Written evidence submitted by Ms Hannah Lewis (MISS0055)

About the author

Hannah Lewis is an independent body image expert with extensive academic, professional, and lived-experience.

Fuelled by her own lived-experience of body dysmorphic disorder and bulimia nervosa, Hannah has worked in the mental health charity sector for over 5 years, where she has specialised in mental health policy, research and practice focusing on body image and eating disorders. Hannah has also worked on many projects where she would go into schools and deliver evidence-based interventions on body image and eating disorders in order to prevent the onset of body dissatisfaction.

Now, after conducting a systematic review on body image education policy for the MSc thesis, she is currently completing her PhD in Psychology which focuses on the inclusivity of the proposals made in the Children and Young People's Mental Health (CYPMH) green paper to deliver group body image interventions to those at risk of developing body dissatisfaction and eating disorders. Her study will use co-production to evaluate the relevance of the current evidence-base of group body image intervention with young people from different ethnicities.

Her influential work and incessant campaigning in the sector was recognised by being awarded a Mental Health Collective Fellowship in January 2019.

This response will be influenced by Hannah's academic work, where she is more than happy to present oral evidence for the committee if required to do so.

Body image: a public health issue

Body dissatisfaction is a major public health concern, with serious mental health implications such as eating pathologies and body dysmorphia – both of which can escalate to clinical mental disorders known as eating disorders (ED) and body dysmorphic disorder (BDD). Body dissatisfaction has been said to be "a critical component" of the majority of ED, where symptoms can include: having a distorted body image; excessive dieting and severe weight loss; a consequent pathological fear of regaining weight; and frequent episodes of "out of control" binge eating sometimes followed by inappropriate purging such as self-induced vomiting or laxative use[1]. Anorexia nervosa (AN) has the highest mortality rate of any other psychiatric disorder, as eating disorders often have severe physical health implications of a cardiovascular and endocrinological nature[2].

BDD is another psychiatric disorder which is underpinned by an individual's body dissatisfaction, and is defined as a preoccupation with an 'imagined' or 'perceived' flaw or defect in appearance, where the preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning[3]. The impact of this disorder is equally as devastating as those with ED, with it being reported that suicidality is 45 times higher than that of the general population[4].

Muehlenkamp and Brausch[5] highlighted how body dissatisfaction has been overlooked as a potential risk factor in non-suicidal self-injury (NSSI). NSSI is defined as "destruction of body tissue without suicidal intent and for non-socially sanctioned purposes"[6] and can include behaviours such as skin picking and scratching, hair pulling, interfering with wound

healing, serious fingernail biting, and minor skin cutting[7]. This provides preliminary evidence that more research into the relationship between body image and self-harm is necessary.

Other health implications of body dissatisfaction include an increased risk of depression, which in turn increases the risk of engaging in more risk-taking behaviours such as self-harm, lack of precaution during sexual activity, substance abuse, smoking to control appetite and cosmetic surgery[8].

The committee should consider the severity of untreated body dissatisfaction, and its potential to develop into a severe mental disorder. By framing body dissatisfaction as a public health concern, body image can be regarded as a key consideration to be embedded across all health and social care policy.

Schools: an opportunity for prevention and early intervention

In light of the severity of body dissatisfaction and related disorders, upstream prevention strategies – such as school-based interventions – are of the utmost importance. A systematic review by Yager and colleagues[9] reiterated how school settings are widely recognised as appropriate settings for interventions to improve body image among adolescents as they offer the potential for sustained interactions with young people at a developmentally appropriate age[10].

There is also sufficient evidence to suggest that cultural and ethnic variations are worth considering in the discourse of school-based interventions to prevent the onset of body dissatisfaction, with the PSHE Association stating that "few existing resources directly address the issue of body image in BME pupils and there is no existing guidance on how best to support these pupils specifically"[11].

Recent policy developments include a mandate for mental wellbeing – which covers healthy eating and disordered eating – to be a compulsory part of the curriculum from 2020[12] as well as the establishment of Mental Health Support Teams (MHSTs) who intend to provide group-based body image interventions for those at risk of developing ED[13].

Therefore, with the pace of policy developments in terms of school-based body image interventions, it is of utmost importance that exploratory research which seeks to understand the role of ethnicity and culture in body dissatisfaction is conducted.

The committee should consider recent policy developments – such as the CYPMH green paper proposals – as an opportunity to embed prevention and early intervention of body dissatisfaction across educational settings, both as part of the MHST offering as well as across the health and wellbeing curriculum.

Cultural and ethnic variations in body image

There is an abundance of emerging literature on the intersection of culture, ethnicity and body image. For example, Cheng[14] has identified how racial discrimination can become a risk factor for body dissatisfaction and disordered eating among Asian women, as the exoticisation of the Asian female who has been racially and sexually objectified by the media often results in the internalisation of these concepts thus making ethnicity a risk factor in this instance[15].

Furthermore, the evidence base exploring the relationship between religion – which is often a prominent part of an individual's culture - and body dissatisfaction remains conflicted[16]. In a

study conducted by Mussap[17] which examined the relationship between cultural identity and disordered eating among Muslim-Australian women, the level of western mainstream identification was found to correlate positively with body dissatisfaction and disordered eating symptomology, and benefits were found in retaining cultural values and heritage[18].

Similarly, in a study amongst adolescent Muslim girls, those who wore the hijab and attended madrassa had a higher rate of body satisfaction, despite a higher body weight than adolescent Muslim girls who wore westernised clothes and attended a state school[19].This study identifies a positive correlation between the degree of body satisfaction, and the degree of body coverage, potentially as those wearing religious clothing were less likely to be exposed to the looks of others and are consequently not judged by other people, thus could be proved useful in prevention strategies. An alternative interpretation is that religion and spirituality can make an individual feel that they are loved by an omniscient deity in despite of their physical appearance[20].

Although religion has also been identified as a protective factor for body satisfaction[21], the conflict resides in cultural adaptation and the formation of a bi-cultural identity when adhering to Western beauty standards. Furthermore, in a study with Bangladeshi university students, a variety of risk factors including being a late adolescent (17-19 years), high religious involvement, overweight body perception, low body appreciation, having had cosmetic surgery, and current binge drinking were found to be associated with an ED risk, which invites further exploration into the role of body dissatisfaction and consequent disorders in this demographic[22].

The committee should consider the role of ethnicity, race and culture in the presentations of body dissatisfaction, and how this should be integrated into school-based interventions. Engaging with people from underrepresented and involving them in the co-design process is crucial to ensure that the voices of those we are trying to serve are central to any cultural adaptations of body image interventions.

'Obesity' and body image

From engaging with young people, one of the biggest risks to a person's body image and their relationship with food is the role of stigmatising obesity campaigns and public health messaging – including the national child measurement programme (NCMP). The unintended consequences of public health policy which aims to 'tackle' obesity lead to young people being overly concerned with their weight and shape, which we know leads to body dissatisfaction and disordered eating. Promoting health in a way which is inclusive of shape and size could be a more effective way to promote health behaviours in young people.

The committee should consider how obesity policy and public health messaging should be examined through a body image and eating disorder prevention lens, and consider the utility of the NCMP given the unintended consequences.

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Endnotes

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