Written evidence submitted by the Body Dysmorphic Disorder (MISS0056)

About the BDD Foundation

The BDD Foundation is the UK's only charity dedicated to raising awareness and alleviating the suffering caused by Body Dysmorphic Disorder (BDD).

This response will focus on 'the impact of poor body image' by demonstrating the debilitating effects of a lesser known body image disorder, assessing the current state of service provision and identifying areas of improvement.

As the UK's only charity focused on BDD, the Foundation would be delighted to be called upon to provide further written or oral evidence for the committee.

What is Body Dysmorphic Disorder?

BDD is a serious mental disorder, which causes devastating distress and interferes substantially with the ability to function in life. It affects about 1-2% of the adult population and sadly has one of the highest suicide rates of all mental health conditions with 1 in 50 making an attempt on their life. It can also be the cause of many unnecessary cosmetic treatments.

The recent prevalence survey on child and adolescent mental health[1] estimated the overall prevalence of BDD in 5 to 19 year olds was estimated at 1%, with it **disproportionately affecting young women and girls aged 17-19 (5.6%).**

Alongside BDD there is high comorbidity with depression, anxiety and eating disorders. This means that people with BDD often have complex needs, severely impaired functioning and a low quality of life, which is why early identification and intervention are of utmost importance.

Service provision

In terms of the current evidence base for BDD, cognitive behavioural therapy (CBT) has been demonstrated to be an effective line of treatment alongside medication such as a high dose of Selective Serotonin Reuptake Inhibitors (SSRIs). The NICE guidance (CG31[2]) outlines a stepped-care approach which recommends 6 opportunities for intervention at varying levels of intensity, ranging from psychological and pharmacological intervention delivered in the community to inpatient and specialist treatment, with the underpinning principle that "Each Primary Care Trust (PCT), mental healthcare trust and children's trust that provides mental health services should have access to a specialist OCD/BDD multidisciplinary team offering age-appropriate care[3]". These guidelines should adhere to the Quality Standards for Anxiety Disorders which include that evidence-based psychological interventions, or 'talking therapies' should be the first line of treatment.

In order to access talking therapy, people with a diagnosis of BDD will often be referred to an Improving Access to Psychological Therapy (IAPT) service, where the IAPT Manual[4] includes the diagnosis of BDD as a condition to be treated by IAPT services. However, from engaging with our beneficiaries the reality of accessing care via an IAPT service is much more complex. We often hear that people who access the evidence-based treatment for BDD – which is CBT – do not often receive appropriate or tailored CBT to address their BDD.

A reason for this could be due to the fact that in Module 2 of the IAPT High Intensity CBT curriculum[5] ('CBT for Anxiety Disorders') it is encouraged that specific diagnoses are to be

covered, including: "Specific Phobia, Panic Disorder, Social Phobia, Obsessive Compulsive Disorder, PTSD, GAD and Health Anxiety." However, to cover BDD is deemed as optional as the curriculum states: *"Body Dysmorphic Disorder, which is covered in the same NICE Guidance as Obsessive-Compulsive Disorder, may also be included."* Inconsistencies in training can lead to inconsistencies in care and service provision. This often results in people falling through the gaps between IAPT and secondary care – often deemed too complex for IAPT services, but without the severe mental illness (SMI) diagnosis needed to access secondary. As people with BDD become more chronic and severe, demand for tertiary services – such as the consortium of national specialist services commissioned by either local Clinical Commissioning Groups (CCGs) or NHS England – increases.

Despite being included in the guidance for 'common mental health problems'[6], BDD is a mental illness which causes severe impairment and should be treated as such. This should be considered in terms of diagnostic thresholds for primary and secondary care, as per the IAPT manual:

"IAPT services need to develop strong relationships with professionals across a broad range of mental health care pathways, as well as social care, to ensure that people with needs that are either not appropriate or too complex for IAPT services receive the necessary care in the right place."[7]

To overcome this issue, **we would like to see appropriate measures put in place to meet the needs of people with BDD in secondary care**. By focusing on the 'grey area' of the stepped-care model we can ensure that people who are currently being turned away from both primary and tertiary care can access a service within secondary care where evidence-based treatment is readily available and both a person's psychological and social needs can be met.

Within the current context of the NHS Long Term Plan[8], and the commitment to radically transforming community mental health services for adults, the policy landscape is ripe for innovative solutions to the problems outlined. Whilst the framework for secondary adult community services[9] has already outlined two specialist pathways for eating disorders and personality disorders, **we believe that OCD/BDD specialist practitioners should be embedded into the multidisciplinary teams in every new community model for adults severely affected by mental illness,** as recommended by the NICE guidance.

Furthermore, Lovell and Bee[10] describe Steps 3-6 of the stepped-care approach to include groups for OCD. Group therapy is a cost-effective way to deliver CBT, combined with one-to-one support if necessary, as per the model for eating disorder treatment. Although not yet part of the NICE guidance for BDD, we at the Foundation have conducted a pilot study (n=11) which has evaluated the effectiveness of delivering specialist CBT-BDD in a group format, where the results have been wholly positive and provide the beginnings of an evidence-base for group CBT-BDD. The group improved accessibility to evidence-based CBT-BDD treatment by being delivered online, and for a longer duration of 20 weeks as opposed to the 6-12 weeks provided by IAPT services. **The Foundation would welcome further randomised controlled trials evaluating this approach.**

<u>Prevention and early intervention</u>

Whilst the Foundation acknowledges the role of sociocultural influence including the media, we believe that the focus should be shifted onto educational settings to promote early identification and intervention.

We welcome the commitment from recent policy developments including a mandate for mental wellbeing – which covers healthy eating and disordered eating – to be a compulsory part of the curriculum from 2020[11]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 body dissatisfaction and disordered eating[12]. The BDD Foundation recognise that this is an opportunity to integrate BDD awareness into the curriculum for Educational Mental Health Practitioners (EMHPs) who will be delivering the group-based body image interventions – especially as the EMHP curriculum is said to be based on the IAPT Psychological Wellbeing Practitioner (PWP) curriculum.

The BDD Foundation also see this as a prime opportunity to integrate awareness of BDD into the PSHE curriculum as well as recognition of the risk factors, such as: trauma, bullying, and school-refusal.

Content promoting cosmetic surgery/interventions

Given that a person with BDD has a distressing preoccupation with a flaw (or flaws) in their appearance, it is only natural that people seek physical solutions to their appearance concerns. Many people with BDD consider cosmetic or dermatological treatments; sometimes a person with BDD may be satisfied with the results but their symptoms of BDD persist. Some procedures may be safer than others.

The majority of people with BDD are not satisfied after the outcome of their chosen procedure. This can lead to a preoccupation with further surgery to try to get a better result, which in some cases will do more harm to a person's appearance and emotional wellbeing than good. Even when sufferers are happy with the improvement to one area, the focus of their BDD often moves to another area of their appearance. The key message here of course is that BDD is a psychological or psychiatric problem and thus needs psychological or psychiatric treatment, not treatments or interventions of a physical nature.

Unregulated advertising can pose a significant risk to people with BDD, and we believe that this should be a consideration in the online harms white paper due to be published.

However, we believe that the wider issue – as reflected in the NICE guidance – is that "specialist mental health professionals in BDD should work in partnership with cosmetic surgeons and dermatologists to ensure that an agreed screening system is in place to accurately identify people with BDD and that agreed referral criteria have been established"13 . This is to ensure that training opportunities for cosmetic surgeons, dentists and dermatologists are provided to aid in the recognition of BDD.

Regulation and government policy

Amongst people diagnosed with BDD, there is a high comorbidity of disordered eating or a clinical eating disorder. In terms of government policy, we would encourage the public health messaging concerning obesity to be reviewed with a more compassionate lens. We often hear from our beneficiaries, who have appearance-based preoccupations regarding their weight and shape, that public health messaging that focuses on calorie restriction and/or has undertones of weight-stigma and fat-shaming can fuel preoccupation and distress.

Summary of Recommendations:

Service provision

- In accordance with NICE guidance, every mental health trust should have access to an OCD/BDD specialist team at a secondary care level
- IAPT services should be consistent in their offering for people with BDD, ensuring that all High Intensity Therapists understand how to tailor CBT for BDD in Module 2 of the curriculum
- Diagnostic exclusion should not determine whether someone with BDD is appropriate for secondary mental health care – the transformation of community mental health services should be inclusive of the needs of people with BDD
- Controlled trials of group CBT-BDD – combined with individual support – should be considered as a line of treatment for people with mild to moderate symptoms of BDD

Training and Education

- Health Education England should update the IAPT curricula ensuring that covering BDD is compulsory and not optional
- Akin to the recommendation from *Ignoring the alarms: How NHS eating disorder services are failing patients*[14] report, which called for GP training, we also encourage The General Medical Council (GMC) to conduct a review of training for all junior doctors on BDD to improve understanding of this complex mental health condition
- The British Association of Aesthetic Plastic Surgeons (BAAPS) should also conduct a review of training provided as part of Continued Professional Development (CPD) which covers the psychological risks of cosmetic surgery for people with BDD

Educational settings

- Group body image interventions delivered by MHSTs should cover content on the risks, presentation and treatment of BDD
- Comprehensive anti-bullying policies should include appropriate follow-up to assess the risks of developing BDD

Cosmetic procedures

- Regulation is needed from the Advertising Standards Agency (ASA) regarding the accessibility of cosmetic surgery and this should be a key feature of the online harms white paper.
- We encourage the Care Quality Commission (CQC) to ensure in its inspection of cosmetic surgery clinics that they demonstrate that they follow the NICE Guidelines for OCD / BDD (CG31) and screen for Body Dysmorphic Disorder and conduct better assessment pre-operatively.

Further research

- Psilocybin assisted psychotherapy shows great potential in treating BDD (and a range of mental disorders such as depression and OCD with ruminative thinking). However, it is extremely difficult to conduct medical research as psilocybin is classified as a Class 1 illegal drug. This make it extremely costly to conduct medical research. Psilocybin is very safe when taken with medical preparation and assistance. The

Home Office should be encouraged to alter psilocybin to Class 2 illegal substance as this would allow more research to be conducted and reduce suffering.

July 2020

Endnotes

[1] NHS Digital. 2018. Mental health and children and young people in England.
[2] National Institute of Clinical Excellence. 2005. Obsessive-compulsive disorder and body dysmorphic disorder: treatment.
[3] National Institute of Clinical Excellence. 2005. Obsessive-compulsive disorder and body dysmorphic disorder: treatment.
[4] NHS England. 2018. The Improving Access to Psychological Therapies (IAPT) Manual.
[5] NHS England & IAPT. 2019. National Curriculum for High Intensity Cognitive Behavioural Therapy Courses.
[6] National Institute of Clinical Excellence. 2014. Anxiety disorders.
[7] NHS England. 2018. The Improving Access to Psychological Therapies (IAPT) Manual.
[8] NHS England. 2019. The NHS Long Term Plan.
[9] National Collaborating Centre for Mental Health & NHS England. 2019. The Community Mental Health Framework for Adults and Older Adults.
[10] Lovell and Bee. 2008. Implementing the NICE OCD/BDD Guidelines.
[11] Department for Education. 2017. *Policy Statement: Relationships Education, Relationships and Sex Education, and Personal, Social, Health and Economic Educatio*n.
[12] Department for Education and Department for Health and Social Care. 2017. *Transforming Children and Young People's Mental Health Provision: a Green Paper*.
[13] National Institute of Clinical Excellence. 2005. Obsessive-compulsive disorder and body dysmorphic disorder: treatment.
[14] Parliamentary and Health Service Ombudsman. 2017. *Ignoring the alarms: How NHS eating disorder services are failing patients.*