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Young people's experiences of body dysmorphic disorder in education settings: a grounded theory

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ABSTRACT

Body dysmorphic disorder (BDD) is characterised by a distressing preoccupation with perceived defects or flaws in one's appearance. BDD most typically emerges in adolescence and is estimated to affect 2.2% of the UK adolescent population. There is a dearth of research into children's and young people's lived experiences of BDD, particularly in relation to educational contexts. Using Constructivist Grounded Theory methodology, interview data from 10 young people between the ages of 16 and 25 were analysed for this study. Findings informed the development of a psychological model of BDD in young people: *The Shame-Identity Model of BDD in Young People*. This paper focuses on the educational aspects within this model. Implications for educational professionals are discussed.



KEYWORDS

Body dysmorphic disorder; BDD; adolescent mental health; obsessive compulsive and related disorders; OCD

Introduction

Body Dysmorphic Disorder (BDD) most typically occurs in adolescence (Bjornsson et al., 2013; Gunstad & Phillips, 2003; Phillips et al., 2006b). It is characterised by a distressing preoccupation with perceived defects or flaws in one's appearance, which are either not visible to the outside eye or are attributable to normal human variation (American Psychiatric Association (APA), 2013). In one of the larger studies of individuals diagnosed with BDD ($n = 188$), the mean age at onset was 16 years (range = 4–43 years), with BDD beginning before the age of 18 in 70% of cases (Phillips & Diaz, 1997). BDD is estimated to affect 2.2% of the UK adolescent population (Veale et al., 2016) and has one of the highest suicide rates associated with any mental health diagnosis (Phillips, Menard et al., 2006; Phillips et al., 2006b; Veale et al., 2016). The appearance preoccupations characteristic of BDD can make it difficult for young people to attend school, socialise, and even leave the house, sometimes for many months or even years (Phillips et al., 2006b). In one study, 15% of a sample of 33 adolescents (Albertini & Phillips, 1999) had dropped out of school permanently due to BDD-related distress.

There is a slowly growing body of research exploring the lived experience of adults diagnosed with BDD. This research suggests that adults diagnosed with BDD typically experience feelings of hopelessness and suicidality (Phillips, 2007); engage in excessive grooming, skin-picking, mirror-checking and camouflaging of aspects of their appearance

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(Phillips, 1991, 2007; Phillips & Diaz, 1997; Phillips et al., 2013; Phillips et al., 2005; Veale et al., 2015, 1996); have a tendency to process visual information locally as opposed to globally (Feusner et al., 2010); experience rumination (Kollei & Martin, 2014); have pre-occupations that absorb up to eight hours of their day which are difficult to resist or control (Phillips & Hollander, 2008); and have a pervasive feeling of ugliness (for example, Phillips & Diaz, 1997). However, despite the growing body of research into adults' lived experience of BDD, there is a dearth of research into the lived experience of young people and their families (Phillips et al., 2006b).

Adolescence, the time at which BDD most typically emerges, is a critical stage in the development of identity (Marcia, 1967, 1991; Meeus, 1996; Waterman, 1993). In the modern Western world, adolescents arguably seem to be seeking their identities in a society within which appearance ideals are becoming increasingly narrow, prescriptive, and extolled as synonymous with success, happiness, and lovability (All Party Parliamentary Group on Body Image, 2012; Mental Health Foundation, 2019; Women and Equalities Committee, 2020). Societal notions of the optimal appearance of different body parts may be particularly compelling for adolescents, as identity formation is a key characteristic of this life stage. Adolescence is a stage in which identity strategies are trialled and challenged, and infantile identifications become identity (Kroger, 2004; Marcia, 1989). Adolescents may construct imaginary representations of themselves based on societal discourses that are not directly accessible to the conscience (Guichard & Huteau, 2001; Santisi et al., 2014; Wigfield & Wagner, 2005). It seems plausible that these representations are assimilated from societal notions of lovability and beauty, including via educational experiences and interactions with peers in education settings (Bissell & Rask, 2010; Moradi et al., 2005).

Preliminary literature review

Consistent with Constructivist Grounded Theory (CGT) methodology, a targeted literature review was conducted after data collection and analysis (Charmaz, 2014) and incorporated into the study discussion. A preliminary search was also carried out to establish context and avoid duplication (Chiovitti & Piran, 2003; Dunne, 2011). The purpose of this preliminary review was to obtain an overview of the current knowledge base of young people's experiences of BDD and identify gaps in the research to inform the research questions (Birks & Mills, 2015).

The preliminary literature review comprised 34 papers. The Critical Appraisal Skills Programme (CASP, 2016), a critical-appraisal research tool, was used to assess each paper's aims, sampling, study design, data collection, data analysis and findings.

The preliminary literature review revealed a paucity of qualitative research into the lived experience of BDD in children and young people. The studies which explored young people's lived experiences were either single-case studies largely focused on the role of medication and/or specific treatment programmes (Adebayo et al., 2012; Burrows et al., 2013; Phillips et al., 1995; Thein-An et al., 2017; Thungana et al., 2018), or solely used a range of scientifically-validated assessments to gather experiences (Albertini & Phillips, 1999; Calogero et al., 2010; Damercheli et al., 2017; Kaymak et al., 2009; Mastro et al., 2016; Pecorari et al., 2010; Phillips et al., 2006b; Veale et al., 2014; Woodie & Fromuth, 2009). None asked open, exploratory questions about young people's experiences with BDD, posed in-depth

questions about educational experiences, or sought to explain the nuances of young people's experiences. From the existing research it is unclear what impact educational experiences have on BDD in young people or how BDD affects and impacts upon young people in education settings.

Materials and methods

The current study aimed to address knowledge gaps and exploration omissions by developing a Constructivist Grounded Theory of young people's lived experiences of BDD, including within the educational context. The research questions were as follows:

- (1) What informs and perpetuates young people's experiences of BDD, including in education settings?
- (2) How do educational experiences inform the emergence and experience of BDD?
- (3) Does BDD impact a young person's experience of education and, if so, how?

This research also had an emancipatory element. The researcher considered participants may experience feelings of empowerment as a result of talking about their experiences which, until now, have largely been absent from the literature.

Ethics approval and consent

An ethics application to the university was reviewed and approved in June 2018. The research complied with the British Psychological Society (BPS) *Code of Ethics and Conduct* (BPS, 2009) and the *Standards of Conduct, Performance and Ethics for Practitioner Psychologists* (Health Care Professions Council (HCPC), 2008). The author sought and was granted permission from the BDD Foundation and OCD Action to use their membership lists for recruitment purposes, and from the Michael Rutter Centre at the Maudsley to send emails to young people who had consented to be contacted for research purposes.

Participants were provided with detailed, written information about the study at least two weeks' prior to taking part, via an information sheet (BPS, 2009, 1.3: 1). Prior to their signing a written consent form, potential participants were informed they would be at liberty to withdraw at any time (BPS, 2009, 1.4: 2).

The author made participants aware that a small study, such as this one, would carry greater risks in terms of participant identification, but every effort would be taken to ensure anonymity. This included removing parts of the transcripts that could compromise the participants' identities (for example, names of towns/therapists/peers) and giving each participant a pseudonym for all written material and records kept.

Method

The methodological approach chosen for this research was Constructivist Grounded Theory (CGT), a contemporary revision of Glaser and Strauss's (1967) original Grounded Theory (GT). The constructivist approach to GT (CGT) has historically been built on theories of social justice with a focus on "furthering equitable distribution of resources, fairness, and eradication of oppression" (Charmaz, 2005, p. 203). Whereas traditional

Objectivist Grounded Theory (OGT) (Glaser & Strauss, 1967) seeks to identify and conceptualise a core concern, CGT typically presents a theoretical product of a more diffuse nature in keeping with the ontological relativism of multiple realities (Martin, 2006). While OGT aims to erase the social context underlying the data, CGT emphasises the importance of context and reflexivity of researcher interpretations, including the social context within which the data gathering process takes place. Thus, CGT results in an analytic interpretation of participants' experiences and the processes which constitute how these experiences are structured.

From the outset of this study, the author acknowledged, in line with the social constructivist position, that any resultant theory would be an interpretation, as the author did not conceive it was possible to analyse data independently of the author's personal experiences, opinions, and values.

The author considered other qualitative methods of data analysis, including ethnography. Following supported reflection with the research supervisor and a discussion with an expert ethnographer, it was felt that ethical concerns related to subjecting young people who struggle with appearance-focused distress to extended observation rendered this approach, both ethically and practically, unfeasible.

All ten young people who came forward, met the criteria, and who could travel to the designated interview space within a mental health trust setting were permitted to take part in the study, following signatories on the consent forms. Interviewing all participants within this mental health setting was a condition of the study approval required by the Ethics Committee; it was felt that the setting would provide a safe, containing space with mental health professionals close-by should the young people become distressed.

Due to the small sample size, and for reasons of confidentiality and anonymity, a limited amount of information in relation to the participants' identities is disclosed (Table 1).

Of these participants, nine identified as white-British and one as Caribbean. Two were attending secondary school, two were attending university, four were in work and two were neither in education nor employment due to BDD.

Semi-structured interviews were used to collect data (see Appendix for the Interview Schedule). Interviews were conducted by the author and all took place in an interview room selected for its privacy within the mental health setting. The content and structure of the interview were determined by questions which afforded an opportunity to address all research aims. The initial question invited the young person to reflect on a personal

Table 1. Research participants' gender identifiers, ages, and ascribed pseudonyms.

Self-Identified Gender	Age at Time of Interview	Ascribed Pseudonym
A (Female)	24	Angela
B (Female)	22	Beth
C (Female)	22	Catherine
D (Female)	25	Dion
E (Male)	16	Edward
F (Female)	18	Fiona
G (Female)	24	Gill
H (Female)	22	Hattie
I (Female)	18	Ingrid
J (Male)	22	John

object/piece of artwork they had been requested to bring with them, which they felt said something about their experience of BDD. Part of the reason for this decision was existing research suggesting that individuals with a diagnosis of BDD are more orientated than the general population towards artistic pursuits and careers (Veale & Lambrou, 2002). The final question prompted the young person to share anything further which they felt had not been covered. Thus, the interview both opened and closed in a person-centred manner. In line with social constructivist thinking, the author used the interview schedule questions as a guide only, employing flexible discernment and allowing the self to be led by the participants' verbal and nonverbal responses.

As the interview process unfolded, some early themes emerged. These themes were then woven into the interview schedule to further elucidate the emergent open and focused codes. For example, the theme of romantic relationships emerged in the first two interviews. Thus, the author asked all further interviewees about romantic relationships in the context of their experience of BDD. Therefore, the interview schedule was not static; rather, it was reviewed and amended throughout the interview process, both in the moment and between the interviews with different participants. Interviews lasted between 38–72 minutes and were transcribed verbatim.

The data analysis process involved iterative cycling between data collection, reading/re-reading transcripts, and replaying audio recordings. Reflexive processing was conducted simultaneously; that is, considering thoughts, reflections and researcher position in relation to the data being analysed. The author used three phases of coding for this study in line with Charmaz's (2014) recommendations: (1) open; (2) focused; and (3) theoretical.

This process raised four theoretical codes (Charmaz, 2014). These theoretical codes supported the emergence of a description of an overarching, core conceptual category: *Appearance-based identity becomes the focus of adolescent identity formation in BDD, informed by relational experiences of shame and low self-worth.*

Education-related findings

The CGT presented here proposes that young people's experiences of BDD are complex and multifaceted, revolving around a core sense of shame which is then projected onto a perceived appearance defect, around which adolescent identity formation then becomes focused. The author summarised this as the central theoretical category: *Appearance-based identity becomes the focus of adolescent identity formation in young people's experiences of BDD, informed by relational experiences of shame and low self-worth.* The study findings and emergent theory formed the basis of a newly proposed model, the *Shame-Identity Model of BDD in Young People*, as outlined in Figure 1.

The following four sections outline how the conceptual theoretical categories informed the CGT in relation to educational aspects.

Theoretical category one: appearance-based identity is informed by and informs relationships in young people's experiences of BDD

All participants talked about the impact of various relationships on their experience of BDD, including relationships with peers and educational staff. They also spoke about the

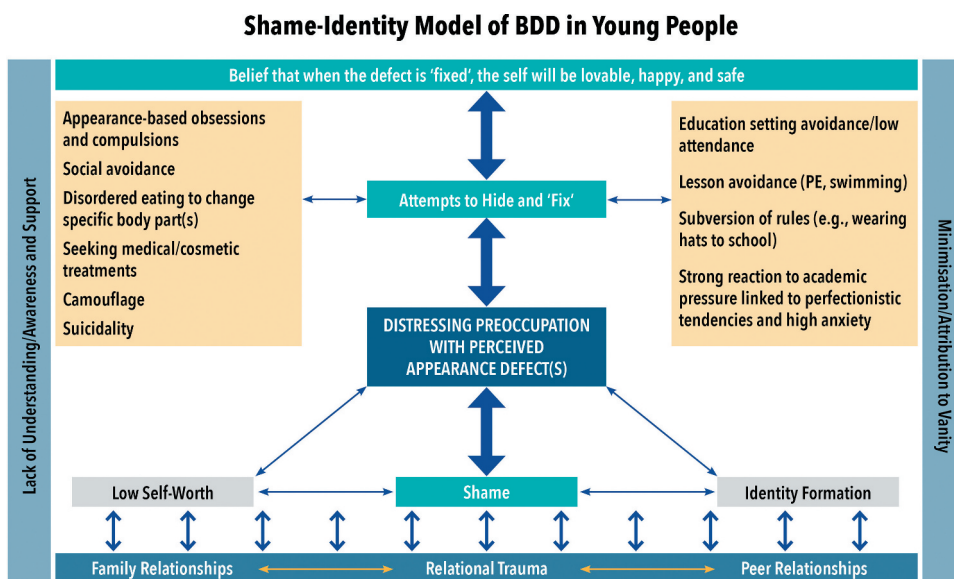


Figure 1. Shame-Identity Model of BDD in Young People.

impact these relationships had on the development and experience of their distressing preoccupation with their appearance.

The task of “belonging” in adolescent identity formation came through strongly in every interview. Some participants spoke about social pressure within their peer group being linked to their experience of BDD, including the need to fit in within education settings. Four participants spoke about the pressures of being part of the in-group, explaining how difficult it was to be “cool in general” (Hattie).

Most participants spoke about anxiety related to social relationships. Participants talked about feeling as though they had nothing to offer in social relationships: they also shared experiences of social anxiety in education settings (for example, “I remember specifically, the thought of being in lecture halls and seminars with other people was just so overwhelming. I just had to avoid that altogether.” [Angela]).

Social paranoia was a prevalent code across participants, which expressed itself in such statements as, “comparing and seeing people looking at me, which makes me extremely uncomfortable most of the time” (Edward). It was not unusual for some participants to regularly engage in “scanning the area and sort of listening to what other kids were saying, and if they were talking about me, or assuming that if they laughed, they were laughing at me” (Beth). For Ingrid, “it got to the point where I couldn’t go outside, in case people looked at me and judged me”.

Bullying and teasing in the context of peer relationships was spoken about by five participants as an aspect of their BDD experience. Gill described it as “the nail in the coffin” of her appearance-focused distress. Most of these participants experienced appearance-focused teasing within an education setting. Angela described her experiences of bullying as being “... definitely a catalyst, the bullying, and I think that sort of triggered the self-focused element of BDD.” John explained he had

forgotten his close friends would tease him about his nose until they reminded him some years later.

Theoretical category two: characteristics of BDD are expressions of shame and low self-worth

Each of the characteristics of BDD were described by the participants as an attempt to protect, amend, and make sense of a fractured identity, and/or to remove and/or soothe feelings of shame. Participants talked about engaging in appearance-focused compulsions, including within education settings, to remove their sense of shame and amend their physical appearance: and thus, their core identity, from a “bad” person to a “good” person, who was acceptable to the self and others and worthy of attention and love.

Experiencing aspects of their appearance as ugly/repulsive had an impact on their educational experience to some degree for all participants: they described perceiving themselves as a “*monster*”, an “*alien*”, and a “*non-human*”.

Feelings of depression and anxiety were shared, to some degree, by all participants. For nine participants, suicidality and/or hopelessness was a feature of their experience of BDD. Three reported, during the interview, that they had made suicide attempts, and each of these three had made more than one attempt. Fiona’s two suicide attempts were prompted by feeling coerced into returning to school before she felt she was ready. Participants who spoke about feeling suicidal cited reasons such as: (1) feeling life was pointless; (2) wanting cosmetic surgery and being unable to get it; (3) feeling like things were not going to get any better; (4) fear of others judging their appearance; (5) feeling as though there was no point in trying when one could take “the easy way out”; and (6) believing nobody cared about them. The sense of life not being worth living if one does not belong and/or is not cared for by others was a strong narrative across participants’ interviews.

Each of the participants spoke about, or strongly alluded to, feelings of inadequacy/low self-esteem which were broader than their perceived appearance defects. Beth explained, “*My sort of big fear is that I’m unlovable, and I will always be alone.*”

Theoretical category three: educational experiences trigger and are affected by BDD

The findings of this study suggest participants yearned to be understood, validated, and empathised with in the educational setting. They hoped, within their educational setting, to avoid further experiences of shame and to have their identity recognised, esteemed, and bolstered. Some participants seemed to feel as though they had lost their individual identity after transitioning to secondary school (becoming just one of a large crowd), in addition to experiencing increased academic pressure and social pressure from peers. It appeared that the formation of these participants’ identities was being informed by relationships with peers and educational staff, in addition to familial relationships.

The findings of this study suggest young people experiencing BDD may miss a significant amount of education as outlined in [Table 2](#):

Table 2. Overview of missed education for each participant.

Participant	Overview of Missed Education
Angela	Missed numerous university lectures and seminars. At one point, stopped going to university altogether.
Beth	Missed most of five years of school (going in only for the odd day, with attendance increasing to 30–40% in sixth form). Currently, low attendance at university (is gradually improving).
Catherine	No mention of missed school. Intermittent missed work days and changing jobs frequently, due to BDD.
Dion	No mention of missed school.
Edward	Regularly skipped Fridays at school (due to PE). Averaging 69–72% for GCSE years. Absent from school for multiple weeks during inpatient hospitalisations.
Fiona	Regularly didn't come into school until lunchtime (due to getting ready). Attendance regularly dropped as low as 12%. Described being " <i>hardly there</i> " for GCSE years.
Gill	Often arrived late for school, due to appearance-focused behaviours beforehand. Missed majority of lectures and seminars at university.
Hattie	Stopped going to school altogether at the age of 12/13. Raised attendance to 40% for GCSE year. Often skipped PE.
Ingrid	Stopped going to school in year eight. Rarely went to school thereafter. Did not sit any GCSEs.
John	Retracted his plans to go to university due to appearance-focused distress.

Reasons cited for missing education related to BDD included: (1) taking a long time to get ready in the morning; (2) depression (including finding it difficult to get out of bed); (3) anxiety (particularly social anxiety); (4) eating challenges (for example, feeling weak due to not eating enough); (5) feeling overwhelmed by BDD; and (6) being "*hungover*" (Gill) (due to drinking a lot of alcohol to numb BDD-related feelings and bodily sensations).

Two participants spoke about the struggle experienced by their parents when trying to get them to school each morning. Three participants spoke about finding it difficult to concentrate on schoolwork due to their BDD. Some participants engaged in compulsions to alleviate their anxiety and improve their concentration. Edward would "*... sneak out of school, run home, brush my teeth, and come back ... without it, I feel ... I don't know ... I just feel really irritable, and I can't concentrate.*"

Disconcertingly, seven participants spoke about being punished in educational settings due to their BDD-related behaviours. Edward received a "*few detentions*", due to his BDD-related behaviours, and described his sense that one of his teachers "*hated*" him because of these behaviours. He felt his teachers "*saw it as me not trying ... 'he's just bunking the lessons' ... they started to be a bit mean to me ... it must have seemed like I was just, you know, at home, just messing around.*" Angela also received a detention related to her BDD. These punishments are hypothesised to have further compounded participants' sense of shame and feelings of being both misunderstood and rejected.

Particularly difficult lessons cited by some participants were PE and swimming. Reasons were linked to the fear of: (1) removing clothing; (2) wearing shorts and short-sleeved tops; (3) getting their hair wet; (4) putting their hair up; and (5) smudging makeup. Three participants would skip school specifically on the days they had PE and/or swimming.

Participants were asked about any elements of their education and/or education settings that had been helpful during their experience with BDD. A few participants explained that, in terms of keeping up with schoolwork during absences, they appreciated schoolwork being sent home and missed schoolwork being placed on an online portal to negate them having to ask their peers. One participant appreciated extended deadlines, three participants found it helpful to sit exams in a separate room, and one participant found it a relief to receive exam results alone. A few participants felt part-time schooling

and/or a flexible timetable would have been beneficial and found college/university easier than secondary school for this reason.

Six participants shared that individual teachers were helpful and supportive. This appeared to have been invaluable. Having a key adult to validate their identity beyond their struggles appeared to help participants perceive a broader identity for themselves and reduce feelings of being misunderstood and ashamed.

Participants cited the following as particularly helpful in terms of support from individual teachers: (1) knowing about BDD/knowing why they had been absent from school; (2) allowing the young person to approach them for support in their own time, while making it clear they were available; (3) gently inquiring about specific behaviours (for example, refusal to take the blazer off in lessons); (4) providing a point of contact during absences; (5) thinking outside the box (for example, one teacher texted the young person to collect their GCSE results once the other pupils had left); (6) being non-judgemental; (7) not publicly questioning unusual behaviours (like leaving the classroom to mirror-check); and (8) conveying a genuinely caring attitude.

Theoretical category four: lack of understanding of BDD deepens shame and leads to stagnation of identity formation

Experiences like minimisation, attributing BDD to vanity, and punishing a person for their BDD-related behaviours were cited as increasing experiences of shame and further impacting on participants' self-concept, sense of identity, and self-esteem. Typically, this appeared to lead to the young person becoming increasingly preoccupied by, and focused on, fixing their perceived defect in order to be accepted and to belong, so they would no longer be seen (as they perceived it) to be *"abnormal"*, *"vain"*, or *"selfish"*.

All ten participants spoke in some way about other people's misconceptions about BDD. This included the supposition that BDD is linked to vanity, particularly in the context of the societal normalisation of adolescents' focus on physical appearance. As Ingrid explained, *"I think it came across as me being vain, and I don't think they really got it at first. It's quite hard to understand. I'm a teenage girl, you know; I'm going to go through those phases, like experimenting with my hair, and etc. So, in a sense, it is normal, but it's not."* A few participants described BDD as the direct opposite to vanity. Angela explained, *"They think it's something to do with vanity or narcissism or something but, oh, gosh, that couldn't be further from the truth, I don't think."*

Participants highlighted other shame-inducing misconceptions made by others: (1) BDD is caused by social media; (2) BDD always results from bullying experiences; (3) People with BDD are selfish; (4) BDD only affects one aspect of a person's life; (5) BDD is only related to dissatisfaction about appearance; and (6) BDD isn't a serious mental health struggle. Participants spoke about others (including teachers and education staff) minimising and trying to normalise their distress, which left them feeling invalidated, shamed, and misunderstood.

Discussion

The young people in this study yearned to fix and/or change their appearance in order to become a worthy person (that is, to remove feelings of shame, to fit in with peers and to

embody their ideal self). The characteristics of their experience of BDD (for example, camouflaging, seeking surgery) then appeared to be attempts to hide or fix the identity they felt to be unacceptable. Indeed, appearance-based self-discrepancies have been found to exist between “actual self” and “ideal self” in individuals diagnosed with BDD (Veale et al., 2003). Moreover, self-discrepancy theory posits that these discrepancies can lead to negative affect, including feelings of shame (Higgins, 1987). The findings of this study suggest experiences of shame underpin, perpetuate, and result from the experience of BDD in young people.

Participants in this study shared their experiences of peer judgment/teasing/bullying in relation to their appearance, including their weight, the shape of their nose, their skin tone, and their height. These experiences appear to have posed a threat to their identity and feelings of lovability. Adolescents’ aversive peer experiences have been found to have distinctive roles in predicting emotional maladjustment (London et al., 2007; McDonald et al., 2010). Participants in the current study expressed strong feelings of rejection within their peer groups, alongside pervasive feelings of non-belonging. One study ($n = 2510$; BDD group $n = 45$) found young people diagnosed with BDD are more likely to have experienced appearance-related teasing than the general population (40% versus 15.6%, [Buhlmann et al., 2011]) and to remember the incident more vividly and as more traumatic. In a study by Webb et al. (2015), BDD symptoms were higher when adolescents ($n = 188$, 54.8% female) self-reported more appearance-related teasing and higher social anxiety. Interestingly, appearance teasing by cross-sex peers, rather than same-sex peers, was distinctly associated with elevated BDD symptoms. These associations were found to be partially mediated by appearance-based rejection sensitivity (Park, 2007).

Belonging becomes particularly important to identity formation in adolescence. During this time, the ability to establish and maintain positive peer relationships is related to higher levels of sociability, perceived competence, and self-esteem, as well as reduced anxiety, hostility, and depression (Buhrmester, 1990). To belong, adolescents may strive to look like their peers, since appearance differences are a potential source of teasing and social rejection (Cash, 1995). Some participants in this study felt their appearance was different to their peers prior to struggling with BDD.

Participants talked about being significantly taller than their peers, being the first in their class to have acne, and going through puberty early. These differences seemed to lead to fears of not fitting in/belonging, being teased (including actual, related experiences of teasing), and being somehow a bad person, or even a non-person. Participants used words like “alien”, “monster”, “Martian”, and “hideous” to describe how they thought they looked. Angela had once been convinced she was conceived via artificial means, given her so-perceived aberrant appearance. This relates to Festinger’s (1954) social comparison theory, which suggests human beings have an innate drive to evaluate themselves by comparing themselves to others. The disparity between desired others and the perceived self typically results in behaviour intended to eliminate the perceived discrepancy.

Young people may not have the cognitive or emotional resources to make sense of their situation without blaming themselves (Johnstone et al., 2018). Predominantly, participants in this study spoke about or strongly alluded to feelings of shame, rather than guilt, as being related to their appearance-based struggles and wider experiences. For many, receiving a label of BDD was eventually a relief, as it allowed them to imagine

that perhaps they were not as ugly as they believed themselves to be. Conversely, the label of BDD itself induced feelings of shame in some participants, including those who had experienced some initial relief after receiving the diagnosis. This mostly appeared to be linked to other people's ignorance of, and misconceptions related to, BDD including within education settings; particularly that BDD is related to vanity in some way.

Experiences of being punished for BDD-related behaviours in secondary-school settings were a disconcerting finding of this study. Participants shared feelings of blame and shaming experiences within the educational setting. These experiences had palpable overtones of power imbalance and dominance. It was clear that these experiences of shame further isolated these young people, making it even more challenging for them to attend school. It also seemed to result in a higher propensity to hide their distress from others.

Implications for EP and educational profession practice

The approaches and philosophies that participants found helpful and unhelpful have far-reaching implications for educational psychology practice, and indeed the practice of other educational professionals. They are summarised in a leaflet the author created for educational professionals as a result of these findings, which can be found on the BDD Foundation website: <https://bddfoundation.org/wp-content/uploads/BDD-Leaflet-for-Education-Professionals.pdf>

The following areas comprise the headings in this leaflet:

- (1) Offer pastoral support
- (2) Ensure a joined-up approach between professionals
- (3) Validate appearance-related distress
- (4) Address BDD-related behaviours with interventions, not punishment
- (5) Support peer relationships
- (6) Liaise with parents, carers, and other family members
- (7) Recognise that physical treatments (for example, dentistry, dermatology, cosmetic surgery) are rarely beneficial for young people experiencing BDD
- (8) Be aware of perfectionistic tendencies and high anxiety levels
- (9) Offer alternatives to communal showers/toilets
- (10) Allow time off school to attend therapy sessions
- (11) Avoid a forced return to school before the young person feels ready
- (12) Offer educational amendments (for example, timetable amendments)
- (13) Include BDD in the PSHE curriculum
- (14) Value the whole child/young person

Thus, educational professionals may wish to:

- Provide key, attuned adults in the educational setting who check in with the young person regularly;
- Support attendance and/or send work home in a sensitive manner (for example, via email, to negate the young person having to ask their peers);

- Ensure close liaison between home and school, particularly regarding school absences;
- Refrain from punishing young people for their BDD-related behaviours, including making assumptions about the young person's behaviours;
- Provide a sensitively-planned timetable, which may involve alternatives for swimming and PE lessons, and the provision of a separate room for exams;
- Provide additional support for the transition from primary to secondary school, and additional support/vigilance in the secondary-school environment for possible BDD-related triggers and behaviours;
- Be vigilant and provide support for adverse peer experiences, including bullying experiences;
- Consider the provision of individual toilet and shower facilities, perhaps without the presence of mirrors;
- Consider excusing the young person from having school photographs taken;
- Carefully consider the functions and outcomes of any camouflage used by the young person, including potentially increased social vulnerability; and
- Liaise closely with any providers of BDD-specific therapy, as any exposure tasks and the reduction of safety behaviours will also likely need to take place in the educational environment.

The findings and emergent GT of this study have the following implications and important considerations for young people experiencing BDD, as well as their families:

- The importance of keeping the educational setting informed of the reasons for a young person's absence;
- Awareness that educational professionals may not have heard of BDD and may say something that causes the young person to feel misunderstood;
- The necessity of refraining from pressurising young people to return to school before they feel ready, as this may have negative outcomes;
- Ensuring any traumatic family experiences are addressed; including being open about these to any professionals supporting the young person; and
- That young people should be prepared to understand that camouflage and safety behaviours (for example, mirror-checking) may draw unwanted attention to themselves, including in the education setting.

Educational psychologists are well-placed to address and influence discourses about BDD in education settings; to aid education staff in recognising the signs that young people may be experiencing a distressing preoccupation with aspects of their appearance; challenge punitive approaches; co-produce esteeming avenues of support; and provide targeted, evidence-based interventions and appropriate signposting.

Limitations and ideas for future research

The author recognises that the interpretation of the findings is informed by the author's theoretical viewpoint and experiences including: (1) a historic diagnosis of BDD; (2) charitable work with the BDD Foundation; (3) and career experiences as a teacher, school

counsellor, and EP. The author recognises that her experiences and opinions will have informed the way in which data were collected and analysed.

Undoubtedly, the author's experiences have shaped this research to some degree and, the author considers, have enriched the emergent GT. The author has the sense that the core aspects of shame and identity would have revealed themselves to a non-expert-by-lived-experience researcher as one possible GT within the data, as they so evidently underpinned each of the aspects of BDD shared by participants. Additionally, the author considers that their experiences afforded an inferential development towards the notion that BDD is a bid for resolution: the perceived defect or defects become the means through which a young person tries to make sense of, and emerge beyond, their felt sense of shame, and the way they attempt to forge a self-perceived acceptable identity for themselves. Thus, one could argue that BDD is an act of hope, as opposed to a destructive act; that BDD is possible evidence of an attempt at order, as opposed to being a disorder.

The ethical approval given for this study mandated all participants to be interviewed in a designated mental health setting. Several participants who came forward for this study would have only been willing to be audio-interviewed over the internet (without video). This was unsurprising, given the nature of BDD. Therefore, it would appear those most affected/incapacitated by their experience of BDD were unable to participate.

Furthermore, the author would have preferred to conduct interviews in a non-medicalised environment. Coming to the mental health setting ignited anxiety in some participants, particularly in those with previous mental health setting experiences. The author considers that the location may have possibly increased the power differential and unconsciously and erroneously communicated to participants that the author was a medical person who presumed them to be ill. This may have impacted the experience, both for the participants and the data gathered.

Only one male participant initially came forward to take part in this study. Given the prevalence rate of BDD is almost equal between males and females (Veale et al., 2016), the reason for this paucity of male participation warrants further reflection and investigation. Two additional male participants came forward for this study following theoretical sampling, yet only one was able to attend the interview, as the other felt too distressed to leave the house. As Edward explained, he felt it was more difficult for him to both deal with and talk about his BDD as a male, as he felt it to be less societally acceptable for him to be distressed by his appearance. The findings of this study may not be adequately reflective of experiences across genders.

Additional research on the experiences of males who have a diagnosis of and/or self-identity as having BDD would appear to be of high importance, particularly given the high suicide rate of males with this diagnosis.

Nine of the ten participants in this study were white-British, and one participant was of Caribbean descent. Cultural differences across experiences of BDD were not explored and warrant further investigation.

This study comprised a small sample size wherein seven of the 10 participants were White-British females. The findings and suggestions for practice may not be generalisable or relevant for all young people of varying demographics experiencing BDD.

The ten interviews conducted for this research were rich and replete with information. Therefore, the author necessarily had to condense large amounts of information into

limited word counts, and, as such, it is possible some of the intricacies and nuances of participants' individual experiences of BDD were lost/reduced in some areas.

This study raises important questions about the role of parents, teachers, and peers of young people struggling with BDD. Future suggested lines of inquiry include: (1) parents' experiences of supporting a young person with a diagnosis of/who self-identifies with BDD; (2) teachers' and other educational staff members' experiences of teaching/supporting young people struggling with BDD; and (3) how peers can support friends experiencing BDD. Further research with those under the age of sixteen is also recommended.

Many of the participants in this study both sought and received cosmetic/dermatological/dentistry procedures and/or attempted do-it-yourself procedures at home. Important areas of further research are: (1) why and how young people struggling with BDD seek and receive physical treatments; (2) what the emotional outcomes of these treatments are in the short- and long-term; and (3) if and how screening is employed by cosmetic surgeons/dentists/dermatologists.

Of significant concern was an open code entitled, "Being punished in school for BDD-related behaviours", which emerged early in the research. The author considers that this holds a wider implication for EP practice, in terms of how young people experiencing mental health struggles may be treated within educational institutions in general. It strikes the author that an important aspect of the EP role is to notice and actively address aberrant power dynamics within educational settings, including between teachers and their pupils. Further research on both treatment of young people struggling with BDD in educational settings, and the wider treatment of young people with mental health difficulties in educational settings, appears to be indicated, perhaps particularly within the secondary-school environment.

Summary

Body Dysmorphic Disorder (BDD) is a complex mental health experience which most typically emerges in adolescence. This study involved interviewing ten young people between the ages of sixteen and twenty-five who either self-identified or had been diagnosed with BDD, seeking to understand their experiences both within and outside of the education setting. The *Shame-Identity Model of BDD in Young People* emerged from this research alongside a greater understanding of how educational setting-based experiences can both feed into and be impacted by an experience of BDD. Key findings included the requirement for increased awareness and understanding of BDD in young people by educational professionals and in wider society.

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Availability of data and material

All data are available on request.

Disclosure statement

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Code availability

Not applicable

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Appendix.

Interview Schedule

How does the object/poem/artwork you have brought along speak to your experiences of BDD?

Prompts: Tell me a bit about the object/poem/artwork etc. you have brought along. Why did you choose it? Did you consider any other objects etc. before choosing this one? What aspects of your experience does it make you think of? How does looking at this object make you feel? What thoughts does it bring up?

Tell me more about your experiences with BDD.

Prompts: How would you describe BDD? When did you first hear of BDD? When did you first notice that you were feeling distressed about aspects of your appearance? What caused you to notice? Or did others notice before you did? Were/are you focused on a particular aspect of your appearance? Why do you think this is/might have been? Have you ever tried to change this aspect of your appearance in any way? How? What were you hoping to achieve with this? (that is what feelings were you trying to change, if any?). Have you had any difficult experiences related to this aspect of your appearance or other aspects of your appearance? That is, difficult experiences at home, bullying at school, exam pressure etc. ?

What is it like to be a child/young person experiencing BDD?

Prompts: Has your life changed since you started to feel distressed about aspects of your appearance? If so, can you give me some examples of how? How does this compare with your life before you started to struggle in these ways? What help have you received (if any)? Do you feel that your friends understand what you are experiencing? Your family? Your teachers? Professionals working with you like mental health professionals, educational psychologists etc.? If I were to ask your family/friends/teachers about your current experiences, what do you think they might say? What would you like them to say?

What have you found helpful/unhelpful in school/college/university in relation to your experiences with BDD? What might have made your experiences with BDD easier in school/college/university?

Prompts: Has your experience of school/college/university changed since you started feeling distressed about your appearance/aspects of your appearance? How? Does anyone at your school/college/university know you are struggling with this? Who? How did they come to know? Would you like people to know? Do your friends know and, if so, how did you go about telling them? What was their reaction like (helpful/unhelpful aspects)? Have your school/college/university done anything you feel has been helpful since you started struggling with this?

Do you feel you have been supported by people in your school/college/university? How? How could you have been better supported? What would the ideal school/college/university environment look like for a child/young person struggling with BDD? What would the worst possible such environment look like?

What would you like teachers/education professionals to know about BDD? Why would it be important for them to know this?

Prompts: Do you think teachers etc. know what to do when they come across a person struggling with BDD? What makes you think this? What do you think are the common misunderstandings about BDD? If a leaflet were to be produced telling teachers etc. about BDD, what do you think it should include? Why? What makes it difficult to talk to teachers etc. about your experiences with BDD? What do you think would make it easier?

Is there anything else you would like to tell me? Do you have any questions for me?