Doctorate in Professional Educational, Child and Adolescent Psychology

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Doctorate in Professional Educational Child and Adolescent Psychology

Doctoral Thesis

What Impact Does a Bespoke Training Package Have on the

Understanding EPs Have of Body Dysmorphic Disorder and their

Ability to Identify and Support It?

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Word count: 34845

I, Alexander Mummery, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

ABSTRACT

This study aimed to evaluate a bespoke training package for educational psychologists (EPs) about body dysmorphic disorder (BDD), an under-recognised condition that affects a large number of young people. The training was evaluated in terms of: how well EPs received it and which aspects were most effective; their attitudes towards BDD, particularly in relation to their practice; their knowledge of BDD; their ability to identify and support BDD; and the impact on EP practice in real-terms. A mixed-methods approach was used, incorporating questionnaires before and immediately after the training and again 6 months later. EPs received the training well, particularly interactive elements and those involving the lived experience of young people with BDD. They predominantly felt that BDD was important to their practice. Prior awareness of BDD was low but significant increases were found in terms of knowledge of BDD, as well as self-reported ability to identify and support BDD, all of which were maintained at the 6-month follow-up. EPs felt better equipped to ask about BDD when they suspect it, to cascade information to schools and to make referrals to other professionals when needed, instances of all of which had already occurred at the follow-up. A smaller number felt that direct work with young people with BDD would be possible for low-level cases. The study emphasises the importance of raising awareness of BDD and suggests that this training package is effective for doing so, with impact already being felt on practice. Further deliveries to more EPs and a broader range of professionals should now occur.

IMPACT STATEMENT

This is the first study directly connecting BDD with EP practice and the knowledge acquired by participating EPs will hopefully spark an interest that will spread within the profession, so that the topic can be explored further by others. This may particularly relate to the prospect of EPs delivering therapeutic interventions for low-level BDD, a possibility created for EPs that took part in the training that was unable to be fully explored in the current study.

The current study has already demonstrated an impact on EP practice for some participants, who have begun to identify and support potential cases of BDD through their work. This will clearly benefit the young people involved, as well as the EPs whose professional practice has been developed in this area. Some participants had also already begun to cascade the training information onward to schools, colleagues and other professionals. This suggests the training could have a far-ranging systemic impact, beyond simply raising awareness of BDD and competence amongst participating EPs, feasibly resulting in further instances of more effective early identification and support by others also.

Given that the training package was found to be effective for raising awareness of BDD and tentatively improved identification and support, it can now be delivered more widely by the current author or by others. Other trainers will not need special training but a personal experience with BDD would be helpful, as talking about this was an element that was most well-received by participants.

CONTENTS

Figures, Tables and Charts:

1. INTRODUCTION

People with body dysmorphic disorder (BDD) are afflicted with a highly distracting and distressing obsession with one or more "defects" in their physical appearance (Veale et al., 2016). However, these "defects" are in fact minimal and part of normal variation, rendering them unnoticeable to others (Krebs et al., 2017). A common feature of the disorder is poor insight, (Phillips et al., 2006), meaning that people with BDD (hereafter referred to as BDD-individuals) find it difficult to understand their perception of themselves differs to others, leading them to feel physically abnormal or repellent (Eisen et al., 2004).

Most commonly, BDD onsets during adolescence, with estimates ranging between 12 (Thungana et al., 2018) and 16 years old (Bjornsson et al., 2013). Lack of insight is often more severe at this age (Phillips et al., 2006), making it unlikely that younger BDD-individuals will disclose their symptoms to professionals, who are otherwise unlikely to identify the disorder given the lack of visible symptoms. This may explain why professional awareness of the disorder appears to be low, even amongst mental-health workers (Phillips, 2005). The current author's preliminary study (hereafter referred to as the preliminary study) found this also extended to a large sample of educational

psychologists (EPs) (n=235) (Mummery, 2019)[1]. BDD could therefore be considered a hidden disorder, concealed from professionals and even from those experiencing it.

The current study examined the impact of a bespoke training package designed to raise awareness and understanding of BDD amongst EPs, which was cited as the most the most popular and effective way to do so by EPs within the preliminary study (Mummery, 2019). The package was evaluated using a mixed-methods approach involving questionnaires and interviews, measuring knowledge EPs have of BDD before and after the training, as well as their ability to identify and support it. EPs are professionals who may be among the first to encounter young BDD-individuals, so it is hoped the result will be more ubiquitous early identification, the absence of which precludes effective treatment.

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[1] The preliminary study utilised a mixed-methods approach, with an online questionnaire (n=235) and a series of interviews (n=6). All participants were EPs. 1.3% judged themselves to have extensive knowledge of BDD, 10.2% had a moderate level, 62.6% a limited level and 25.8% had no awareness whatsoever. At the midpoint of both interviews and questionnaires, an information sheet about was provided that broke BDD down into 24 key characteristics, in order to measure the specifics of the EPs' awareness. EPs level of understanding of these characteristics correlated with their subjective ratings of their knowledge. The majority felt that BDD was relevant to their practice (90.6%) and predominantly these EPs saw their role as involving consultation or referral to specialists. A minority (19.1%) were willing to incorporate therapeutic interventions (mainly CBT) for low-level cases, but many more did not see this as a possibility, either because of their own level of competence or for more practical reasons, such as constraints on their time or the way in which they are perceived by the schools commissioning their services. EPs felt that training would be the best method by which to raise awareness, closely followed by published research and discussion amongst EPs on online forums such as EPNET.

2. LITERATURE REVIEW

This literature review will examine the most pertinent and well-evidenced information about BDD to include in a training package for EPs. It will begin with generic characteristics of BDD and continue through to a more specific account of the potential role for EPs in identifying and supporting BDD, ending with theoretical models that informed the study.

2.1. KEY FEATURES OF BDD

The occurrence of repetitive and obsessive behaviours amongst BDD-individuals (Altamura et al., 2001) has led to BDD's recategorisation as a form of obsessive compulsive disorder (OCD) in both the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) and the *International Classification of Diseases* (ICD-11) (APA, 2013; World Health Organization, 2018). These behaviours are attempts to attenuate anxiety and can take many forms, the most common being 'checking', which involves extended periods in front of a mirror or a camera scrutinising body parts and facial features, sometimes for hours at a time (Krebs et al., 2017). Other behaviours include constant mental comparisons to others, reassurance-seeking and disguising of body parts. Such behaviours must occur for at least an hour a day to meet criteria for BDD. Additionally, although dissatisfaction with one's appearance is certainly not unusual, BDD is set apart by the clinical levels of anxiety and preoccupation that accompany this feeling (Schieber et al., 2015). A diagnosis is also contingent on significant dysfunction in one's social or occupational life, the

extent of which is likely to correlate with the level of anxiety and preoccupation an individual is experiencing.

There is a sub-type of BDD known as muscle dysmorphia, which specifically involves the perception that one's physical frame is too slight, with all other accompanying criteria (Wolke & Sapouna, 2008). Although the gender ratio of BDD is roughly even (although this varies between contexts and appears to affect females slightly more) (Veale et al., 2016), muscle dysmorphia affects males almost exclusively (Phillips et al., 2010). It was originally referred to as 'reverse anorexia' by some (Pope et al., 1993), but in fact, anorexia nervosa and other eating disorders are kept separate from BDD diagnostically at present, in part due to differences in effective treatment pathways (Hartmann et al., 2013). Therefore, although they can co-occur and share similar preoccupations with body-image, BDD is also diagnosed by *not* being better explained as an eating disorder, which would involve a preoccupation that centres on body fat or weight (APA, 2013).

A lack of insight is another issue common to BDD-individuals, but it is one that varies and is therefore measured on a spectrum from 'absent' to 'excellent' as another specifier (along with muscle dysmorphia) (Phillips et al., 2006). A lack of insight was previously referred to as "delusionality" (Phillips, Menard, Pagano, Fay, & Stout, 2006), as to varying degrees, BDD-individuals do not realise the severity or presence of the "defect" is imagined, meaning they believe they are genuinely physically abhorrent to others (Eisen, Phillips, Coles, & Rasmussen, 2004). However, this terminology has shifted, given that visual perception is subjective (perhaps especially given the potential neurological differences outlined below) and therefore the lived experience of

BDD-individuals is arguably not a delusion, but one that simply differs to that of others. A greater level of insight therefore allows BDD-individuals to understand that despite the way they see themselves, they are not unusual or hideous to others, making it more likely they will accept having a mental-health issue and subsequently seek treatment (Eisen et al., 2004). Inversely, BDD-individuals with poorer insight are less likely to do so, as they are more convinced that their problem is entirely the result of physical characteristics, which would in their mind render psychological treatment futile, which can delay all important early intervention (Marques et al., 2011). Given that a longer duration before treatment has been connected to significantly worse outcomes longitudinally, this could lead to a more severe prognosis for BDD-individuals (Phillips, Menard, Quinn, Didie, & Stout, 2013).

Estimates of the prevalence rate of BDD in the general population fall between 1.7% and 2.9% (Kelly & Phillips, 2017), with an average of 1.9% between adult studies (Veale et al., 2016). In terms of similarly serious disorders, this is higher than that of schizophrenia (0.4–0.7% across international studies) (Saha et al., 2005) and similar to eating disorders when taken together (2.2% across European studies) (Galmiche et al., 2019). BDD prevalence varies between samples, such as adult psychiatric inpatients (7.4%) and university students (3.3%) (Veale et al., 2016). Given that a desire to alter body parts is common, prevalence was 12.2% within cosmetic surgeries (Veale et al., 2016). In one large study of 200 BDD-individuals, prevalence rates of additional co-morbidities were found to be markedly high and highlight the potential severity (Phillips et al., 2005). These included: major depression (74.5%), anxiety disorders (70%), substance abuse (48%), suicidal

thoughts (80%) and suicide attempts (24-28%). A similar rate of suicide attempts was recently replicated within a community study, suggesting it is not only those within clinical settings at risk (Krebs et al., 2020). However, this was a cross-sectional study, meaning that common causational factors of both BDD and suicidality cannot be discounted.

2.2. CAUSES OF BODY DYSMORPHIC DISORDER

Large scale studies of pairs of twins have estimated a heritability rate of between 42% and 49% for BDD (Enander et al., 2018; López-Solà et al., 2014; Monzani et al., 2012) (n=15377, n=6950 and n=4050 respectively). Similarly, a study of 200 diagnosed BDD-individuals found that 6% of all immediate family members also had probable BDD, which is significantly higher than the 1% found in the general population (Phillips et al., 2005). These figures were derived from family history records and the twin studies used a generic dysmorphic concern questionnaire, meaning these estimates are not based on fully-informed clinical diagnoses of BDD, which limits the validity of drawing clear conclusions. However, measures notwithstanding, the large sample sizes improve the reliability of establishing a genetic link with BDD.

Only one study has currently examined the site of this genetic basis, but it found preliminary evidence of culpability in serotonin-transporting and anxiety-modulating genes (Phillips et al., 2015), which could explain symptoms of anxiety, as well as the success rate of treating BDD with selective serotonin reuptake inhibitors, to be discussed in more detail later (Phillips &

Hollander, 2008). However, these were trend associations and not statistically significant results, which may be due to the small sample size (n=50). More gene studies of BDD will be required to support this finding.

In terms of neurobiology, BDD may relate to certain brain differences. A dominance for local over global connectivity has been associated with BDD symptom severity (Arienzo et al., 2013). The ventral visual system (VVS) has also shown heightened activity, this being the region that predominantly processes detail in visual information, as opposed to its holistic totality (Grace et al., 2017). This detail focus seems to extend to facial recognition, meaning that individual features are processed separately, rather than faces as a whole (Feusner et al., 2007), which can interestingly result in a significantly superior ability to *recognise* faces (Jefferies et al., 2012). This could suggest that, in a very literal sense, BDD-individuals perceive themselves differently to how others do. This hyperactivation in the VVS has also been found to correlate with that of the amygdala, an emotional centre in the brain, which could explain the intense distress caused by focusing on physical details (Bohon et al., 2012). However, it is not clear in which direction this relationship flows, meaning it is possible that activation in the amygdala *causes* focus on details instead.

The obsessive-compulsive symptomatology of BDD may be explained by dysfunctional activity in the orbito-frontal region, similar to that found in OCD patients (Grace et al., 2017). As with OCD, this may create difficulty with inhibiting compulsions, such as excessive grooming and 'checking' behaviours. These obsessive behaviours may arise from a susceptibility to 'not just right experiences' (NJREs), which are also present in OCD. NJREs are

described by OCD patients as feelings of "unease" about the configuration of the environment, most often in terms of a lack of symmetry (Veale & Lambrou, 2002). In BDD, this feeling appears to be transferred to one's image, with one study finding that approximately 30% of a sample of BDD-individuals had a concern relating to symmetry in their appearance (Hart & Phillips, 2013).

These findings should be taken as indicative rather than conclusive, as unless otherwise stated, the above neuropsychological studies did not find statistically significant differences between BDD-individuals and controls, only trend associations. This may be due to the small sample sizes, with between 12 and 17 BDD-individuals in each study and similarly sized control groups.

Environmental factors also appear to play a large part in the onset of BDD, given that genetic factors account for less than 50% of variation (Enander et al., 2018). For example, in one sample of BDD-individuals, experiencing long-term appearance-based bullying was the most commonly cited trigger of BDD symptoms (Weingarden et al., 2017). Another study took the top-down approach of asking patients whether they had experienced potential triggers predicted from past studies, including emotional and physical abuse, instances of which were significantly higher than for control participants (Veale et al., 2015). Abuse was only mentioned by 8 subjects in the previous study, so it is possible that more direct questioning unearthed details that participants are less willing to disclose independently. It could be argued that as both bullying and abuse in the home are closely linked with diminished feelings of self-worth and self-esteem (Hesapçıoğlu et al., 2017; Liu et al., 2018), these studies are tapping into a common causal trigger of BDD. Indeed, a recent qualitative study theorised an underlying basis of shame and low self-

worth for BDD-individuals, based on commonalities between experiences (Schnackenberg, 2021).

In the previously mentioned study, a culturally-instilled impression that physical attractiveness was important for success was the second most common self-reported trigger of BDD symptoms (Weingarden et al., 2017). In support of this, there is a difference in terms of the pattern of obsession demonstrated by males and females with BDD that reflects respective societal images of beauty: male BDD-individuals tend to be preoccupied with their genitals, musculature and hair loss, whereas female counterparts are more often obsessed with their breasts, thighs and buttocks (Phillips et al., 2006)

Drawing on evolutionary psychology, physical attractiveness *is* a factor in attaining social and sexual success, but perhaps BDD-individuals have developed an overinflated sense of its importance in establishing relationships and, by extension, their chances of attaining contentment and happiness (Stein et al., 2006). In support of this, BDD-individuals have rated appearance as more important than controls in both explicit and implicit association tests, the extent of which correlated with symptom severity (Buhlmann et al., 2011). It should be noted that this was the only study of its kind in which this difference reached significance. Additionally, all of the above studies were conducted in Europe or North America, which could be argued to share somewhat homogenous cultural values, meaning that environmental triggers of BDD cited may be somewhat specific to these areas.

Bringing together these various potential causes of BDD, it may be that an environmentally-triggered sense of low self-worth and an overinflated sense of the importance of physical attractiveness combine to varying degrees

with the aforementioned perceptual and cognitive propensities, to create a distressing preoccupation with natural and healthy physical imperfections. With cautious interpretation, genetic and neuropsychological evidence challenges the notion that environmental factors are solely to blame for BDD, an opinion voiced by some EPs in the preliminary study, most commonly in reference to the growing prevalence of unrealistic beauty standards presented by social media (Mummery, 2019). Indeed, some felt that a diagnosis of BDD was a needless pathologisation of typical adolescent image-concern, which they felt could be fully explained and attenuated by environmental factors. It therefore seems important that EPs are given a clear understanding of genetic and neurological causes also.

2.3.   TREATMENT FOR BDD

The currently accepted pharmacological treatment for BDD is a prescription of selective serotonin uptake inhibitors (SSRIs). Results are consistent across all studies of SSRI use for BDD (n=7), with between 53% and 73% showing significant improvements to symptoms. Two of the studies were randomised control trials (RCTs), the gold standard for evaluating the effectiveness of medications and interventions, due to the use of randomised assignment of control groups, which theoretically discounts extraneous variables (Hollander et al., 1999; Phillips et al., 2002). These specific studies showed improvements in 65% and 53% of subjects respectively, results that were significantly greater than for controls receiving a placebo.

SSRIs have been shown to lower levels of distress, anxiety and depression, as well as the frequency of obsessive and compulsive behaviours, with a smaller number of studies finding improvements in insight also. SSRIs have also been found to be the safest and most consistently effective medication for anxiety disorders, such as social anxiety (Blanco, 2003; Jakubovski, 2019). This perhaps further highlights the overlap between BDD and anxiety disorders, one that is also shown by their high comorbidity rates (Phillips, 2005). As has been found with SSRIs and social anxiety (Jakubovski, 2019), high doses are usually required for BDD but side-effects seem minimal or tolerable (Phillips, 2005). Different SSRIs have not currently been compared but switching between them has not been found to cause any significant changes (Phillips et al., 2001).

Due to its growing evidence-base, cognitive behavioural therapy (CBT) is currently the most widely used therapeutic treatment for BDD. Eight RCTs have evaluated CBT for BDD and all showed encouraging results, with significant reductions in symptoms and large effect sizes (Harrison et al., 2016; Wilhelm et al., 2019). There were also significant, although smaller, improvements in comorbid depression and insight. Three studies measured outcomes longitudinally and significant positive effects were still present after two to four months (Enander et al., 2016; Mataix-Cols et al., 2015; Rabiei et al., 2012). However, some minor regression had occurred, suggesting that more longitudinal studies would be welcome, to ensure positive outcomes are sustained. One study addressed this with a follow-up conducted two years after initial therapy, by which time symptoms had improved even further than when first measured (Enander et al., 2016). However, extraneous factors that

may have resulted in these additive effects were not explored and all responders were self-selecting, suggesting they may have been more active in overcoming their BDD than other participants.

All but one of the above studies incorporated exposure response prevention (ERP) into the delivery of CBT, which involves incrementally phasing out obsessive behaviours and exposing the site of fixation. For example, this could involve someone gradually wearing less make-up each time they leave their house. However, studies using ERP in isolation have found that results were not maintained at follow-up and so how integral this element is to therapy is unclear at present (Le et al., 2017).

It should be noted that all but two of the above studies (Marques et al., 2011; Veale et al., 2014) used a no-treatment group as control, meaning that the efficacy of CBT compared to other intervention approaches is not currently clear. This leaves us with the possibility that therapist contact and the patient-client relationship is the key to the success of CBT, not the content of the sessions themselves (Mataix-Cols et al., 2015). Indeed, one study found no significant differences between outcomes for CBT and psychotherapy when used to treat BDD at one hospital (although CBT fared significantly better at a second hospital, which suggests extraneous variables may have interfered at the first, warranting further comparative studies) (Wilhelm et al., 2019). Overall, the consistency of results is encouraging, but more comparative studies and RCTs would help to bolster CBT's standing as the *most* effective treatment for BDD.

2.4.   BDD IN ADOLESCENCE

Studies differ on the most common age of onset for BDD, but all agree that it most often establishes during adolescence, with estimates ranging from 12 to 16 years of age (Bjornsson et al., 2013; Thungana et al., 2018). However, it seems the seeds of BDD may be sown earlier, as in a large sample of BDD-individuals the mean age of the emergence of body *dissatisfaction*, or sub-clinical BDD, was found to be 12.9 years of age (Phillips et al., 2005). Any measure of average age of onset is somewhat imprecise, as it is often based on recollections of *adult* BDD-individuals. However, although difficult to pinpoint, BDD does seem to commonly onset at some point from early to mid-adolescence.

In a sample of 464 adolescents, 2.2% met criteria for a diagnosis of BDD (Mayville et al., 1999), which is higher than the mean prevalence of 1.9% derived for the adult population in a meta-analysis (Veale et al., 2016). When this average was separated out between genders, adolescent females showed a higher prevalence of 2.8%, whereas males only showed 1.7%. This may be due to the fact that young men are less likely to admit mental-health issues to professionals, as this discrepancy evened out for older subjects. It is not clear at present why it is particularly young *white* females who present with the most severe symptoms, although studies have mainly been conducted in America, so this may not be an international trend (Mayville et al., 1999). Aside from those found in psychiatric and cosmetic surgery settings, prevalence rates peak during university and college years (3.3%) (Veale et al., 2016). It may be that younger BDD-individuals are less likely than adult counterparts to have

begun seeking or receiving treatment, which eventually results in instances of remission in older demographics. It may also simply be that additional risk factors in adolescence result in this higher prevalence rate.

As previously mentioned, appearance-based bullying was the most commonly cited trigger of BDD and as these experiences are more likely to occur during adolescence, this may explain the higher prevalence rate (Weingarden et al., 2017). Due to increased social awareness and a desire to be accepted by peers, this can lead to feelings of isolation and rejection, the cause of which may be attributed to one's physical appearance (Smith & Juvonen, 2017). Other commonly cited triggers, such as physical and emotional abuse, are also often likely to occur during adolescence when children and young people (CYP) may be more vulnerable to these experiences having a long-term impact on their mental-health (Veale et al., 2015). Additionally, although social media could be argued to receive undue culpability for *all* body-image issues, the increasing ubiquity of artificially perfected images targeted at CYP can only exacerbate these problems (Tiggemann & Slater, 2013).

To highlight another major risk-factor, adolescent BDD-individuals appear to have even poorer insight than adult counterparts (Phillips et al., 2006). This means that despite higher estimated prevalence rates, adolescents are less likely to present in mental-health clinics than adults (Phillips et al., 2006). In fact, adolescent BDD-individuals are more likely to present in cosmetic surgeries, with the hope that fixing their "defect" will resolve their distress (Thungana et al., 2018). Unfortunately, an external

transformation rarely, if ever, provides the solution to BDD and the fixation often simply transfers to another body part (Bowyer et al., 2016).

Adolescence is a key period of development and BDD can be disruptive to this in a number of ways: academic achievement can be affected, rates of school-refusal and even complete dropout are high and social functioning is often impaired (Phillips et al., 2006). Comorbid symptoms have also been found to be more severe during adolescence (Thungana et al., 2018), with one sample of BDD-individuals who had developed BDD before the age of 18 showing elevated rates of substance abuse and suicide attempts (Bjornsson et al., 2013). Additionally, a longer duration before treatment has been connected to significantly worse outcomes in terms of remission in a 4-year follow-up study (Phillips et al., 2013). Therefore, as age and level of insight appear to correlate, the younger someone is when they develop BDD, the longer they are likely to forego treatment, which may lead to a more severe prognosis. As further evidence of this, one sample of adult BDD-individuals, whose symptoms remained untreated for many years, were significantly less likely to fully remit than those whose treatment had commenced during adolescence, which highlights the importance of early identification of BDD (Phillips et al., 2013).

The current evidence-base for the use of CBT for BDD during adolescence is limited but encouraging, with two studies finding significant improvements to symptoms compared to controls (Greenberg et al., 2016; Mataix-Cols et al., 2015). However, there is reason to suspect that outcomes could differ outside of a clinical trial. For instance, adolescents receiving CBT are unlikely to voluntarily maintain treatment without coaching from adults,

meaning the long-term positive impacts found for adult were not present in adolescent studies incorporating naturalistic or non-experimental observations (Phillips et al., 2013). Additionally, as we have seen, adolescents present with significantly poorer insight than older patients, which would logically suggest CBT-approaches reliant on introspection will need to be more intensive at this stage of development (Phillips et al., 2006). However, although poorer insight has been associated with lower *engagement* with treatment (Eisen et al., 2004), if it is sustained, the level of insight does not appear to impede positive outcomes (Phillips et al., 2013).

There have been similarly few trials measuring the efficacy of SSRIs for adolescent BDD-individuals, but results so far have been analogous to adults studies, with 53% showing significant improvement in symptomatology in one study (Albertini & Phillips, 1999). Although CBT and SSRIs have not been measured in conjunction, one could hypothesise that an improvement in insight through SSRI treatment could feasibly allow younger patients to engage more readily with CBT, which is thought by some to be the key to complete recovery (Williams et al., 2006).

It was considered important that EPs were made aware of the potential onset, severity and persistence of BDD within adolescence, given that their work covers CYP from birth to 25 years old (UK Government, 2015). EPs are well-placed to support young BDD-individuals and guide them towards the treatment and recovery that the evidence arguably allows us to be optimistic about.

2.5. LACK OF PROFESSIONAL AWARENESS OF BDD

Although EPs are well-placed to support BDD, within the preliminary study, 88.4% of a sample of 235 EPs self-reported themselves to have limited or no knowledge of BDD, a perception reflected in the number of key features they were able to identify (Mummery, 2019). A lack of awareness of BDD has also been found amongst medical and mental-health professionals, with some having no awareness of the disorder whatsoever (Phillips, 2005). It is important to better understand the reasons for this lack of awareness, given that it presents a significant barrier to effective identification and support of BDD.

Firstly, BDD has no externally apparent symptoms other than those already associated with anxiety and depression, such as social withdrawal and hyper-vigilance (Harrison et al., 2016). Similar and related body-image disorders such as anorexia nervosa are less common but arguably more well-known, both in public and professional spheres, perhaps owing to concerning images of morbidly underweight patients (Phillips, 2005). There are of course tell-tale behaviours of BDD, such as excessive mirror-gazing and comparisons to others, but in terms of adolescents, these can be easily missed amongst an already appearance-conscious group (Krebs et al., 2017). This can lead to a BDD-individual's needs being misunderstood simply as depression or social phobia, which results in inappropriate and ineffective interventions (Phillips & Hollander, 2008).

Secondly, there are a number of factors that prevent BDD-individuals from disclosing their symptoms to professionals. Feelings of shame and

embarrassment were the main reason for not seeking treatment cited by 55% of adults in a large sample (Marques et al., 2011). Although no such studies have been conducted with adolescents, it could be argued that feelings of shame and embarrassment are likely to be at least equally pronounced for this sub-group. In another study, BDD-individuals also prominently mentioned: not wanting their families to find out; not knowing BDD existed; and not knowing where to look for help (Veale et al., 2015). Elsewhere, self-reported barriers have included: logistic and financial factors; scepticism that treatment would be effective; and lack of insight (Hartmann et al., 2013). To highlight the extent to which some BDD-individuals withhold the underlying cause of their distress, some did not disclose their BDD symptoms during and even *after* receiving treatment, unless they were asked directly (Rief et al., 2006; Veale et al., 2015). The BDD-individuals in these studies were of course eventually able to talk to the researchers about their symptoms and in some cases did so electively (Marques et al., 2011), but there are likely to be many more who continue to keep their BDD to themselves.

Finally, BDD is not widely taught or talked about in the relevant professional circles. In the preliminary study, only 8% of EPs recalled BDD being referred to on their professional training course (Mummery, 2019). Of course, courses are unable to extensively cover every possible scenario that trainees might encounter, placing the onus on professionals to broaden their knowledge post-qualification through continued professional development. However, only 3.8% of the same EPs had received training on BDD *following* qualification, so it seems this is not something currently occurring with regularity (Mummery, 2019).

The above factors make BDD hard to recognise, particularly in adolescence, and the nature of the disorder makes BDD-individuals unlikely to come forward with their symptoms. Therefore, if awareness is not raised and professionals such as EPs are not vigilant for signs themselves, BDD may remain a hidden disorder for many young sufferers.

2.6. THE ROLE OF EPs IN RELATION TO BDD

If awareness of BDD is raised amongst EPs, we are left with the question of what actions they may take subsequently. There are no studies involving BDD in relation to EP practice whatsoever, but the *potential* actions an EP might take can be explored. The five main areas of EP practice have been outlined as consultation, assessment, intervention, training and research (Scottish Executive, 2002), with these operating across multiple levels: direct work with individual children; broader work with groups of children, families and schools; then moving further out to encompass entire local authorities. EPs are legally obligated to respond to mental-health issues, so potential ways of doing so in relation to BDD and the typical EP role will now be explored (UK Government, 2015).

2.6.1. Multi-Professional Approaches

In the preliminary study, the most commonly cited action EPs expected to take (58%) was referral to dedicated mental-health professionals, such as clinical psychologists, who have the specialised knowledge to carry out

treatment (Mummery, 2019). It should be noted that within one study, Child and Adolescent Mental-Health Services (CAMHS) were only take up an estimated 10 to 20% of cases referred to them, which leaves a large number of CYP without treatment (Atkinson et al., 2014).

2.6.2. Individual Level

If EPs are made aware of key warning signs of BDD, they would be better equipped to identify BDD within assessment work, particularly if behavioural signs coincide with instances of anxiety, depression, school avoidance or a decline in academic performance that they often support with (Phillips et al., 2006). Although EPs may not be involved in the diagnosis of BDD, if it was suspected, there are a number of short and accurate screeners that could be used to explore this hypothesis, some only a few questions long (Veale et al., 2016).

EPs are mandated to carry out therapeutic interventions by government legislation (UK Government, 2017). For many EPs, therapeutic work already occurs with regularity (Atkinson et al., 2013) and it is included as a mandatory competency by both *The Health and Care Professions Council* (HCPC) and *The British Psychological Society* (BPS) (BPS, 2018; HCPC, 2018). Although not an obligatory competency, EPs are often trained in cognitive behavioural approaches and some are fully CBT-qualified, making direct work with young BDD-individuals a possibility (Hoyne & Cunningham, 2019). There are many other direct approaches commonly utilised by EPs but few have been researched in relation to BDD.

2.6.3. Family and School Level

'Family accommodation' has been identified as a risk-factor for BDD, which relates to how families act in response to BDD behaviours, such as by providing reassurance or by facilitating avoidance behaviours. These accommodations can be time-consuming and cause extensive disruption, often due to missed opportunities for occupational and social activities, with subsequent burdens on finances and well-being. Although the intention is to manage anxiety, there is anecdotal evidence that symptoms only worsen and conflicts regularly arise (Jassi et al., 2020). This study was exploratory and the direct impact of family accommodations on BDD will need to be explored further, but with OCD they have been associated with poorer response to treatment and their reduction has resulted in better outcomes (Merlo et al., 2009). Supporting families to understand the impact of accommodations and help manage them could be a key way in which EPs could support BDD. Related to these accommodations, another study highlighted why reassurance can be unhelpful, as even *positive* comments about appearance can be triggering of BDD, perhaps because they highlight that others are assessing one's appearance, without altering the perception that one is ugly (Menees et al., 2013). This would be important information for EPs to understand when they work with BDD-individuals.

Consultation is another core part of EP practice and involves a solution-focused process of collaborating with parents and teachers to find a way forward with a presenting problem (Kennedy, 2019). If EPs have a good understanding of how BDD can be supported within schools, they will be well-

placed to collaborate with schools and families to think around what is already helping and what resources might be available to further support the young person.

EPs tend to operate peripatetically and work only with children referred to them, so it may be up to schools to identify the signs of BDD initially, making it important that they have an understanding of BDD and its impact also (Gutkin, 2012). However, research has found that school staff do not currently have a nuanced understanding of mental-health needs (Weeks et al., 2017). EPs could therefore play a role in training and upskilling school staff in regard to BDD, as cascading information in this way is a common part of EP work.

2.7.   STUDIES EVALUATING TRAINING PACKAGES

Having evaluated the most relevant information about the BDD, the need for the training and the impact it might possibly have on EP practice, it is important to also look to previous studies that have evaluated training. There are no training packages that directly relate to BDD, however, there are a number that evaluated training about similar disorders, such as OCD (White et al., 2011) and eating disorders (Brownlow et al., 2015; Hart et al., 2012; Maguire et al., 2019; McVey et al., 2009; Rosenvinge et al., 2003).

Sessions varied from a single 2-hour session to 17 days of eclectic teaching methods. Some included explanatory videos, interactive exercises and group tasks, as well as didactic elements (Maguire et al., 2019; McVey et al., 2009). The study that covered OCD, which relates closely to BDD, covered definitions, clinical characteristics, epidemiology, behavioural manifestations

and treatment and management options, which coincides closely with the material chosen for the current training (White et al., 2011). Studies were mostly evaluated with a mixture of quantitative and qualitative measures, mainly involving self-reported measures and additional interviews. However, some incorporated objective tests of knowledge that used either true-or-false (Hart et al., 2012) or multiple-choice questions (White et al., 2011), covering key features of eating disorders, such as warning signs and treatment options. All but one found significant improvements in the variables they measured, such as knowledge of eating disorders and skills in terms of assessing and treating them (Brownlow et al., 2015). Some incorporated follow-ups to see what had been implemented within practice (Hart et al., 2012).

Some important considerations will be incorporated into the BDD training package. One study highlighted the importance of time for discussion, given that individuals can learn from peers by sharing experiences (Chalk & Smith, 1995). In terms of evaluation, one highlighted the potential for a Hawthorne effect with self-reported measures, that makes additional objective measures an important consideration for validity (Howard & Thatcher, 1990). Similarly, another study highlighted the need to carry out a follow-up, as data collected immediately following training does not necessarily translate into changes within participants' professional practice (Murphy & Claridge, 2000). One study attempted to cover OCD, Tourette's syndrome and ADHD within a single 2-hour session and did not find significant improvements in knowledge as measured by an objective test (White et al., 2011), which perhaps highlights the risk of providing too much information within a session with a shorter duration, which in the case of the current study will be just one hour.

In terms of content, one study highlighted that a lack of awareness can create stigmatisation of disorders, with eating disorders being perceived as the fault of sufferers (Maguire et al., 2019). In the case of BDD, this could relate to normalisation or perceptions of vanity and as such, attitudes to BDD will be important to measure also. One study also measured prior experience with OCD, which is another important inclusion, as increased exposure to BDD will clearly impact on participants' data (White et al., 2011).

Other inclusions were deemed important but may be difficult to implement within the BDD training package. For instance, one study used a problem-based learning framework that allowed participants to deploy new knowledge within the training itself (Seaton, 2018), which is beneficial given that interactive elements encourage the utilisation of new information that allows for greater consolidation (de Beer, 2017). However, this training package was carried out over six sessions, whereas the scope of the current project only allows for one hour-long session. Additionally, awareness of BDD is anticipated to be low (Mummery, 2019), meaning that extensive introductory information is required, leaving less space for group activities. The current training will however include interactive elements wherever possible.

2.8.   CHOSEN THEORETICAL PERSPECTIVES

2.8.1. The Conscious-Competence Model

Aside from EPs citing training as their preferred way of learning new information (Mummery, 2019), there are psychological theories underpinning the assumption that training would cause a change in chosen dependent variables (see section 3). Firstly, the conscious-competence model was referred to (see figure 2.1), the origin of which has been attributed to a number of authors, albeit in slightly different guises (Cannon et al., 2010).

Fig. 2.1.

Conscious-Competence Model
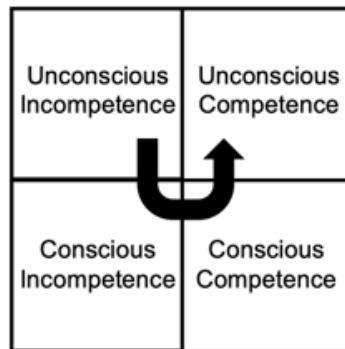
The model is sequential and assumes that learners begin in a state of unconscious-incompetence (unaware of what they don't know), before moving through conscious-incompetence (aware of what they don't know), conscious-competence (aware of what they do know), ending on unconscious-competence (in a different sense, unaware of what they know, having

achieved mastery). Most pertinent to the current study, as awareness of BDD is low amongst EPs (Mummery, 2019), an initial state of unconscious-incompetence was anticipated. Given that the model is sequential and that training sessions ran for just one hour, the end goal was limited to moving participants onto the stage of conscious-incompetence, through an introductory session that highlighted the importance of considering BDD within practice and encouraged further learning and thinking about the actions participants might take in response.

2.8.2. Bloom's Revised Taxonomy of Learning

In relation to this, the study also utilised Bloom's revised taxonomy of learning to provide a hierarchical framework within which to design the training (Anderson et al., 2001). This is another hierarchical and sequential model of learning, operating on two dimensions. The first involves 'cognitive processes', the most basic of which are: basic recall of information; understanding or constructing meaning; and applying knowledge within a situation. Higher levels of learning are considered to be analysis, evaluation and creation, but again, given the sequential nature of the model, these are less relevant to the current study. In addition to cognitive processes, the 'knowledge' dimension operates in parallel and moves through: factual; conceptual; procedural; and meta-cognitive knowledge. Proponents of this model intend for it to be used alongside objectives of teaching and it was therefore important to outline these:

- **Objective 1:** For participants to *recall* and *understand* the key features of BDD.

- **Objective 2:** For participants to begin to think about how they will *apply* this understanding within their practice.

- **Objective 3:** For participants to be *motivated* to learn more about BDD and incorporate it within their practice in real-terms.

Applying it to the model (see Fig. 2.2), the first objective operated at the lower levels of knowledge and cognitive processes, which again reflected the anticipated low levels of awareness of BDD (Mummery, 2019). Towards the end of the training, the learning moved onto the higher level of application, by looking at potential next steps for EPs, as well as leaving space for discussion between participants, intended to encourage prospective application to practice.

Fig. 2.2.

Bloom's Revised Taxonomy of Learning

	Recall	Understand	Apply	Analyse	Evaluate	Create
Factual	Ob1	Ob1	Ob2			
Conceptual	Ob1	Ob1	Ob2			
Procedural	Ob1	Ob1	Ob2			
Metacognitive						

In addition to the two dimensions outlined, some have added an affective element to the model (Savickiene, 2010). This involves feelings, values and attitudes towards the material, as learning will be applied most effectively if the information is deemed important and relevant to practice. This

was important given the attitude of some EPs within the preliminary study, who felt that BDD was *not* relevant to EP practice (Mummery, 2019). This has been linked to motivation, which linking back to the conscious-competence model, is thought to be necessary for moving from a state of conscious-incompetence to conscious-competence (Cannon et al., 2010). The training therefore emphasised the impact BDD can have on education and well-being, particularly through the use of a real-life case-study video. The training also emphasised the serious and intractable nature of BDD (unless treated) through neuroscientific evidence and the link to OCD, whilst also creating a hopeful picture through the strong response to treatment that has been found.

2.8.3. Self-Efficacy

The training also emphasised the impact EPs could have on BDD and the ways in which this might happen. In this way, it was hoped that EPs' sense of self-efficacy would also increase, their perception of their own ability to make an impact (Bandura, 2010). This was considered important, as a lack of confidence around supporting BDD was also common within the preliminary study (Mummery, 2019). As such, participants' ratings of their own ability to identify and support BDD were measured, as these subjective perceptions were predicted to contribute to motivation to implement within practice. Therefore, it was hoped that participants' sense of the importance of BDD to their practice would combine with a sense that they are capable of supporting BDD to achieve Objective 3: For participants to be ***motivated*** to learn more about BDD and incorporate learning into their practice. In this way, although

the training was necessarily limited to achieving conscious-incompetence, it was hoped that EPs would be encouraged to learn more about BDD themselves, seek out further training (planned for by the current author, covering the advanced levels of Bloom's revised taxonomy and the unconscious-competence model) and begin to incorporate it within their practice.

3. RATIONALE

As has been demonstrated, BDD is a highly anxiety-inducing disorder with the power to severely disrupt both educational and social functioning. During adolescence, when BDD is most likely to have its onset, the symptoms are more severe and levels of insight are even lower than for adults. EPs are likely to encounter young BDD-individuals and there is potential for them to contribute to identification and support of BDD. However, awareness levels present a barrier to this happening as frequently or effectively as it could. On the other side of this issue, young BDD-individuals are unlikely to come forward with their symptoms, making the issue of identification doubly difficult.

3.1. RESEARCH QUESTIONS

With the overarching objective of raising awareness of BDD, this research project's aim was to evaluate a bespoke training package about BDD designed for EPs, in terms of three dependent variables: the level of understanding EPs have of BDD; their ability to identify BDD; and their ability to provide support for young BDD-individuals. The approach, content and structure of the training package were developed in line with the literature review. As such, the final research questions (RQs) for the study reflect the learning objectives outlined for the training itself (see chapter 2.8 above):

RQ1. How well do EPs receive the training package? What aspects were effective and ineffective and why?

RQ2. What are EPs' attitudes towards BDD in relation to EP practice? Were they changed by the training?

RQ3. Does EPs' *knowledge* of and ability to *identify* and *support* BDD increase after participating in a bespoke BDD training package? If so, are these changes maintained after 6 months?*

RQ4. Contingent on the answer to RQ3, how do participants anticipate applying these changes within their practice? Which changes have already occurred in practice after 6 months?

3.2. HYPOTHESES

In line with previous studies, including the author's own, it is predicted that prior awareness and knowledge of BDD will be low amongst this sample of EPs (Mummery, 2019). As such and in line with similar studies and the theoretical underpinnings outlined in the literature review, it is hypothesised that the training will cause an increase in knowledge of BDD amongst participants, as well as in their ability to identify and support it.

4. METHODS

4.1 RESEARCH DESIGN

The researcher found that in relation to the current study, there were advantages and disadvantages at each extremity of the ontological and epistemological spectra, which will now be explored (Somekh & Lewin, 2005). At the broadest level of ontology, the philosophical concept of the nature of reality, research can be said to fall somewhere between the poles of objectivism and constructivism (Matthews & Ross, 2010). Objectivism posits that reality and social phenomena exist separately to human minds and relationships and is therefore theoretically accessible to objective measurement. Constructivism however does not see the social world as external to human actors, rendering deductive assumptions futile. Related to ontology is epistemology, the philosophical concept of how knowledge can be derived (Briggs & Coleman, 2007). Here, the spectrum runs from positivist to interpretivist, the former seeing knowledge as derivable only from direct objective study, the latter seeing knowledge as derivable only from subjective experience.

According to some, ontology and epistemology are inextricably linked and research should reflect the researcher's philosophical positioning on each (Denzin & Lincoln, 2021). However, the current researcher does not hold strong ontological views, as the question of whether or not objective reality (at least in terms of the social world) *could* be measured by positivist means is obscured by the fact that it most often *cannot* be, as human experience and

behaviour is too complex and context-specific for general laws to apply (Biesta, 2010). As such, the researcher assumes a pragmatic epistemological approach, which suggests that different facets of knowledge can be accessed in different ways and that methods should therefore flow from RQs, not the other way around (Onwuegbuzie & Johnson, 2006).

From the above ontological and epistemological considerations will stem a mixed-methods design. Although quantitative methods align most neatly with a positivist epistemology, and qualitative with interpretivist, there is not a perfect overlap (Biesta, 2010). Within the current study, both quantitative and qualitative methods will be used to answer the RQs above. It is considered that RQ3 will be answered most efficiently using numerical, quantitative measures that will incorporate all participants, to achieve breadth. However, if a clear change in the dependent variables is determined, the specific nature of the impact this may have on professional practice (RQ4) is considered to be best answered using qualitative methods, allowing for more in-depth exploration with a smaller number of participants (Creswell, 2003). As such, the study will use a sequential explanatory design, by determining a potential change in dependent variables, the presence or absence of which will then be explored further (Punch, 2005). This means that the specific nature of qualitative methods will be contingent on the initial quantitative data.

To clarify, each question will be answered using a mixture of quantitative and qualitative methods. The exact pattern is outlined in Table 4.1.

Table 4.1.

Pattern of Quantitative and Qualitative Methods

	Quantitative	Qualitative
RQ1	✓ *	✓
RQ2	✓	✓
RQ3	✓	
RQ4	✓ *	✓

*Quantitative frequencies derived from qualitative data

The training was evaluated following Kirkpatrick's Four-Level Training Evaluation Model (see Fig 4.1.) (Kirkpatrick & Kirkpatrick, 2006). The first level involved asking participants for their *reaction* to the training, in terms of a number of variables, including most helpful aspects and overall satisfaction (see Appendix A). The second level involved assessing *learning*, measured by quantitative measures (see 4.1.3). The third level involved *behaviour*, or what EPs expected to do with the information in practice, which was mainly measured qualitatively, with some additional quantitative data (see 4.1.4). A 6-month follow-up also measured subsequent behaviour in real terms. The final level of the model is *results,* which is intended to measure impact at an organisational level, as a summation of the behaviours measured at level 3. Given that in this case EPs attended from a range of organisations, this was harder to measure and examining impact for specific EP services was therefore beyond the scope of the current study. However, any changes in behaviour recorded at level 3 that resulted in identification or support of BDD

will be discussed, as the potential implications of these behaviours occurring on a wider scale can be cautiously inferred.

Fig 4.1.

Kirkpatrick's Training Evaluation Model

| 1. Reaction |
| 2. Learning |
| 3. Behaviour |
| 4. Results |
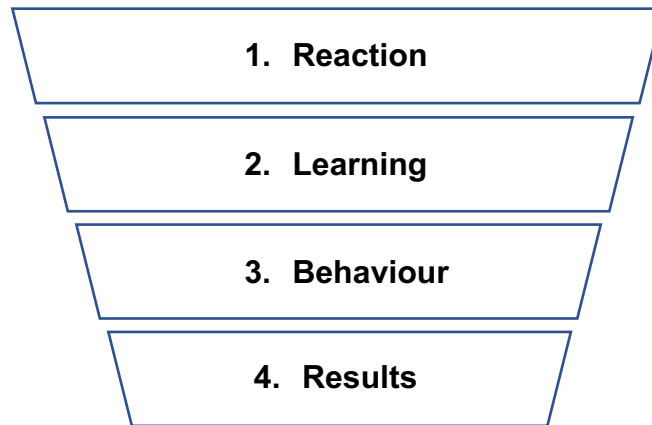
Kirkpatrick's model is widely-used for evaluating training and a large number of studies have utilised it to this end (Reio et al., 2017). However, it is quite difficult to assess the impact of a tool that is designed to assess impact, as the validity and reliability of the data collected is not necessarily related to the model itself. A large number of studies within one review had only utilised the first two stages, which Kirkpatrick himself emphasised should be avoided, as the model is sequential and hierarchical, meaning each stage builds on the last and develops a more complex picture of the impact of the training (Lim et al., 2013). As such, the current study made sure to work through all possible levels of the model. Additionally, the model has been criticised for not taking into account existing organisational and individual factors that will interact with the training to influence outcomes (Bates, 2004). In an attempt to counteract this, any previous experience with BDD was measured, as well as years of

practice as an EP. Overall, the inherent difficulty of evaluating training is acknowledged and the model was chosen for its simple and practical framework, as it was hypothesised that prior experience and knowledge of BDD would be low (Mummery, 2019), meaning that resulting behaviours will be more easily related to the training itself.

Quantitative data was gathered via three online questionnaires delivered using Qualtrics, administered to all participants before and immediately after the training, with the third questionnaire being delivered to a smaller number of willing participants 6 months later. RQ3 was addressed with a quasi-experimental one-group pre- and post-test design (Breakwell et al., 2012). Scores on pre- and post-measures were used to measure change in dependent variables (knowledge of BDD, ability to identify BDD, ability to support BDD), with scores at the 6-month follow-up measuring how this potential change was maintained (Breakwell et al., 2012). Within the post-training questionnaire only, RQ2 was addressed quantitatively by asking participants to what extent they expected to make use of information within the training, on a scale of 1-to-5. Also within the post-training questionnaire, qualitative data regarding RQs 1 and 4 was later converted into quantitative frequency data.

Qualitative data was gathered through semi-structured interviews (Briggs & Coleman, 2007). In order to answer RQ4, this entailed examining how a smaller number of EPs envisaged utilising the information learned, as well as the scope of their role in terms of identifying and supporting BDD. To address RQs 1 and 2, interviews also explored attitudes towards BDD in terms of its importance to EP practice, as well as further details of the aspects of the

training that were deemed most effective within questionnaires. Interviews took place immediately or shortly after delivery of the training.

4.2. PARTICIPANTS

A purposive sample was used, as a specific population of interest (EPs) was being drawn from (Cohen et al., 2007). Participants were contacted online, either via email or through EPNET (the online forum to which a large majority of EPs are subscribed). A power analysis was conducted using G*Power software to estimate the appropriate sample size. The means and standard deviations of a similar study were used, one that evaluated training on OCD that also utilised a bespoke quiz, incorporated very similar elements and lasted for a similar duration (2 hours) (White et al., 2011). This indicated that to achieve a moderate effect size of 0.5, according to Cohen's rules (Savilowsky, 2009), a sample of 89 would be adequate and so this was aimed for as a minimum. Roughly 250 EPs received the training (exact number unknown due to difficulty monitoring attendance across multiple sessions) and 160 completed questionnaires. From this sample, 15 of the EPs who stated they are willing to be interviewed were selected at random to take part in the interview stage. Questionnaire respondents were also asked if they are willing to be contacted for the 6-month follow-up. 104 agreed and all were contacted, of which 68 completed the follow-up questionnaire.

4.3. MEASURES

No existing questionnaires would have adequately measured the dependent variables and so a questionnaire was specially designed (see Appendix A). Questionnaires began by asking whether EPs had encountered BDD within their work, as this was likely to affect self-reported ratings that followed (Robson, 2011). Questionnaires then measured EPs' sense of their own knowledge of BDD, as well as their competence in terms of identifying and supporting it. Respondents denoted responses on a numerical sliding scale from 1-to-10, to allow for the change in dependent variables to be measured with sensitivity and precision (Cohen et al., 2007).

Self-reported measures are inherently subjective and therefore difficult to compare between subjects, limiting generalisability (Cohen et al., 2007). Additionally, professionals receiving free training may be inclined to exaggerate their ratings, creating a Hawthorne effect (Breakwell et al., 2012). Therefore, a short quiz about BDD was included, to objectively measure the specific knowledge that participants had, an approach that has been utilised in a previous study evaluating the impact of training about OCD (White et al., 2011). The quiz was made up of true-or-false and multiple-choice questions regarding key information about BDD found within the training. As such, this only addressed the variable 'knowledge of BDD', as performance on this test was not predicted to necessarily correlate with ability to identify or support BDD.

The test could not be measured for internal consistency, as each question accessed knowledge on different aspects of BDD and therefore there

was no a priori reason to expect items would correlate (Wolf et al., 2019). This impacts validity, as the variable 'knowledge of BDD' is arguably too broad to accurately measure. However, given that research into BDD is limited, the training materials and test measure cover a significant proportion of key objective information that exists. Additionally, content validity was sought by sending the proposed questionnaire to experts in the field of BDD (Stager, 1993), specifically the group of clinical psychologists working at the Maudsley Hospital in London who deal with BDD exclusively and who collaboratively designed the training package. They deemed the measure relevant, comprehensive and accurate for testing knowledge of BDD, although the panel were unfortunately not large enough to achieve a meaningful score using the Lawshe ratio, a test typically used to measure content validity (Ayre & Scally, 2013). The measure was also piloted to 15 peers of the researcher, who were asked for their opinion on the questionnaire's clarity, to achieve face validity (Hart et al., 2012).

Within the post-session questionnaire, participants were asked to what extent they expected to use the information and how they would do so. Using 1-to-5 scales, they were then asked how they would personally rate the training in terms of: the breadth of topics covered; the use of engaging learning activities; delivery of the session; and general satisfaction with the session. This covered the first 'reaction' level of Kirkpatrick's model (Kirkpatrick & Kirkpatrick, 2006). The final few questions asked participants to cite the most successful aspects and make suggestions for improvements. In the post-session and 6-month follow-up questionnaires, the self-reported measures and objective test were administered again, to allow for direct comparison.

Together with pre-session scores, these addressed the second 'learning' level of Kirkpatrick's model (Kirkpatrick & Kirkpatrick, 2006). The follow-up questionnaire also asked participants for information on any further learning they had undertaken about BDD, as well as any instances of suspected BDD within their practice, alongside their chosen next steps. Along with the interviews, the follow-up questionnaire therefore addressed the third 'behaviour' level of Kirkpatrick's model (Kirkpatrick & Kirkpatrick, 2006).

Interviews examined what new information participants found most useful or relevant to their practice and also how they viewed their role in terms of identifying and supporting BDD in light of this. Interviews began by asking participants what they knew about BDD prior to the training (if anything). It was considered important to cover prior knowledge of BDD, as this would clearly influence subsequent questions. Indeed, one question was only delivered to professionals with prior knowledge of BDD, to explore how this came about (see Appendix B for full interview schedule).

If the respondent had no prior knowledge of BDD, the interview moved on to their attitude towards the importance of BDD to EP practice and their perception of their specific role and ability in relation to identifying and supporting BDD. This was considered important as greater awareness will arguably not count for much if professionals are unwilling or unable to do anything about it (Savickiene, 2010). They were also asked about the training itself in terms of particularly successful or unsuccessful elements and their suggestions for improvements or changes that could be made.

The training package itself was designed in collaboration with the National & Specialist BDD service at the Maudsley Hospital. The training

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began with an interactive poll to gauge participants' responses to a few key features of BDD. It then covered the key areas of BDD outlined in the literature review, in this order: symptoms and diagnostic criteria (including insight); causes (genetic and environmental); key statistics (prevalence rates, age of onset, comorbidities); common misconceptions; behavioural signs and treatment options. It also then featured suggestions for ways of working with BDD-individuals for schools and EPs that were identified by the National & Specialist BDD service, as well as helpful resources. There was a summary at the end and an opportunity for questions and discussion. The training was delivered by the author and incorporated a PowerPoint presentation that was accompanied by a script, to allow for consistency between sessions. Each session was delivered online and included between 10 and 20 participants. It was delivered multiple times to allow for a larger sample size. An example slide from the presentation is shown in Fig. 4.2.

Fig. 4.2.

Example Slide from Presentation

There were interactive elements within the training, such as opportunities for reflection and the brief online poll that displayed participants' responses. These were designed to access higher-order learning opportunities, as encouraging the manipulation and utilisation of new information allows for greater consolidation (de Beer, 2017). An animation involving a real-life case-study also featured, to support affective learning of the impact of BDD on well-being (Savickiene, 2010). There was then consideration of how information could be incorporated into professional practice, but this was not covered extensively, as it was felt that each EP had the autonomy and professional training to decide this for themselves. This also meant they could respond to questionnaire or interview questions in line with their own perception of their role, rather than with one put forward by the presentation, which they may otherwise feel pressured to conform to (Breakwell et al., 2012).

4.4. ETHICAL CONSIDERATIONS

The study took a deontological ethical stance, meaning that equitable and benign treatment of participants was considered more important than the overall positive impact of the study (Parker & Tritter, 2006). However, no detrimental impact was predicted beforehand and the quality of EPs' practice in this area was only expected to improve as a result of their participation, in turn benefitting young BDD-individuals due to improved early identification and treatment (Wiles, 2013). If participants had felt uncomfortable or emotional

answering questions, they would have been reminded of their right to withdraw and given a clear opportunity to do so.

For questionnaires, the front page featured a box for participants to tick to indicate consent. For interviews, an individual form was signed and the researcher's commitment to confidentiality and the participants' right to withdraw were made clear. It was emphasised that audio recording could be stopped at any time. Interviews took place online, allowing participants to feel comfortable in a location of their choosing. Identifiable details were removed in the process of transcription and audio recordings were subsequently deleted. Personally identifiable information was not elicited by questionnaires. Ethical approval was obtained by the UCL IOE Research Ethics Committee and the Data Protection Office assigned the data protection number Z6364106/2020/04/119.

4.5. PROCEDURE

Fig. 4.3.

Research Timeline
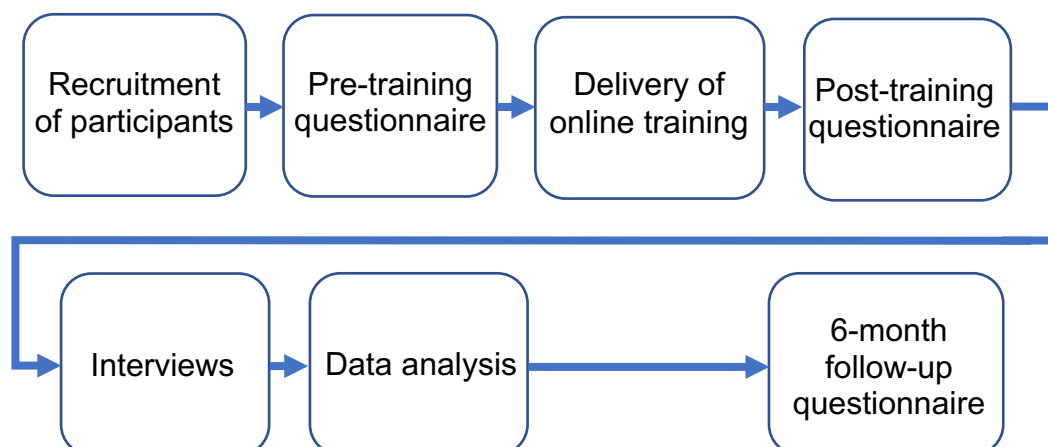
Questionnaires were completed anonymously via the Qualtrics online service. Interviews lasted around 20 minutes each and were conducted via online video communication platforms. Although potentially disrupting neutrality, interjections by the researcher were allowed for, such as corrections of any misconceptions or misunderstandings that remained following the training, to ensure that EPs had a complete understanding of BDD on which to base their responses (Holstein & Gubrium, 1995). Both questionnaire and interview schedule were piloted to make sure questions were transparent and easy to answer, with changes being made if necessary (Baker & Edwards, 2012). Questions were not made available prior to training as this could have allowed for additional information gathering that would have influenced responses (Seidman, 2006).

The training was delivered by the researcher, who has a personal history of BDD, a special interest in the disorder and strong knowledge of the area, allowing for a well-informed question-and-answer session. Given the current situation regarding COVID-19, training sessions were delivered via Zoom or Microsoft Teams software. Sessions lasted approximately one hour. The session was piloted to the author's peers prior to delivery to qualified EPs.

4.6.   DATA ANALYSIS

Descriptive statistics were used for most quantitative measures derived from the questionnaires, using SPSS software (Mertens, 2014). Differences between pre- and post-measures of the three dependent variables were analysed for statistical significance. For self-reported measures, this involved

a comparison of median scores using a Wilcoxon matched-pairs signed-ranks test, given that the data is ordinal and involves repeated measures. For subjective quiz scores, a matched-pairs t-test was used, given that the data was interval (Field, 2017). Quiz scores were able to be compared by being binary (true-or-false) or having a finite range of possible answers. For example, the training outlined the four diagnostic criteria of BDD and participants were subsequently asked to name them, with a ratio of 1 for correct responses being derived (e.g. 3 out of 4 would give 0.75 for that particular question). The test had a possibly maximum score of 18. Self-reported and objective quiz score measures of knowledge were correlated with each other to see how closely they matched, to further evaluate validity and reliability. These measures were also correlated with years of experience as an EP and the number of young BDD-individuals EPs have encountered, to measure how influential prior experience was on data. Effect sizes (EFs) will be given for correlations, following Cohen's rules, which consider 0.2 to be a small EF, 0.5 to be medium and 0.8 to be large (Savilowsky, 2009).

Interviews and qualitative portions of questionnaires were analysed using thematic analysis (Clarke & Braun, 2013). This was chosen instead of more inferential qualitative data analysis methods, such as interpretative phenomenological analysis (Smith et al., 2009). This is because the subject matter pertained only to participants' professional practice, making the double hermeneutic approach of interpretation of another person's implied or unconscious meanings an unnecessary complication, resulting in semantic rather than latent themes (Smith et al., 2009). As such, the approach could be best described as 'coding reliability', a version of thematic analysis that adopts

a neo-positivist approach by attempting to attain objective and unbiased coding (Braun & Clarke, 2019). This meant contacting interviewees following the coding process to check that codes reflected their intended meaning, to which all replied in the affirmative, with some minor corrections. However, given the study's pragmatic stance, the inevitable influence of the researcher's interpretive input is acknowledged (Braun & Clarke, 2020). Responses were divided into discrete chunks of information and then coded and grouped under broader themes. These were edited into short sentences with repetitions and unnecessary utterances removed, unless considered relevant. Across the interviews, the broad themes were compared and a final set of superordinate themes was decided upon (Smith, 2009).

5. RESULTS

Within qualitative sections, the main body of text contains edited remarks made by interviewees. Full quotes can be found within quote tables (QTs) in Appendix E, which will be refenced within the text e.g. *(see QT12)*. Individual quotes are coded to indicate table number and participant number e.g. *(Q4.12).* Integrated quotes that are not found in complete form within appendices will be labelled simply with the interviewee number e.g. (EP9).

5.1. EPs' REACTION TO TRAINING PACKAGE

In line with the first level of Kirkpatrick's model, reactions to the training were measured (Kirkpatrick & Kirkpatrick, 2006)**.** Participating EPs were asked to rate the training on a scale of 1-to-5 based on the following criteria: breadth of topics; mix of learning activities; delivery of presenter; and overall, how satisfied they were with the training. The results are presented in Table 5.1.

Table 5.1.

EPs' Ratings of Training

	Breadth of Topics	Mix of Activities	Delivery of Presenter	Overall Satisfaction
Mean	4.38	4.11	4.71	4.72
Standard Deviation	.73	.79	.51	.52
Minimum	2	2	3	2
Maximum	5	5	5	5

Within questionnaires, participants were asked to cite the most effective elements of the training (see Table 5.2). This was an open question, without suggested responses. EPs could provide multiple answers.

Table 5.2.

Most Effective Elements of Training

	Number of EPs
Animated video w/real case study	34
Hearing personal experiences of BDD	31
Clarity of information	9
Resources provided	9
Knowledge of presenter	8
Relaxed delivery	7
Presentation of slides	7
True or false poll	6
Concise	6
Question and answer session	5
Pace	4
Eclectic elements	4
Overall structure	3
Engaging	3
Presenter's enthusiasm	2
Using chat box for questions	2
Introductory nature of training	2

Interviewees were asked the same question and their elaborated responses gave further insights. In line with the two most popular choices above, EPs mentioned the lived experiences of BDD. Some said the video was *"really impactful"* for *"including the actual voice of those experiencing it"* (EP11) and to *"illustrate the point"* (EP5) with *"a young person's perspective"* (EP15) that *"brought it to life"* (EP14). Similarly, EPs mentioned the personal experiences incorporated by the presenter *(see QT1)*, which caused a *"shift in thinking" (Q1.6)* and made it *"more meaningful" (Q1.10)* and *"something real" (Q1.8).*

EPs appreciated the short-form nature of the training, using words like *"succinct"* (EP3), *"concise and complete"* (EP4) and *"a manageable chunk…of information"* (EP5). One also added *"it was short, but punchy…you've got*

enough information…to get people interested, but also enough to pass…onto other people, like I did with my school SENCO" (EP15). Similarly, one felt it had *"a good balance between…the key and basic stuff…then adding a bit more"* (EP10). Similarly, one mentioned the introductory nature, saying *"it always helps…when it's completely new…as an introduction…the basics is what you need to start thinking…seeing how it can affect your practice…then you can make the biggest step with that"* (EP2).

EPs mentioned the opportunity for asking questions, which allowed for "*sharing experiences…learning about what…different team members' experiences have been"* (EP2). One appreciated that *"you took questions as we went along"* (EP3) and another liked use of *"the chat box…how you very much welcomed questions*" (EP11).

Also mentioned was the message of hope that closed the training. One EP said, *"the thought of hope that there is…something that can be done to make things better"* (EP1) and another said, "*the bit that really stuck out…was the hopefulness thing, as a really clear role for us…offering that hope that things can change"* (EP8).

Within questionnaires, EPs were asked to make suggestions for how the training could be improved, in terms of content or delivery (see Table 5.3). This was an open-ended question and EPs could provide multiple answers.

Table 5.3.

Suggestions for Improvements to Training

	Number of EPs
Case studies to contextualise information	18
More interactive activities (pairs or groups)	14
More time for discussion	13
More links to EP practice	8
More personal experiences	8
More examples of how to talk to CYP w/BDD	8
Longer session	5
More on how schools can support	4
In-person session	3
Ideas for prevention	3
Where to refer, other than CAMHS	3
Less 'medical model' content	2
More on separating from typical image-concern	2
More on when to refer	2
More research evidence	2
Reflection on impact of BDD on presenter's practice	1
Screening tool	1
Discussion of labelling	1
Correct quiz answers	1
More on CBT	1
More on causes	1

Interviewees were asked the same question. As reflected in questionnaire data, more interactive elements were mentioned most frequently *(see QT2).* For example, case studies would help explore *"things to say…things to not say" (Q2.7)* so as to avoid saying *"something that might make things worse" (Q2.14).* Others *"wondered about some activities"* to explore *"things you might do on an individual basis…or that school staff could feasibly do"* (EP7).

Similarly, although some praised the time for discussion, some would have welcomed more of this *(see QT3),* to allow *"time to bounce ideas and reflect" (Q3.9)* about *"any experience around BDD…support or multi-*

professional support they've been involved with" (Q3.15). Again, although the short-form nature was praised by some, others mentioned that the training *"was only a short snapshot"* which meant they felt "*a follow-up session*" (EP11) or *"a reflection group…a few months down the line would be really helpful…just to keep it in people's minds"* (EP12).

5.2. ATTITUDES TO BDD IN RELATION TO EP PRACTICE

Attitudes towards BDD, particularly in relation to its relevance within EP practice, were measured within questionnaires and interviews. Following the training, questionnaire respondents were asked to what extent they expected to make use of information about BDD within their practice on a scale of 1-to-5 (see Table 5.4).

Table 5.4.

Extent to Which EPs Expect to Make Use of Information

Mean (Possible total = 5)	3.89
Standard Deviation	.82
Minimum	2
Maximum	5

Interviewees were first asked if they felt BDD was important and relevant to their practice. Thirteen of fifteen interviewees felt certain that it was, with a number of specificities provided. Three mentioned the importance of awareness of anything that impacts mental-health and well-being for CYP *(see QT4).* One described EPs as the *"GPs of the SEN world…it's important that we're able to…spot things whereby we could then signpost on"* (EP1).

Two interviewees cited the impact BDD can have on education, with one noting *"if obsessive-compulsive thoughts are difficult…to manage…that's going to impact on…how they're functioning…within friendships and educationally"* (EP14). The other mentioned *"our role is to be as holistic as possible…if body-image is part of that…young person's experience through school, or the wider world then of course it's worth considering"* (EP6). The same EP also noted *"school is often a magnifier of any anxieties…because of the social context…if a child is experiencing BDD, the environment in which we come into contact with them would be a place where it manifests"*, suggesting the school experience may even exacerbate BDD symptoms, making it *"really, very important"* to EP practice.

Two mentioned EPs being potentially the first to identify BDD. One felt *"it's very relevant to the EP role"* because *"we might be the first person they begin to voice that to"* (EP5) and another similarly mentioned that EPs are *"real frontline staff…it highlights to me a huge gap we could be filling…as a profession are remarkably…unskilled in talking about these things and yet so skilled in being able to help when…we do"* (EP8). One added *"school might be the place the concern is first raised…we might be the professionals that are in schools. It might not be something that goes straight to CAMHS"* (EP9).

Finally, one had noticed that *"it's become a much bigger thing that I am aware of with teenagers… this whole thing about their body"* (EP4), suggesting that body-image problems might be becoming more relevant to the EP role over time.

Interviewees were also asked if they felt the training had *changed* how relevant they felt BDD was to EP practice, to which eleven replied clearly that

it had done so. One said, *"it's made me think…this could be something I might have to be more aware of…because it is quite shameful…CYP are unlikely to disclose their symptoms unprompted"* (EP4), suggesting the training had highlighted a need for a more active and exploratory role in identifying certain needs. To highlight this, one EP mentioned having a body-image issue herself as a young person and still not considering it in her work: *"I used to skin pick really badly, so…why do I not think of that? I think…we need to be more aware of it...the training helped with that."* (EP7).

For one EP, the change was due to a sense that *"prior to the training, I probably wouldn't've thought this was our remit"* but that *"following the training, I feel much more confident…this is very much part of our role…this is something we can do, at that low level"* (EP8), suggesting a change in her perception of how far EPs can support needs like BDD. She also attributed this change to *"hearing it's something that's commonly misunderstood or missed by even mental-health professionals"* which *"made it more important…that we're involved",* which again echoes there being a gap for EPs to fill.

However, one EP mentioned that *"when you just did some training…it's more at the forefront of your mind…so I think that's more present"* (EP6), suggesting the change in how important BDD seems could be a product of how recent the training had been and that it might fade later. Three interviewees also attributed such a change to their complete lack of knowledge of BDD before the training *(see QT5)*.

Two EPs seemed uncertain that BDD was relevant to their practice, with one stating that BDD *"wouldn't be…central to my thinking…when I meet*

CYP… it's certainly not something that has come to the fore previously…and I've been working as an EP…for 15 years" (EP3), suggesting having not encountered BDD previously made her question its importance moving forward. Another EP echoed this: *"I haven't actually come across it…and I've been working as an EP for quite a few years"* (EP4).

However, one of these same EPs wondered whether *"perhaps in other contexts… particularly with teenagers…where you're…more involved with the assess-plan-do-review process, it will be something you might come across…so you might get a different response…for EPs in other contexts"* (EP3). She also saw the possibility that *"as people's awareness increases, it may…become more of an issue for EPs…but certainly currently, it's not something…that would be seen as part of the everyday work of an EP"* (EP3).

5.3. EPs' KNOWLEDGE OF BDD

5.3.1. Self-Reported Knowledge

Participants were asked to rate their knowledge of BDD before and after the training, on a scale of 1-to-10. Descriptive statistics are presented in Table 5.5. Wilcoxon signed-rank test indicated the post-training median was statistically significantly higher than the pre-training median ($Z= -10.93, p<.000$). 38 participants who gave scores at the 6-month follow-up were able to be matched with their pre-training scores. Although scores had lowered at the 6-month follow-up, the change from the pre-test score remained significant ($Z= -5.014, p<.001$).

Table 5.5.

Self-Reported Knowledge of BDD

	Pre-Training	Post-Training	6-Month Follow-up
Mean	2.69	6.98	5.63
Standard Deviation	1.84	1.22	1.22
Median	2	7	6
Minimum	0	2	2
Maximum	9	9	8

5.3.2. Objective Measure of Knowledge

To measure knowledge more objectively, questionnaire respondents were asked to answer a quiz about BDD that covered all information contained within the training (see Appendix D). The maximum score was 18. Descriptive statistics are presented in Table 5.6.

Table 5.6.

Scores on BDD Quiz

	Pre-Training	Post-Training	6-Month Follow-up
Mean (Raw score)	10.17	15.13	12.97
Median (Raw score)	9.7	15.73	13.15
Mean (% correct)	57	84	72
Median (% correct)	54	87	73
Standard Deviation	2.11	1.7	1.67
Minimum	4.75	6.25	9.25
Maximum	15.2	17.8	16.7

Looking at the histogram of scores showed a negative skew, which analysis showed to have a skewness statistic of -.544 (a score of 1 indicates no skew) (see Chart 5.1). As such, a Wilcoxon signed-rank test was used

instead of a t-test and found the difference between medians to be significant (Z=10.931, p<.000), so the null hypothesis of no difference was rejected.

Chart 5.1.

Skewness of Post-Training Quiz Score
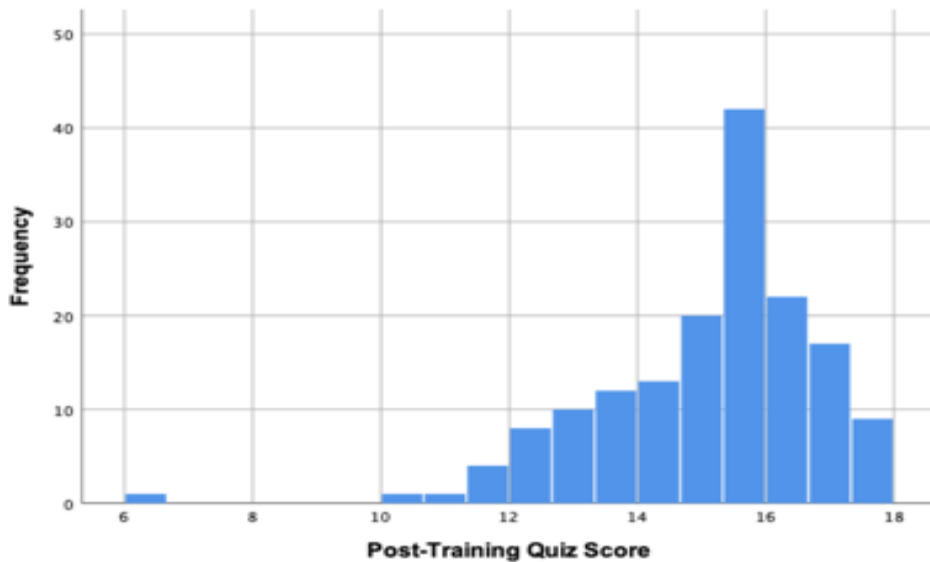
Scores were also compared between pre-training and 6-month follow-up questionnaires, to see if a significant increase was maintained. Only 33 respondents were able to be matched with their responses from the original questionnaire. For pre-training test scores, these particular respondents had a mean of 9.84, with a standard deviation of 2.3. A histogram of scores showed no obvious skewness and so a paired-samples t-test was used to compare means and found a significant difference (t(32) = -3.13, p<.001).

5.3.3. Correlation Between Subjective and Objective Knowledge

To have an indication of how accurate subjective self-reported measures of knowledge BDD might have been, these were correlated with objective scores on the BDD quiz. Spearman's non-parametric correlation coefficient was selected. The results are presented in Table 5.7. All correlations were positive, but as can be seen, only one correlation reached significance, that between pre-training self-reported ratings and pre-training quiz scores (rho=.23,p=.004). This is considered to be a relationship of moderate size according to Cohen's rules (Sawilowsky, 2009).

Table 5.7.

Correlations Between Subjective and Objective Scores

	Pre-Training	Post-Training	6-Month Follow-up
rho	.23	.08	.19
p	.004	3.14	.350

5.3.4. Prior Knowledge of BDD

Questionnaire respondents were asked for the number of children they had encountered with BDD and their years of experience as an EP. The results are presented in Table 5.8.

Table 5.8.

CYP w/BDD Encountered & Years Experience as an EP

	Number of CYP w/BDD encountered	**Years of experience as an EP**
Mean	1.06	7.59
Standard Deviation	2.73	8.22
Minimum	0	1
Maximum	20	33

These variables were also tested for correlations with pre-training self-reported ratings and quiz scores, to see if prior experience had influenced the results (it was not predicted that prior experience would affect results significantly *after* the training). Spearman's non-parametric correlation coefficient was selected. The results are presented in Tables 5.9 & 5.10. As can be seen, only one correlation reached significance, that between pre-training self-reported ratings and the number of young BDD-individuals previously encountered (rho=.26,p=.001), suggesting that exposure to BDD increased self-reported knowledge of the disorder, with a moderate effect size (.26) (Sawilowsky, 2009). Although objective quiz scores correlated more weakly with 'number of young BDD-individuals encountered', this was also a positive correlation, with a small effect size (.12). The correlation between both self-reported knowledge and 'years of experience as an EP' was actually negative, although this was a very weak correlation, as was the positive correlation between objective quiz scores and 'years of experience'.

Table 5.9.

Correlations Between Knowledge of BDD and Number of CYP w/BDD Encountered

	Self-Reported Knowledge	BDD Quiz Score
rho	.26	.12
p	<.001	.137

Table 5.10.

Correlations Between Knowledge and Years of Experience as an EP

	Self-Reported Knowledge	BDD Quiz Score
rho	-.047	.046
p	.768	.806

Interviewees were asked to expand on their prior knowledge of BDD. Five EPs expressed having essentially no knowledge of BDD whatsoever before the training *(see QT6).* Others had some superficial knowledge or "*the basics*" (EP4), such as that it involved *"dissatisfaction with appearance"* (EP10), *"self-perception…an all-encompassing persistent belief…a distortion…to how you might look"* (EP9) or that it "*links with obsessive thoughts…related to body-image…something that was inaccurate…an exaggerated perception"* (EP14). One EP had more specific knowledge of BDD, which stemmed from a personal experience: "*a lot of things were coming back to me as you were talking…so rather than being surprised, I was thinking 'Oh yeah, I remember that"* (EP7), suggesting that prior knowledge was refreshed by the training.

EPs were asked where they had learned what they already knew about BDD. Some mentioned "*a vague awareness from media"* (EP2), what they'd "*read in magazines…on the internet"* (EP8), or informal "*discussions with friends"* (EP14)*.* As mentioned, one EP had had a personal experience that

made her "*aware of the aspects of BDD that I knew about*" (EP7) and another had "*a friend with an eating disorder…conversations around that*" (EP9). Two had researched BDD, because they were "*interested in mental-health generally*" (EP10) or wanted to gain awareness of "*prevalent mental-health difficulties*" (EP13). Only two had gained awareness within their "*undergraduate psychology degree*" (EP13), although one said, "*we haven't covered it since then*" (EP10) and another said, "*it's something we receive very little input on in our doctoral training…perhaps there should be more of a focus on different disorders*" (EP14). One had found that BDD was covered "*partly in my training*" but noted that "*I was trained quite recently on the doctorate*" (EP6), suggesting this may be a recent development. Only two EPs had come across BDD in their casework, where it has "*come up a little bit…things like that*" (EP6), for one EP in both "*primary and secondary settings*" (EP13).

The questionnaires identified a few misconceptions about BDD (see Table 5.11). The true-or-false quiz also reflected some of these misconceptions. The statement with the lowest number of correct responses prior to the training pertained to BDD *not* relating to weight or body fat (36%). Elsewhere, 49% answered incorrectly that 80% of BDD-individuals are female and 30% answered incorrectly that BDD relates to gender. Following the training, these misconceptions were largely resolved, with correct response rates of 88%, 96% and 91% respectively. Interestingly, one statement remained relatively low in terms of correct response rates following the training ('BDD is *not* considered to be a more severe form of typical adolescent image-concern' changed from 49% to 65% following the training).

Table 5.11.

Misconceptions from Questionnaires

	Number of EPs
BDD relates to body shape or size	3
BDD is an eating disorder	2
People with BDD are deformed	1
BDD is a dissociative disorder	1
BDD is commonly comorbid with ASD	1

Within interviews, similar misconceptions were mentioned, such as "*I put it more closely related...to eating disorders…rather than with an OCD difficulty"* (EP14). Another mentioned a *"conflation of body and gender dysmorphia…I suppose I sort of merged the two"* but the training *"has made me think about that and separate it out"* (EP3). It should be noted that this EP still used the term 'gender dysmorphia' following the training, rather than the correct 'dysphoria', which suggests that the similar terminology may invite and perpetuate some of these misconceptions. Similarly, one EP said, *"I think possibly the term Body Dysmorphic Disorder makes you think that a lot of it is about weight" (EP14).* Another EP mentioned the ubiquity of people saying *"'Gosh, you've got body dysmorphia'…this throwaway comment that undermines the significance…perhaps you carry the stigma…you roll your eyes…as if they're just making a funny comment"* (EP10).

5.3.5. Information Most Useful and Relevant to Practice

Questionnaire respondents were asked an open-ended question about what information they deemed most useful and relevant to EP practice (See Table 5.12).

Table 5.12.

Information Deemed Most Useful Within Questionnaires

	Number of EPs
Raising general awareness of BDD	30
List of behaviours	30
Questions to ask CYP	22
Suggested ways EPs can support BDD	17
Things to avoid saying about BDD	13
Diagnostic criteria	12
Separating from gender dysphoria and eating disorders	9
Ways in which schools can support	5
Prevalence rate	4
Treatments	3
Statistics	3
Dispelling misconceptions	3
Lack of insight	2
Causes	2
Having BDD as a new hypothesis	2
Recent research	1
Distorted perception of sufferers	1
Neurological evidence	1
BDD relates to separate features	1

Interviewees were also asked about information they found particularly useful or relevant to their practice, as well as anything that had surprised them. Five mentioned the prevalence rate amongst adolescents, with one saying it *"surprised me"* (EP9) and one labelling it *"quite alarming"* (EP15). One compared it to *"the prevalence of ASD...we see so much ASD in our role…but there's so many other things…at that 1% or 2% level that we never come across, or we haven't been trained in"* (EP9). Similarly, another mentioned that *"you don't realize how prevalent it is…so again…that's awareness raising for us"* (EP7), suggesting this information may make them more vigilant for BDD in future.

One EP mentioned the *"fact it can…be something that males and females experience equally…that was something I didn't know…I might have*

made assumptions around that or schools may have" (EP11), suggesting that prior to the training, they may have discounted the possibility of males suffering with BDD.

Two EPs mentioned learning that BDD relates to "*a specific feature that person doesn't like"* (EP14), with one saying, *"this notion of it being body 'part' dysmorphia...I thought of it as…a whole-body thing and…that really clarified…the difference"* (EP9).

One EP was *"shocked"* by *"the levels of suicidal ideation and suicide amongst young people with BDD…that just brings home how important it is we're aware of this and how much we're exploring it and supporting young people around it"* (EP9).

Four EPs mentioned connecting BDD to OCD and finding it *"interesting that it's been reclassified…under the OCD-type umbrella. I can see how that fits"* (EP5). One felt that *"understanding it more as…an obsessive-compulsive type family of difficulties has helped frame it…that we're talking about those beliefs that we can start to have an impact with"* (EP8). This link lead one EP to see how "*it stems from anxiety…so the training helped me…conceptualise it"* (EP10). Others now saw how BDD might be *"pervasive all the time"* (EP9) by having it *"associated with something that could be a bit more obsessive…more of a preoccupation…the impact of somebody thinking about those things all the time"* (EP14).

Two EPs reflected on better understanding the lived experience of someone with BDD. One mentioned *"the young person…physically experiencing that difference…they really believe that's how they look…so they might not readily be telling anyone"* (EP9). Another said they were *"particularly*

interested in that perceptual issue…a lot of atypical behaviour is because of atypical sensory processing…it's time we were assessing in a more detailed way, rather than jumping into checklists and simple, single hypotheses…looking at a child's experience with the world and how they're taking information in" (EP1).

Two EPs mentioned the causes of BDD. One EP was *"surprised"* by *"this link to neurological activity…not being able to see the whole…focusing on finer detail"* (EP9). They continued "*I thought 'Gosh, that is so incredibly interesting'"*, whilst also reflecting *"you've got to be so careful around neuroscience…the conclusions we draw from it."* The same EP was also interested in how BDD *"is so influenced by the environment…the messages you're getting, how that changes…as young people grow up…exposure they might be having to social media…what their peers are saying or doing."* Similarly, another EP found it particularly relevant to hear about *"how it might present…some of the risk factors, that's something I'll carry forward…I think it's really valuable"* (EP11).

5.3.6. Implications of New Knowledge and Next Steps

Questionnaire respondents were asked what they expected to do with the new information they had acquired. (See Table 5.13).

Table 5.13.

How EPs Expect to Make Use of Training

	Number of EPs
Cascade training to schools	11
Share information with other EPs	8
Share information with other professionals	4
Sharing resources	3
Further reading	3
Including BDD as a hypothesis in casework	2
Including information in service leaflets	1
Looking at local offer for BDD	1
Seek further training in CBT	1

Interviewees were also asked how they expected to make use of information they had learned within the training. Nine of the EPs were caused to think back to past casework *(see QT7)* and reflect that they may have overlooked BDD, both professionally and within their personal lives *(Q7.5/Q7.12).* One EP reflected that the prevalence rate makes the possibility of having encountered BDD eminently likely *(Q7.9).* Another referred to comorbidities and behavioural signs and reflected on recent cases, which made them feel a *"need to get this into my practice…it's something that I can possibly follow up on" (Q7.2).* Two noted the common lack of insight and reflected that this might be the reason they had missed BDD previously *(Q7.1/Q7.14).* In the former case this involved a boy who *"checked"* in a mirror often and in the latter case, this involved a specific case of a pupil refusing to wear school uniform, so these reflections seem to have resulted from learning about the common behavioural signs of BDD. Three interviewees went as far as to reflect that past cases may have resulted in inappropriate courses of action, two of which involved diagnoses of autism due to obsessive behaviours and social difficulties that may have been better explained by BDD

(Q7.13/Q7.7/Q7.15). For one, it was known that their social difficulties stemmed from being *"concerned about their facial features"* (EP15).

The training caused two interviewees to reflect on having too narrow a focus within their practice. For one, the training had *"sparked an interest….as part of a broader uncomfortable sense that we…don't assess children's needs carefully enough…to get sufficiently detailed work"* (EP1). Similarly, the other wondered *"what else we're not considering…in terms of our basic knowledge of SEN...you get very pigeonholed…you get good at looking at symptoms…or how behaviours present and thinking 'Oh, this is ASD or this is whatever'…the way I group things together…and box things in…perhaps things aren't quite as simple as that."* (EP7).

Two EPs were caused to reflect on *current* casework, which is perhaps more encouraging given they were still able to address their concerns. In one case, it was the *"young person herself who said 'Look, I'm pretty sure I've got BDD.' She's been referred to CAMHS…but I wonder…if she hadn't said that would I have started to think BDD myself?"* (EP10). The other EP *"was very grateful for the presentation…because I had...one young person in particular…we had discussed within our team…whose presentation I felt would…have fitted a BDD profile…I wouldn't have gone down that avenue previously…she acquired a prolonged grooming ritual…that prevented her from getting into school on time, and everyone was…veering down that behaviour route of…attendance and lateness"* (EP11). Again, learning of potential behavioural signs, such as extensive grooming and school lateness or refusal, seems to have prompted this reflection.

A common next step interviewees planned to take was to 'cascade' the training information to others, which was also the most common response amongst questionnaire respondents (7%). Four intended to pass information onto their wider EP team *(see QT8),* either in team meetings *(Q8.1/Q8.13/Q8.10/Q8.11),* in supervision *(Q8.2),* or both *(Q8.6).* One EP's team had already incorporated the training into their discussion of a young person *(Q8.11).*

Nine interviewees planned to pass information on to schools, either in the form of training or more informal information sharing *(see QT9).* Three mentioned this somewhat generally *(Q9.2/Q9.4/Q9.10)* and one specified this would be informal awareness raising, rather than a training session *(Q9.7).* Some EPs also felt that training might only be necessary if a case of BDD had already been identified within a school *(Q9.11),* but others mentioned preventative or *"earlier"* work as well *(Q9.5).* Three EPs mentioned that the warning signs of BDD would be the most important information to pass on to schools *(Q9.7/Q9.9/Q9.5).* One related this to the hidden and subtle nature of signs of BDD *(Q9.13),* whilst another mentioned that this would enable schools to refer onwards to EPs or directly to CAMHS *(Q9.9).*

Four interviewees mentioned refreshing and consolidating the information contained within the training itself. One said they would *"revisit the slides and familiarise myself…with the diagnostic criteria"* (EP10). Two mentioned that if BDD came up within their casework, they would *"go back to the comfort of your slides…to actually ask those questions and explore that a little bit"* (EP5) and to *"inform the sort of questions I asked and my thinking*

around it" (EP3). One EP's aim was to use the slides to *"make a document"* for herself that she could refer to later (EP2).

Five EPs mentioned seeking further information on BDD. Two mentioned taking further training, one specifically *"on the evidence-base of interventions"* (EP6) and another saying, *"some follow-up training would be helpful...maybe case-study based, to help us start to identify where this might be an issue…to think about how we would approach a case"* (EP10). Four mentioned further reading, not just about BDD but *"other stuff"* (EP6) that is related, such as *"a book I'm reading at the moment about educating females about their bodies"* (EP9). One said, *"I do intend to actually read more about it…because I do think…nobody really considers body dysmorphia"* (EP12) and another had already *"bought the book the next day* [mentioned within the training]…*so I briefly looked through that…and I have gone on to the website [the BDD Foundation]"* (EP15). They also noted that *"sometimes I go to CPD events and the slides and everything stay on a shelf…but I said 'No, I'm actually going to do something about this and have a little read around this'"*, suggesting the training prompted further learning in a way that other training had not.

5.3.7. Limitations of New Knowledge

A number of EPs mentioned ways in which the information they had learned may be limited. Some EPs were still unsure of certain details of BDD. Although it had been covered in the training, one EP asked *"Does it affect girls more than boys? What are the stats around it? I imagine…in our schools,*

it…wouldn't be likely that there'd be lots of kids in one school with it" (EP10), which suggests the almost even gender ratio and high prevalence rate may not have been communicated clearly.

Five EPs expressed having forgotten some of the information that had been fresh in their minds immediately after the training, when filling out questionnaires *(see QT10).* Two had referred to notes immediately before the interview *(Q10.2;Q10.9),* suggesting the information they were able to recall had been recently refreshed and may not represent what had actually been remembered, which affirms the importance of the follow-up questionnaire in terms of measuring long-term retention.

Elsewhere, EPs mentioned referring back to the training as and when it was needed *(see QT11).* This may suggest that although they haven't *"actually got the knowledge in my head" (Q11.3)* and they *"might not remember now off the cuff" (Q11.7),* a real case would allow information to *"bed in" (Q11.5)* or *"ignite the flame again" (Q11.12).* Therefore, forgetting specific information may not be so important as long as there has been *"consciousness raising" (Q11.3),* meaning that details are less important than general awareness. Although one EP still felt that she'd like to consolidate her knowledge before a case arises *(Q11.12),* another felt that returning to information when it is required may be the only realistic way to operate as an EP, given the vast range of specific needs professionals may be presented with *(Q11.9).*

5.3.8. Next Steps Already Taken with Knowledge of BDD

68 EPs responded to the follow-up questionnaire that was sent out approximately 6 months after the training sessions. They were asked what next steps they had already taken around BDD, to see to what extent the proposed actions mentioned above had already been put into practice. 55% of respondents had followed up the training with further actions (see Table 5.14).

Table 5.14.

Next Steps Taken After 6 Months

	Number of EPs
Further reading	15
Shared information with EP team	10
Discussion with colleagues (informal/supervision)	8
Cascaded information within training to schools	5
Reread training slides	3
Shared or signposted staff to BDD resources	2
Thought about how to identify and support BDD in schools	2
Included in teaching to TEPs	1
Watched documentaries about BDD	1
Looked for signs of BDD in SEN panel paperwork	1

5.4. EPs' ABILITY TO IDENTIFY BDD

5.4.1. Self-Reported Ability to Identify BDD

Participants were asked to rate their own ability to identify BDD before and after the training, on a scale of 1-to-10. Descriptive statistics are presented in Table 5.15. A Wilcoxon signed-rank test indicated that the post-training

median was statistically significantly higher than the pre-training median (Z= -10.820, p<.000). For 38 participants, it was also possible to compare pre-training and 6-month follow-up scores, with this difference remaining significant (Z= -4.997,p<.001).

Table 5.15.

Self-Reported Ability to Identify BDD

	Pre-Training	Post-Training	6-Month Follow-up
Mean	2.31	6.36	5.39
Standard Deviation	1.73	1.42	1.63
Median	2	7	6
Minimum	0	2	2
Maximum	7	9	10

5.4.2. Information Most Useful for Identification of BDD

Interviewees were asked how they felt the training had impacted on their ability to identify BDD and in what specific ways. As was touched on previously, a large proportion felt that simply having general awareness of BDD would make them more vigilant *(see QT12).* Three mentioned now having BDD as an additional hypothesis to draw on within casework *(Q12.2/Q12.3/Q12.7).* Four mentioned common behavioural signs, such as school-refusal or self-harm, and seeing a potential for considering or identifying BDD when they next encounter these signs *(Q12.5/Q12.13/Q12.10).* One EP mentioned that *"having a name to put"* to certain difficulties would help with identification *(Q12.10).*

Five interviewees specifically mentioned potentially having entirely *different* hypotheses about certain BDD symptoms following the training *(see*

QT13). For one, this was in relation to CYP presenting with *"anxiety, low mood"* and *"social phobia" (Q13.8).* For two others, this was in relation to *"lateness" (Q13.11)* and *"school-refusal" (Q13.12),* which for the former would previously have most often led to thinking around *"emotionally-based school avoidance"* more generally, whilst the latter similarly suggested that the underlying *cause* of anxiety is often missed. Two EPs mentioned autism and the *"crossovers…with social anxiety" (Q13.15)* that can manifest with BDD, with another suggesting that our *"binary view"* of autism *(Q13.1)* means that many *"atypical behaviours"* are perhaps too readily labelled 'autistic'.

Eleven interviewees mentioned feeling better equipped to recognise the signs and behaviours that can be indicative of BDD *(see QT14),* particularly *"checking"* and *"disguising behaviours" (Q14.6/Q14.8)* and *"avoiding social contact" (Q14.13).* Three mentioned that warning signs could now be identified indirectly by asking teaching staff about what they had already observed *(Q14.8/Q14.7/Q14.9),* or alternatively, recognising certain signs within observations would now lead one EP to *"ask more questions"* to teaching staff *(Q14.11).* One noted that most of the warning signs are not exclusive to BDD, but *"if the child was showing several…it would now lead me more to considering BDD" (Q14.13).* One also highlighted the potential for *"hiding the anxieties" (Q14.5),* making recognising signs all the more important, whilst another similarly mentioned that they would previously have looked for *"more obvious markers" (Q14.14),* suggesting they would now be looking closely for more subtle ones.

Three interviewees referred to learning about the common lack of insight *(see QT15).* One talked about the *"discrepancy between what they are*

perceiving…and what maybe I am seeing more objectively from the outside" which would lead them to being *"really sensitive but open…with the sorts of questions I'm asking" (Q15.8).* One mentioned the *"genuine belief"* people with BDD may have that means *"this is something young people may not be expressing" (Q15.9).* Similarly, one said they would now *"maybe ask more questions if I heard small comments…whereas before, I probably would have been waiting…for them to essentially tell me"* (*Q15.14*).

Ten interviewees mentioned now having a better idea of how to talk to a young person about BDD and what to ask if they wished to explore it further *(see QT16).* Four mentioned asking about appearance concern when they hadn't previously (*Q16.2/Q16.4/Q16.6/Q16.7*), but three spoke of *altering* the ways in which they already explored appearance anxiety, perhaps in greater depth following the training *(Q16.3/Q16.9/Q16.14).* One EP had even been caused to change her opinion on whether asking about things like BDD *"was necessarily part of the EP role",* now deciding that it could be *(Q16.5).*

Two interviewees mentioned being better able to separate BDD from normal appearance concern, something that can be difficult, especially within teenage populations. One noted that *"normal teenagers do quite a lot of preening"* but now saw *"the fine line…when that becomes dysmorphia compared with what you might normally do…I suppose it's the amount of distress"* (EP3). The other said *"I will now be thinking 'Are people changing their appearance just because it's…almost a fashionable thing or is it because their appearance is causing them this intense level of anxiety? Is their appearance interfering with their daily functioning?'" (*EP4).

Four interviewees mentioned now being better able separate BDD from eating disorders *(see QT17),* with one admitting that she may have conflated the two previously and *"miscategorised"* BDD *(Q17.11).* In terms of tackling other common misconceptions that have already been touched on, one EP mentioned that they "*when it was separated out…the bit about trans issues…I had an image of what it was…now I can see how it's distinctly different"* (EP6). Similarly, one interviewee mentioned they would now be more sensitive to potential BDD in males: "*the prevalence…in males…that's one of the big stereotypes…I would have leant towards noticing it in females more. So it was helpful to have that reminded...it might just present slightly differently"* (EP8).

5.4.3. EP Role in Identifying BDD and Potential Further Actions

Aside from their *ability* to identify BDD, interviewees were also asked *how* this might manifest within their practice, both in terms of what they felt was possible and also how they saw their role as EPs in relation to identifying BDD. In terms of to what extent identifying BDD *should* be a part of the EP role, EPs expressed slightly differing opinions. For example, one was quite emphatic that "*our role is to identify…and also support in identifying or questioning…about anything, that a), has an impact on a child's learning and progress, and b), has an impact on their emotional well-being"* (EP14). One was slightly more cautious, saying "*we are involved in quite a lot of identification"* but emphasised that "*we may not make that final diagnosis, but we are expected to be alert to those things"* (EP4). One EP was more non-committal and said, "*assess it, or identify…wouldn't be the right term, but I*

would consider it and then read up about it, it would be something that might come into my head, as an issue or as a presentation…rather than not doing so" (EP12). She went to say "*I think it should be more within our remit…because otherwise…nobody's going to do it are they? So I suppose it is something that should be what we do",* suggesting that although it may not currently be a part of her role, her view is that it perhaps should be.

In terms of actions and next steps towards identification of BDD, EPs expressed a wide range of possibilities that involved work with CYP, their parents and schools. Firstly, four mentioned they would be likely to explore BDD further with CYP themselves *(see QT18),* with one emphasising that this would need to be a *"sensitive conversation" (Q18.13).*

If BDD was suspected, eight interviewees mentioned sharing their hypothesis with schools and parents and exploring it further, either informally or within consultations *(see QT19).* One mentioned doing this *"more actively" (Q19.2)* and another mentioned having *"a wider range of questions"* following the training *(Q19.3).* One would refer to the *"behaviour checklist…checking out things that fit that, things that don't"* but seemed hesitant to use the term BDD, at least at first, noting that they would not *"say it explicitly" (Q19.7).* One mentioned *"going away"* following a consultation to do more research, before returning to explore further, adding they *"wouldn't have done that before" (Q19.12).* However, one EP raised a potential dilemma in terms of *"intruding on the child's privacy" (Q19.13)* and another mentioned the importance of asking the child's permission to *"talk with parents if they're under 16" (Q19.5),* given that following this point, the decision of what to do would lie with the young person themselves.

Three interviewees mentioned that their role would be limited to collecting and providing *"descriptive evidence…that somebody else can reference"* which they would *"include within developmental history"*, referencing a common section within a written EP report (EP1). This would relate to identification *"in the sense of, this may be something that…ideally is explored further"*, again giving the sense that it would be another professional's role to do so. Similarly, another EP said, *"it's sowing a seed and sharing information with other practitioners and professionals, rather than…being the person to actually diagnose"* (EP15).

Other EPs elaborated on the specific way in which EPs collate information from a holistic perspective. One talked about providing *"further evidence that other people might be considering in terms of the broader picture"* that would *"come out as part of the information you either observed or…the result of the questions you might ask"*, adding that *"we have a perspective to bring…we often see children and young people in a context that medical practitioners don't…it's that triangulation of data because…the young person, the parents, the teachers all tell you things from their perspective and you perhaps have a different perspective…which you can contribute"* (EP3). One EP specified the nature of the EP's unique perspective as *"interactionists…we take in all the factors…social, cultural, biological…educative, the impact at different levels, individual, group and systemic levels, and we know a lot about anxiety…how it affects individuals"* (EP15).

Although most EPs emphasised they would not be the one to 'identify' BDD in the sense of a diagnosis, two felt this might be a possibility. One

thought they *"might be involved in some sort of diagnostic-type pathway or…you may be asked questions about it directly, or…asked to contribute something directly"* (EP3), again suggesting this would mainly involve providing evidence, rather than contributing to a final decision. On the other hand, another EP had had a role *"sitting on the diagnostic panel for autism"* (EP15), so therefore felt there could hypothetically be potential to be involved in diagnosis of BDD more directly. However, in his service, *"we don't have a role anymore because we became a commissioned traded service and nobody wanted to pay for it",* suggesting that this possibility has only become more remote with time (traded services refers to a legislative change that allowed schools more control over their own budgets) (UK Government, 2011). He also emphasised *"the best assessments, like autism…when they're done well is because it's multi-professional."*

5.4.4. Potential Barriers to EPs' Identification of BDD

Interviewees were asked whether they anticipated any barriers to carrying out the role they saw themselves having in identifying BDD. Although the interviewer used the term 'identify', four EPs answered with reference to 'diagnosis', stating this is not something they would be involved with *(see QT20).* The words of one EP highlight this apparent conflation between 'identifying' and 'diagnosing': having previously asserted that if they were *"suspecting BDD may be the issue…I would contribute by way of descriptive evidence"* (EP1), which could arguably be seen as identification of BDD, they also later said *"I wouldn't actually see it as my role to identify it."*

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This overlap between 'identifying' and 'diagnosing' may relate to the issue of labelling, which five EPs mentioned *(see QT21).* For one, this was an issue of consent, as children *"have not asked for"* the label they might be given (*Q21.1*). Another described labels as imprecise and inaccurate, that people *"misuse labels, misattribute labels"* and that they can come *"to define the person"* (*Q21.12*). Similarly, one questionnaire respondent saw labels as medicalising *"a response to our psychologically challenging environment"*. As was described previously and mentioned by two interviewees here (*Q21.12/Q21.15*), a number of EPs see their role as to *"describe behaviours"* or *"look for need"*, without using generic terms. This raises the question of to what extent an aversion to labelling might prevent some EPs from mentioning the needs that constitute BDD at all. For example, the same EP who felt her role was to *"describe behaviours"* also stated that *"I wouldn't…go and write in a report that I thought that was an issue"* (EP12).

Three interviewees gave the other side of the argument regarding the merit of labelling or referring to BDD by its clinical name. One mentioned using the term 'BDD' if "*someone had…been to CAMHS and had that label, I guess that might help me unpick a little bit about 'Okay, what are we working with?'"* (EP6), whilst also mentioning "*the relief of having a label to attach to it… the weight lifted by having it named…that made me think…we're typically nondiagnostic and I wouldn't naturally bring to the table a label, but if it would be helpful for someone to have what they're feeling and experiencing labelled…then maybe I would facilitate that by referring with…this is what I'm thinking."* Another EP felt they might use the term if they were certain these issues were at play, suggesting it would be difficult to talk about it otherwise:

"If we were thinking along those lines…we could either flag it up with parents or we could actually name it specifically with the SENCOs and parents and see what their view was on…if we asked enough questions to be pretty sure...I suppose in order to come up with strategies and things that are helpful, you do put things into boxes" (EP7). Similarly, another EP said, *"In order for you to meet needs sometimes you need to talk about labels, so you have to raise awareness…a lot my EP colleagues would say, we don't diagnose…we want to remove ourselves from labels, whereas I'm aware of the benefits and risks…with labels"* (EP15). Even one EP who said emphatically *"I don't like labels"* also added that "*the concept of body dysmorphia is maybe under acknowledged, and therefore, a label might be helpful to differentiate"* (EP12).

Aside from perceptions of the EP role, there were a number of more practical barriers to identification mentioned by interviewees. Five felt that BDD might be too hidden for them to identify *(see QT22),* with one EP relating this to signs being "*less outwardly obvious"* (*Q22.10*). Two mentioned that the associated behaviours, such as going to the gym and being *"obsessed with appearance"* (*Q22.7*) or *"plastic surgery and changing parts of the body"* (*Q22.4),* are certainly not exclusive to BDD-individuals. Two EPs also mentioned that BDD is not something CYP *"voice to others",* which makes it all the more hidden *(Q22.5/Q22.12).*

Although the training covered differences between gender dysphoria and BDD, two EPs mentioned the difficulty with separating the two, given that they both involve anxiety about appearance. One said, *"it may be…quite tricky unpicking the two…I suppose, it depends on…which is the greatest issue"* (EP3). The other said *"I don't think everything is always*

discrete…sometimes…where people have had issues with their body that link with their gender…sometimes elements can interact as well" (EP6).

Three EPs mentioned not having long-term contact with CYP would make identification difficult (see *QT23*). One mentioned that *"we get a very limited opportunity to talk to them"* (*Q23.3*) and another emphasised the need to *"build a relationship…for them to trust you to disclose anything"* (Q23.4), which highlights how this lack of familiarity could compound the difficulty CYP already have with disclosing their symptoms.

Of course, schools *do* have the long-term contact with CYP that could resolve the issues described above. However, four EPs felt unsure that schools themselves would be able to notice the signs either *(see QT24).* One mentioned that if BDD isn't *"having much of an impact on their behaviour or their learning",* then schools are unlikely to notice the more hidden symptoms *(Q24.6).* One mentioned that school-refusal could be more indicative of a concern *(Q24.3)* but another EP referenced a case where this had occurred and noted that "*she wasn't in enough for them to really know her very well"* (EP10). Another referenced a case she had heard about from a colleague following the training, where the school had been dismissive of a potential case of BDD and passed it off as *"typical teenage vanity"* (EP11).

Four EPs mentioned that even if schools *were* to identify BDD, they would be unlikely to refer this to an EP in isolation. One said *"our focus is on things that affect them in school…so they* [the school] *would probably be coming to us for another reason…they're struggling with the work or…challenging behaviour or withdrawn...I don't think it would be 'We think this child's got BDD'"* (EP7), although she did see potential *"where it is so*

significant that it's impacting on social-emotional skills and mental-health, I think that would come to us." Another EP used the example of *"a significant drop in their grades"* for a school to refer a young person, and that even then *"I'm not sure that will be the first thing that they will be thinking about",* going on to suggest that *"children who…are within the autistic spectrum, or have difficulties managing their emotional regulation….are other presenting difficulties that I think would subsume or hide…more subtle things to do with…body-image"* (EP3), suggesting that more conspicuous and well-understood needs will take precedence over the subtleties of BDD. Similarly, another EP had found that one young person, who was *"one of the most complex young people I've heard of…the school weren't even concerned about her… because she's not a problem in school"* (EP10). The school had only referred her when she stopped attending and the EP added *"I don't think they had a clue that she's got…mental-health difficulties…so I suppose that was a concern for me…these difficulties can be so hidden…we're relying on people knowing about the issue to refer to us."* Finally, one EP felt that due to working within *"an acutely deprived borough…those sorts of needs wouldn't always get prioritised for intervention because…it's around how much of a problem it is for the school, rather than the person"* (EP6).

5.4.5. Next Steps Already Taken in Terms of Identification

Two interviewees had already begun to incorporate questioning about BDD into their practice *(see QT25).* One had inquired about the extent of checking, using the diagnostic criteria to think about the level of need

(*Q25.10*). The other described a case in detail, where a child had been suspected of having *"autism or PDA"* and apparent social anxiety (*Q25.15*). With reference to disguising behaviours (*"covering up his face"*) and the potential for *"patchy school attendance"* with BDD, he raised it as a potential that the school could then *"unpick"* themselves, something he *"wouldn't have even asked"* prior to the training, adding "*I will follow it up with the SENCO…they're going to go away and have a little think, a little read around it.*"

47% of respondents to the 6-month follow-up questionnaire had considered that BDD might be an issue for a young person since the training. They were asked what had caused them to suspect BDD (see Table 5.16).

Table 5.16.

EPs' Reasons for Suspecting BDD

	Number of EPs
Referred to diagnostic criteria	15
Behavioural signs mentioned generally	10
Excessive selfies	8
Grooming rituals	5
Lack of insight	3
High distractability	2
Young person disclosed	2
Young person focusing on appearance	2
Young person focusing on individual features	1
Considered common comorbidities	1
High prevalence rate	1

They were also asked what their next steps were. Responses that related to exploring their hypothesis further are presented in Table 15.17.

Table 5.17.

EPs' Next Steps in Exploring Hypothesis

	Number of EPs
Referred back to training materials	7
Discussed in consultation	5
Discussion w/schools	4
Further reading	4
Discussion w/parents	3
Discussion w/young person	3
Incorporated sensitive talk about BDD	2
Multi-agency approach	2
Discussion with colleagues	2
Considered severity in relation to typical concern	1

5.5. EP'S ABILITY TO SUPPORT BDD

5.5.1. Self-Reported Ability to Support BDD

Questionnaire participants were asked to rate their ability to support BDD before and after the training, on a scale of 1-to-10. Descriptive statistics are presented in Table 15.18. A Wilcoxon signed-rank test indicated that the post-training median was statistically significantly higher than the pre-training median ($Z = -10.651$, $p<.000$). When comparing pre-training and 6-month follow-up scores with the 38 participants this was possible for, this difference remained significant ($Z= -5.085, p<.001$).

Table 5.18.

Self-Reported Ability to Support BDD

	Pre-Training	Post-Training	6-Month Follow-up
Mean	2.56	5.68	5.17
Standard Deviation	1.69	1.51	1.34
Median	2	6	5
Minimum	0	2	2
Maximum	8	9	8

5.5.2. Information Most Useful for Supporting BDD

Interviewees were asked what elements of the training had resulted in the change in their perceived ability to support BDD. Seven mentioned knowledge of the evidence-based interventions for BDD *(see QT26).* One said this would allow them to *"recommend [an] evidence-based approach" (Q26.5)* but implied they would be unlikely to deliver it themselves. One might have considered CBT anyway, but now welcomed knowing *"it's evidence-based"* and wondered *"what actually can we do that contributes to that?" (Q26.7).* Finally, one EP felt it was *"reassuring"* to know *"what's actually available and what should be available for that young person" (Q26.14).*

Three EPs also mentioned that the training had equipped them with *"sensitive questioning"* (EP4) that allowed them to *"frame questions in a way that's safe, that's not inappropriate"* (EP11), in reference to the section of the training that covered things to *avoid* saying to young BDD-individuals, given that positive comments can be triggering also. One specifically mentioned *"not jumping to reassurance because that would basically be your human instinct"* (EP6).

5.5.3. EP Role in Supporting BDD and Potential Further Actions

Within questionnaires, EPs were asked how they intended to support BDD. They were given options to choose from that were predicted to be common answers: direct work (e.g., therapeutic intervention), referral to other

services and indirect work (e.g., consultations and systemic work). There was also an option to provide additional ways to support BDD. (See Table 5.19).

Table 5.19.

EPs' Next Steps in Terms of Supporting BDD

	Number of EPs
Indirect work (consultations, systemic work)	146 (91%)
Referral to other services	144 (90%)
Direct therapeutic work	48 (30%)
Providing support for parents	1
Including advice in a report	1
Multi-disciplinary work	1

Although all interviewees replied in the affirmative that part of the EP role should be to support BDD, they interpreted the concept of 'support' in a number of ways. A large proportion felt they could offer direct support for BDD. For eight EPs, this might involve using CBT which as we have seen, is currently the most well-researched evidence-based treatment for BDD *(see QT27).* However, not all were fully CBT-trained as of yet *(Q27.5)*. Two EPs added the caveat that CBT would only be possible if *"so many sessions" (Q27.4)* allowed them to *"work with a child for that long" (Q27.6)*.

Three interviewees mentioned cognitive behavioural *approaches (see QT28),* rather than CBT *"in its truest form" (Q28.7)*. One mentioned working to change *"core beliefs"* and *"dysfunctional thought patterns" (Q28.8)* and described feeling more confident now that she understood BDD could be treated this way. One was more hesitant, saying *"there's a limit to what we can do",* but did see scope for using *"cognitive behavioural approaches" (Q28.14).*

There were a few more approaches that interviewees mentioned in terms of direct support. One EP mentioned using an approach based on

personal construct psychology: *"I was thinking about the Ideal-Self drawing, that could be a really helpful tool"* (EP9) (Moran, 2001). This was felt to be *"a more non-threatening way than going straight in with these questions."* In this way, she felt that *"using more generic tools"* would allow BDD to be explored without recourse to explicit questioning.

Another interviewee mentioned *"lots of exploration through narrative work and thinking about 'What is the story you tell about this part of your body, how could you shift that narrative to have a more positive perception of yourself?'"* (EP6). This related specifically to *"body neutrality stuff…that really is a helpful concept…to be promoting within schools, to be having conversations about with students."* She related this to CBT in that the aim would be to realign the young person's thoughts to be less focused on their appearance, rather than attempting to change their appearance in any way. She saw herself *"helping them to shift the perception of…how we feel about the situation if we can't change it…the idea that your body is this kind of vessel and…it will be different in different stages in your life…for young people to have that message much earlier on…your body goes on a journey with you, it's not necessarily you, it's just there."*

Three interviewees mentioned finding ways to access the voice of the child would be a contribution they could make *(see QT29).* For all three, this would be with a view to achieving a *"co-construction of solutions" (Q29.11),* in terms of what would help *"make the time…in school as positive as possible" (Q29.14)* and what *"adaptations…amendments and differences need to happen in the provision in order to better meet their needs" (Q29.15).*

Two interviewees mentioned taking a psycho-educative approach with CYP, which the first described by saying "*working with CYP...to help them understand the diagnosis…what their difficulties are*" (EP10). The other suggested saying to a young person "*we've got some level of neurological explanation, I think what reassurance for a young person…to hear, rather than…negative stereotypes or…stigmatising comments…being vain or…it's a problem with your personality and who you are…to actually have that biological…explanation. I think that could be really empowering and freeing for them*" (EP9). This reflects a view that neuroscientific evidence may help CYP separate their sense of self from the appearance anxiety they are experiencing.

Finally, on an individual basis, one EP felt they could offer "*self-esteem work*" (EP7) and another mentioned taking "*a person-centred approach to supporting their school experience and…their inclusion, in whatever way that would manifest*" (EP11).

One EP mentioned working directly, but at the group level in a preventative capacity. They said "*there'd be a lot of children in the school who would possibly fit criteria for BDD and…I'm sure there's many more who would be insecure in their physical self…so you have a target group of students, possibly running small intervention groups…on a graduated approach rather than necessarily those just at the diagnosable end*" (EP6), suggesting that focusing on individual cases disregards preventative work that could keep BDD from reaching the stage where a referral is necessary. Another EP continued this thought about preventative work and felt that "*if we were able to do more of that, the pressure on CAMHS could be…reduced, if we*

were…coming in at a lower level of need, we could really be preventing things from escalating" (EP9). Preventing escalation was mentioned by one other EP: *"early intervention and prevention, in general, should be more of our role, because…if certain things are in place, it will be less likely to escalate…in school situations"* (EP12).

A number of EPs indirect or systemic support, meaning work that is not conducted with the young person themselves, instead incorporating other members of a family or working across a school setting and perhaps beyond. Three EPs mentioned advocating for young BDD-individuals with families and schools *(see QT30).* One said the purpose would be *"giving the autonomy and control to the young person…to communicate their needs…what they'd like to call it…which labels would they like to use or not use" (Q30.9).* Another wanted to help adults *"be in their shoes a little bit more"* to ensure that any *"amendments and differences that need to happen in the provision in order to better meet their needs" (Q30.15)* were made. One noted this would be *"especially at secondary school",* where CYP begin to develop the agency to *"know what they want themselves" (Q30.14).*

Two interviewees mentioned working with parents, with one focusing on *"how to repair their relationship and their attachment…helping parents understand how to support the young person"* (EP10). The other similarly mentioned helping parents to understand their child's needs but added *"I suppose it depends where the parent was in terms of their knowledge and acceptance of that…how things were going at home"* (EP14).

Four EPs mentioned preparing schools to support CYP who might have BDD *(see QT31).* Two mentioned *"providing advice"* or *"helping school staff"*

to plan support within consultations *(Q31.3/Q31.9),* whilst another similarly spoke of *"coming up with strategies"* with schools *(Q31.14).* One EP went so far as to suggest that school staff could be trained to *"use the CBT model"* to think about *"how you might behave differently or how you might think differently" (Q31.7).*

Four interviewees mentioned using psychoeducation to change the school's perspective on BDD and similar issues *(see QT32).* One mentioned *"trying to create more empathy"* quite generally *(Q32.11),* but the other three mentioned specific or potential incidents where *"certain behaviours…could be misunderstood and therefore not tolerated"* by staff, or *"just put down to general anxiety" (Q32.12).* One mentioned the importance of including *"discussions with senior management staff" (Q32.7)* in terms of creating top-down change. One mentioned a real case they had encountered, where faced with such a misunderstanding, a young person had been more likely to avoid school altogether, creating a need for more *"understanding that a young person isn't being defiant or bad or rude…these are all the things that they're dealing with in their head*" (Q32.14).*

Two interviewees mentioned recommending interventions within their written reports. One said she would *"put it in his report...a mixture of CBT-type approaches and the regular exposure sort of approaches as well"* but also emphasised this would be *"no more than at the level of awareness because I won't have special responsibility for delivering any therapy"* (EP1). The other said *"because the evidence-base is…strong for supporting young people with CBT who have BDD…we could write it into EHC advice, and then it could be delivered that way, they won't be able to wriggle out of it"* (EP10), referencing

the legally binding nature of education, health and care plan (EHCP) documents (UK Government, 2015). However, she also added: *"But that's a bit contentious…in our service, we're currently figuring out…when an intervention like CBT is a requirement and when it would just be quite useful"*, suggesting that this might not currently be a common occurrence.

Twelve EPs mentioned supporting BDD through referral to other services *(see QT33).* Two mentioned signposting somewhat generally to *"someone who could do some more in-depth work" (Q33.4)* or *"the right kind of services" (Q33.14).* Two mentioned a referral to the GP *(Q33.7/Q33.11)* and six mentioned referral to CAMHS *(Q33.11-Q33.1).* Two implied that referral would most likely be the most common course of action: *"BDD would typically be passed over to CAMHS" (Q33.10)* and *"my gut feeling is that we would refer on to our local CAMHS" (Q33.13).* One EP went further and said they *"would do no more than signposting to other services" (Q33.1).* One EP felt they *"wouldn't necessarily have referred on to mental-health services before"* the training *(Q33.6).* As well as other professionals, two EPs mentioned signposting to *"websites" (Q33.2)* and *"sources of information" (Q33.3).*

Following referral, four interviewees mentioned following up with the other professionals involved to collaborate *(see QT34).* One said they would be *"checking out their knowledge* [CAMHS]*"* to make sure they understand the implications of BDD. One mentioned a complementary approach of *"supporting other aspects"* rather than "*the intense therapy"* CAMHS would deliver *(Q34.9).* One mentioned *"sharing some information"* to help *"other professionals think about the social care aspect" (Q34.10).* Finally, one cited EPs' *"knowledge of school systems and child development"* to support work

around mental-health that they currently see as "*dominated by clinical psychologists*" *(Q34.14).*

5.5.4. Potential Barriers to EP Involvement with Support of BDD

Interviewees were asked if they envisaged any barriers to supporting BDD, in order to fully examine what may occur within EP practice in real terms. Six mentioned that the direct therapeutic work many saw as a possibility was not currently a common occurrence in EP practice *(see QT35).* One noted direct therapeutic work used to be more a part of the EP role but hadn't happened for "*a really long time*" *(Q35.2),* whilst another was disappointed by the "*move further away from doing individual work…I went into educational psychology thinking there will be a real balance between being able to do that individual therapeutic work and affecting the systems around the young person*" *(Q35.8).*

Aside from whether direct therapeutic work *can* be a part of the EP role, two interviewees questioned whether it *should* be. One was firm in saying that "*I don't think it would be our role to be doing that intense level of therapeutic support*" (EP9). For another EP, although her own opinion was that therapeutic support was "*hugely…part of our role*" she had noticed that this "*is not a common view…some people are very much in that systemic place and don't see that as a helpful way…to market ourselves*" (EP8). She saw something of a split amongst EPs, in that "*there's always this drive towards getting clinical psychology and educational psychology more in line, but then resistance to that as well and seeing them as very distinct*". She felt that "*some people are*

not comfortable to do that level of work and there's a whole thin layer of argument around it not being our role, but actually it probably comes down a lot to…individual EPs not feeling comfortable with that type of work." It is perhaps relevant to note that this EP previously worked as a *"mental-health support worker."*

In terms of the discomfort EPs may have about delivering therapeutic intervention mentioned above, nine interviewees cited limits to their own competence as a barrier *(see QT36).* Two mentioned not feeling confident enough to deliver therapeutic interventions *(Q36.10/Q36.11)* whilst one mentioned feeling *"nervous"* about the idea *(Q36.2).* Another recalled knowing *"a psychiatrist who specialized in treatment of anorexic girls…in the end, she felt like she was being burned out because it was so demanding, so complex, and she was a psychiatrist…she's spent years training in it"* (EP12), suggesting that despite anorexia being a separate disorder, the potential complexity of BDD made them hesitant to consider this within their role. One seemed in two minds when they said, *"I don't think I'm really well trained…to actually work with a young person on it"* whilst then adding *"I do feel I could do a bit more" (Q36.4).* Another echoed this uncertainty by saying *"we perhaps underrate ourselves as EPs" (Q36.3).*

In terms of what might overcome this lack of confidence, one interviewee felt they *"might actually be somebody that could offer that support because we are technically trained in those approaches, but…I'd check with a supervisor…because you wouldn't want…it to not be the right thing for them"* (EP14). One felt with *"further training"* they might *"feel confident to deliver that [therapeutic work]"* and they *"would certainly see that within an EP skill-set"*

(EP11). Another felt that therapeutic work was something they *"really should upskill myself on"* (EP13). However, one EP was concerned that *"we can't get any external training because there's just not the money to do it…we only have the in-house CPD…you couldn't say 'I want to go do a CBT course'"* (EP9), suggesting the training that would facilitate direct therapeutic support by EPs might not be easy to come by*.*

Two interviewees specified it would be particularly severe or specialist cases that might exceed the limits of their competence, potentially leaving space for work with 'milder' cases of BDD. One said *"it will come down to how ingrained it is and the severity…for that child…I would be more inclined to refer onto mental-health services for the severer end"* (EP6), whilst also adding this might apply "*if it interacts with anything else…I was thinking particularly of a child…their skin tone was a big issue for them, so it was linked with race as well…so we found someone who was more aligned to helping them understand their racial identity*." Another said, "*it's just about being mindful about whether you're the right person…whether those difficulties are more severe and would need support from somebody else"* (EP14).

A number of practical barriers to providing ongoing support for BDD were cited by interviewees. Nine mentioned the issue of time and resources *(see QT37).* One mentioned *"SEN reforms"* and *"austerity"* as one cause of this *(Q37.2).* Two mentioned that CBT takes a large number of sessions, both because *"BDD…seems to be something that you dwell on for…a long time"* *(Q37.4)* and because of the need for *"building up a relationship with a young person" (Q37.8).* Although one EP had proposed recommending CBT within an EHCP (see above), they wondered *"who then funds it?" (Q37.10),*

suggesting that despite being legally binding, an EHCP is no guarantee of suggested provision.

In terms of why EPs might have limited time and capacity, six interviewees mentioned their high workload *(see QT38).* Three linked this to a high level of statutory assessments *(Q38.7-Q38.12)* and two mentioned the pressures of being a traded service *(Q38.6;Q38.1).* One felt *"hopeful for the future"* (Q38.1) that this pressure was starting to ease off, but another felt *"increasing pressure" (Q38.10)* that had already prevented her from ongoing working with a young girl who had self-identified with BDD. This suggests that the situation may vary between local authorities.

There were also a number of barriers to ongoing support that relate to the behaviour of other professionals. Six interviewees mentioned that schools would be unlikely to commission on-going support for one young person *(see QT39).* Three related this to traded services, where schools buy in EP time, meaning they would perhaps not see this as an effective use of their budget *(Q39.5-Q39.11).* Instead, they felt schools would prefer EPs to do *"preliminary work for…an EHCP" (Q39.10),* which can lead to funding, or *"something more systemic" (Q39.11)* that would benefit more children. Two EPs mentioned that although BDD can clearly have a *"heavy impact for that individual" (Q39.6),* schools may not realise how it can have a *"significant impact on children's achievements in school" (Q39.3).*

One interviewee felt this issue may stem from *"a misunderstanding of what an EP can do"* by schools (EP12). In response to this, one EP said, *"it's something that you have to be really quite assertive about",* that direct work is *"a really good use of our time… I would push for it and I would keep my skill-*

set up to be able to offer that" (EP8). Similarly, another EP felt it was about *"trying to have that conversation with schools to promote the range of work we do…not just having us boxed in that individual assessment, or training…that narrow view of us"* (EP11).

Four interviewees mentioned that EPs do not connect with CAMHS and other professionals often enough, which creates a barrier to providing support *(see QT40).* One felt that EPs could go *"through referrals…in a multi-agency way"* with CAMHS, which would allow EPs to work with more low-level cases *(Q40.10).* One EP recognised this might happen *"in more enlightened parts of the world" (Q40.1),* whilst another remembered previously having *"regular meetups with paediatricians, with CAMHS…to do joint work" (Q40.2).* However, they attributed the current lack of multi-disciplinary work to there being *"no time at the moment" (Q40.1)* and a lack of *"people resources, which leads to time resources" (Q40.2).* This suggests the follow-up work EPs had envisaged earlier may not be possible at present.

Three interviewees also mentioned that a lack of awareness of BDD amongst mental-health professionals would also prohibit collaborative work *(QT41).* One noted they had never seen BDD mentioned in another professional's report *(Q41.2),* whilst one referred to this as something that stood out for them in the training *(Q41.8)* and one mentioned a personal account of a GP misunderstanding her own experience with a BDD-type concern *(Q41.7).*

5.5.5. Next Steps Already Taken in Terms of Support

47% of respondents had considered that BDD might be an issue for a young person since the training. Their next steps regarding support for BDD are presented in Table 5.20. Four respondents mentioned not having the opportunity to implement the learning or take next steps due to COVID-19.

Table 5.20.

Next Steps Taken by EPs Regarding Support for BDD after 6 Months

	Number of EPs
Signposted/referred to CAMHS/other organisations	5
Included recommendations for support within report	3
Incorporated non-triggering ways of talking about BDD	2
Multi-agency approach	2
Raising awareness to help school support	2
Person-centred planning	1

6.   DISCUSSION

This section will draw out the implications of each area of the results section in turn and in the same order, relating findings back to RQs, chosen theoretical underpinnings and material from the literature review.

6.1. EPs' REACTION TO TRAINING PACKAGE

To answer RQ1, participating EPs expressed strong satisfaction with the training in terms of the breadth of topics, mix of activities, delivery and overall satisfaction within quantitative questionnaire measures. Referring to Kirkpatrick's model, this is considered the first step towards creating change, as satisfaction is presupposed to be a pre-requisite to implementation (Kirkpatrick & Kirkpatrick, 2006). Interview participants emphasised the clarity of the presentation and structure and praised the visual elements for being appealing yet minimal.

Given that satisfaction was found, RQ1 also asked which elements were considered to be the most effective. The animated video that recounted a real-life experience of BDD, as well as hearing personal experiences from the deliverer of the training, were cited most often. There was a sense from interviewees that these features were impactful, memorable and helped to illustrate the lived experience of someone coping with BDD. It therefore seems important that when delivered in the future, the trainer will also have had a lived experience of BDD. Although specificities will of course change, this

element helped to fulfil the affective dimension of learning that the current study aimed for (Savickiene, 2010).

Given that awareness of BDD was anticipated to be low prior to training (Mummery, 2019; Phillips, 2005), the package was designed to be introductory, in line with the hierarchy of Bloom's revised taxonomy and the fact that sessions were limited to one hour (Anderson et al., 2001). A number of EPs appreciated being concisely presented with the basic information about BDD, whilst still being provided with enough information to put into practice and pass onto others.

Interactive elements were also appreciated, such as the poll at the start of the presentation, the fact that questions were fielded throughout and the question-and-answer session and discussion that made up the final 15 minutes. These elements were intended to tentatively touch on the higher levels of Bloom's revised taxonomy (Anderson et al., 2001), where information is manipulated and applied to allow for deeper processing and consolidation (de Beer, 2017), which seems to have been successful for some. Finally, the clear message of hope for recovery that closed the training was mentioned by some interviewees, which perhaps begins to connects with their sense of self-efficacy, that there is something they can do to help with BDD (Bandura, 2010).

RQ1 also asked what improvements could be made to the training for future delivery. The most common suggestion in both questionnaires and interviews was the inclusion of case studies to help contextualise information within practice, along with similar suggestions of more interactive activities and time for discussion. Although some appreciated the succinct and introductory nature of the training, clearly some also saw this as its main weakness.

Although this was an explicit intention of the training, it could be considered that future deliveries will move further into the 'application' level of Bloom's revised taxonomy, with interactive elements being expanding on to further enhance learning and transference to practice (Anderson et al., 2001). As will be seen later, there are specific elements of the content of the training that are arguably irrelevant to EPs that could potentially be removed to make space for more interactive elements. Given that EPs are highly-trained professionals, perhaps the aim of simply moving participants into a state of conscious-incompetence was unnecessarily unambitious and future deliveries could aim to move participants closer towards a state of conscious-competence, by incorporating more prospective applications to their practice (Cannon et al., 2010). Alternatively, a follow-up session could also be provided to achieve this end.

6.2. ATTITUDES TO BDD IN RELATION TO EP PRACTICE

To answer RQ2, the vast majority of interviewees and questionnaire respondents expected to make use of the information they'd learned with the training and felt that BDD was relevant to their practice. This is perhaps unsurprising, given that legislation relevant to EPs emphasises their legal obligation to address mental-health issues when they encounter them, even if this simply involves referral to other services (UK Government, 2015). For some, this change in attitude was simply a result of their complete lack of awareness of BDD prior to the training and therefore doesn't necessarily reflect the *quality* of the training. However, a small minority did mention feeling

that BDD was *not* relevant to their practice prior to the training, an opinion that had now changed, which does perhaps speak to the persuasive nature of the package. This again connects with the training's aim of operating on an affective level, motivating EPs to make necessary changes within their practice (Savickiene, 2010).

The potential severity of BDD during adolescence certainly supports the notion that BDD is important to EP practice (Thungana et al., 2018). Additionally, aside from those with a clinical diagnosis, within a large sample of 1118 teenagers, 34% felt anxious and 35% felt depressed about their body-image (Mental Health Foundation, 2019). Some interviewees also noted that EPs may be amongst the first professionals to encounter BDD. Given that young BDD-individuals find it difficult to talk about their concerns (Marques et al., 2011), EPs' expertise in accessing the voice of the child in creative and differentiated ways further supports the importance of their input (Smillie & Newton, 2020).

A small minority of interviewees were unsure if BDD would be relevant to their practice and some questionnaire respondents did not expect to make much use of the information within their practice. One interviewee related this to having not encountered BDD within their practice previously, making them doubt they would in future. Given that BDD goes under-recognised and under-diagnosed, even within clinical settings (Crow, 2001), this line of reasoning is arguably unfounded. Although the training covered the hidden nature of BDD, this is an element that may need to be emphasised in future iterations.

Aside from these reservations, EPs were overwhelming affirmative that BDD was relevant to their practice. This contrasts with the preliminary study,

which found that 9.4% of a sample of 235 EPs felt that BDD was *not* relevant to their practice (Mummery, 2019). However, within this earlier survey study, information about BDD was only provided in a short information sheet, which suggests that the more extensive material provided in the current study may have been more effective at changing the minds of some EPs. It may be that, as some interviewees mentioned, the clear demonstration of the impact BDD can have on educational outcomes (Labuschagne et al., 2013) and emotional well-being (Thungana et al., 2018) found within the training created this difference between the studies.

6.3. EPs' KNOWLEDGE OF BDD

6.3.1. Overall Increase in Knowledge

To partly answer RQ3, the training clearly caused an increase in knowledge about BDD for participants, which was statistically significant for both subjective self-reported measures and objective measures derived from quiz scores, an outcome that was maintained at the 6-month follow-up. This fulfils the second level of Kirkpatrick's model, that of 'learning' (Kirkpatrick & Kirkpatrick, 2006). As was predicted from previous studies of awareness of BDD amongst mental-health professionals (Phillips, 2005) and amongst another sample of EPs (Mummery, 2019), awareness of BDD amongst this sample of EPs was arguably also low prior to the training. This supports the study's assumption of having to initially move participants from a state of

unconscious-incompetence to one of conscious-incompetence (Cannon et al., 2010).

6.3.2. Validity of Increase in Knowledge

Given that many EPs had almost no knowledge of BDD (or rated themselves as such), it is perhaps unsurprising that a significant difference was found within statistical analyses, which perhaps limits inferences as to the quality of the training itself. Additionally, aside from those taken pre-training, self-reported measures did not correlate significantly with objective quiz scores, which could be said to impact the validity of either of these measures. There is the possibility that the wording of true-or-false quiz questions within the quiz already implied the correct answers, of which there were of course only two possibilities. Although this possibility was acknowledged and carefully accounted for, these questions may not accurately reflect knowledge of BDD. Indeed, the negative skew found in post-training scores may support the notion that the quiz was too easy, at least immediately following the training, as most scores fell just short of the maximum. However, distribution was normal at the 6-month follow-up and the difference remained significant, suggesting that questions were not overly suggestive and that a good amount of knowledge had been retained. It should be noted that scores at the 6-month follow-up had shown signs of regression, which raises the question of how much information would have been retained at a later date.

6.3.3. Exploring Low Prior Awareness of BDD

In terms of where prior knowledge had been gained, personal or professional experience with BDD was cited a few times. This correlated positively and significantly with self-reported pre-training measures of knowledge, although only a weaker positive correlation was found with pre-training quiz scores. This suggests (perhaps obviously) that to some extent prior experience with BDD influenced prior knowledge of BDD, although perhaps not to the extent that some participants imagined. However, the most common number of CYP with BDD that had been encountered was zero, suggesting this factor wouldn't have had a large impact on results overall. It was interesting that years of experience as an EP correlated *negatively* (although with a very small effect size) with self-reported knowledge of BDD. Only two EPs recalled being taught about BDD during their training and one specified they had trained quite recently, which perhaps explains this trend and suggests that awareness of BDD amongst newly-qualified EPs may increase further over time.

Elsewhere, prior knowledge had been acquired through mass media, which may explain why awareness was low and certain misconceptions were present. One common misconception before the training was that BDD is related to weight or body fat (Center for Discovery, 2019), in this case seemingly given rise to by the term itself: *'body'* dysmorphic disorder, which perhaps implies that the whole body is the site of fixation, rather than specific parts (Veale et al., 2016). Interestingly, having fallen from 64% to 12% following training, instances of this misconception rose again to 38% at the 6-

month follow-up. Although BDD and eating disorders are closely linked (Harrison et al., 2016), without clear clarification, many EPs may still not expect to encounter clinical anxiety in relation to anything other than bodily weight and size. This is perhaps an important consideration for future deliveries.

The one statement that remained relatively low in terms of correct response rates following the training was 'BDD is _not_ considered to be a more severe form of typical adolescent image-concern' (rising from 49% to 65%). This statement pertained to the fact that BDD is considered to be a form of OCD within international diagnostic manuals (APA, 2013; World Health Organization, 2018), suggesting a qualitative difference between typical adolescent image-concern and BDD, rather than simply a more severe form. This perhaps highlights a fault with the wording of this specific statement, as BDD *is* arguably a more severe form of image-concern, depending on your definition. However, it may also allude to a propensity within the EP community to think outside of medical diagnoses, such as OCD and even BDD itself (Pearson, 2017), which will be explored imminently.

6.3.4. Information Most Useful and Relevant to Practice

In terms of information deemed most important to their practice, EPs cited the high adolescent prevalence rate (Crow, 2001), equal gender ratio (Veale et al., 2016) and fact that it relates to individual features most commonly (Bowyer et al., 2016). Also cited were the level of severity in terms of suicidal ideation (Altamura et al., 2001), level of preoccupation (Kelly & Phillips, 2017)

and the fact that insight can be so poor, especially in adolescence (Phillips et al., 2006). Taken together, this suggests that prior to the training, some EPs may have been less expectant of encountering BDD within their work, especially amongst males, and may also have also discounted the potential severity.

Common behavioural signs of BDD caused a number of EPs to re-evaluate past and even present casework, in terms of having missed BDD or perhaps even having taken inappropriate actions. This has been identified as a common issue for young BDD-individuals (Phillips & Hollander, 2008), so it seems important that BDD is highlighted as an alternative explanation for certain symptoms that have previously been explained by other means. Related to this, one interviewee raised the question of whether EP assessment is often too simplistic or narrow, perhaps focused on a small handful of needs that have become prominent within education, whilst more hidden disorders such as BDD go under the radar (Phillips, 2005). This EP asked whether a more fine-grained process might be needed, in this case by examining individual differences in sensory perception, given that these could have far-ranging impacts on learning (Steele, 2020). Although this was something she had considered before, the training seemed to have galvanised her thinking around it. This is perhaps a consideration that could be highlighted more explicitly in future deliveries.

6.3.5. Neuroessentialism

Although some interviewees found neurological differences interesting, these same EPs seemed cautious about over-interpreting this evidence and only one questionnaire respondent professed to finding this evidence useful. Similarly, pharmacological evidence was not mentioned by interviewees or questionnaire respondents as being important or relevant to them. However, environmental triggers of BDD were mentioned frequently as being useful. This may reflect a move away from 'medical model' thinking within the EP profession and the way in which EPs are trained to take a more holistic approach to need, one that places consideration of environmental factors over those termed 'within-child', the latter of which may imply that a young person's difficulties are inherent and intractable (Lehohla & Hlalele, 2012). Indeed, there has been a marked shift within the EP profession to address issues pre-emptively and at a systemic level, to prevent the need for individual treatment once diagnosable disorders have established themselves, and known environmental triggers of BDD are therefore important for EPs to understand (Gutkin, 2012). Additionally, although the impact of neurological differences can potentially be attenuated with medication (Phillips & Hollander, 2008), this is not an area an EP would be involved in, rendering this information less useful to their practice.

As was mentioned within the literature review, neuroscientific and pharmacological evidence was included not only because it makes up a significant portion of the research into BDD, but also because it was deemed important to challenge the notion that a diagnosis of BDD is an unnecessary

pathologising of typical adolescent image-concern, which was the most commonly cited reason for why 9.4% of EPs in the preliminary study did not consider BDD to be an important consideration for their practice (Mummery, 2019). However, as one interviewee said, *"sometimes those things* [neuroscientific evidence]…*offer us nice explanations, when maybe there's…lots of other things going on…we're drawn to those neurological explanations for things"* (EP9). This illustrates a potential pitfall of the current study. The sense that the most valid way to explain psychology is through reference to the brain has been referred to as 'neuroessentialism', which has been criticised due to the fact that, as the EP above puts it, neuroscience offers *"nice explanations"* that can override or obscure the importance of environmental and sociological factors (Schultz, 2018). Indeed, purely neurological explanations of depression have been found to reduce the sufferers' sense that change is possible through therapy, subsequently affecting outcomes negatively (Kirsch, 1997).

On the other hand, there are perhaps other benefits to the inclusion of more 'medical model' information. Firstly, neuroscientific explanations have been found to reduce stigma around mental-illness (Speerforck et al., 2014) (although it should be noted that other studies have found the opposite trend) (Schomerus et al., 2014). Secondly, if genetic and neurological factors are involved in the onset of BDD, we cannot be certain that purely environmental and preventative measures will prevent this occurring, making this evidence relevant also. Additionally, regardless of the ways in which BDD has been caused to onset, once established it has been found to be persistent unless treated on a direct individual basis and there is currently no evidence

suggesting that holistic or environmental intervention can be effective (Phillips & Hollander, 2008). It could therefore still be considered important that EPs understand the full extent of the aetiology of BDD, including its seemingly somewhat genetic and neurological origin (although it should be noted that genetic evidence is stronger than neuroscientific, due to the small sample sizes used in studies of the latter).

There are therefore arguably pros and cons to the inclusion of neuroscientific or 'medical model' forms of evidence that need to be weighed, but perhaps the reaction of some EPs to this kind of information presents the deciding factor. Although no interviewee voiced such opinions, some questionnaire respondents did not welcome these additions:

"I think it's entirely the wrong way to conceptualise…young people's feelings and experiences (i.e. through the within-child lens…)"

"A valuable role for EPs would be to oppose…the language of diagnoses, treatment and disorders…instead challenging those responsible (schools, parents, peer groups, wider society)."

"Almost all children…struggle with appearance…practitioners risk focusing on pathologising and making more of something than there should be."

"I thought it was a very medical view of mental-health. Lacked evidence that there was a medical 'cause'…lack of insight into impact of trauma and other environmental factors."

Although labelling the current training 'neuroessential' would be arguably inaccurate, given that it covered environmental causes equally to genetic and neurological ones, these participants seem to have perceived it as such and have been left with an overall impression of the training focusing on 'within-child' or 'medical model' factors. In terms of achieving satisfaction

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within Kirkpatrick's first level of training evaluation (Kirkpatrick & Kirkpatrick, 2006), or of changing affective attitudes towards BDD (Savickiene, 2010), the training has clearly failed in the case of these participants and seems less likely to be implemented within practice as a result. Therefore, given that no EPs found these elements particularly useful, and for some they seem to have been actively detrimental, perhaps their inclusion should be reconsidered in favour of the further practical elements that were suggested for future deliveries.

6.3.6. Next Steps Already Taken with Knowledge of BDD

Examining how EPs' foresaw their next steps, as well as the ones that were already taken at the 6-month follow-up, allows us to move into Kirkpatrick's third stage of assessing impact: 'behaviour' (Kirkpatrick & Kirkpatrick, 2006). Providing training themselves was the most commonly cited next step in relation to the information EPs had learned. Given that training is a core part of EP practice (Sundhu & Kittles, 2016), this is perhaps unsurprising, but it does suggest that the initial training session could have far-reaching impact due to being cascaded onwards by professionals who are well-trained and versed in providing adult education. Indeed, within the 6-month follow-up questionnaire, this had encouragingly already occurred in a number of cases, most commonly to other EPs and colleagues, but also to schools in three cases. Although not yet measured, this will hopefully result in greater understanding, identification and support for BDD within schools.

A number of interviewees mentioned planning to undertake further learning about BDD, which is encouraging, but some also felt this would be necessary for consolidation. The fact that EPs felt the need to seek more information perhaps supports the training's aim of achieving conscious-incompetence (Cannon et al., 2010), coupled with a motivation to learn more about BDD (Savickiene, 2010). Interestingly, of the questionnaire respondents, only one said they would seek further training on BDD and only three said they would read into BDD more extensively, which could suggest that interviewees were already more interested in the subject matter than most questionnaire respondents, which is perhaps why they agreed to be interviewed. There is therefore potential that some EPs will remain in a state of conscious-incompetence about BDD. However, within the 6-month follow-up questionnaire, further learning about BDD was the most commonly cited action that had already been taken, suggesting the above aim of the training has been at least somewhat successful.

6.4. ABILITY TO IDENTIFY BDD

6.4.1. Self-Reported Ability to Identify BDD

To continue to address RQ3, questionnaire respondents showed a statistically significant increase in their self-reported ability to identify BDD, which was maintained at the 6-month follow-up. It would be expected that given the lack of prior knowledge of BDD, participants' perceived ability to identify BDD would also be low, and again, a statistically significant increase

was therefore likely to be found. Additionally, an objective measure of EPs' ability to identify BDD would not necessarily have validity and so it is difficult to extrapolate impact on practice from quantitative data in terms of this dependent variable. However, the outcome does suggest that self-efficacy amongst EPs has increased in terms of identifying BDD, which the study considers an important pre-requisite to creating change (Bandura, 2010). Overall, qualitative interview data and the impact in real terms found within the 6-month follow-up are more valid in terms of further examining impact within Kirkpatrick's third stage of 'behaviour', which will now be discussed (Kirkpatrick & Kirkpatrick, 2006).

6.4.2. Information Most Useful for Identification

When EPs were asked what information would specifically relate to their improved ability to identify BDD, there was some crossover with 'knowledge' they felt would be important to their practice, but here these aspects were applied specifically to aiding identification. Firstly, given that BDD was essentially unknown to many EPs, some mentioned simply that general awareness would give them a new hypothesis to consider in their casework, perhaps reassessing certain SEMH-type needs they might encounter in a new light. For example, symptoms such as school-refusal and self-harm (Rautio et al., 2020) would now be considered through the lens of BDD, given their high co-occurrence. Additionally, social anxiety, a significant co-morbidity of BDD (Gunstad & Phillips, 2003), may have previously been misattributed to something like autism. This led some to suggest that a narrow

or binary view of atypical behaviours can lead to certain needs being overlooked, which is often thought to be the case with BDD within clinical settings (Phillips & Hollander, 2008). Similarly, some EPs mentioned being better able to separate BDD from eating disorders. This could be important, as although there are significant crossovers between individuals with BDD and eating disorders (Ruffolo et al., 2006), the efficacy of treatment pathways diverges within the literature (Hartmann et al., 2013).

As well as seeing certain behaviours in a new light, a number of EPs felt they would now be vigilant for more BDD-specific signs, such as checking and disguising behaviours, that they perhaps wouldn't have considered relevant at all prior to the training (Toh et al., 2017). This seems particularly important given the reluctance of many young BDD-individuals to disclose their symptoms without prompting (Veale et al., 2015) and sometimes even *with* prompting (Rief et al., 2006). Some also felt that looking more closely would enable them to separate BDD from typical appearance dissatisfaction, which can be difficult, especially within teenage populations (Giraldo-O'Meara & Belloch, 2018). Information regarding the intense level of distress (Kelly & Phillips, 2017) and impairment on daily social or educational functioning (Weingarden & Renshaw, 2016) was expected to be particularly influential for achieving this aim. Finally, a number of EPs mentioned thinking more carefully about males having BDD and other body-image concerns, which given the near 50/50 gender split would seem an important change in terms of improving identification (Phillips et al., 2006). This suggests the above factors were particularly influential in causing the change to self-reported ability to identify

BDD and were therefore important inclusions that could perhaps be expanded upon within future deliveries.

6.4.3. EP Role in Identifying BDD and Potential Further Actions

To further explore the 'behaviour' level of Kirkpatrick's evaluative model, EPs were asked what their next steps would actually be in terms of identifying BDD (Kirkpatrick & Kirkpatrick, 2006). Some interviewees mentioned that in future they would be more active in asking about BDD, particularly in reference to the level of preoccupation it can cause (Kelly & Phillips, 2017). They would also be less inclined to wait to be told that someone is suffering with BDD, which is encouraging given the difficulty with disclosure already mentioned (Rief et al., 2006). This exploration would first occur directly with CYP, but EPs also mentioned sharing information with schools and parents to explore their hypothesis further. Given that school staff may have a less nuanced understanding of mental-health needs, this seems like an important role for EPs to take (Weeks et al., 2017). However, given that feelings of shame and embarrassment so often underlie non-disclosure of symptoms (Marques et al., 2011), EPs will need to be sensitive about sharing their concerns with adults, whilst balancing this with the limits on their confidentiality if they suspect a young person is at risk of harming themselves (UK Government, 2018). Only a small proportion of questionnaire respondents mentioned discussions with CYP, staff or parents, but as they were not directly asked about identification, this does not necessarily mean they would not take similar steps, highlighting a potential weakness with the measure.

The extent to which these propositions had already been implemented was explored, to partly answer RQ4, which related to impact on practice in real terms. Interviews took place only a short time after the training, but already a few EPs had explored appearance anxiety in greater depth within consultations, especially around social anxiety in combination with disguising behaviours or inconsistent school attendance.

Within the 6-month follow-up, nearly half of the respondents had considered that BDD might be an issue for a young person since the training, most often due to common behavioural signs, specifically excessive selfie taking, grooming rituals (Albertini & Phillips, 1999), an apparent lack of insight (Eisen et al., 2004) and high distractibility (Kelly & Phillips, 2017). The diagnostic criteria were also referred to (APA, 2013; Khoury et al., 2017). This suggests that these elements may be particularly influential for improving identification of BDD in real terms.

In terms of exploring their hypothesis, some EPs had spoken with CYP themselves and a small number mentioned doing this in accordance with considerations that reassurance and normalisation can be detrimental (Menees et al., 2013; Neziroglu et al., 2018). EPs had also commonly discussed BDD in consultations, specifically with schools and parents. They had also been prompted by their hypothesis to refer back to training materials or read further about BDD, which supports the notion that aiming for conscious-incompetence and general awareness of BDD had been sufficient, as EPs are capable of expanding on this basic information as and when they need to (Cannon et al., 2010).

6.4.4. Labelling

Many EPs mentioned providing evidence descriptively, without making reference to the label 'BDD' itself, with the onus falling on other professionals to "diagnose" BDD, which perhaps alludes to the tendency within the EP profession to think outside of labels and encapsulate need with reference only to the individual in question (Pearson, 2017). It was also commonly mentioned that EPs are trained to take a holistic perspective, considering all factors within a young person's life that may contribute to their current concerns, rather than using diagnostic criteria to describe someone's entire experience (Cameron, 2006). It is understandable that most EPs would not see diagnosis or labelling as part of their role, given that they are not medically trained nor expected to do so, although they may occasionally be a member of a diagnostic panel (Mansell & Morris, 2004). As we have seen, attitudes towards the 'within-child' factors a label could arguably imply were potential impediments to the training being implemented elsewhere (Savickiene, 2010). As such, the pros and cons of labelling will now be explored, to examine to what extent use of the term 'BDD' is necessary in future deliveries of the training to other EPs.

Some interviewees were open to the idea of labelling, either if the label had already been used to diagnose or if they felt it might be of benefit to the young person. This possibility has been raised in the literature previously, in terms of CYP feeling understood and validated (Kinderman et al., 2013) and for young BDD-individuals themselves, the label has been found to help with insight by highlighting their problem as psychological rather than physical (Schnackenberg, 2021). Additionally, the label could help alter common

tendencies for normalisation and minimisation (Schnackenberg, 2021) and it is arguably not one that is currently in danger of being over-applied, which is a criticism aimed at other labels, such as ADHD (Hill & Turner, 2016). Some EPs also raised that it can be difficult to discuss need without recourse to labels (Gross, 1994) and that having a name to put to certain difficulties would help with identification (Wright et al., 2007).

For other interviewees more averse to labels, this was often a matter of consent for CYP who have not requested one. For others, labels suggested too neat a categorisation of need, when large variation and crossover nearly always occur, which is certainly the case with BDD (Gunstad & Phillips, 2003). Labels were therefore seen as imprecise, which can lead to misunderstandings that create self-fulfilling prophecies through the behaviour of others and even of sufferers themselves, the possibility of which has been raised within the literature previously (Robinson, 2009). For BDD specifically, the behaviour of others in relation to the label, in terms of seeing it as vanity, has been found to induce further feelings of shame for some CYP (Schnackenberg, 2021). Some also felt that labels medicalise needs by suggesting that responses to one's environment reflect innate characteristics, which can diminish the sense that there is potential for change (Schultz, 2018).

These factors highlight the potential pitfalls of labelling that are important considerations and suggest a case-by-case approach is needed, one that always incorporates the voice of CYP. However, in the case of BDD, although comorbidities occur frequently (Gunstad & Phillips, 2003), the presence of the four criteria of a diagnosis of BDD do by necessity co-occur between sufferers and there are seeming specificities to this cluster of

symptoms in terms of effective treatments (Harrison et al., 2016), as well as somewhat consistent parallels between experiences (Schnackenberg, 2021). As such, although labels can only describe need with imperfect accuracy, as long as the individual's particular circumstances are considered carefully alongside, they can provide a deductive starting point from which to start that need not even involve outward application of the label to individuals. Therefore, in terms of the current study, the issue of communication was deemed most salient and referring to BDD by its clinical name was felt to be more impactful in terms of raising awareness, given that if the label was later encountered, participants would have an immediate reference point (Gross, 1994). However, the training could perhaps more clearly delineate this argument from the offset, so that EPs' attitudes are not impacted by their concerns about labelling (Savickiene, 2010).

6.4.5. Potential Barriers to EPs' Identification of BDD

With reference to the above section about labelling, it is interesting that many EPs responded to a question about 'identification' by discussing 'diagnosis', suggesting some conflation between the two concepts. This raised an interesting question: to what extent does 'identifying' need equate to 'diagnosis' for some EPs and would this hesitance to pathologise prevent them from effectively communicating their concerns regarding the needs that constitute BDD at all? One EP stated that although they would describe behaviours, they would not write into a report that they thought BDD was an issue, raising the question of how they might clearly communicate their

concern to other professionals. These were elements of the training that some EPs seemed to vacillate on and it would therefore perhaps be beneficial to allow more time for discussion of these issues within the training.

EPs also mentioned a number of potential practical barriers to the identification of BDD, including the fact that BDD can be hidden (Marques et al., 2011), that many symptoms are not exclusive to BDD (Giraldo-O'Meara & Belloch, 2019) and that it can be difficult to separate from similar and comorbid disorders (Gunstad & Phillips, 2003). However, EPs also mentioned that these factors might be less problematic following the training and the fact that nearly half had considered BDD as a potential within casework at the 6-month follow-up suggests this may already be the case. However, it was too soon to examine outcomes of these hypothesised cases of BDD, so it remains to be seen to what extent they remain as barriers to identification.

There were also a number of practical barriers that training is unfortunately unable to address, such as the fact that EPs potentially do not have the long-term contact necessary to notice signs of BDD, or to build the relationship necessary for CYP to disclose. This was an issue also found within the preliminary study (Mummery, 2019), where participants cited traded services and the dominance of EHCP assessments within their practice as major hindrances to other forms of work (UK Government, 2019). This highlights the importance of schools picking up on BDD themselves, but as other EPs mentioned, schools may not notice the signs themselves or perhaps won't be concerned about them unless they are seriously impacting on attainment. Although decline in academic performance is a distinct possibility with BDD (Kelly & Phillips, 2017), there are certainly many cases where it may

have a more subtle manifestation that schools could easily miss. Indeed, research has found that school staff do not currently have the nuanced understanding of mental-health needs that would allow them to notice the more hidden signs of BDD and relay this to EPs or other professionals (Weeks et al., 2017). This raises the important role EPs might play in terms of cascading the training to schools, which fortunately a large number of EPs highlighted as a role they envisaged for themselves and which some are already undertaking.

6.5. ABILITY TO SUPPORT BDD

6.5.1. Self-Reported Ability to Support BDD

To answer the final component of RQ3, the training did cause a statistically significant increase in EPs' self-reported ability to support BDD, suggesting that their self-efficacy was also impacted in this area (Bandura, 2010). However, this increase was less dramatic than for knowledge or ability to identify BDD and the final mean was also lower than for both of these variables. This may be because the necessarily introductory nature of the training meant that sections involving the ways in which EPs and schools can support BDD were not extensive. It may therefore be important that a follow-up session focusing on these aspects is given. However, EPs' self-reported ability to support may also be lower because some EPs don't see this as a predominant part of their role, which will be explored within coming sections.

6.5.2. Information Most Useful for Identification

In terms of information useful for improving their ability to support BDD, interviewees mentioned proposed ways in which to talk to CYP who have or may have BDD, which involve carefully avoiding normalisation and reassurance, given that these can be triggering (Menees et al., 2013; Neziroglu et al., 2018). This seems to have given these EPs more confidence and self-efficacy in terms of discussing BDD (Bandura, 2010). Interviewees also mentioned that learning of the evidence-base for CBT in relation to BDD would allow them to recommend or even deliver this as an evidence-based approach, something that is a major consideration for EPs within their practice (Kratochwill & Shernoff, 2004). As was previously mentioned, no one specifically mentioned valuing information on SSRIs, which again suggests that this information is somewhat irrelevant to EP practice.

6.5.3. EP Role in Supporting BDD

Within questionnaires, the most popular way to support BDD was through indirect or systemic approaches (91%), meaning those that operate on a broader scale than direct work with CYP themselves. For some, this would involve communicating on behalf of CYP, which could be important given the difficult they may have with talking about their BDD themselves (Veale et al., 2015). EPs are skilled at eliciting and incorporating the voices of CYP (Harding & Atkinson, 2009), which may help to circumvent one issue with labels that was cited: CYP consenting to having one applied to them. Given

the age at which BDD is likely to emerge (an average of 16 in one study) (Bjornsson et al., 2013), this issue should be able to be discussed freely with fully informed consent in most cases. This seems important, given that within one sample of young BDD-individuals, some found the label helpful for understanding their needs, whilst others found it detrimental, mainly because of how it made others perceive them (Schnackenberg, 2021). As was previously touched on, each case will need to be taken individually and an important role for EPs could be to work with CYP to explore how they would like their needs to be described.

As an extension of this, some EPs suggested they might help families and schools to better understand the needs of CYP and help them to develop strategies and a path forward within consultations, a cornerstone of EP practice (Kennedy et al., 2009). In terms of families, given that a common self-reported trigger of BDD has been dysfunctional familial relationships (Weingarden et al., 2017) and that inversely, behaviours associated with BDD can cause stress within a family, this may be another important way for EPs to intervene (Jassi et al., 2020).

In terms of schools, they have been found to have limited understanding of mental-health needs (Weeks et al., 2017) and in the case of BDD, this can lead to BDD behaviours being addressed with inappropriately punitive measures, which can make school-refusal worse (Schnackenberg, 2021). Given that another prominent trigger of BDD is appearance-based bullying, it seems important in terms of prevention that schools understand the importance of nurturing and empathetic environments (Weingarden & Renshaw, 2016). Therefore, enabling schools to better understand BDD would

be another important contribution of the EP in terms of creating preventative and systemic change.

Some EPs also mentioned recommending interventions that they would not themselves be carrying out. One suggested that schools might be trained to use the CBT model themselves. However, given that it requires somewhat extensive training and is not recommended to occur without, this possibility seems doubtful (Stallard, 2007). Elsewhere, EPs mentioned including CBT within EHCP advice, which given the legal nature of an EHCP would theoretically ensure the delivery of CBT (UK Government, 2014). However, this does raise the question of who would carry out the intervention, given that even a large proportion of CAMHS workers are not fully CBT-trained (Stallard, 2007).

Within questionnaires, signposting and referral to other services and sources of information was the second most cited approach EPs would take to support BDD (90%). Directing families and CYP to other sources of information could be helpful in terms of enabling them to further develop their own understanding and find their own path to treatment and recovery. In terms of other services who could provide therapeutic support for BDD, this would most likely fall to CAMHS, with whom some EPs saw scope for a complementary relationship in terms of the systemic and holistic perspective they could provide. However, a number of EPs mentioned a lack of opportunities for such multidisciplinary work due to a lack of time and resources resulting from austerity measures (Zafeiriou, 2017). Additionally, CAMHS are often overstretched, with one estimate suggesting they can only take up an estimated 10 to 20% of referrals (Atkinson et al., 2014). An

alternative could of course be psychologists practicing privately, but this would prohibit parents who have less resources to spare. For many families of young BDD sufferers, this appears to make therapeutic support an unlikely prospect.

Although cited by a smaller proportion of EPs (30%), there may be scope for direct work by EPs that would fill the gap in therapeutic support described above. Some interviewees felt that delivering CBT themselves might be possible. Many EPs already undertake therapeutic work (Atkinson et al., 2013) and the ability to do so is a mandatory area of competence outlined by both the HCPC and BPS (BPS, 2018; HCPC, 2018). Some EPs are fully CBT-qualified, but most would use generic cognitive behavioural *approaches,* which were mentioned more often than CBT itself (Hoyne & Cunningham, 2019). There is currently no research connecting BDD with more generic cognitive behavioural approaches, but absence of evidence is not always evidence of absence, making this an important area for future study.

Another contribution to alleviating the pressure on CAMHS could be preventative work, which was cited by some EPs. They saw this as picking up on signs early and working with small groups to prevent image-concern escalating. There was no mention of what form these groups might take, but group CBT-based interventions have been used successfully by EPs with adolescents (Weeks et al., 2017). Although there is currently no published research into group therapy for BDD, one study is currently in writing and has shown strong preliminary results in terms of reducing symptoms, as measured by the Appearance Anxiety Inventory (BDD Foundation, 2021). The study involved delivery by peer facilitators who were trained by clinical psychologists with expertise in BDD and EPs would therefore be more than capable of

delivering this intervention also. This is an important area for further research and funding, as more efficient and affordable therapeutic approaches for BDD would allow for broader uptake.

Aside from CBT, there were a number of other individual direct approaches that EPs felt they might use. Some of these have been tested in relation to BDD, such as narrative therapy. Although research has been minimal, narrative therapy has been found to be effective at reducing BDD symptoms in two studies (Bassak et al., 2012; Costa et al., 2007). Another approach cited was the ideal-self drawing, a personal construct psychology approach that explores a young person's conceptions of the person they would never wish to be and the person they would most like to be (Moran, 2001). By talking in hypothetical terms about an imagined self, this could help ease anxiety that can come with direct discussion about BDD (Menees et al., 2013). Personal construct approaches have also been found to be useful for helping CYP think around an alternative self-image and to alter maladaptive behaviours (Hardman, 2001) and have even been used to explore BDD before (Veale et al., 2003). Although there is no suggestion that the ideal-self drawing could *treat* BDD, it could be a helpful approach for EPs to take when exploring it with a young person in a supportive way.

As well as helping parents and schools to understand BDD, as was previously outlined, some EPs mentioned helping CYP themselves to understand their own needs through psychoeducative approaches. One EP mentioned the possibility of incorporating neuroscientific information into psychoeducation, which has been found to be successful in the treatment of other disorders, such as substance use disorders (Rezapour et al., 2020) and

anxiety and depression (Field et al., 2016), which in the case of the latter was incorporated into CBT. Although this has not been researched within BDD, neuroscientific psychoeducation could be useful for helping CYP to understand that their BDD is not a physical problem. However, the previous section regarding neuroessentialism and the attitude of many EPs towards these forms of evidence perhaps makes this unlikely to be a common occurrence within EP practice.

A range of barriers were mentioned that might prevent some of the direct ways of working described above. Firstly, perhaps because a state of conscious-*incompetence* was aimed for by the training, some EPs felt unconfident about delivering therapeutic interventions for BDD. EPs are of course legally bound to work within the range of their own competency (HCPC, 2019) and have previously expressed a lack of confidence to deal with more high-level issues (Hoyne & Cunningham, 2019), which BDD would certainly often be categorised as. As such, direct intervention for BDD by EPs may not be an option if their lack of confidence is well-founded and reflected in their therapeutic ability. However, one study successfully utilised a manualised form of CBT for more moderate BDD cases, meaning that specialist training was not required (Wilhelm et al., 2011), and given evidence that BDD may be treatable with group interventions led by peers following training, it is perhaps less intractable than these EPs perceive (BDD Foundation, 2021). This impression may be the fault of the training itself, which emphasised the severity of BDD without extensively acknowledging the spectrum of need and the potential for less severe cases, where individuals may have greater insight (Veale, 2004). Although the training gave a message of hope, which was well

received by some, there may have been a sense that BDD-individuals can improve only through the intensive therapy a BDD specialist can provide. This is an impression that could be rectified in future iterations.

On a structural level, the dominance of EHCP assessments within EP practice was mentioned, which has previously been cited as a major hindrance to other forms of work (UK Government, 2019). Studies evaluating CBT for BDD, even the previously mentioned manualised and group forms, have all occurred over a large number of sessions, making this a significant barrier to EP involvement in therapeutic work (Wilhelm et al., 2011). Studies of more short-term forms of CBT would therefore be welcome. Similarly, a lack of funding and the reliance on school-commissioned work in the context of traded services means that schools will need to perceive this kind of work as an effective use of their budget, as well as something that is part of the EP role (Kratochwill & Shernoff, 2004). As such, an important starting point for EPs may be to highlight to schools the educational impact of BDD and the ways in which they can help support it (Phillips et al., 2006).

6.5.4. Next Steps Already Taken in Terms of Support

To address RQ4, some EPs had already incorporated support for BDD within their practice. EPs had most commonly discussed support for BDD in consultations, specifically with schools and parents, with additional signposting or referral to CAMHS or other organisations. No-one had directly supported BDD as of yet, but a few highlighted the impact of COVID-19, suggesting that more could happen at a later date.

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7.   CONCLUSIONS

7.1. SUMMARY

This section will summarise the key information from results and discussion sections to answer each RQ in turn.

RQ1: How well do EPs receive the training package? What aspects were effective and ineffective and why?

In line with Kirkpatrick's first 'reaction' level of training evaluation, EPs clearly received the training well on the whole and felt that it was clear, engaging and informative (Kirkpatrick & Kirkpatrick, 2006). Particularly well-received were the elements involving lived experiences of BDD: the animated video and the experiences of the presenter himself. There was a sense that these elements successfully contributed to the training's aim of causing *affective* learning, generating a sense of the importance of BDD to EP practice (Savickiene, 2010). Interactive elements, such as the true-or-false poll and the section for questions and discussion were also well-received. Some also appreciated that the training was concise and introductory and felt that the information given was enough to instigate further learning and for them to implement within their practice. However, it was specifically these elements that some EPs would have appreciated more of. Most often mentioned was the inclusion of case studies to contextualise information within practice, as well as more time for group activities and discussion. The aim of the training

was to move participants into a state of conscious-incompetence that would combine with motivation to learn more themselves (Cannon et al., 2010) and as such, it only tentatively began to move into the 'application' and 'procedural' stages of Bloom's revised taxonomy (Anderson et al., 2001). Although this aim was arguably met, this approach seems to have had mixed success in terms of its reception by EPs.

Two issues arose that impacted EPs' reception of the training, even for those who greatly appreciated and valued the training overall: neuroessentialism and labelling. Firstly, the inclusion of neuroscientific and pharmacological evidence was not widely valued and was even repudiated by some, who felt this implied 'medical model' thinking, which is at odds with the predominantly socioecological approach of EPs, one that favours holistic and environmental considerations over 'within-child' explanations. As an extension of this, the label of 'BDD' itself was a stumbling block for some EPs, given that it could be taken as a reductive suggestion that BDD is innate and inevitable. This was not the case for all EPs and some even saw the benefits of medical evidence and labels, but these EPs were in a minority. It was therefore considered that medical evidence may be unnecessary within the training. However, on the issue of the label of 'BDD', although the author would be cautious about attributing it to CYP themselves, it was deemed important to use the term when communicating with other professionals at this stage.

RQ2: What are EPs' attitudes towards BDD in relation to EP practice? Were they changed by the training?

Questionnaire participants were confident that they would make use of the training within their practice and interviewees were overwhelmingly certain that BDD was relevant to their practice, which further fulfils the aim of influencing affective learning about BDD (Savickiene, 2010). This was considered to be a change in attitude, in part because most EPs had never considered BDD in terms of their practice before, but also because there was a sense that EPs could be the first professionals who are able to help CYP talk about their appearance anxiety, given the common problems with insight and disclosure. A minority of EPs felt unsure that the training would be useful or that BDD was relevant to their practice, mainly because they hadn't encountered it before. However, they considered that it might become more relevant over time and would be more relevant to certain EPs, especially those working within secondary schools.

RQ3: Does EPs' knowledge of and ability to identify and support BDD increase after participating in a bespoke BDD training package and why? If so, are these changes maintained after 6 months?

In terms of Kirkpatrick's second evaluative stage of 'learning', according to quantitative self-reported measures, the EPs' knowledge of BDD increased significantly (Kirkpatrick & Kirkpatrick, 2006). Their perceived ability to identify and support BDD also increased significantly, suggesting that their self-efficacy had also been influenced. These increases were all maintained at the 6-month follow-up. For knowledge of BDD, an objective quiz measure was used and also found a significant increase that was maintained after 6 months.

However, the validity and reliability of the measures used were questioned, which will be discussed further within 'Limitations'.

Elements that were deemed particularly useful and influential on causing the above changes were: key statistics (prevalence rate, gender ratio, potential severity); the link with OCD and subsequent compulsive and ritualistic aspects to behaviour (checking, disguising etc.); and the fact that it relates to body *parts,* not the body as a whole. A minority also mentioned neuroscientific evidence that perceptual differences make BDD a real lived experience for sufferers. In terms of knowledge, a few misconceptions seemed difficult to shake and reappeared at the 6-month follow-up, particularly that BDD is an eating disorder or relates to weight and body fat and that it affects females predominantly.

In terms of identifying and supporting BDD, EPs found it useful to: understand common behavioural signs; learn about the ways in which to explore BDD with CYP in a sensitive non-triggering way (no normalisation or reassurance); be able to recommend or deliver evidence-based treatments (particularly CBT); and understand that insight can cause BDD to be hidden without inquiry from professionals, which it was felt would lead to looking for more subtle signs and asking more questions with CYP and staff. Many EPs felt that the training had given them an entirely new hypothesis to draw on and this caused them to reflect they may have overlooked BDD previously, reassessing certain behaviours they had encountered, such as school-refusal and social phobia. Some also felt better able to separate BDD from typical adolescent image-concern (through the heightened level of distress), eating disorders and gender dysphoria.

RQ4: How do participants anticipate applying these changes within their practice? Which changes have already occurred in practice after 6 months?

In line with Kirkpatrick's third level of evaluation, 'behaviour', prospective and actual impact on practice were measured (Kirkpatrick & Kirkpatrick, 2006). EPs were caused to reflect on current casework after making connections with common signs of BDD, such as grooming rituals that cause lateness and absence, which led some to think about more fine-grained assessment in future. Many EPs expected to pass on information to colleagues and schools in the form of informal discussions or training, especially in terms of common warning signs, so that schools were better able to refer BDD to the right professionals. A number of EPs had already taken this action at the follow-up. Further reading about BDD was also projected and had been undertaken in a number of cases, which suggests the aim of encouraging further learning from a point of conscious-incompetence had been somewhat successful (Cannon et al., 2010).

In terms of identification, there was less certainty about the EP role. Some EPs expected to explore BDD further with CYP if they suspected it was an issue, or in consultation with schools and parents. This had already taken place in some cases, after suspicions had been raised in reference to common behavioural signs, particularly grooming, checking and a lack of insight. Although some suggested multi-agency diagnosis might be possible, EPs mainly expected to provide descriptive evidence of BDD and did not plan to use the label or to suggest a diagnosis might be necessary. However, some

mentioned the potential benefits of labels for some CYP, as well as making professional communication more efficient, whilst acknowledging the importance of incorporating the voice of the child in this decision. Some EPs were still concerned that BDD would be too hidden from schools and themselves to be effectively identified.

In terms of support, systemic or indirect work was expected to be equally as common as referral to other services. Advocating for CYP was a common next step, in terms of communicating their concern in the ways they wished. Work within families was mentioned, helping to intervene in potential dysfunction that can both cause and be caused by BDD. Also common would be working with staff and parents within consultations to find solutions and ways to support CYP at school. Similarly, educating staff if a case of BDD had arisen, so that their setting could be more nurturing and accommodating, which had already taken place in some cases. Recommending interventions was also a possibility, although there was some question of how feasible implementation would be. Referral to other services was projected to be common and had already taken place in a number of cases, with subsequent support in terms of providing a holistic context for therapeutic work. However, the low rate of referrals CAMHS are actually able to take up remains an issue.

A smaller number of EPs felt that direct work would be possible, with some citing CBT, although the large number of sessions and low potential for schools to commission such ongoing work made this seem unlikely in the context of traded services. Workload and time constraints were also factors, as many EPs felt the rate of EHCPs they had to complete made ongoing direct work unlikely. Additionally, some EPs felt that BDD exceeded the limits of their

competence due to its potential severity. Elsewhere, cognitive behavioural approaches, personal construct psychology, psychoeducation, work on self-esteem, co-construction of solutions with young person and narrative approaches were cited, the latter of which does have evidence to support it in relation to BDD (Bassak et al., 2012; Costa et al., 2007). Preventative group work was also mentioned and a promising unpublished study suggests this could be a potential direction to take (BDD Foundation, 2021). These proposed direct approaches had not actually taken place as of 6 months after the training, but some related this to lockdown measures resulting from the COVID-19 pandemic.

7.2. IMPLICATIONS

The training was well received by the majority of EPs, who felt it was important and would be influential to their practice. It also successfully increased knowledge of BDD and EPs' perceived ability to identify and support BDD. As was seen at the 6-month follow-up, EPs were already beginning to incorporate the training and this had occurred in a few key ways: further learning about BDD; providing training to schools and colleagues; discussing potential cases of BDD with schools and families and how to support; and referrals to other agencies. This suggests the training could have a far-ranging systemic impact, beyond simply raising awareness of BDD and competence amongst EPs. This provides tentative evidence for it fulfilling Kirkpatrick's fourth level of evaluation, 'results', in terms of providing improved identification and support for BDD in real terms (Kirkpatrick & Kirkpatrick, 2006). It is

perhaps too early to say whether EPs will provide direct support for BDD, especially given the COVID-19 pandemic. In terms of delivering CBT specifically, although there seemed to be potential for some EPs, this seems an unlikely prospect at present. However, a number of more short-term direct approaches common within EP practice were mentioned that may be implemented when it is possible, some of which have promising evidence in terms of supporting BDD and others which may still prove helpful for young BDD-individuals.

Evaluating the training raised a number of issues that will influence future deliveries of the package. Many EPs felt that the training could have incorporated more interactive elements that touch upon actual application within their practice, such as case studies and group activities. Sessions could be extended to incorporate these, or a follow-up session could be offered. Alternatively, certain elements could be removed that were considered less successful or relevant to EPs, particularly neuroscientific and pharmacological evidence. EPs do not tend to take a 'medical model' view of need and they will not be involved with prescribing medication. Given that for some EPs these elements appeared to interfere with their reception of the training, they could hopefully be removed without altering its impact. In terms of the label of 'BDD', although some EPs were critical of the concept of labelling entirely, it is deemed important to ease communication and to highlight an underrecognised and commonly co-occurring set of needs. However, discussion of the potential pitfalls of labelling and an acknowledgement of this decision could be included to prevent this negatively affecting EPs' reactions to the training. Other additions will include more discussion of the ways EPs

can intervene, so that it is made clear that BDD is not always as severe as the most extreme cases, to further raise EPs' self-efficacy in terms of intervening themselves (Bandura, 2010). The aim of achieving conscious-incompetence will therefore be made more ambitious, instead aiming for conscious-competence for EPs, by the end of an altered or extended session, or perhaps after a follow-up session (Cannon et al., 2010).

Overall, the study suggests that this training package is effective for educating professionals about BDD and provides tentative evidence that it can also improve effective identification and support for BDD. As such, the training package can be deployed to more EPs and adapted to be delivered to a broader range of other professionals, including teachers, head teachers, SENCOs, mental-health leads and perhaps even clinical psychologists,

7.3. EVALUATION OF STUDY

This is the first study connecting BDD with EP practice in any form, apart from the author's preliminary study (Mummery, 2019). The strengths of the study are the large sample size, range of evaluative methods that allowed for triangulation and the actual measure of impact on practice, which appeared encouraging at the 6-month follow-up. Additionally, the fact that training was carried out online allowed it to reach a wider audience at no cost whatsoever to trainer or trainees.

However, a number of limitations apply also. Self-reported measures of knowledge and ability to identify and support BDD clearly do not directly translate to impact on practice, which is perhaps an inherent difficulty with

evaluating training. Additionally, self-reported measures are vulnerable to a Hawthorne effect, in that participants want to demonstrate to the trainer (and perhaps themselves) that the training has been useful and effective (McCambridge et al., 2014). Indeed, following the training, some EPs suggested the ratings they gave may not have accurately reflected their knowledge of BDD, with some suggesting they had underestimated their prior knowledge and some feeling they had *over*estimated. For some, this was due to a misunderstanding of exactly what BDD was, with one entirely confusing it with gender dysphoria. For others, the information within the training either made them realise they already knew more or less than they had realised beforehand.

Additionally, given that awareness of BDD was so low prior to the training, the statistically significant increases do not necessarily speak to the quality of the training itself. For instance, training about autism would be much less likely to attain a significant result in terms of increasing EP knowledge and competence, given that it is an area that so many have an advanced understanding of already. To counteract this, the training could have been evaluated with a control group receiving an alternative training package, perhaps designed with differing objectives. For example, one package could have been introductory and operated at the lower levels of Blooms' revised taxonomy, as the current one did (Anderson et al., 2001), and one could have focused on application within practice, to examine how important the basic information about BDD actually is. This would address the fact that the training was potentially not ambitious enough in its aim of achieving conscious-incompetence, rather than conscious-competence (Cannon et al., 2010).

In the case of 'knowledge of BDD', an objective quiz measure was used to bolster validity, but this measure itself also had a number of limitations. Firstly, in terms of how well subjective and objective measures of knowledge correlated, although positive trends were found, this only reached significance prior to the training. This potentially suggests that either self-reported measures were unreliable or the quiz measure lacked validity in terms of measuring 'knowledge of BDD'. Secondly, negative skew in the quiz scores post-training suggested that the measure was too easy for participants, especially so soon after receiving the training, therefore inaccurately reflecting what they had learned. This may be because the measure did not use open-ended questions, so that statistical comparison could be made. This meant it partly involved true-or-false questions, from which the correct answers may have already been implicitly suggested. For example, asking 'Is it true or false that approximately 80% of people with a diagnosis of BDD are female?', a common misconception, could imply that this is perhaps not the case, simply by it being asked. Other questions used a delineated range of answers e.g. the four diagnostic criteria. For certain questions, these delineations were arguably subjective, such as when asking for the 'ten common behavioural signs of BDD'. Although most predominant within the literature, this list was certainly not exhaustive and they were simply the behaviours chosen to be outlined within the training. Aside from these issues, scores at the 6-month follow-up quiz were normally distributed and arguably were therefore more informative of what information EPs had actually retained.

Although the current research did not claim to allow for generalisability to the wider EP population, this could still be seen as a limitation. By not

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utilising a probability sample drawn from all possible EPs (a difficult but potentially plausible task), it could be argued that only EPs already interested or knowledgeable about BDD self-selected themselves to respond, potentially making the results less representative. This extends even further within interviews and the 6-month follow-up, as EPs that participated in these stages were likely to have responded well to the training and were perhaps more likely to have implemented BDD within their practice already, making their responses even less generalisable. Additionally, the 6-month follow-up had a much smaller sample size and an even smaller number of participants were able to be matched to their original responses (n=30). The follow-up also could have involved a more longitudinal and in-depth measure of impact using additional short interviews, as the answers given within the questionnaire were somewhat terse.

7.4. FUTURE RESEARCH

BDD is a somewhat under-researched area and no prior studies exist in relation to EP practice. As such, there are many avenues that could be explored in future research. As described above, a more longitudinal and in-depth examination of the impact of the training in real terms would be welcome due to the limitations of the current study. Following adjustments to the current training package, or perhaps after devising an extended session or sessions, the training could be delivered and evaluated again, to see if these changes are impactful. Alternatively, a web-based training program could be devised

and evaluated, one that participants would complete in their own time, which would allow for much greater participation.

Given the low rate of referral CAMHS are able to take up (Atkinson et al., 2014), studies should also be carried out to explore the potential for direct therapy delivered by EPs. This could potentially be group-based, to allow for more prevention and efficient use of EP time and school resources. Group-based CBT for BDD is currently being researched (BDD Foundation, 2021), but more studies would be welcome in this area also. There is currently a large gap to be filled, between the most severe cases already receiving treatment, down to milder or developing cases that would benefit from preventative work and early intervention. Preliminary studies could further explore the possibility of EPs incorporating more therapeutic interventions into their work, both in terms of practical issues and the attitudes of EPs themselves.

The issue of awareness may also be examined from the perspective of adolescent BDD-individuals themselves, asking those with a diagnosis how they managed to come forward with their symptoms, as a common lack of insight makes this less likely. Additionally, it is also important for teachers, SENCOs and mental-health leads to have awareness of BDD. The training package was originally designed for teachers, but the COVID-19 pandemic postponed these sessions. Once they are possible again, it will be important to evaluate impact within this population also.

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APPENDIX A: QUESTIONNAIRE

Before training:

1. **How many children and young people with (confirmed or suspected) BDD have you worked with over the last year?** (estimate if exact number not known)

   _____

2. **How would you rate your <u>knowledge</u> of BDD?**

   Very low ————————————————————— Very high

       0   1   2   3   4   5   6   7   8   9   10

3. **How would you rate your skills in <u>asking about or identifying</u> BDD?**

   Very low ————————————————————— Very high

       0   1   2   3   4   5   6   7   8   9   10

4. **How would you rate your skills in <u>helping</u> children and young people with BDD?**

   Very low ————————————————————— Very high

       0   1   2   3   4   5   6   7   8   9   10

After training:

5. **How would you rate your <u>knowledge</u> of BDD?**

   Very low ————————————————————— Very high

       0   1   2   3   4   5   6   7   8   9   10

6. **How would you rate your <u>skills in asking about or identifying</u> BDD?**

   Very low ————————————————————— Very high

       0   1   2   3   4   5   6   7   8   9   10

7. **How would you rate your <u>skills in helping</u> children and young people with BDD?**

   Very low ————————————————————— Very high

       0   1   2   3   4   5   6   7   8   9   10

In your contact with children and young people with BDD:

8. **Do you expect to make use of what you learnt in the teaching in your workplace?**

   Not at all   1   2   3   4   5   Very much

9. **How do you expect to use what you have learnt?**
Direct work ☐
Other direct work (e.g. teaching) ☐
Referring on ☐
Indirect work (e.g. supervision, case co-ordination) ☐
Other (please state) _____

10. **How appropriate was the breadth of topics covered?** (e.g. mix of research findings, clinical case examples)

       Not at all   1   2   3   4   5   Very much

11. **How would you rate the mix of learning activities and structure of the teaching?**

    Very poor   1   2   3   4   5   Very good

12. **How would you rate the delivery of the session?** (were they engaging, interesting?)

    Very poor   1   2   3   4   5   Very good

13. **In an overall, general sense, how satisfied are you with the teaching?**

       Not at all   1   2   3   4   5   Very much

14. **What was the most helpful part of the teaching for you personally?**

15. **What change, if any, would you recommend?** (e.g. to content or teaching)

16. **Please make any other comments that you would like to offer:**

Many thanks for your participation in the teaching, and for taking the time to complete this feedback form!

I would like to conduct short interviews to further examine the impact of this training package. This would take around 15-20 minutes. If you would be willing to be interviewed, please tick the appropriate box:

Yes ☐ No ☐

I would also like to contact you in a few months' time to see how you are applying what you have learned today. If you are happy to be contacted for this purpose, please tick the appropriate box:

Yes ☐ No ☐

If you indicated that you are happy to contacted for either purpose above, please type your name and e-mail below:

APPENDIX B: INTERVIEW SCHEDULE

1. Can you please briefly outline your role, including any specialist training?

2. What did you know about BDD prior to the training session, if anything?

If answer to Q.2 in *yes*:

1. Can you tell me specifically what you already knew?

2. How did you find out this information?

3. Had you ever come across a young person diagnosed with BDD or otherwise considered it a possibility?

4. If so, can you say a little more about this case?

For all:

5. Did any of the information in the training surprise you? Do you have any thoughts on why you were unaware of those details?

6. Was there any information that you found particular important or relevant to your professional practice? How do you think this information will influence your work?

7. How important do you feel it would be for yourself and other EPs to consider BDD in relation to their work with young people more frequently in future?

8. To what extent do you feel that the information you have just learned will influence you to consider BDD in your practice more often in future?

9. Do you now feel you have an adequate enough understanding of BDD to identify it more effectively? Do you see identification as a part of your role in any way?

10. Do you think that you would feel able to provide support for BDD once it was identified? How do you feel you would be able to do so?

11. Do you have any other comments on how would you view your role in terms of supporting BDD in future, both individually and perhaps in collaboration with other professionals also?

12. Do you foresee any obstacles to considering BDD in your work more regularly?

13. Which parts of the training itself did you find most effective?

14. Do you have any further comments about the training itself?

APPENDIX C: 3-MONTH FOLLOW-UP QUESTIONNAIRE

1. Following the training, were you prompted to follow up with any further actions regarding BDD, such as further reading or sharing of the information with others?

   1b. What actions did you take?

2. Did the training prompt you to think about BDD for any young people you work with?

   2b. What specifically suggested to you that BDD might be an issue?

   2c. What were your next steps?

3. How would you currently rate your knowledge of BDD?

4. How would you currently rate your skills in asking about or identifying BDD?

5. How would you currently rate your skills in helping or supporting children and young people with BDD, in whatever way you feel is appropriate to your role?

APPENDIX D: FULL LIST OF OBJECTIVE QUIZ MEASURE RESPONSES

Question		Before training (%correct)	After training (%correct)	6-month follow up (%correct)
BDD is caused solely by environmental factors (F)		93	99	92
BDD most commonly emerges before the age of 18 (T)		86	96	92
BDD is less common than anorexia nervosa (F)		78	94	88
The majority of people with BDD understand that in truth, they are **_not_** actually physically abnormal or unusually ugly (F)		77	93	100
BDD is thought to be partly neurological in origin. True or false? (T)		74	99	81
BDD is a sub-type of eating disorder (F)		74	96	92
If a young person's preoccupation centres on a body part because of the gender it signifies, a diagnosis of BDD would be appropriate (F)		70	91	81
Approximately 80% of people with a diagnosis of BDD are female (F)		51	96	76
BDD is **_not_** considered to be a more severe form of typical adolescent image-concern (T)		49	65	85
If a young person's preoccupation is centred on their weight, they would **_not_** meet criteria for a diagnosis of BDD (T)		36	88	54
There are 4 diagnostic criteria for BDD in the DSM-5. Are you aware of any of them?	1. Preoccupation with appearance	17	81	64
	2. Distress/impairment	11	81	68
	3. Repetitive behaviours	8	61	46
	4. Not solely about weight	3	23	18
Can you name the 4 common comorbidities that occur in at least 30% of people with BDD that may act as warning signs?	1. Depression	26	88	68
	2. OCD	21	63	36
	3. Social phobia	6	26	68
	4. Substance abuse	1	22	11
There are 10 common behavioural signs that might indicate a young person is suffering with BDD. Are you aware of any of them?	1. Checking	16	85	64
	2. Disguising	19	66	71
	3. Social avoidance	16	61	61
	4. Self-injurious behaviour	11	51	29
	5. Poor attendance/school-refusal	2	48	21
	6. Signs of anxiety	12	38	39
	7. Signs of depression	8	38	11
	8. Decline academic performance	1	36	11

	9. Voicing concerns	9	35	14
	10. Body alteration	8	32	18
There are 2 treatments for BDD that are recommended by NICE guidelines. Are you aware of either of them?	1. Cognitive Behavioural Therapy	17	81	86
	2. SSRI medication	8	61	29
The following true or false questions are based on recommendations for asking young people about BDD given by mental-health workers at a BDD clinic.	If a young person has an image-concern and you suspect BDD, it is recommended that you ask them further questions about the extent of their concern (T)	89	94	85
	If a young person has an image-concern and you suspect BDD, it is recommended that you avoid reassuring them that their appearance is completely normal (T)	74	89	96
	If a young person has an image-concern and you suspect BDD, it is recommended that you reassure them that all adolescents feel image-conscious from time to time (F)	63	96	89
	If a young person has an image-concern and you suspect BDD, it is recommended to ascertain which specific part of their body they are obsessed with (F)	41	73	39

APPENDIX E: QUOTE TABLES (QTs)

QT1.

Most Effective Elements: Personal Experiences of BDD

(Q1.6) You told personal stories…they made it quite relatable…that was the start of some of the shift in thinking of like, "Okay, so that was quite an interesting insight from a more personal level". So I thought that was useful.
(Q1.10) One of the most effective things I found, was you talking about your personal experience…as EPs we tend not to really draw upon that as much as maybe we could…for me it made it kind of more meaningful, you were very open in kind of sharing some of your reflections and experiences…which I think made it even more interesting and useful.
(Q1.8) I think bringing it to life a bit with individual...examples was really helpful. That shows the severity sometimes, rather than it being a superficial, abstract judgment that we have…that can't be underestimated, the fact that you shared your experiences, I think that really grips people in from the start…it makes it something real…something that we can then relate to…obviously that's not available to every EP to talk about, but from your perspective, it came across as a really powerful tool.

QT2.

Suggestions for Improvement: More Interactive Elements

(Q2.7) I hate roleplay…but…something a bit more practical that…makes you remember it a little bit more perhaps, with the checklist or the, or the things to say, things to not say, would be useful I think.
(Q2.10) Maybe having like a case study example, and getting EPs to think about how they would approach a certain case…types of questions they'd ask or how they would start to identify…maybe in pairs.
(Q2.14) I think with something like this, you'd have to tread really carefully, because you could quite easily say…something that might make things a bit worse…so it might actually be really important to have an exercise where people actually practice talking about what questions they'd ask, so that somebody who knows a bit more about it can say "That's a really good

question…but we might need to change how we word that because it might make them feel like that."

QT3.

Suggestions for Improvement: More Time for Discussion

> (Q3.9) I think it's good for consolidation…being able to talk about it…time to bounce ideas and reflect and things.

> (Q3.10) Some of the questions you've asked in this would probably be quite useful for reflection.

> (Q3.11) Just the opportunity to have a dialogue.

> (Q3.13) Having that kind of dialogue in person is much more suited to my style.

> (Q3.15) I think getting the people to buy into it is about asking them their experiences or…whether they've had any experience around BDD, any support or multi-professional support they've been involved with…or if they've, you know, they've considered it in their work as a hypothesis…whether it's a webinar or training, that's the whole purpose is, that you learn from others.

QT4.

Relevance of BDD to EP Practice: Importance of Awareness of Mental Health Needs

> (Q4.2) *To be aware that you're not being limited, by the way you're looking at things and the questions you're asking and to be aware of the sorts of issues that might impact on young people.*

> (Q4.14) *I think it's really important for EPs to know about that, just like it's important for EPs to…have knowledge of any kind of mental-health difficulty that causes those obsessive thoughts… it's just as relevant as any other mental-health problem, which is something that we'd be asked for advice on.*

> (Q4.7) *Anything that feeds into kind of social emotional behavioural type… functioning would…come under our remit.*

QT5.

Change to Sense of Relevance of BDD to EP Practice: Prior Lack of Awareness

(Q5.9) *It's something I hadn't really thought about, because it's not something I've come across in my work…so it raised the profile of it for me…which…does make it, feel more important as a thing for me to be aware of.*
(Q5.12) *Yes, I think because I've never really thought about it before or didn't really know much about it at all.*
(Q5.14) *I did have limited knowledge of BDD before…I learned a huge amount…I think that changed my perception.*

QT6.

No Prior Awareness of BDD

(Q6.2) *The one [their rating of their knowledge] was probably reflecting my complete lack of knowledge.*
(Q6.3) *I suppose I haven't really thought about it very much beforehand.*
(Q6.5) *it's something that I'd never really heard or come across and hadn't read about it or attended any training.*
(Q6.11) *Before your presentation, it wasn't really something, it wasn't something I really had...I had no knowledge of, if I'm honest. It wasn't something that I knew anything about.*
(Q6.12) *I was not really aware of it in...to any extent, really.*

QT7.

Training Causes Reflections on Past Casework

(Q7.5) That's really interesting…I'm just thinking of cases I've had in the past.

(Q7.12) We obviously do come across a lot of children and young people who possibly might suffer from body dysmorphia and…we're not really aware of it…I did actually think of other people I've known personally and professionally…it actually made me reflect upon the experiences I've had, or my perception of the way other people were.

(Q7.9) After having the training…I thought "Gosh", I looked back and I thought "I wonder if there's times that I've missed this"…the stat that was like 1 in 50 adolescents, which is such a high statistic and so I think the training really alerted me to how prevalent it could be and how much you might be coming across this in our schools.

(Q7.2) I was just thinking back to the last few pieces of work I've done and I just thought, 'Oh, I didn't ask about that. I should have.' When it was mentioned, the things that could be comorbid or could be indicators…it has halted me in my tracks and made me think I need to get this into my practice…it's something that I can possibly follow up on, at some point....so the training was brilliant in that respect…in terms of orienting you to that being a possible explanation for, for behaviours.

(Q7.1) Have I met children along the way when this possibly was the issue and it's gone unnoticed? Possibly…I've certainly never come across a young person who has said...as you clarified, they're unlikely to because they won't have that personal insight. In fact, one just popped into my mind. There was a boy where the social worker and I noticed there was something interesting about how he was constantly checking himself in the mirror.

(Q7.14) I don't think it's something I've encountered in the work that I've done, but it might have been… it made me think actually of a young lady I was working with last year who's in year nine, and she was getting into a lot of trouble with SLT for not following uniform rules…and it wasn't something…that young person had actually mentioned or talked about out loud…so I wouldn't know about it.

(Q7.13) I've worked in primary and secondary schools. And it made me reflect on children who may have been experiencing it at that time, but I didn't have the knowledge for that…I can think of one student now, who is...she's probably in the early to mid 20s now…it came to my attention that she was self-harming, so that was supported…I would have appreciated being upskilled at that point, and I believe my colleagues would have as well…I think most pertinent for me is the consideration of BDD when we possibly jumped to other answers, I guess.

(Q7.7) I suppose your thought process around it and your hypothesizing might end up kind of taking you down an ASD kind of line…because of the fact that they're not being sociable, or they might have their hood…and that's a comfort thing…and now I'm thinking back to some looked after children…girls in particular, thinking "Oh God…I wonder if I've missed something there"…I'll definitely think about it more, as I go forward.

(Q7.15) About 10 years ago…I remember a child who received a diagnosis of autism, but it was specifically around them not wanting to be around other people, because they were concerned about their facial features.

QT8.

Next Steps with New Information: Cascade Training to EP Team

(Q8.1) One of the things we do within our service, if people do CPD that's interesting, we share it with the team if we think it's useful…I will certainly share the training with my wider team.

(Q8.13) My intention is to discuss [the training] during one of our EP team meetings.

(Q8.10) Maybe that's something we can do as a team in a CPD session or something. And just to think in practical terms on the ground, how can we apply all this knowledge?

(Q8.2) Bringing it up in our supervision will help to keep things alive…knowing what colleagues are doing and how...if they're raising it and what the response has been, will also be helpful. I find that a really helpful way of kind of integrating new learning into practice.

(Q8.6) I'm supervising a trainee and we talked about it afterwards…we found it very interesting as a service, we all talked about it afterwards, around moving forward…in casework.

(Q8.11) We had a team discussion about…it was very much people…trying to understand why this young lady couldn't be drawn away from this ritual and needing those two hour sessions to do her makeup and to perfect it.

QT9.

(Q9.2) Bringing it to school's awareness as well…maybe they can request extra training from somewhere if they need it.

(Q9.4) I suppose in in terms of schools, and actually, you know, awareness as well about it…my role can be quite significant…in helping them to know about it or understand it and being alert to it.

(Q9.10) I'd be really interested to try and develop some in-school training for teachers to be more aware of this…using our knowledge to support schools understanding of different types of OCD-based difficulties.

(Q9.11) Potentially do some training with school…a session on BDD, if you felt that was later on down the line, something that you know, was a very real hypothesis.

(Q9.5) Another way…would be for me to cascade your training into schools where …if there is a young person who has been identified or as a more preventative awareness raising type thing, then that could be another way that I might take things forward.

(Q9.7) It's a conversation that we need to have with them [SENCOs], because they only bring to us what they feel is appropriate…when it's not an assessment that comes through panel for an EHC plan…what I could probably do is a bit of… not training but I could…go over it with some of my SENCOs so that they're aware…of some…warning signs and…what to do if they think a child might have BDD…perhaps it's consultation with us first around whether it could be that or something else, so perhaps it's more awareness raising with SENCOs at the earlier point as well.

(Q9.9) Supporting schools to recognize signs of BDD…through training…skilling schools up to be able to identify whether there might be an issue and then perhaps make onward referrals to CAMHS….and then there's…those working with and supporting them…helping them think…about questions they may ask, questions they should avoid asking.

(Q9.15) I think the warnings signs are extremely important to kind of hold in mind and actually share and help other people develop their awareness of it as well…I think conversations with people…are really

important…we've got an abundance of resources…it's developing other people's awareness and sharing those things.

(Q9.13) By the nature of body dysmorphia, the schools may struggle to identify the children who are experiencing it…so I think, step one for us would be to discuss and to raise awareness with our local schools.

QT10.

Limitations of New Knowledge: Information Forgotten

(Q10.12) It does seem a long time ago [the training] and it's a bit vague now.

(Q10.7) I can't remember now, what did you go through, like the things on...the list of things, can't remember what they were! [Laughs]…the time lapse probably isn't helping.

(Q10.10) Does it affect girls more than boys? What are the stats around it?… I imagine…in our schools, that the prevalence wouldn't be likely that there'd be lots of kids in one school with it.

(Q10.2) My half-life for remembering things…I'm terrible at making notes…I suppose just looking over there the documents that you sent through refreshed it in my head.

(Q10.9) I can't remember all of the ones that you listed, that'd be something I'd be pulling out if this was kind of a theory I had in my mind to be able to ask about the checking behaviours…I found myself before today, I did have a quick look back over my notes because I thought "Oh god, I want to go into this remembering things!"

QT11.

Limitations of New Knowledge: Training Will Be Referred to When Needed

(Q11.3) I think it's the consciousness raising, isn't it as much as anything. I think if...I'm not saying that I've actually got the knowledge in my head, but I now know where to look.

(Q11.7) I think the difference is now that I would have it more in my mind than I had previously…I might not remember now off the cuff, but...I think I

would see things now, in a school setting and I'd perhaps be thinking "I remember now actually, that that was one of the things in the training."

(Q11.5) I think it will take a real case to come up for it to…bed in and for me to conceptualize some of the symptoms and the presentation.

(Q11.12) Probably something would ignite the flame again…it will be there somewhere…but I would like before I get faced with a situation…to actually be a bit more informed so I have more knowledge of it.

(Q11.9) We can't ask a question about everything…there's so many things that…we only have some awareness until we kind of are faced with it, and then we develop our practice.

QT12.

Information Most Useful for Identification: General Awareness

(Q12.2) Even just if it was a hypothesis at one point, during kind of an exploration.

(Q12.3) Just that general awareness raising.

(Q12.7) We have to think through things and hypothesise and work out what's going on with children…what the underlying issues are…so I think the awareness of BDD…and to be thinking of that as a hypothesis.

(Q12.5) Where you've got…what would be quite a fairly typical SEMH type of presentation…school-refusal or…presentations of anxiety or self-harm…it's holding that in mind as a potential hypothesis.

(Q12.13) We do work with a lot of children on an individual basis, with social emotional mental-health difficulties…so it would give me a greater chance of identifying any of those children who I believe were experiencing BDD.

(Q12.10) I think just being more aware of what the specific types of difficulties that people have in terms of their mental-health and…having a name to put it to.

QT13.

Information Most Useful for Identification: A New Hypothesis

(Q13.8) It's changed the way that I would now look out for those things. So noticing where a young person is presenting with anxiety, low mood…social phobia…I've got that framework to think about that in a different way, that there could be something like body dysmorphia underlying that.

(Q13.11) Thinking about things like…lateness, and some of those presenting behaviours, where you might be inclined to go down one avenue, and actually just been able to factor this in this as a hypothesis is invaluable…it just wouldn't have been part of my dialogue...previously, I might have gone down avenue of, you know, emotionally-based school avoidance**.**

(Q13.12) In relation to school…school-refusal…or just not attending school, all the things that are usually considered to be due to anxiety, there's that general word anxiety, no one even seems to really consider what raises the anxiety in the first place.

(Q13.15) We're trying to unpick and formulate what a child or young person's needs are…there's obvious crossovers with autism and social anxiety and being around people but it's good to have that different hypotheses and that level of awareness.

(Q13.1) For things like autism…we have a rather sort of binary view…of many of those atypical behaviours.

QT14.

Information Most Useful for Identification: Better Able to Recognise Signs

(Q14.1) I will certainly be more alert to those signs of it.

(Q14.10) Starting to identify some of the signs or risk factors…that could be manifesting as BDD.

(Q14.15) The warning signs… that's very clear…holding that in your formulation processes.

(Q14.6) I thought some of the criteria…you gave a clear definition and then some possible observable behaviours that were useful…you gave the example of frequently checking in the mirrors or obsessing over a particular feature.

(Q14.8) The symptoms and things to look out for was particularly helpful, not only for me but in being able to educate staff or just listening to things staff are saying, those sorts of things will jump to mind a bit more…like the kind of checking behaviours, disguising behaviours.

(Q14.7) Warning signs…some of those I hadn't really thought about, so that was really useful...that's helpful for EPs because you've got a kind of checklist…in your head to be thinking through…if you're observing or you're listening to things that members of staff have said.

(Q14.9) There's the recognition of it as well…being more aware of behaviours or indicators of it…as well in terms of flags, if school were raising a child with you, you'd be able to refer to that list of behaviours…or with parents or with the young person as well…to see, are these the types of things we're seeing.

(Q14.11) The more specific detail around how it can present and some of those presenting behaviours…I'd probably unpick a bit more carefully and ask more questions around.

(Q14.13) Avoiding social contact, when we might think it's a trait of something else…all of the warning signs really could easily be linked to other difficulties…but if the child was showing several of those warning signs, it would now lead me more to considering BDD, rather than looking elsewhere.

(Q14.5) The potential of hiding the anxieties and the obsessive sort of behaviours or the checking behaviours, I think I'd be more aware.

(Q14.14) I think before I would have been looking for far more obvious markers than I would be now.

QT15.

Information Most Useful for Identification: Lack of Insight

(Q15.8) The lack of insight…that really struck me as a really key part…so being really sensitive but open…with the sorts of questions I'm asking, or what I'm listening…thinking about that discrepancy between what they are perceiving about themselves or what they believe, and what maybe I am seeing more objectively from the outside…that would be a real change in terms of what I would be looking out for.

(Q15.9) This is something that young people may not be expressing often…because it's that genuine belief, isn't it, that there's something wrong so there's nothing to help you.

(Q15.14) I would maybe ask more questions if I heard small comments…whereas before, I probably would have been waiting…for them to essentially tell me that that was what was going on. Whereas now I might be looking for…more subtle, or less obvious, markers than I might have been previously.

QT16.

Information Most Useful for Identification: How to Talk to Young People About BDD

(Q16.2) The questioning that you can use with a younger person, the ages that you should be starting to maybe ask those questions a bit more…I think just knowing to ask and what to ask, makes all the difference.

(Q16.4) If it comes up…what sort of things I might say, or explore it a bit more…how I might react to it, and how it might unfold…it's made me more aware in that way.

(Q16.6) I would equip myself…if I was going to have a conversation…with the other person around this...what would be the language I would look for…that's where I took it.

(Q16.7) I suppose we need to ask the right questions…your guidance around that actually was useful, you know, around how to kind of approach that, if you are talking to them on an individual basis.

(Q16.3) The training has made me think about questions that I might ask…for example, on the Butler Self Image profile… one of the questions…says 'I like the way I look'. I've never…explored that with children, I ask some questions about some of the others, but never particularly about that one…having done the training, if they put zero 'not at all like me', then that actually might make me think about some questions that I'd want to ask them and talk to them about…so it's been really helpful in that sense.

(Q16.9) We're good at asking curious questions that aren't leading and hopefully don't create difficulty for the young person…if appearance came up in a conversation, it might just be something I would explore differently to how I might have done before.

(Q16.14) When I'm talking to them about being attractive…being liked…might be useful to ask some of those questions about how often they think about those things and how important those things are to them. Which is perhaps...an avenue, I wouldn't have gone down before.

(Q16.5) I wouldn't have felt comfortable to ask about it or wouldn't have thought that it was necessarily within the EP role…so more confidence to ask a young person about how much they think about their appearance…in quite a general, safe, open way.

QT17.

Information Most Useful for Identification: Separating BDD from Eating Disorders

(Q17.5) It's useful to conceptualise it very differently to an eating disorder or weight-based kind of anxiety.

(Q17.6) I think the like separating out was quite helpful, when you're around anorexia and bulimia and body dysmorphia.

(Q17.14) I just think the knowledge that I have now about…not always having a link with eating disorders.

(Q17.11) I might've...miscategorized it as…an eating disorder…I had a less nuanced understanding previously cos it just wasn't on my radar at all really…having a really clear kind of distinction between the presentations, I find that memorable for me and helpful.

QT18.

EP Role in Identification of BDD: Explore Hypothesis with Young People

(Q18.2) If we're going into schools, we're seeing young people and having conversations about how they're getting on, what they're finding difficult.
(Q18.9) When we're already involved with the young person…using our questioning…to be exploring facts if we've got a hypothesis that BDD might be in play here.
(Q18.5) If I had reason to believe it was quite a plausible hypothesis…I would discuss with the young person…that this might be a thing.
(Q18.13) Having a conversation with the child…obviously a sensitive conversation, asking them how they feel about their body-image.
(Q18.6) I would probably use something like the ideal self…to explore it a little bit more…that could be quite an interesting tool that I could use that it might be a way that might highlight some of those issues.

QT19.

EP Role in Identification of BDD: Exploring Hypothesis with Schools and Parents

(Q19.7) If we'd thought of it, we could then flag it up with the SENCO or even with parents if we were talking to them about it…we might explore those hypotheses.…we might not say it explicitly, at first, but we might be asking questions…going through your behaviour checklist in a way in our heads and checking out things that fit that, things that don't fit.
(Q19.12) I wouldn't particularly use the terms in discussions with staff, but I would maybe describe it…and explain what my perception of what was going on was with that in mind…I would actually, maybe do some observation and consultation, and then perhaps go away…read about it…look into it more…see whether that comes into play…whereas I wouldn't have done that before.
(Q19.13) I suppose then…it would be a conversation with school, but it's a fine line of intruding on the child's privacy and wants. So…I would probably discuss it with my principal EP and be supported by her.

(Q19.2) I think that's a good time to have those conversations and then working out how we can share that information…I suppose talk to other people about it…parents or school staff…we're starting to have planning meetings…so I suppose that's a good forum, when we're talking about individual children.

(Q19.5) I would use a similar framework to…if a young person disclosed that they were self-harming and this was the first that they'd told anyone…it could be something that we could look at getting some more support for, and explain to them that I'd like to talk to their parents if they're under 16 and potentially school SENCO or safeguarding or someone they felt comfortable with.

(Q19.9) To work with parents, school with the young person to…start to test out that hypothesis…there's us helping others identify, and there's us being involved in that…process of identification as well…having that knowledge that you can impart on others in consultation.

(Q16.3) I think it would be something that we would need to be thinking about and aware of…when we ask questions in consultation…it has influenced my thinking in terms of perhaps giving me a wider range of questions and thoughts that I might ask about.

(Q19.11) If I had been in the school, I just think...exploring it as a hypothesis really, would have been, what I would have liked to have done…they've got concerns…the young person's not attending or they're spending prolonged periods in the bathroom…having that initial consultation, trying to unpick it with them as to what's going on.

QT20.

Barriers to Identification of BDD by EPs: Not Diagnosing

(Q20.3) I think it's like all sorts of diagnostic things are medical diagnoses, and I suppose this will be a medical diagnosis in the end, wouldn't it?

(Q20.6) So I always consider us as like non-diagnostic, so I wouldn't particularly see as in a role of diagnosing.

(Q20.13) I think it's more important we raise it and help people to understand that it's another hypothesis…I think it's appropriate for us to have those discussions, but probably not to go down the diagnostic route.

(Q20.14) I don't really want to go down that clinical route of knowing diagnostic criteria and all that medical model stuff, because I don't really like that kind of approach.

QT21.

Barriers to Identification of BDD by EPs: Dangers of Labelling

(Q21.1) I really worry about the children who end up with labels that they have not asked for…I will be including it in my thinking around something that I go as far as questioning as part of identifying need. But I wouldn't cross the line into a definitive "Yes, this is what it is."

(Q21.3) I don't think I'll be writing in my report, I think such and such has got body dysmorphia…I'll be presenting the evidence of…there are some issues around body-image, that this might warrant exploration.

(Q21.6) I wouldn't necessarily bring that as a term or a label to the party.

(Q21.12) I don't really like labels, I just think that there are certain things that are different from maybe other labels that people might attribute…I think a lot of young people end up with a diagnosis of autism, when actually, it's not autism, it might be developmental trauma…It's the same sort of thing…I don't generally put labels in my reports, I describe behaviours and responses to behaviours…I just think people do misuse labels, misattribute labels, and they're not really very helpful, because it's almost like it comes to define the person.

(Q21.15) It's appropriate to consider, if it's a diagnostic term…some EPs are quite divided on that. I tend to look for need, as opposed to attaching a label

QT22.

Barriers to Identification of BDD by EPs: BDD is Too Hidden

(Q22.4) It's quite a tricky subject because it is so hidden…I suppose I think about girls and how they look and it's becoming more with boys…and about plastic surgery and changing parts of your body…it seems to be blurring the lines a bit…people say, "Oh, this is wrong with my body or that's wrong with my body."

(Q22.5) Young people might tend to kind of hide their thoughts or their feelings or perceptions of their particular body parts and whether it might be such a hidden thing…that they haven't voice that to others.

(Q22.12) I'm working with a girl at the moment who is quite high functioning autistic… but actually will not accept that she's autistic, does not want anyone to know and it's incredibly difficult both for her to manage, but also for any professionals or school staff to help her…I assume that will be the case with body dysmorphia.

(Q22.7) if people go to the gym a lot and they're obsessed with their appearance…I suppose you wouldn't necessarily think that they'd be unhappy…you could potentially see that as "Oh, they like the look of themselves."

(Q22.10) I mean, you might notice they put a strange amount of makeup on their nose or they cover it up…there are those signs, but it's much less outwardly obvious.

QT23.

Barriers to Identification of BDD by EPs: No Long-Term Contact with Young People

(Q23.3) We tend to see children only when we are being asked for psychological advice. So we get a very limited opportunity to talk to them.

(Q23.4) If someone doesn't want to disclose it openly and in my EP work, I see a young person…two or three times and…whether I can actually make some kind of assessment is quite difficult…because you've got to build a relationship with that person, to actually then for them to trust you to perhaps disclose anything…so that time restriction as a bit of a barrier in terms of being able to identify these sorts of needs.

(Q23.13) I can only speak for our service, but I imagine it's similar across the country. We're not in the fortunate position of working with the children in schools every day.

QT24.

Barriers to Identification of BDD by EPs: Schools Won't Notice Signs

(Q24.3) They would think about all sorts of other things first, they might get around to that because the young person themselves might actually give them enough clues or tell them…but I don't think it would be their first port of call in thinking about it…it may only come to that point when they actually stop coming to school.

(Q24.6) So if that child is just ruminating on it themselves, that doesn't necessarily mean that in the classroom, it's having much of an impact on their behaviour or their learning. So I could see it going under the radar.

(Q24.7) I don't think it will be really obvious…so teachers…might not actually pick up on it really in terms of…what the issue is.

(Q24.10) I don't think the school would identify it, therefore they would never refer a young person to us for that, it would be quite unlikely I think, in my schools anyway.

(Q24.11) I think they didn't see it… as having an anxiety basis, seeing it as…typical teenage kind of vanity…that kind of narrative, "Oh, they're all obsessed with social media."

QT25.

Next Steps Taken in Terms of Identification: Incorporating Questioning about BDD

(Q25.10) You were talking about the criteria, she was literally like ticking all the boxes and I then spoke to her again afterwards and I asked her some of the questions that you suggested around 'How much time would you say you spend looking around your face?'… So I think that would be something I'll be better able to do.

(Q25.15) It certainly has impacted on me with my planning meetings that I've had this year already. One case in particular, I've already asked the question "Have you considered something else as well?"…they were having hypotheses around whether it was autism or PDA, but it was a control over things associated to their appearance…it looked like it was social anxiety but when we unpicked, it was actually more about their appearance…they were saying "Well we don't understand why he doesn't like social interactions…he likes to face away from people. He's constantly covering up his face and he's worried about what other people might think about his appearance"…because he'd been previously on an assessment for autism…he'd had very patchy school attendance…and I just happened

to kind of throw it out there "Have you considered this as being a hypothesis?" and they've gone "Well, we'll talk to the PSA"…so they've gone away with like a little nugget to kind of like unpick and I signposted them to some resources as well…if it wasn't for your training…I wouldn't have even asked that question, I wouldn't even thought about it. And it was fresh in my mind…so it's giving them another pathway to go down as well that hopefully allows them to understand this boy's needs a little bit more as well. I will follow it up with the SENCO…they're going to go away and have a little think, a little read around it.

QT26.

Information Most Useful for Supporting BDD: Evidence-Based Interventions

(Q26.1) Information about the treatment part.

(Q26.2) Having an understanding and awareness of what the helpful interventions are.

(Q26.4) You can work with it with using cognitive behavioural therapy…I thought about that and how that could be used.

(Q26.5) I would be able to write in a report that CBT is a recommended evidence-based approach…I'd feel more confident to know that that's the pathway to go down and get the right support, even if it's not me delivering it.

(Q26.6) The intervention element, I thought was the most helpful part.

(Q26.7) Before, I probably would have had an idea that that was an intervention [CBT], but now I know it's evidence-based…so what actually can we do that contributes to that?

(Q26.14) The fact that CBT…can be really effective, was almost a bit reassuring, because …sometimes when you're working with a young person, and you've got this new thing that you…don't have a lot of experience of, it can be a bit frightening to think about what's actually available and what should be available for that young person.

QT27.

EP Role in Supporting BDD: Cognitive Behavioural Therapy

(Q27.10) You highlighted that CBT is one of the best evidence-based interventions for it…so delivering some CBT with appropriate supervision. That would be quite doable.

(Q27.5) In our service, lots of EPs do deliver CBT…we do have in house CBT supervisors…I would like to do the training, just haven't got around to it yet. So yeah, that is a possibility.

(Q27.8) I'm from a mental-health background, so I'd be more than happy to do that…individual CBT.

(Q27.9) I'd love to, I loved doing…the CBT informed kind of intervention.

(Q27.11) I personally would love to do that kind of thing [CBT].

(Q27.4) I have done some CBT so…I do feel fairly confident about it…it's possible…it would take time…I do feel I could do a bit more. I suppose if I could work with a young person to build a relationship with them, if I had so many sessions I could do that.

(Q27.6) I think I would probably take that sort of CBT approach…if I was able to work with a child for that long.

QT28.

EP Role in Supporting BDD: Cognitive Behavioural Approaches

(Q28.7) We're not qualified in CBT to…an extent where you would deliver it in its truest sense, but we could do elements of that…basic CBT-type strategies…it's evidence-based…that type of approach works.

(Q28.8) We know how to help young people with those core beliefs…the dysfunctional thought patterns…the way that we've been trained to support young people around the cognitive behavioural models…it's gone from something that I didn't really understand quite what it was or how to go about it, to something that actually fits really neatly into what we do anyway.

(Q28.14) There's a limit to what we can do, so, of course, I know that I don't have extensive knowledge of how to work with young people who have BDD and CBT…but as part of my training, we were trained in cognitive behavioural approaches, so in theory, if you're working with that young person…you could use the principles of those.

QT29.

EP Role in Supporting BDD: Accessing the Voice of the Child

(Q29.11) Potentially with the young person, gaining their views around it…that will be central to involving them in…co-construction of solutions…a key one for me would be…the young person's experience of school…that they're as included as possible and that the environment works for them.

(Q29.14) Working with the young person, asking "How can we make the time when you're in school as positive as possible?"

(Q29.15) Gaining the voice of the young person…would be the first step, because it's about their lived experience…then we can start unpicking the actual needs…and what adaptations, what amendments and differences need to happen in the provision in order to better meet their needs.

QT30.

EP Role in Supporting BDD: Advocating for Young People

(Q30.9) That's a big part of our role…working with the young person and advocating for them, for how they communicate what their needs are and how those are supported…supporting the young person to be able to talk about their difficulties with the people that are close to them…what they would like in terms of help within school, how they'd like to communicate their needs, what they'd like to call it.

(Q30.14) Working with the young person, asking 'How can we make the time when you're in school as positive as possible? What do you want me to share with your teachers?'…often particularly at primary school, you sort of make plans for children…but especially at secondary school…you don't know what young people want themselves, so need to come up with a plan…that they're going to feel comfortable with.

(Q30.15) It's about the advocacy role and gaining the voice of the young person…and sharing that more widely…they would be the first steps

probably because it's about their lived experience…then we can start unpicking the actual needs…and what adaptations, what amendments and differences need to happen in the provision in order to better meet their needs…trying to help the other practitioners, including school staff, and other people, maybe parents as well sometimes, who are not understanding the child's needs and the anxieties around those...helping them to be in their shoes a little bit more.

QT31.

EP Role in Supporting BDD: Supporting Schools to Support Young People

(Q31.3) The role that we have in terms of our authority is in terms of largely assessment and providing advice and consultation with school staff.

(Q31.9) Helping school staff and parents…think a little bit about how they're supporting young people and at that consultation level is where our support might happen.

(Q31.14) I think it'd be about educating and coming up with strategies with staff and then working with that young person to put a plan in place that they are happy with.

(Q31.7) We're suggesting things that members of staff could maybe do to help…perhaps working with the schools on the way that it presents in school…if it's around lack of engagement with peers or whatever, trying to facilitate that through the staff. We could teach members of staff to use the CBT model and to help students and people to kind of think about 'Right well, what was your thought process before, during and after you did the behaviour?'…how you might behave differently or how you might think differently…perhaps even just helping the members of staff to look for resources that would be useful and to work with them either on an individual basis or a group basis.

QT32.

EP Role in Supporting BDD: Psychoeducation in Schools

(Q32.11) I guess trying to create more empathy…see BDD as potentially having that anxiety basis and therefore…that might change the school's narrative around what they would put in place.

(Q32.7) You might end up with staff that are at loggerheads with young people…if they're keeping their coat on and they've got a hood up, that kind of thing…that would be potentially around changing mindsets in school, making staff aware of the issues and actually, that it's not helpful to ask children to take makeup off or whatever…because for them, that might be a really big psychological type issue…especially discussions with senior management staff.

(Q32.12) There's probably certain behaviours that…would be misunderstood and therefore not tolerated…or just put it down to general anxiety...anxiety presents in many different ways.

(Q32.14) So when she's faced with the...'Well, either I wear the wrong shoes, or awful shoes that are going to make my feet look so much bigger, or I have an argument with a member of SLT, and I miss school for a day'…she's going to probably take that second option…I think it would be about and working with staff to get a better understanding and an acceptance and acknowledgement of what some of the behaviours they might be looking out for are…understanding that that a young person isn't being defiant or bad or rude…these are all the things that they're dealing with in their head, so we need to have a bit more understanding of that.

QT33.

EP Role in Supporting BDD: Referral to Other Services

(Q33.4) Maybe I have some questions and then I would have to say…perhaps refer this on to someone who could do some more in-depth work.

(Q33.14) Signposting on to the right kind of services.

(Q33.7) Signposting definitely…that would be a big thing…depending on how severe is a suppose, signposting to other agencies that are better placed to deal with it from a medical point of view…saying 'Do you think it's worth a visit to the GP?'

(Q33.11) Potential signposting on as well…to GPs, CAMHS…if you all together feel that might be something that is worth exploring further.

(Q33.5) Maybe we could look at a referral through to CAMHS…I guess I would kind of follow that sort of process.

(Q33.9) To work with parents, school with the young person…to start to test out that hypothesis and then be able to…make a referral onto CAMHS as required.

(Q33.10) BDD would typically be passed over to CAMHS to be supported, I think.

(Q33.13) I would like to say that we would support with that, but my gut feeling is that we would refer on to our local CAMHS.

(Q33.1) I'm not quite sure how I would broach the issue other than…referring to CAMHs…most of my colleagues will say…signpost it and keep it in mind as part of your formulation but would do no more than signposting to other services.

(Q31.6) Perhaps I wouldn't necessarily have referred on to mental-health services before, I would have just worked through it as, as a piece of casework…perhaps maybe I would more so if having it defined might be helpful for that person.

(Q33.2) Leading on to signposting…maybe signpost them to some websites on it…I think at the moment…I can't really think of anything more than that.

(Q33.3) It will largely be around signposting to either other professionals or to sources of information, which would presumably then give them access to…other sources of support.

QT34.

EP Role in Supporting BDD: Collaborating with Other Professionals

(Q34.5) If it did get to a stage where we're putting together a referral to CAMHS, I'd be linking up with that CAMHS professional…checking out their knowledge and understanding of BDD, because by the sounds of things from your research, it feels fairly new in the CAMHS world as well…then them applying…that to their knowledge of CBT to…work together collaboratively.

(Q34.9) So we may be supporting other aspects that affect that young person…not the intense therapy that they would be having through

CAMHS, which is when it comes to this idea of a joined-up approach and multidisciplinary working, it's going to be really important so that you've got everything in place for that young person.

(Q34.10) If we were invited to those multi-agency safeguarding meetings to help to risk assess the young person...sharing some information and giving some input around that to the other professionals to think about the social care aspect.

(Q34.14) An educational psychologist with the kind of background we have, knowledge of school systems and child development…would be quite a useful person to have in those kinds of fields, maybe a little bit more than they are at the moment, when it's probably dominated by clinical psychologists, and clinical staff.

QT35.

Potential Barriers to EPs Supporting BDD: Direct Work Not a Common Occurrence

(Q35.1) I suppose I probably wouldn't in my role.

(Q35.3) I don't think it would be seen as being anything that we would particularly be directly involved in…that's partly the result of our context, because we don't actually do any direct therapeutic work with children.

(Q35.4) Whether I could do that in my EP role anyway, I'm not sure.

(Q35.7) We probably won't be dealing with it on a kind of individual level.

(Q35.2) We haven't done direct intervention for a really long time...years…we've done CBT training and VIG training, so we did used to do quite a lot of it.

(Q35.8) I do think there's a huge role for EPs there, but I think, as times go on, and we move further away from doing individual work, it's a real loss actually, there's a gap and I think actually, we've got a huge skill set to be able to offer that, that sort of CBT-type approach.

QT36.

Potential Barriers to EPs Supporting BDD: Limits to Competence

(Q36.9) What we know works for supporting BDD, has to come from more of a clinical, therapeutic route in which as an EP, I'm not trained.
(Q36.5) Me personally, I haven't done enough CBT training to deliver a comprehensive CBT intervention.
(Q36.10) I think for me, it would be about confidence in supporting a young person with it…identifying and doing assessment, that would be within my area of confidence and competence…but in terms of actual intervention, for example, CBT, that would be more specific.
(Q36.11) I still lack the training, and the confidence.
(Q36.2) That would make me quite nervous at the moment [direct intervention]…I would feel less sure about doing something like that without any further input on it.
(Q36.4) I don't think I'm really well trained about that, you know, to actually work with a young person on it...I do feel I could do a bit more.
(Q36.3) We perhaps underrate ourselves as EPs…but I think if I say honestly, I don't think I would have...feel I would have any skills in terms of therapeutic work.

QT37.

Potential Barriers to EPs Supporting BDD: Lack of Time and Resources

(Q37.3) Time is always a barrier.
(Q37.12) Time factors.
(Q37.13) Time constraints. We are an under-staffed service.
(Q37.5) All the usual barriers to doing different kinds of work in terms of time.

(Q37.9) Time, money…in terms of local authority funding and schools...if it's a traded service, then being able to have money to buy in that time.

(Q37.2) It was the SEN reforms and probably austerity…there's been a bit of a loss of opportunity and also skill. Which I'm sure is still there.

(Q37.4) BDD is not going to be something that you can…remedy fairly quickly...CBT is quite a number of sessions…it seems to be something that you dwell on for a long, long time, and it could go on for so many years.

(Q37.8) Time I suppose, building up a relationship with a young person…it's all about resources within the local authority to be able to give because…we're not talking about one or two sessions, we're talking about a sustained period of time to get that real therapeutic value.

(Q37.10) We'd need time as well for the CBT supervision...supposing I wrote that into the EHCP for this young person...I think I actually did after your training...who then funds it?

QT38.

Potential Barriers to EPs Supporting BDD: High Workload

(Q38.7) Part of this is around capacity… the majority of the work we pick up is statutory work that comes through panel.

(Q38.9) Statutory demands within local authorities…we don't have as much time to do preventive work as we might want to.

(Q38.12) Statutory commitments…capacity within EP services.

(Q38.6) All the boundaries that are in place with traded services…whether you have the capacity.

(Q38.1) We have 12 full time equivalents to do statutory work, and we have to deliver traded as well. Most of us tend to have no more time unless it's initial consultation, assessment. It's very, very rare that any of us do any kind of ongoing work…it's starting to change now, so I'm hopeful for the future.

(Q38.10) It was very limited. It was for an EHC sadly…it's limited with how much I can support, but she does go to one of my schools, so I'm hoping I'll be able to follow up…I think time constraints and the EHCP pressure…being a traded service with priorities being statutory assessment in that way are probably the main constraints at the moment…increasing pressure to see more and more children each term, and our school's time keeps being cut every term because we've got more and more of a backlog of EHCPs to do, it's quite demoralizing.

QT39.

Potential Barriers to EPs Supporting BDD: Schools Unlikely to Commission

(Q39.5) It depends on service models…in the service I work in we are traded or semi-traded. But schools tend not to ask us to do sort of therapeutic work, it tends to be quite assessment focus or consultation focused.

(Q39.10) We're a traded service, and schools are increasingly wanting us to see kids to do the preliminary work for getting them an EHCP, which I know is quite a typical trend across the country…in an ideal world, I would…deliver CBT for this young person, but they're never going to commission that because they want four kids to be seen with the same amount of time.

(Q39.11) I imagine it would be traded work and the traded model of delivery...that tends to be a barrier for schools commissioning us…some of them do use…their sort of money to do that…but that targeted individual casework…not many schools would commission us for that, unfortunately…they'd want something more systemic, or they'd want you to do…a report towards a needs assessment.

(Q39.3) I think it probably will be seen as being fairly low down the concerns that schools would have in terms of education…I think these would not be children that would come anywhere near an EP…I don't think they would necessarily see it as something that would present as being a significant impact on children's achievements in school.

(Q39.6) Whilst it could have a heavy impact for that individual, it might not have a heavy impact for the school…I could see it not necessarily meeting the school's criteria of priority for that much time.

QT40.

Potential Barriers to EPs Supporting BDD: Multi-Agency Work Not Happening

(Q40.11) If we could join up with CAMHS colleagues or…receive training. That would be brilliant. But not at the moment, but I'd welcome it.

(Q40.10) In an ideal world, if there were no restrictions, I think we should be embedded in CAMHS services…going through referrals that come in in a multi-agency way.

(Q40.1) The interface between educational psychologists and clinical psychologists and psychiatrists…I think this happens in the more enlightened parts of the world, clearer links between educational psychology and CAMHs. We don't have that here, at the moment…there are no formal ways of doing it because there's no time at the moment…whereby we would say "we will be part of that multidisciplinary team".

(Q40.2) The extent that we collaborate has also gone down...over the last few years…we used to have quite regular meetups with paediatricians, with CAMHS, around how we work, the sorts of things that are coming out…we used to do joint work together…it's time resources and people resources, which then leads to time resources.

QT41.

Potential Barriers to EPs Supporting BDD: Lack of Awareness of Other Professionals

(Q41.2) I honestly can't think about a time when I've read a professional report or actually probably spoken to someone and BDD has come up as something to look at.

(Q41.8) The other big, surprising thing for me was mental-health professionals not fully understanding it, that was quite concerning, that even amongst people trained to do that sort of thing…they're missing it.

(Q41.7) I went to the GP, got a really unsatisfactory answer, something like...because I said "I can't stop skin picking" the response was "Well, you've got quite long nails maybe have you thought about cutting your nails" and I thought "Oh, no, you're not getting this at all", because I'd be doing it with tweezers or scissors or something else if it wasn't my fingernails…if the GP…doesn't kind of recognize it...and if the person doesn't persist with…going down that route.