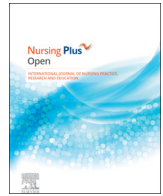




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Supporting patients with body dissatisfaction: A survey of the experiences and training needs of european multi-disciplinary healthcare professionals



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ABSTRACT

Appearance-related concerns resulting from disfigurement or pressure to conform to beauty ideals, indiscriminately affect patients' mental and physical health. Healthcare professionals face the challenge of addressing patients' support needs. Therefore a European University Consortium developed a course to address learning needs. Prior to its design, a study with multi-disciplinary European healthcare professionals was conducted to maximize its relevance and acceptability. Healthcare professionals (n = 718; 48% nurses, 30% doctors, 22% allied health professionals) were surveyed regarding the nature and impact of patients' appearance concerns, confidence in key areas associated with detecting/addressing concerns, and training/educational needs. Participants reported that this subject is highly relevant and 70% described the psychosocial impact of appearance concerns across the lifespan resulting from disfiguring conditions, disability, neurological disease, ageing and weight/shape dissatisfaction. Participants, irrespective of their experience, self-reported inadequate knowledge regarding appearance-specific care, 87% requested further information and 70% wanted access to an accredited course; barriers deterring participation in training were identified. Healthcare professionals across multiple specialties are caring for patients with a wide-range of appearance concerns that impact on physical and mental health and want to increase their appearance-specific knowledge and expertise. Results have informed training/courses which have the potential to improve patient care and ameliorate health-related outcomes.

1. Background

Appearance is highly valued in our society and body image (BI) dissatisfaction resulting from disfigurement, or the consequence of perceived social pressure to conform to unrealistic and narrow beauty (and ageist) ideals is reaching epidemic proportions; indiscriminately affecting the mental and physical health of a significant and growing proportion of patients (All Party Parliamentary Group on Body Image, 2012). Low self-esteem (Field et al., 2005), depression, anxiety (World Health Organisation, 2015), self-harm (Muehlenkamp & Brausch, 2012) and disordered eating (Stice, 2002) are associated with negative BI,

appearance-related concerns and low body confidence (Harper & Tiggemann, 2008). Furthermore, there are well-established links between appearance concerns and health-compromising behaviours including drug and alcohol misuse, avoidance or over-indulgence in exercise and use of steroids (Kanayama, James, Harrison, & Pope, 2006), and smoking initiation and ongoing use as an appetite suppressant (Amos & Bostock, 2007; Stice & Shaw, 2003). BI concerns are also known to impact on health care decision-making and adherence to medication and can also impact on recovery. For example, influencing choices regarding aesthetic and reconstructive surgery (Harcourt et al., 2016) and acceptance of and adherence to appearance-altering cancer

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Table 1

The mean scores (range 1–10, 1 = not at all confident and 10 = very confident) and standard deviations of participants' responses to eleven statements indicating areas of knowledge and competence in providing body image /appearance related care.

Variable	Number of responses	Mean	Standard Deviation
I can describe what body image is	665	7.16	2.16
I can describe what a visible difference/disfigurement is	662	7.34	2.19
I can explain to others about different types of visible difference /disfigurement	663	6.10	2.44
I can describe the psychological and social challenges & difficulties associated with a visible difference/disfigurement	665	6.47	2.16
I can describe health behaviours associated with appearance or body image dissatisfaction	667	6.40	2.25
I can describe resources that promote body confidence	664	5.86	2.40
I can describe different types of interventions used to address concerns about appearance	663	5.33	2.39
I can identify patients with appearance worries/concerns	665	6.45	2.29
I can have a conversation about appearance with my patients	666	6.71	2.47
I can support patients with appearance concerns or issues	667	6.41	2.37
I can locate additional appearance-related support for my patients	666	5.77	2.56

treatments (Williamson & Rumsey, 2016).

In addition, a significant proportion of patients have a difference in appearance (disfigurement) that is visible to others, resulting from congenital anomalies (e.g., cleft lip), disease (e.g., skin conditions), trauma (e.g., burns), or medical treatment (e.g., chemotherapy). Advances in medical, surgical and life-saving treatments are also increasing numbers surviving with an altered appearance following accidental or combat injury, cancer treatment and congenital or neurological conditions. For many, this acquired or congenital 'difference' negatively impacts upon self-esteem, compromises social and emotional development and functioning (Newell, 1999; Rumsey & Harcourt, 2004), and can lead to social discrimination that negatively impacts on personal aspirations, education and work opportunities (Etcoff, Orbach, Scott, & D'Agostino, 2004; Lovegrove & Rumsey, 2005).

Healthcare professionals (HPs) from diverse health and social care areas are increasingly being exposed to the challenges of identifying and addressing the needs of patients burdened by complex and unique psychosocial issues associated with appearance-related concerns. Although HPs are perfectly placed to ameliorate these issues (Clarke & Cooper, 2001), qualitative studies report they often lack the necessary expertise to help (Charlton, 2003; Konradsen, Kirkevold, & Zoffman, 2009; Rumsey, Clarke, White, Wyn-Williams, & Garlik, 2004) and a quantitative survey of 116 psychosocial specialists from 15 European countries indicated a perceived need for additional training and greater awareness of the psychosocial issues associated with visible differences (Harcourt et al., in print). In addition, patients living with a disfigurement recount that many HPs have insufficient understanding of the specific challenges they face (Dahl, Wickman, & Wengström, 2012; Moi & Gjengedal, 2008). Increasing HPs' awareness and understanding of patients' experiences and confidence in responding appropriately to patients' support needs, therefore has potential to improve healthcare provision for people affected by disfigurement and more general BI dissatisfaction; consequently improving associated physical and mental health-related outcomes.

An EU funded consortium of university partners in the UK, Italy, Sweden, Turkey and Lithuania, selected for their geographical spread and cultural diversity, together with the European Cleft Organisation in the Netherlands (selected to provide a user-perspective), is therefore designing, testing and implementing a multi-modal, evidence-based resource for HPs. It will be a higher education course with extensive materials to enable health trainee and qualified professionals identify and manage patients and clients affected by disfigurement and BI concerns. Material could, for example, illustrate research detailing the causes and consequences of appearance anxiety, indicate the importance of HPs using skills to create a culture where appearance concerns are routinely explored, validated and normalized, and draw on evidence underpinning the tools and techniques available to both prevent and target appearance anxiety.

Prior to its design and implementation, the consortium conducted a study that sought evidence from multi-disciplinary HPs from the UK,

Italy, Sweden, Turkey and Lithuania to inform the content of the course and to maximize its relevance and acceptability to potential recipients. More specifically, the objectives of this study were to identify HPs' perspectives regarding the nature and extent of their patients' BI concerns and their understanding of the psychosocial and health impact of these concerns; their levels of confidence and expertise in working with and supporting patients with appearance-related concerns, and their training/educational needs with respect to these issues, including preferences for how these needs should be met. Members of the consortium were also members of the Appearance Matters COST Action (www.appearancematters.eu), a network of researchers and practitioners across the EU with extensive knowledge of the area, and were not aware of any higher level educational courses for multi-disciplinary health professionals specifically focusing on this issue.

2. Methods

An anonymous, self-administered and brief online survey (an equivalent paper-based survey was used in Sweden) of 23 closed and open questions was designed in collaboration with UK clinical advisors and members of the Centre for Appearance Research (www.uwe.ac.uk/car) with expertise in appearance-related care and research. Partners were then invited to pilot the survey with potential participants in their countries, discuss recommended edits with the group and then translate it. Questions requested demographic information related to the participant's role and work experience, their experiences of the topic area (e.g. "Do you come across patients with appearance concerns or body image issues as part of your work? If so, please give some examples") and preferences regarding further information or training on the subject (e.g. "Would you like to know more about how to support your patients with body image/appearance concerns? Why/why not?"). Participants' confidence in relation to 11 essential areas related to the topic and the provision of BI/appearance-related information and supportive care was assessed on a scale of 1–10 (1 = not at all confident; 10 = very confident) (see Table 1).

Recruitment was opportunistic and limited by project constraints to a 2 month period (Feb-March 2015). Partners judged it was feasible to recruit 100–200 participants per country within this timeframe, and planned to reach those with varying levels of experience (student and qualified HPs) within a wide-range of specialities to maximize sample representativeness. Partners disseminated the survey once via email or in person to those attending a variety of courses for student and qualified HPs at their universities and to their contacts/collaborators at local hospitals and in a range of healthcare settings. Participants were encouraged to disseminate the survey via e-mail to colleagues. There were no exclusion criteria and participants self-selected to take part. Ethical approval was obtained from the lead university in the UK.

Quantitative data were analysed using SPSS for windows (version 20). Descriptive statistics of participants' characteristics based on means and standard deviations or frequencies and percentages (as

appropriate) were presented for the whole sample and item by item separately. Pearson correlation was used to assess relations between items of the questionnaire. Means were compared by independent *t*-tests. Qualitative data were analysed using thematic analysis (Braun & Clarke, 2006).

3. Results

Participants were not obliged to complete all questions; therefore numbers of participants responding to individual items vary and reflect missing data. A total of 718 participants provided data, 28% from the UK, 17% from Italy, 19% from Lithuania, 14% from Sweden and 22% from Turkey; of these, 74% were female. Respondents (*n* = 674) were students (52%) and qualified HPs (48%) and practical experience of working directly with patients ranged from 1 to 540 months (*M* = 331.92, *SD* = 204). Respondents (*n* = 718) were nurses (48%), doctors (30%), mental health professionals (8%), public health professionals (7%), physiotherapists (3%), dieticians (2%), hospital social professionals (1%) and occupational therapists (1%). Participants (*n* = 667) worked in a range of specialist areas: elderly care (18%), paediatrics (18%), general surgery (14%), neurology (11%), acute care (4%), burn care (4%), oncology (4%), primary care (4%), nephrology (3%), craniofacial (3%), plastic surgery and laser clinics (3%), endocrinology (3%), rheumatology (3%), midwifery (2%), dietetics (2%), learning disability care (2%) and reproductive health (1%).

3.1. Experience of patients' body image concerns

Participants (*n* = 669) typically reported they had experience of caring for patients with BI/appearance concerns (70%), a minority had not (18%) or did not know (12%) In response to open questions, participants representing all specialities (*n* = 359) detailed a wide variety of conditions that in their experience can result in, or are the result of, BI concerns. These included conditions known to be associated with body dissatisfaction within the field of appearance and body image research (Harcourt and Rumsey, 2012), including eating disorders/disordered eating, scarring and body form changes from surgery, cancer, burns, limb loss, stoma formation, mastectomy and from craniofacial, skin, and congenital hip conditions. In addition participants provided insight into conditions and patient concerns rarely discussed in the psychological literature, including the impact of lymphoedema resulting from heart failure, scarring from self-harm, chronic wounds, visible internal cardiac defibrillators/ pacemakers and a range of rheumatological, neurological and degenerative conditions. Appearance concerns were believed to affect patients' psychosocial well-being, potential recovery and access to social support. For example, participants witnessed patients' reluctance to meet family members and engage in typical social activities for fear of negative reactions to their altered appearance: *we see the manifestation of appearance problems when it comes to visiting times, many won't see family or*

friends after surgery... when they need support the most (UK, nurse). Participants also stressed that although appearance issues particularly affect females and adolescents, they frequently observed BI concerns among men and across the lifespan: *increasingly males are just as worried as some of the girls, but can be more reluctant to talk about it* (Sweden, nurse); *disordered eating is happening in younger and younger people* (UK, dietician); *elderly people often say they are not that bothered about their appearance, but in my experience they usually are, but are embarrassed to admit it* (Italy, plastic surgeon). Participants also expanded on general BI issues experienced by patients, not associated with appearance-altering conditions. These included body dysmorphia, general dissatisfaction with body parts (e.g.: breast size, genitalia, teeth), feeling vulnerable when their bodies are exposed during procedures and self-conscious/distressed if they are unable to maintain their normal grooming routines, such as when wearing hospital gowns (especially for women with no bra) or being unable to wear make-up, manage their hairstyle, shave their legs/underarms or take a shower.

3.2. Knowledge and competence

Mean scores indicative of confidence and knowledge in relation to 11 essential areas related to the topic and the provision of BI/appearance-related information and supportive care are presented in Table 1.

Participants were most confident in their ability to describe BI and visible difference/disfigurement but, comparatively, lacked knowledge regarding the psychosocial impact of living with a disfigurement and the health impact of BI dissatisfaction. They also lacked confidence in how to support patients, including how to access resources and specialist support. However, standard deviation scores were high, suggesting variation in knowledge and competence among participants.

Given the nature of experiential learning (Kolb, 1984), it is reasonable to assume that the amount of time participants have spent working as a HP might influence their knowledge and skills in this area; as might exposure to those specialities (e.g. burns, dermatology) known to focus on psychosocial care and appearance-related issues. Pearson product-moment correlation coefficients were computed to assess the relationship between respondents' experience (i.e. time as a HP) and knowledge/competence.

Overall there was minimal correlation between experience and knowledge and competence (Table 2), with only weak positive associations between 'experience' and 'confidence in describing health behaviours associated with appearance or BI dissatisfaction' (*r* of 0.09, *n* = 675, *p* = 0.01), ability to 'identify patients with appearance worries/concerns' (*r* of 0.08, *n* = 674, *p* = 0.02), and ability to 'have a conversation about appearance with patients' (*r* of 0.19, *n* = 673, *p* < 0.00). As student participants had not completed their education (which may include training in this area), the same analysis was conducted using data from qualified participants only. Similar results were found. Overall there was poor correlation between experience and knowledge and competence, with only weak positive associations

Table 2

Pearson product-moment correlations between knowledge and competence in providing body image/appearance related care and experience as a healthcare worker.

Variable	Number of responses	Pearson correlation	Sig. (2-tailed)
I can describe what body image is	556	0.06	0.15
I can describe what a visible difference/disfigurement is	672	0.05	0.19
I can explain to others about different types of visible difference/disfigurement	671	0.01	0.70
I can describe the psychological and social challenges/difficulties associated with a visible difference	671	0.01	0.66
I can describe health behaviours associated with appearance or body image dissatisfaction	675	0.09*	0.01
I can describe resources that promote body confidence	673	0.00	0.92
I can describe different types of interventions used to address concerns about appearance	671	0.01	0.67
I can identify patients with appearance worries/concerns	674	0.08*	0.02
I can have a conversation about appearance with my patients	673	0.19**	0.00
I can support patients with appearance concerns or issues	675	0.05	0.14
I can locate additional appearance-related support for my patients	674	-0.02	0.53

**Correlation at < 0.01(2-tailed): * Correlation at < 0.05(2-tailed).

Table 3

Comparison of scores in response to eleven statements indicating areas of knowledge and competence in providing body image/appearance related care of healthcare professionals in psychology and appearance-related specialties compared with those in non-appearance related specialties.

Variable	Appearance n = 69 mean (SD)	Non-appearance n = 598 mean (SD).	t-value	Prob.
I can describe what body image is	8.21 (1.59)	7.12 (2.13)	3.44	0.00**
I can describe what a visible difference/disfigurement is	8.02 (2.24)	7.26 (2.17)	2.32	0.02*
I can explain to others about different types of visible...	6.81(2.47)	6.06 (2.43)	2.04	0.04*
I can describe the psychological and social challenges ...	7.60 (1.91)	6.38 (2.15)	3.82	0.00**
I can describe health behaviours associated with appearance ...	7.35 (1.72)	6.33 (2.27)	3.06	0.00**
I can describe resources that promote body confidence	6.79 (2.01)	5.78 (2.41)	2.82	0.00**
I can describe different types of interventions used to address...	6.36 (2.44)	5.26 (2.37)	3.07	0.00**
I can identify patients with appearance worries/ concerns	7.42 (6.38)	2.12 (2.28)	3.04	0.00**
I can have a conversation about appearance with my patients	7.25 (2.71)	6.67 (2.44)	1.56	0.11
I can support patients with appearance concerns or issues	6.96 (2.56)	6.36 (2.34)	1.67	0.09
I can locate additional appearance-related support ...	6.29 (2.50)	5.73 (2.56)	1.46	0.14

*Significant difference at < 0.01(2-tailed); * Significant difference at < 0.05(2-tailed).

between 'experience' and 'confidence in describing health behaviours associated with appearance or BI dissatisfaction' (r of 0.11, $n = 350$, $p = 0.02$) and ability to 'have a conversation about appearance with patients' (r of 0.13, $n = 337$, $p < 0.00$).

In addition, HPs currently working in psychological and appearance-related specialties (e.g.: psychologists and those in craniofacial, plastic, laser and burn specialties) were compared with those working in the remaining specialties (those less likely to focus on appearance-related issues and outcomes: Table 3).

Independent t -tests indicated those in appearance-related professions were significantly more confident in many areas compared to those working in other roles and specialties. However, there was no statistically significant difference between appearance-related professionals ($M = 7.25$, $SD = 2.71$) and non-appearance-related professionals ($M = 6.67$, $SD = 2.44$) in their levels of confidence in 'having a conversation about appearance with my patients' ($t(666) = 1.56$, $p = 0.11$); there was no statistically significant difference between appearance-related HPs ($M = 6.96$, $SD = 2.56$) and non-appearance-related HPs ($M = 6.36$, $SD = 2.34$) in their ability to 'support patients with appearance concerns or issues' ($t(667) = 1.67$, $p = 0.09$) and no statistically significant differences between appearance-related HPs ($M = 6.29$, $SD = 2.50$) and non-appearance-related HPs ($M = 5.73$, $SD = 2.56$) in their ability to 'locate additional appearance-related support for their patients' ($t(666) = 1.46$, $p = 0.14$).

3.3. Learning needs

Out of $n = 706$ respondents, the majority (87%) wanted to know more about how to support patients with BI/appearance-related concerns; of these, 94% were Turkish, 88% Italian, 85% Lithuanian, 78% British and 77% Swedish.

Of these, 22% provided explanations for this request that were organised into three themes:

- 1. An important and highly relevant issue.** Participants felt that BI issues affect everyone, and have a potentially detrimental impact on patients' physical and psychosocial well-being: *Worrying about their looks disturbs patients' everyday activities...promotes destructive behaviour and other health damage* (Lithuania, nurse); *It affects patients' ability to recover* (Sweden, nurse). Participants stressed that a course would be interesting, address inadequate knowledge of the issues involved, improve competence in tackling the problems associated with appearance/BI concerns, and could ultimately reduce healthcare costs: *This is vital. In my experience providing support/treatment for disfigurement is perceived by healthcare commissioners as a cosmetic or vanity issue and has a low priority. More input is required to demonstrate to commissioners the return on investment from this type of training* (UK, nurse).
- 2. Lack of specialist courses available:** Participants identified that

there were a lack of specialist courses available: *I think this is a very under-researched and under-appreciated area and one that many health professionals lack confidence in addressing* (UK, occupational therapist); *there seems to be a lack of good training in this field* (Sweden, nurse); and *I am hoping to specialise in the field, but I don't feel enough specialist information in this area has been covered in the teaching element of my clinical psychology training course* (UK, psychologist).

- 3. Dissemination:** participants expressed a desire to share knowledge with junior staff and colleagues within their multi-disciplinary team: *I want to attend a course and then share knowledge with junior staff and colleagues* (Lithuania, nurse).

In contrast, a minority (13%) provided reasons for declining further training:

- 1. Knowledge already sufficient:** Some felt they already had considerable experience of the area or access to learning resources.
- 2. Unable to prioritise:** Participants, who were qualified and from a range of professions, did not have the finances or clinical time to prioritise this subject and explore BI issues with their patients as other more physical care issues demanded their attention: *I want to know more about how to be helpful, but I haven't got enough time to attend a comprehensive course* (Turkey, doctor).
- 3. Irrelevant:** Some participants, again those who were qualified and from a range of professions, reported that BI issues were either not relevant to their role, or appearance concerns were not commonly reported by patients within their speciality. This latter point was often made by those working in acute care settings.

3.4. Mode of training delivery

Out of 669 respondents, the majority (70%) reported that they would attend an accredited training course, with a preference for content focusing on evidence-based best practice and practical skills rather than theory and models of care. Those with some experience in the area (i.e. psychologists and those working in plastic and burn specialties) requested a short Continuing Professional Development (CPD) intervention-focussed course, and those with limited time requested an online course or access to reading materials only.

4. Discussion

This is the largest survey to date reporting European student and qualified HPs' experiences of caring for patients with BI/appearance concerns and their confidence in recognizing and addressing these issues. Participants from multiple specialties across 5 countries, with a range of experience and multi-disciplinary roles, provided evidence of considerable work-place exposure to male and female patients with wide-ranging and sometimes extensive and psycho-socially debilitating

appearance/BI changes and issues across the lifespan.

Most felt that this subject area is highly relevant to their practice and the majority (87%) wanted to know more about how to support their patients. Participants identified a lack of specialist training available and 70% were willing to attend an accredited course to address knowledge and skill deficits. However, of particular pertinence, is evidence of organisational barriers that prevent qualified participants from accepting further training, such as being unable to prioritise psychosocial care because of time pressures, competing demands to focus on physical care and lack of financial resources. These findings replicate evidence from qualitative research (Williamson & Rumsey, 2016). Targeting students and addressing this topic whilst health professionals are still in training may help to address these barriers (Bucchianeri & Newmark-Sztainer, 2014).

With regard to informing course content, participants varied in their knowledge and confidence across a range of essential skills, but generally lacked knowledge regarding the psychosocial and health impact of living with a visible difference and the health impact of BI dissatisfaction, and would therefore benefit from training around how to support affected patients, including how to access resources and specialist support. Although psychologists and those working in appearance-related professions were significantly more confident in their abilities than those from other specialities, findings suggest they too may benefit from education on the subject of discussing appearance issues with patients, interventions to support patients and guidance on how to locate additional appearance-related support for their patients. A resource that includes information and training to ensure HPs are informed about the causes, effects, treatment and referral options for affected patients, that reflects the range of patient concerns reported by HPs in this survey, is therefore recommended.

Preferences for the mode of course delivery varied. Not all those wishing to increase their knowledge wanted to attend an accredited course, and as reported previously (Williamson & Rumsey, 2016) barriers were identified that might prevent course uptake. Providing multi-modal delivery that can be tailored to meet HPs' individual learning needs and caters for those that lack time and finances would therefore be prudent. For example, more experienced HPs such as psychologists and those working in specialities that focus on appearance-related conditions might only require training around intervention delivery; and those pressed for time might benefit from online or brief written materials to ensure that they can recognise and validate concerns and refer those that are struggling to HPs with greater training.

Indications that BI concerns are ubiquitous and witnessed in the majority of specialities provides further evidence to support Bucchianeri and Neumark-Sztainer's (2014, p. 64) assertion that there is a 'critical need to address the prevalence of body image concerns as a public health issue' and endorses their recommendation for the training of HPs to enable them to address patients' appearance-related concerns and improve body image satisfaction. The notably poor correlations found between length of work experience as a HP and perceived competence in many areas, would also suggest a course might be relevant to HPs across specialities and at any stage of their career.

5. Limitations

Findings relate to a self-selected sample with an associated risk of selection bias that reduces their reliability and generalisability. Nonetheless this was a large sample and 30% of participants made a cogent argument for their lack of interest in the subject area or reluctance to prioritise training, suggesting this sample may not be solely restricted to those with a particular interest in appearance. When considering sample size, it is also important to highlight that the weak significant correlations observed may be an artefact of working with a large sample, rather than reflecting a true association. By design, the analyses generally focused on the sample as a whole, rather than specifically investigating cultural differences in the experiences or training

needs of HPs per country, and did not permit a thorough investigation of the relationship between role and speciality and demand for further training. One caveat to consider when interpreting low correlations between experience and competence, is that the relationship between length of work experience and ability to locate and describe support resources may not be a linear one, as work to develop evidence-based interventions for individuals with body image concerns has increased over recent years (see, for example, reviews by Lewis-Smith, Diedrichs, Rumsey, & Harcourt, 2016; Norman & Moss, 2015), and thus these resources were unlikely to be available to long-serving HPs in their early careers.

However, participants reported BI/appearance concerns among their patients that replicate multiple patient self-reports (Rumsey & Harcourt, 2012) and demand for greater knowledge was high among HPs from all participating countries, indicating that BI concern is a cross-cultural issue and training to address deficits in knowledge and skills would be well-received internationally. This inference does not preclude the need for further research to differentiate the impact of culture on patients' BI experiences (research is limited in this area; Naqvi & Saul, 2012), nor the need to tailor courses and materials to ensure they reflect cultural and ethnic differences.

6. Conclusion

A large percentage and range of health care professionals across multiple specialities are witnessing patients struggling with a wide-range of general body image concerns and with an altered appearance caused by a multitude of different conditions/injuries that impact on physical and mental health outcomes. The breadth and depth of patient concerns and the impact these can have on physical and mental health suggests that body image dissatisfaction is a public health concern. Irrespective of their levels of experience, participants varied in knowledge and skills indicative of their ability to identify and address patients' body image and appearance-related needs. With the exception of those working in psychological services and in appearance-related specialities, the majority lacked knowledge regarding the psychosocial and physical impact of living with a visible difference and body image dissatisfaction, and information regarding how to support patients, including how to access resources and specialist support. The majority requested further information to improve deficits in knowledge and skills and would attend an accredited training course, with some offering preferences for a multi-modal or short courses tailored to their specific educational needs. Findings provide valuable information to assist with the educational content and delivery mode of a body image-related course for EU healthcare professionals, which has the potential to ameliorate the health-related outcomes of the numerous patients this community reaches. Findings also built on the consortium's impetus to develop a course/training materials to meet the learning needs of the EU healthcare community and provided valuable information to assist with the course content and its subsequent delivery and dissemination (see <http://www.whenlooks.eu/>).

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Conflict of interest

None

Ethical approval

University of the West of England ethics committee: UWE REC REF No: HAS/14/10/21

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