angelakis et al., 2016, p. 64).

Despite this, comorbidity with other disorders, such as social anxiety disorder, increases the effects of Body Dysmorphic Disorder in the affected individuals’ life (Lydiard in Fang & Hofmann, 2010), and the high rates of suicidality are reflected in adults and adolescents in a similar amount of cases (Singh & Veale, 2019; Phillips, 2014; Phillips et al., 2006).

Worst of all, Phillips and Menard, in 2006, stipulated that “suicidality in BDD has been minimally studied, and no study has examined any aspects of suicidality prospectively” (p. 1280); ten years later, Angelakis et al. (2016) expressed that “suicidal ideation and suicide attempts has received scant research attention” (p. 56). As this disorder is under-evaluated, the information given is alarming, and many people are in danger silently.

5. Conclusions

In this article, we have responded to the following research questions: 1) how cultural narratives of power are engendered by and through the articulation of new symbolic and psychological configurations; 2) in which ways online social networks have played a vital role in the creation and regulation of recent embodied crises; 3) how the Mirror Syndrome exemplifies novel ways in which power is exercising new interactions that emerge as profoundly social and medical challenges amplified by daily technological experience.

The concept of Body Dysmorphic Disorder has been present for more than a century but accentuated and re-engineered under the context of the last crises that have restructured our social fabrics during the advent of the 4th Revolution: namely, the so-called digital turn. BDD responds to a mental disorder in which people develop an overstated preoccupation about minor or unreal physical defects. Patients who suffer from it are convinced that their appearance problem is real and notorious, and as a reaction to it, they usually spend hours in front of a mirror. Also, they are constantly maintaining the hope that the image reflected in the mirror will be different and they will reach their idealized image.

There does not seem to be a definitive treatment for the Mirror Syndrome. However, it is not advisable to incur cosmetic procedures because these can

aggravate the symptoms and the medical situation. It is estimated that up to 80% of people diagnosed with Body Dysmorphic Disorder present suicidal ideation; 25% commit suicide.

Today many of the interactions people have in their daily life take place in online social networks (Castells, 2012a, 2012b, 2013, 2018). Moreover, while social media does not cause BDD, it can amplify that condition. On Instagram, for example, a user's motivation to share his /her photos is the recognition (e.g., the total number of likes) received from the other users. When this does not happen, though, users may feel rejected, and this can trigger a series of negative consequences for their physical and emotional health, a great example of which is the Mirror Syndrome.

In a nutshell, Mirror Syndrome is a silent mental disorder that affects many people, but it is misdiagnosed as it is part of the dominant cultural narrative and its rituals. The consequences of this disorder have a ripple effect on individuals who are experiencing it. Appropriate psychiatric treatment is vital for recovery diagnosed patients and, in that way, avoiding the worst consequences that a mental disorder could have: suicide. In this sense, raising awareness about the lack of information and investigation related to how the misuse of social media and beauty standards can affect people worldwide is crucial. This mental disorder selects its victims without discriminating their nationality, race, social conditions, or age. It is a silent enemy that attacks people and destroys their lives, making them suffer from BDD to hate and hurt themselves physically and even dying. Cultural narratives of power executed by advertising media and, now social networking sites, have overexposed the body image of, above all, young people (mainly women) with impositions of cultural narratives of beauty canons that do nothing but damage the environment and the lives of individuals by means of imposing a new bio-politics of permanent embodied crises. Such narratives are no more than commercial mechanisms that endanger human lives when these commercial impositions stereotype users. As our article demonstrates, the body is, today more than ever, a space subjected to monetization and commodification which seriously jeopardizes the well-being of citizens. If any crisis is always a trauma, these embodied permanent crises caused by BDD amplification in online social networks, notably on Instagram, require a multidisciplinary approach to not only understand the underlying power mechanisms but also to emancipate the bodies from cultural narratives of power whose only goal is to perpetuate the body into a never-ending state of crisis.

6. References

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