



Psychosocial adjustment to skin conditions resulting in visible difference (disfigurement): What do we know? Why don't we know more? How shall we move forward?☆



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ABSTRACT

This article offers an overview of the current understanding of the psychological factors and processes that play a part in the continuum of distress and positive adjustment in people who are affected by dermatological conditions that affect appearance. Despite research demonstrating the significant psychosocial challenges posed by visible difference and mounting evidence of the role played by psychosocial variables in the etiology, exacerbation, and treatment of skin conditions, current healthcare provisions focus predominantly on the amelioration of physical manifestations. Impediments to progress in the understanding of psychological adjustment, blocks to the development of effective interventions, and challenges to the implementation of integrated psychological and medical care are reviewed. A route map to advance current understanding and care provision is proposed. © 2017 The Author. Published by Elsevier Inc. on behalf of Women's Dermatologic Society. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

Background

We live in a society in which considerable importance is attached to an attractive, healthy appearance. A variety of forces, including social media, the Internet, and advertising funded by the ever-expanding cosmetics industry, have conspired to produce and fuel unprecedented levels of dissatisfaction, worry, and anxiety with appearance in most segments of the population (Nuffield Council on Bioethics, 2017). In our daily lives, we are surrounded by images of appearance ideals, replete with explicit or implicit messages that suggest that our bodies are malleable. To a greater or lesser degree, we internalize the imperative to reduce the gap between our own appearance and these ideals, often motivated by the belief that this will enhance our relationships, social lives, and occupational achievements (Halliwell and Diedrichs, 2012). The value that is placed on outward appearance is becoming greater and more disproportionate to other aspects of self-esteem and self-worth.

Most societies attach considerable importance to the complexion. Beauty ideals in all cultures include an even skin tone that is free from blemishes. Yet skin conditions are very prevalent. In the United Kingdom, more than half (54%) of the population is affected by a skin disease each year, and 15% to 25% of primary care consultations

relate to skin disease (Bundy, 2012). In addition to patients with diagnosable skin conditions who seek to normalize their appearance, a dermatologist's caseload will include patients who are motivated by the prospect of psychosocial gains to seek cosmetic enhancement (e.g., remove blemishes or reduce visible signs of ageing).

In this article, I focus on the current understanding of wellbeing in those with skin conditions that result in a visible difference. Readers who are interested in the psychological care of patients who seek esthetic enhancement are referred to the Nuffield Council on Bioethics' recent report on *Cosmetic Procedures* (2017). Because self-esteem has been defined and operationalized in very variable ways in research in this field (see the section entitled "Why do we not know more"), this article considers psychological adjustment more broadly.

What do we know about adjustment to skin conditions?

Psychological challenges

A condition that results in an appearance that is visibly different from current norms and ideals is widely acknowledged to result in significant psychosocial challenges (Rumsey and Harcourt, 2012). Despite the diverse range of etiologies, symptoms, and severity, skin conditions are very similar in the psychological issues they present (Bundy, 2012). Whether transitory, progressive, or episodic, the majority of conditions are associated with a range of significant

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psychosocial symptoms that affect key areas of daily living and quality of life (QoL), including emotional, cognitive, and behavioral impacts on self-systems, relationships, and social and occupational functioning. Many of the challenges are common to those experienced by people with a range of disfiguring conditions, and researchers who specialize in dermatology are likely to find this broader literature helpful (see, e.g., Clarke et al., 2014 in relation to intervention). It should be noted, however, that skin conditions with unpredictable trajectories (e.g., alopecia and psoriasis) have been reported to be particularly distressing, with recurrence after an improvement particularly challenging (Bundy, 2012; Sharratt et al., 2017).

The seriousness and prevalence of psychological problems secondary to a skin condition should not be underestimated. It is consistently reported that 25% of people experience significant challenges in several key areas of living. In a 2012 survey by the British Skin Foundation (BSF; reported in APPGS, 2013), the top three areas of concern for the 729 respondents were a “fall in confidence,” the “negative effects on working life,” and “making friends.” QoL among those with skin conditions is frequently reported as lower than that in the general population, with approximately 25% to 50% of adult patients experiencing heightened levels of psychological distress (Evers et al., 2005). Schmit-Ott and Steen (2010) reported that the impact of psoriasis on the quality on patients' lives was just as pronounced as the impact of other chronic and possibly life-threatening diseases, including cancer, heart attack, or chronic pulmonary diseases.

Reports of negative emotional impacts include enduring states of anxiety, depression, and social anxiety, as well as more transitory states of shame and embarrassment from the stigma of feeling different, negative body image, anger, guilt, and self-consciousness. The loss of eyebrows and eyelashes can radically change a person's facial appearance and contribute to issues of identity (Hunt and McHale, 2012), and the loss of skin pigmentation in a patient with vitiligo may threaten an affected person's ethnic identity (APPGS, 2013).

Bundy (2012) has summarized reports of psychiatric disorders associated with some conditions. The prevalence of body dysmorphic disorder among people with acne ranges from 14% to 21%. People with disorders that involve significant hair loss have been reported to be at a higher risk for developing a range of psychiatric disorders, including a serious depressive episode, anxiety disorder, social phobia, or paranoid disorder. The presence of psychiatric disorders is significantly higher in patients with alopecia areata than in those without skin conditions. In addition, suicidal thoughts have been reported in up to one in 10 people with psoriasis (Psoriasis Foundation, 2012).

As with other disfiguring conditions, visible skin disorders can create a considerable social burden, particularly in relation to forming friendships and forging and maintaining relationships. Unwanted reactions from others, including questions, comments, staring, or avoidance, can be taken very personally, exacerbating the negative effects on the QoL associated with the physical symptoms. Fears of contagion and/or lack of hygiene may lead to social avoidance by others (Papadopoulos and Walker, 2003) and may contribute to a sense of social isolation. Avoidance of social situations (e.g., swimming pools and public changing rooms) has been widely reported.

In the BSF survey (APPGS, 2013), 29% of respondents felt that their condition was an active barrier to finding a partner. In some cultures, beliefs, myths, or taboos may affect the marriage prospects of the affected person. Sharratt et al. (2017) have noted that the cumulative effects of negative social experiences can be considerable, and disruption to relationship development, physical intimacy, and sexual activity may be influenced by embarrassment, shame, or fear of this in others. Twenty percent of respondents to the BSF survey felt that their skin disease was the driving factor behind the breakdown of their most recent relationship or a previous one. Fragile skin in conditions such as epidermolysis bullosa can interfere with touch and thus

affect key psychological functions of affiliation, friendship formation, and support.

There have also been reports of limits on occupational functioning for people with visible skin conditions. In a survey of people with psoriasis, 67% claimed that their condition limited their job opportunities (APPGS, 2013), and discrimination from potential employers in relation to front-of-house jobs was reported by the Changing Faces (2014). A skin condition may also limit performance in some aspects of an existing role, such as the avoidance of invitations to appear in public for those with hyperhidrosis.

Lifestyle choices with the potential to negatively affect self-esteem and QoL have also been described in the literature, including clothing choices for those trying to prevent the exacerbation of itch, avoidance of social situations, limits on holiday choices for those with photosensitivity, or the need to avoid allergens that might exacerbate the condition (Bundy, 2012).

Wellbeing and physical health may also be affected by a sedentary lifestyle that results from the avoidance of exercise due to the possibility of excessive sweating, exacerbation of itch, or the need to wear particular types of clothing. The incidence of obesity has been reported as higher in people with psoriasis than in the general population (NICE, 2012). Rates of engagement in other unhealthy lifestyle behaviors, including alcohol consumption and smoking, have also been reported (Bundy, 2012). Reasons for these increases are unclear but are likely associated with psychological distress. In addition, sleep deficits that result from itching and scratching with some skin conditions may result in behavioral and cognitive deficits that affect wellbeing as well as social and occupational functioning (APPGS, 2013; Evers et al., 2005).

Individual differences in adjustment

Recent research on the impact of conditions that result in a visible difference over the past decade has demonstrated a wide range of individual differences in adjustment that range from minor inconveniences in the course of daily life to devastating effects on psychological wellbeing (Bundy, 2012; Rumsey and Hamlet, 2017). A consistent finding, often in contrast to the beliefs of healthcare professionals and the lay public, is that the etiology and severity of a disfigurement are not good predictors of adjustment. A very noticeable disfigurement is not an insurmountable impediment to a good QoL and sex, age, or socioeconomic background are not good predictors of adjustment (Clarke et al., 2014).

Instead, research has focused on psychosocial factors and processes that contribute to resilience and distress and have highlighted the key role of a person's outlook on life (e.g., propensity to optimism or pessimism) and the role appearance plays in self-system (e.g., the extent to which perceived evaluations of their appearance by others feature in their self-concept and self-esteem). The more a person has internalized messages from advertisers, social media, and peers about what they “should” look like and the greater they perceive the gap to be between their own appearance and these ideals, the more likely they are to feel dissatisfied and unhappy with their appearance (Clarke et al., 2014; Diedrichs, 2016; Fardouly et al., 2015).

Many of the factors that are identified as contributing to the wellbeing of people with visible differences are amenable to change, which further highlights the potential of psychological support and intervention to improve the extent to which dermatological services can more effectively meet patient needs.

Interventions designed to improve adjustment

Despite increasing agreement about the significance of psychological and social factors and processes to the experience, treatment, and outcomes of patients with skin conditions, the current provision of psychosocial care within dermatology services is patchy at best,

relying in most clinics on ad hoc local arrangements that are driven by the interest, training, and expertise of individual clinicians.

In attempts to ameliorate the negative impacts of skin conditions, a range of interventions have been reported. Camouflage can be very helpful in reducing negative emotions that are commonly associated with a visible difference, such as social anxiety and avoidance of social situations (Muftin and Thompson, 2013), but psychosocial specialists believe that this should not be used to the extent that it becomes a crutch (e.g., when anxiety is experienced about when and how to reveal in a developing relationship or in the context of an occupational role; Clarke et al., 2014). Educational interventions have imparted information to patients to facilitate the self-management of the physical aspects of skin conditions with a secondary aim of improving wellbeing through increased perceptions of control. However, no good-quality evidence exists to demonstrate the effectiveness of these approaches on psychological adjustment (Bundy et al., 2013). In response to emerging evidence about the role of stress as an antecedent as well as a consequence of some skin conditions (e.g., see Schwartz et al., 2016 in relation to psoriasis), a variety of stress management techniques, including relaxation, hypnotherapy, and mindfulness, have also been employed. The results of these approaches have been inconclusive (Bundy et al., 2013).

Dures et al. (2011) reported on the desire for peer support among adults with epidermolysis bullosa; however, this is challenging to orchestrate, particularly in relation to assembling functioning groups of people with relatively rare conditions. Peer support that is offered online (either real- or non-real time) for young people with chronic skin conditions can relieve a sense of isolation and increase confidence (Fox et al., 2007); however, the importance of expert moderation to ensure a positive dialogue and to safeguard all members of the group has also been highlighted.

The strongest evidence of effectiveness to date is for cognitive behavioral therapy (CBT; Lavda et al., 2012; Psoriasis Foundation, 2012). CBT explores and challenges dysfunctional appraisals, beliefs, and assumptions with the aim of helping patients come to terms with their condition, facilitating their involvement in treatment decision-making, identifying useful coping strategies, and challenging and dealing with anticipatory anxiety and fear of negative evaluation by others. A CBT-based program called eTIPs has shown promise in people with psoriasis (Bundy et al., 2013). Some CBT-based programs, such as the online programs FaceIt (for adults with visible differences; Bessell, 2012) and YPFaceIt (for young people; Williamson et al., 2015), have also included elements of social interaction skills training that focus on dealing with common social difficulties (e.g., dealing with questions from others, meeting people for the first time) and have been shown to be effective in improving several aspects of wellbeing.

Online interventions have the advantages of overcoming geographical access to specialist interventions and allowing access at times that are convenient to the user. They can also be of particular appeal to young people. However, despite some evidence of signs of the effectiveness of CBT, studies are few and far between, samples are generally small, and rates of attrition from programs are high. Firm conclusions upon which to develop psychological services cannot yet be drawn.

Provision of healthcare for patients with skin conditions

Despite the incontrovertible evidence of the negative psychosocial impacts of skin conditions and indications that psychosocial concerns frequently play a greater part in the motivation to seek treatment than do physical symptoms, reports that these concerns remain unaddressed are widespread. For the majority of patients, discussions about the psychosocial challenges of skin conditions are not part of routine care, and some patient groups have reported that healthcare

professionals lack understanding and empathy for their psychological distress (The All Party Parliamentary Group on Skin, 2013). Reasons for the current lack of appropriate psychosocial care are numerous. Consultation time is limited (particularly in nationally funded healthcare systems such as the UK's National Health Service). Even when the existence of these issues is recognized, healthcare professionals report that they lack the necessary training and confidence to discuss and subsequently appropriately deal with psychosocial issues. Appropriate sources of advice and referral are also not available.

Clinic environment and staff dialogue may inadvertently increase existing societal pressures that contribute to the distress in patients with dermatologic conditions (Nuffield Council on Bioethics, 2017). Advertisements and promotional materials that are used in privately funded dermatology services often include the types of imagery and rhetoric that reinforce the beauty myths that are prevalent in the broader media. These associate greater happiness or success in social and romantic relationship and even occupational settings with looks that are closer to the prevailing ideals. This rhetoric may even also extend to the consultation.

Why do we not know more?

As in other specialties in the broader field of visible difference, the methodological challenges hampering progress in understanding the adjustment to skin conditions are considerable. In addition to common impediments to the generalizability of research findings, including unrepresentative and/or small sample sizes and an overreliance on cross-sectional data, the multifactorial nature of psychological adjustment is particularly challenging. There is a marked lack of consensus among researchers with regard to the primary constituents of a positive outcome to the psychosocial challenges posed by disfiguring conditions. To what extent is adjustment reliant on a person's broader psychological makeup or on responses to a specific disease (i.e., a product of the condition itself)? Is one person more resilient than another to the challenges associated with a skin condition because of their disposition and sociability (e.g., an optimistic or pessimistic outlook on life; level of social skills) or, instead, is this a function of the specific ways they have chosen to cope with their condition? The answer is that adjustment almost certainly contains both elements. Yet, researchers and clinicians are guilty of a degree of myopia. Due to our own interest in and focus on a particular condition, we may home in on condition-specific effects and use only condition-specific measures to assess outcomes.

Measurement strategies have been and continue to be driven by numerous competing agendas (clinical, research, audit, financial, political) rather than by issues of importance to patients. Furthermore, within the research community, many different key constructs are favored as the focus for outcome measurement, making comparisons between studies impossible. Even when different researchers purport to measure one particular construct (e.g., self-esteem), widespread inconsistencies exist in definition and measurement. All too often, conferences and policy groups become competitive fora. Researchers and clinicians promote their own favored measure while criticizing others rather than use these opportunities for the cooperative endeavor that is needed to achieve the consensus in the choice of key constructs and measurements necessary to move the field forward.

Recent research on skin conditions has seen an explosion of interest in patients' QoL, and a brief focus on QoL is offered here as an illustration of the challenges that are inherent in assessing adjustment.

On close inspection, QoL is a slippery construct. Definitions vary considerably, from the philosophical to the pragmatic, and clarity about the extent to which QoL can be used as a proxy measure for other constructs such as happiness, wellbeing, and life satisfaction is lacking. In addition, in relation to skin (and other) conditions, QoL has been operationalized in many ways, including the

assessment of the impact of symptoms and treatment or inferring the impact of a particular condition on self-esteem and social and occupational functioning.

QoL is also a relatively sophisticated construct—one perhaps rarely considered by potential participants in the course of their day-to-day lives. When considering the use of QoL scales, researchers and clinicians are well-advised to put themselves in their participants' shoes and to consider how *they* would respond to the questions posed to patients. How would *I* respond, for example, if someone asked me to define my QoL? If I were asked to complete a scale devised by a clinician or researcher, what are the chances that the scale would represent my own definition of QoL? What if, instead, heeding the calls to take more account of the considerable variability in individual definitions of QoL, the researcher or clinician approached me in a clinic and asked me (probably without advance warning) to describe the key components of my own QoL and their relative influence?

On the spur of the moment, this would feel like an almost impossible task. Furthermore, the chances of much similarity between myself and the previous or next respondent would be very slim, hindering any meaningful comparisons. Hardly surprising perhaps that debates continue to rage about the meaningfulness and validity of existing QoL data and the likely benefits of future efforts to capture these data in a meaningful way.

The utility of theory to drive psychosocial research in this and related fields is also an area of discussion and dispute. Many years of experience of research in this field have led me to the view that the boxes-and-arrows approach that is used in the majority of theories fails to adequately reflect the multiplicity of factors and processes that contribute to psychological adjustment and wellbeing. Slavish adherence to one particular theory and the testing of the precise components (boxes) and directionality (arrows) is very time consuming and can blinker researchers to the existence of other key constructs. Instead, I favor conceptual frameworks as a means of guiding thinking. Compared with theories, their relative flexibility can offer a basis to achieve a consensus in measurement and also a method of driving the development and evaluation of interventions (see, e.g., the Appearance Research Collaboration framework of adjustment to visible difference in Appendix A and the resulting guidance for intervention in the main body of the text in [Clarke et al., 2014](#)).

These and other methodological roadblocks in this and related fields ([Krawczyk et al., 2012](#); for more detail, see [Rumsey and Harcourt, 2012](#)) have resulted in a literature that is contradictory and of questionable utility in assessing the needs of patients and the impact of treatment. Confusion remains about how to move forward, and the challenge of translating research into clinical practice persists.

Moving forward: A route map to underpin healthcare that better meets the needs of patients with skin conditions

When questioned about their motivation to practice dermatology and/or to conduct research in this field, most professionals espouse a commitment to improving the lives of their patients. Because psychological factors play a significant role in aspects of skin conditions, to achieve this aim, we must take urgent steps to improve our knowledge and understanding of the factors and processes that contribute to psychological wellbeing and distress among the people to whom we offer care.

A crucial first step is for clinicians and researchers to put aside their own personal agendas and focus on achieving agreement with regard to key constructs, definitions, and associated measures to underpin the development of a common dataset to drive routine data collection from patients. Qualitative research is the exception rather than the rule in this field, but it is crucial at an early stage in the development of an agreed-upon set of patient-reported outcome measures in which items for quantitative scales to measure the impact

and outcomes of treatment are generated through the qualitative analysis of discussions with the patients themselves ([Staniszewska et al., 2012](#)). The logic of using patients' self-reports to drive a consensus in core measures is even clearer when considering that patients' subjective evaluation of the severity of their condition, the extent to which it causes them concern, and how noticeable it is to other people are more illuminating as indicators of adjustment and distress than objective ratings that are carried out by clinic staff ([Clarke et al., 2014](#)).

The pooling of data with a shared pretreatment and follow-up data collection protocol will achieve a sufficiently powered dataset to enable researchers to highlight key factors and processes in adjustment. Dermatological conditions can require treatment across the lifespan, spanning many developmental stages. There is an urgent need for longitudinal research to unpick the relative importance of the many factors and processes that contribute to wellbeing and adjustment. This shared, longitudinal dataset will facilitate the development of screening tools and enable clinic staff to identify those at greatest risk of distress on a routine basis and develop interventions to meet patients' needs.

The data would also drive the detail of the broad clinical and research agendas that are outlined in the following. Such an initiative would be a major undertaking, requiring a culture change among researchers, clinicians, and patients alike—but it can be done. In the United Kingdom, an agreement has been achieved between a team of researchers and all of the professional groups that deliver care for patients with cleft lip/palate on a common set of measures that are administered at key stages of development in a prospective birth cohort study ([Stock et al., 2016](#)). In a separate initiative, a globally agreed-upon approach to patient outcome measures in cleft care has been reached by an international task force ([International Confederation for Cleft Lip and Palate and Related Craniofacial Anomalies, 2017](#)).

Future directions in the provision of care

Even though we are still in the foothills of understanding the details, the role of psychological and social factors in adjustment to skin conditions is now widely acknowledged and calls for integrated medical and psychological approaches to care are deafening ([The All Party Parliamentary Group on Skin, 2013](#); [Messenger et al., 2012](#); [NICE](#) [The National Institute for Clinical Excellence, 2012](#)). Ideally, as in many cleft, burns, and plastic surgery clinics, psychological screening, assessment, support, and intervention should routinely be part of clinical consultations and patient management plans in dermatology. Alternatively, at a minimum, appropriate local expertise should be located, and a clear, structured referral pathway should be identified for those in need of expert psychological assessment and/or intervention.

The psychological care of patients should be viewed as the responsibility of *all* members of a care team. A stepped approach to care is a helpful way to conceptualize this shared responsibility, with team members matched to levels according to expertise, interest, and opportunity.

In level 1 of a stepped care approach, all clinic team members should have conversations with patients about psychosocial concerns in the normal course of care delivery. Because of the shortcomings outlined, standardized outcome measures should not be used as a substitute for face-to-face conversations, although asking the patient to complete a simple distress thermometer (e.g., from 0–10) can be a useful opener and guide as to whether more specialist assessment, advice, and support are required. Simple actions that all team members should feel confident about initiating include a referral to camouflage services and/or appropriate local or online sources for advice and support. Clinic staff should avoid fueling the beauty myths that are outlined in the Background section of this article and

should use factual, unambiguous language when describing the likely outcomes of treatment, using words such as “clearer skin” rather than value-laden descriptors such as “more attractive” or “younger-looking” skin.

At level 2, clinic team members with a particular interest and additional training should be available to discuss patients' psychosocial concerns in more depth, offer appropriate information and advice (e.g., in relation to how to deal with common social challenges), and signpost appropriate local or online self-help information and services (e.g., those provided by charities in the sector).

More advanced training could be undertaken by one or more team members to operate at level 3, enabling them to feel confident in running a support group or other group interventions such as relaxation, stress management, or social interaction skills training.

Practitioners who operate at level 4 will be psychosocial specialists with sufficient training to conduct specialized assessments and individual or group interventions in-house. At most clinics, it will be necessary to access this expertise via referral to external specialist services.

To achieve this stepped care model or an equivalent, training in psycho-dermatology is urgently needed for both clinicians and psychosocial specialists at undergraduate and postgraduate levels. Development opportunities for those already in post should also be made available. Medical professionals and psychologists already working with people with skin conditions are also likely to benefit from a more detailed understanding of the contribution of psychological factors to the onset and exacerbation of skin conditions, as well as the psychological and social impacts of the condition itself. We all operate within a wider societal context and are prone to the influences of advertising, social media, and celebrity culture; thus, training should also allow clinic staff to explore their own beliefs and the impact of these beliefs on their practice. Clinic staff may make assumptions about the consequences for patients of an appearance that falls short of prevailing ideals—indeed, many may make a living from cosmetic practices that reinforce these ideals. Yet the evidence is clear that a person's actual appearance as judged by others is not predictive of his or her level of happiness (Seligman, 2002).

If funding for training is not available or experts to deliver this material cannot be identified, relevant self-directed modules are available from various websites (see Resources).

Future directions in research

Routinely collected data should be shared and used to improve understanding of the key factors that contribute to and ameliorate distress resulting from skin conditions. A greater understanding will facilitate the development of screening and rapid assessment tools for routine use in primary and secondary care to detect early warning signs of suboptimal adjustment and distress. These data will also facilitate the development, implementation, and evaluation of methods of support, self-management, and intervention that are suitable for delivery by professionals operating at various levels of the stepped care model. Although CBT remains the most extensively studied approach to intervention for patients with more complex needs, newer and innovative interventions such as Acceptance and Commitment Therapy also have potential. Thus, in addition to the need to achieve consensus in relation to the key outcomes for interventions, agreement from psychosocial specialists in relation to the most appropriate content, format, and method of delivery for interventions to facilitate meaningful evaluations will also need to be achieved. This will be no small task.

Furthermore, research is needed to evaluate methods of support that are used or recommended by lay-led organizations such as the many charities in this sector because confidence in the evidence

base and effectiveness of their services is needed for clinicians to incorporate these materials into a stepped model of care.

These challenges are considerable and this is an area to which a relative lack of importance is ascribed by governments, health service managers, and healthcare professionals. In addition, should we ever grow complacent, research is also needed on the relationship between psychological wellbeing and adherence and in relation to the mechanisms at play in the emerging associations between skin conditions and health behaviors with the potential to damage physical health and psychological wellbeing, including diet, alcohol consumption, and smoking.

To achieve the aim of improving the wellbeing of their patients, all involved in the field of dermatology should consider how they can contribute to wider efforts to reduce the social stigma experienced by those with an unusual appearance and instead to promote positive societal attitudes toward diversity in appearance. Societal change is complex and challenging and will require efforts to further educate the public about the causes and consequences of skin conditions, appearance, and treatment. However, research suggests that efforts to bust the beauty myths will benefit substantial segments of the population, not only those experiencing pressure as the result of an unusual appearance (Nuffield Council on Bioethics, 2017). This is not a task that should be shirked by any of us.

Conclusion

In a society in which physical attractiveness and wholeness are valued so highly, there are considerable challenges for those with a condition that results in an unusual appearance. These challenges result in negative psychosocial impacts for a significant proportion of people who are affected by skin conditions. There is an imperative to achieve a consensus in measurement and data collection to improve current levels of understanding of psychosocial adjustment to skin conditions that result in visible differences. Many healthcare professionals lack the skills to effectively meet the psychosocial needs of those affected. A considerable benefit could be derived from better training and the implementation of an integrated model of care.

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Resources

- <http://www.appearancetraining.com/Resurser>.
- <http://www1.uwe.ac.uk/hls/research/appearanceresearch/resources.aspx>.
- <https://www.changingfaces.org.uk/resources>.
- <http://www.facevalue.cc/Resources>.