



Living with vitiligo: Dealing with difference

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Objectives. Individuals with a disfigurement are at risk of experiencing psychological distress, but the level of this distress is only marginally associated with clinical severity. This study examines the experience of living with the skin condition vitiligo with a view towards understanding its impact and the ways in which participants deal with this chronic and disfiguring disease.

Design. The qualitative method Interpretative Phenomenological Analysis was used.

Methods. In a semi-structured interview, seven white female vitiligo sufferers were asked to describe their experiences from the time the vitiligo first became apparent to the time of the interview. They were encouraged to elaborate on their own reactions and how they dealt with the reactions of others.

Results. Initially, participants felt overwhelmed by their illness but over time they developed several strategies in order to 'contain' their difference in appearance within manageable limits. The behavioural strategies of avoidance and concealment had several disadvantages, whereas cognitive strategies were less problematic but difficult to sustain consistently. Social support served to facilitate the development of coping methods associated with acceptance of difference. However, maintaining this acceptance was a struggle and the process fragile.

Conclusions. Living with vitiligo was a continuous struggle. The results are consistent with Leventhal's (1970) notion that coping is a problem-solving process and with Moos and Schaefer's (1984) contention that dealing with a chronic disease involves the development of a variety of strategies in order to regain equilibrium. Further research is needed to examine whether the experiences described here are common to other disfiguring conditions.

Vitiligo is a disease that causes progressive and permanent depigmentation of the skin. Patches of skin turn white, leaving the sufferer visibly disfigured. The overall

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prevalence of the disease is thought to be between 1 and 4% and it appears to affect males and females equally. The majority of people develop it before the age of 20 (Ortonne, Mosher, & Fitzpatrick, 1983). As vitiligo does not result from a traumatic event, or significantly impair physical health, or cause any pain, it represents an ideal model for examining the psychological phenomena of living with an appearance altering disease.

There is growing evidence that such appearance altering diseases can have profound behavioural, emotional and cognitive impacts upon sufferers (Lansdown, Rumsey, Bradbury, Carr, & Partridge, 1997; Thompson & Kent, 2001). Concealment and avoidance are common strategies in coping with such conditions, often used in order to avoid negative reactions from others (Ramsey & O'Reagan, 1988). Many studies have found higher than average levels of psychological distress particularly manifest in the form of anxiety, but also depressed mood and lowered self-esteem. For example, Jowett and Ryan (1985) found that 80% of a sample of psoriasis out-patients reported experiencing shame, lowered mood and self-esteem in relation to the appearance of their skin. Similarly, a study of vitiligo sufferers found that 75% were distressed by their appearance (Salzer & Schallreuter, 1995). Specifically, vitiligo sufferers have reported difficulty in forming new sexual relationships, avoidance of places and situations where their loss of skin pigment might be visible, and experience of stigmatization and intrusive reactions such as staring (Porter & Beuf, 1988, 1991; Porter, Beuf, Lerner, & Nordlund, 1990). Cognitively, appearance altering dermatological illnesses can have a profound effect on self-concept and body image. Papadopoulos, Bor and Legg (1999) found a high frequency of appearance-related negative thoughts in their study examining the utility of psychological interventions for helping clients with vitiligo.

There is no straightforward relationship between severity of disfigurement or disease process on the one hand and the degree of psychosocial difficulties experienced on the other (Baker, 1992; Malt & Ugland, 1989; Porter & Beuf, 1991). For some people relatively minor blemishes can be associated with extreme distress and disability, while others report low distress despite a high level of clinical severity (Robinson, 1997). Several quantitative studies have explored possible influences on this relationship. The results of research examining the role of demographic factors are equivocal. Some studies have found that women living with a disfigurement experience higher levels of distress than men but similar levels of anxiety and social avoidance and distress (e.g. Robinson, Rumsey, & Partridge, 1996), but Porter and Beuf (1991) found no significant relationship between age, race, or gender with degree of distress in vitiligo sufferers. A variety of potential psychological factors have also been explored: coping strategies, social support and social skills have all received some limited support in being able to account for individual variation in adjustment (Moss, 1997). Although visibility can be relevant, this seems to be the case mainly for those whose social anxiety is high (Kent, 2001). The quality of perceived social support has been found to be particularly important in relation to adjustment in a number of studies (Baker, 1992; Blakeney, Portman, & Rutan, 1990; Browne *et al.*, 1985). However, it remains unclear as to how social support actually assists with adjustment, and how individual differences might mediate the uptake of such support (Moss, 1997).

Clearly, then, psychological research has only recently begun to identify the factors that might account for adjustment to disfigurement. An understanding of adjustment is important both theoretically and therapeutically. Theoretically, any model designed to explain the psychological consequences of disfigurement will need to provide an explanation of the relationship between disease and distress. Therapeutically, it is

possible that clinicians may have much to learn from people who are able to deal with an altered appearance effectively (Thompson & Kent, 2001).

This understanding might be improved in three ways. First, a greater appreciation of the dynamic nature of adaptation to disfiguring diseases is required. Cross-sectional studies of adjustment such as those described above take a 'snap-shot' of distress on a particular occasion. They are based on the notion that people have preferred coping styles and often assume that adaptation to chronic difficulties is a relatively stable and discrete process unaffected by current life-events and personal resources. That is, it is often presumed that although people may move along a path to adjustment at different rates, they remain 'well-adjusted' once a satisfactory level is achieved. However, more recent approaches to coping emphasize the importance of self-regulation of emotions and see coping as a dynamic problem-solving process, the success of which depends on a variety of contextual factors (Leventhal, Suls, & Leventhal, 1993). For example, Yoshida (1993), in her work with people with spinal injuries, illustrated how adjustment to such injuries is dynamic. In her sample, patients would swing between understanding themselves as 'disabled' and 'non-disabled' on a frequent basis, depending on external events. Secondly, most previous research in this area has concentrated on adjustment *outcome*, rather than exploring the *process* involved (Moos & Schaefer, 1984). Even when a variable has been identified as being relevant, it is not clear how that variable actually influences how people see themselves and their relationships with others. For example, although the quality of perceived social support is an important factor in adjustment, it is not clear why this is so. It may be that social support assists disfigured individuals by increasing their sense of being accepted (Baumeister & Leary, 1995) or by encouraging effective coping (Carver & Scheier, 1981), but such possibilities have not been explored.

Thirdly, most previous research in this area has largely used theory-led quantitative methodologies, taking an 'outsider perspective' by viewing the illness from outside the experience itself (Conrad, 1990). It can be argued that this approach can reduce the chances of discovering how individuals actually adapt and perceive themselves and their relationships. The dearth of qualitative research within the disfigurement literature is unfortunate, as the increased flexibility provided by the use of such methodologies could yield rich information on the process of adjustment to living with a chronic appearance altering condition. This current qualitative study uses Interpretative Phenomenological Analysis (IPA; Smith, 1995) to strengthen the research in this area. IPA is specifically designed to explore the meaningful experiences of individuals as they deal with aspects of their life, allowing them to describe how a disease or other life-event has affected them over time. It is thus ideally suited to an exploration of the psychological processes involved in living with vitiligo. The specific aim of this study was to achieve an understanding of how individuals thought about, and dealt with, this chronic and appearance altering condition. It sought to examine the processes by which the participants arrived at their current level of functioning and how they managed ongoing concerns.

Method

Participants

After gaining ethics approval, the participants were selected from a sample of patients who had attended the collaborating NHS dermatology clinic. Patients were considered

for inclusion if they had been diagnosed with vitiligo for 3 years or more and excluded if they had any other chronic illness or prior psychiatric history. The medical consultant screened the clinic list for potential participants; of the 58 possibilities, 12 indicated their willingness to be interviewed. However, in order to keep the sample homogenous, two females who were found to have other chronic illnesses and the three males were not included in the final sample, leaving seven white women in the study. They ranged in age from 18 to 39 years. All considered their vitiligo to be noticeable, with six currently in long-term relationships. Consent was gained for quotes from the interviews to be published, but identifying information has been removed in order to ensure anonymity.

Data collection and analysis

Data were collected and analysed according to Smith's (Smith, 1995; Smith, Osborn, & Jarman, 1999) recommendations, with specific questions being tailored to the emerging account. The semi-structured interview began with open-ended questions about when the participants first noticed the condition, how they reacted to it and how feelings had changed over time. Following this, they were asked to describe the effects of vitiligo on their life, and how they dealt with any issues that had arisen. The impact of other people was also explored, both in terms of social support and how they reacted to their condition. All interviews took place in a private room within the dermatology department and lasted approximately 1 hour. Interviews were audiotaped and on completion notes were made on the process of the interview. The interviewer (first author) was a white male, without any visible skin disease, aged 28, with clinical experience of conducting sensitive interviews.

The first transcript and set of notes were read and preliminary summarizing and connecting comments recorded. The transcript was then re-read and preliminary themes tentatively identified. Through analytical re-reading, the preliminary themes were modified and structured hierarchically. A master list of themes was then produced. This process was repeated for each transcript. As the list of master themes emerged for each transcript, it was critically compared with earlier lists. This process led to the master list for all transcripts.

Established strategies were used to ensure validity (Elliott, Fischer, & Rennie, 1999). Responses were reflected back during interview, in order to check that the meaning of the account had been understood and to establish data credibility (Streubert, 1994). An audit of the first author's account of the thematic selection process was conducted by the junior authors, to ensure that the findings were warrantable (Streubert, 1994).

Results

A summary of the results is given in Fig. 1, which describes the most important themes that arose from the data. The central issue reported by the participants was their concern with the difference in appearance that resulted from having vitiligo. They described how a period of uncertainty and anxiety, when symptoms first appeared, involved a growing sense of difference and of being overwhelmed by the social implications of the condition. At that time, they became preoccupied by the disease and how they were seen by others. Subsequently, participants struggled to manage the effects of the disease, a struggle that continued at the time of the interview. As Moos

Initial reactions to the development of vitiligo: becoming different
 Discovering a difference
 Becoming preoccupied with difference
 Living with vitiligo: trying not to be different
 Behavioural strategies
 Avoidance
 Concealment
 Confronting and explaining
 Cognitive strategies
 Attention monitoring
 Attributions
 Social comparisons
 Social support: getting help with being different
 Taking the risk
 Seeing things differently
 Living with vitiligo: a fragile acceptance of difference

Figure 1. Summary of the master and sub-themes arising from the participants' accounts.

and Schaefer (1984) would predict, a variety of behavioural and cognitive strategies were used to minimize the impact of the disease on their lives. However, while these strategies were useful in 'containing' the disease as only one aspect of the self, they could also have negative consequences. Social support helped some participants develop and maintain these management strategies, but the ability to use them was fragile and sometimes participants felt unable to use them successfully due to transient feelings and current life-events.

Initial reactions to the development of vitiligo: Becoming different

Discovering a difference

Vitiligo became apparent for most participants during adolescence and young adulthood. When white patches began to show they were initially dismissed or ignored as normal variations in the skin's appearance, but anxiety was raised as the patches spread. At that time a difference in appearance was first recognized:

Kate: I don't think I was too bothered, not initially, but once it started to spread I sort of got upset by it and I was really self-conscious. It was mostly on my hands and my face. The rest of me I could cover up.

A variety of emotional and behavioural reactions followed diagnosis. Some participants were angry at the lack of information they received, but the predominate reactions were worry about being different from others and finding, because vitiligo has no cure, that they were unable to control this difference. Initially, the discovery of difference was highly distressing and reinforced by instances of stigmatization, bullying and negative comments:

Zoe: I got called a witch, the lot, because I was different.

Sam: Everyone in physical education used to say 'What is that on you?' and people calling you names like 'jig saw skin'. It definitely did hurt me.

but also due to adolescence and young adulthood being a time when being 'normal' and part of peer groups was crucial for well-being (Coleman, 1974):

Sam: age 19 at the time of interview: I'm quite a shy person underneath and I just don't think I need something else that people are going to notice about me. I much prefer to be part of a group and not stick out. I just think the first thing people are going to notice about me is the vitiligo. I'm just worried about other people's reactions and that.

Debra: It's not a big deal [now], but then when you are young it is important.

Becoming preoccupied with difference

As a result, participants described a range of intrusive cognitive reactions that revolved around the implications of the disease for their sense of self and their relationships with others:

Kate: I know at first when my hands were quite patchy if we went for a drink I would be thinking everybody was staring at my hands and I was really self-conscious.

Zoe: How big are [the patches] going to get? What's it going to do to me? Will I be all right when I'm older? I might pass it on to my children.

Many felt that their self-confidence and self-esteem had been eroded as they feared how they would appear to others:

Sam: I was worried about what other people thought of me. I don't know, I just felt a bit ridiculous in a way but it changed how I felt about myself.

Sara: [Other people thought] that I probably looked strange. I was concerned that I wasn't like everybody else ... it was very uncomfortable if I was stared at.

Thus, most of the participants came to believe their appearance was undesirable and became preoccupied with the disease, to the extent that it might be thought of as 'saturating' their identity. The belief that they were different from others, diseased and disfigured had several emotional and social consequences. Not only did the expectation of rejection develop, but levels of anxiety and depressed mood were raised:

Joanne: People I work with. I work in a kitchen so they used to torment me. I'd say 'I'll get some gravy browning and paint in it' [and they would say] 'Don't worry, we'll paint it in for you.' You had to laugh but you were cringing inside. You had to laugh along with them. Inside it hurt.

Living with vitiligo: Trying not to be different

Once participants acknowledged that they now had a chronic and appearance altering disease, one which led them to feel different from others and which could lead to social exclusion, the real struggle of living with vitiligo began. Paralleling Leventhal's (1970) comment that coping involves both management of the external setting and management of thoughts and emotions, Pruzinsky (1992) has noted that people with a disfiguring condition face two challenges: dealing with their own emotional responses to the condition, and dealing with others' behaviour. In this study, participants managed these challenges by using both behavioural and cognitive strategies.

Behavioural strategies

Most participants described a variety of behaviour-based strategies that they used to reduce the chances of being discredited by others (Goffman, 1963) and were attempts at impression management (Leary & Kowalski, 1995). *Avoiding situations* where their disease would be visible, such as not engaging in sports such as swimming or not

becoming sexually intimate, were common. Some participants also described escaping from situations where their condition had become visible or had been noticed. Such reports are commonly found in quantitative studies and so are not novel, but here the participants also expressed their ambivalence about relying on avoidance. Although it might be used as a way of managing anxiety, there were clear disadvantages as well:

Joanne: I think it restricts you from doing [activities]. It shouldn't but it does because you think that people are always looking at you. [I should be able to take a] 'I don't care attitude' and 'you can look if you want', but you know that it goes through you that they may be looking. You've got to hide.

Similarly, many people with vitiligo use *concealment* of the skin, either by wearing specific types of clothes to cover their skin or cosmetic creams to camouflage their patches, but here again there was much ambivalence about their use:

Joanne: I can't wear shorts. I suppose you can, but because you don't want people looking at you don't and things like that, because people stare ... Like when the sun's shining and you want to put a vest on or shorts and you think well, I've got to put a shirt on, a long-sleeved shirt. Then you get a bit annoyed. Because really you'd like to be like everyone else. But then people look at you because you've got more clothes on than most people and then you're still different ... you're different because you've got more clothes on.

Kate: I found some of the creams were a bit powdery so I felt uncomfortable, being all clogged up because I had to put it on all the time and on my hands ... It's supposed to be waterproof but you like actually just pat dry, and it's awkward. I get a bit het up sometimes. I don't want to go through all this rigmarole every day, putting this stuff on.

Participants also reported using other behavioural strategies, such as *confronting* others' negative reactions and intrusive stares, and *explaining* the nature of the disease:

Zoe: I mean it does get you sometimes. If you see them actually staring at you, it's not very nice. And you say 'Stop staring' and [they] say 'I wasn't looking', [and you say] 'Yes you were' ... then they just change 'Oh, OK, I'm sorry'.

There's nothing to be sorry about, it's just one of those things, it's part of life ... then they're usually fine.

Sam: Well, mainly I just explain it. That it has just come on and it's nothing I've done that has caused it. And it's just here permanently, that you won't catch it and you don't need to worry about it ... That's all I really say.

Cognitive strategies

Participants also described a number of cognitive strategies which were aimed at modifying how they felt about being different and how they interpreted others' behaviour. These appeared to be more successful than the behavioural strategies of avoidance and concealment, and little ambivalence about their use was expressed. As is the case for other anxiety-based difficulties (Rapee & Heimberg, 1997), people with disfigurements can become hypervigilant to others' behaviour and there may be interpretive biases which can serve to maintain and exacerbate any difficulties. Here, however, some participants became aware of these tendencies and *monitored the attention* they gave to threat:

Debra: I think that people just blow things out of proportion and probably don't realize

that the majority of people don't notice. We have just bought a new car and before I never noticed that make, but now you notice them everywhere. And before I had vitiligo I never noticed it on anybody and then when I got it I started, you know, to really notice it.

Another cognitive strategy involved an *attributional analysis* of staring or discrimination. When they encountered stigmatization the participants were able to make an external attribution for the behaviour, seeing this as being due to a problem residing in the other person, rather than in themselves:

Sara: I don't think that people deliberately [stare] to embarrass you. You know, it's just human nature for people to stare. I mean it's part of life. I mean I do accept that. It doesn't make me feel better but I accept that there is nothing malicious or anything like that in it. I mean they're not doing it deliberately to make me feel uncomfortable, you know. I do try to accept that's just the way things are.

Debra: There are a lot of petty people about ... and if they are going to be like that it's probably a waste of time knowing them anyway. They are the ones that have problems. You usually find that those that persistently take the mickey out of you are the ones that are perhaps a bit insecure and need to have someone to take the pee out of you to try and make themselves bigger.

Thirdly, all of the participants indicated that making *social comparisons* between themselves and their condition and others with more threatening or even potentially fatal illnesses helped them to put their appearance into perspective. Comparisons were made with others perceived to be in worse situations, serving to reduce the importance of the disease in their lives:

Debra: It's really easy to blow it out of proportion, and there is always somebody worse off. I mean you only have to look at the news, you know ... that girl who's been killed, you know, she was only 14.

Kate: I think to myself it could be worse like dark skinned people. It would be really noticeable on them, and so I think to myself ... sometimes it's worse for other people. I'm not as bad off as other people.

Social support: Getting help with being different

The social support provided by significant others was important in dealing with difference in a variety of ways, including encouragement to enter anxiety-provoking settings, reassurance that the participants were accepted regardless of their appearance, and in the development of adaptive cognitions. These reports were consistent with Carver and Scheier's (1981) conclusion that social support can serve to facilitate the development of problem-focused (behavioural) and emotion-focused (cognitive) coping strategies.

Taking the risk

As noted above, avoidance and concealment were used by the participants as ways of managing their anxieties about being seen as different. While such strategies were apparently helpful in the short term, participants were ambivalent about their use because they led to restriction of activities. Significant others in the participants' social network encouraged alternative ways of coping. Their assistance was often crucial in

helping participants to take the risk of exposing their skin and to talk about their condition with others:

Joanne: I remember when I went on honeymoon with my husband and I'd got this shortish skirt on and I'd got some patches on my legs. So we were coming down these steps and [other holiday makers] turned round ... you cringe inside and my husband said 'Come on, you're alright. Keep walking.' At that point I could have turned and gone back up the steps. I couldn't have [gone on] without him, if he hadn't been there to say 'Come on'.

Zoe: [My husband] has given me a lot of confidence in myself. I used to tell people 'that won't hurt you', whereas now I will actually tell them what's happening, and what's wrong, and they can't catch it.

Seeing things differently

Social support from others was a source of cognitive as well as behavioural change. Friends and relatives helped by making comments or explaining their viewpoints about the minor importance of skin appearance and their acceptance of skin colour difference. These comments were internalized by the participants, giving them alternative cognitions about their appearance, and were used as part of their self-talk:

Claire: I think something my friend said to me was ... she said it's still healthy skin. I suppose it is. It just hasn't got any colour in it but yes, I suppose it is. And she sort of saw it in that way ... that had an impact on me.

Zoe: The fact that [my husband] came in and said, 'Oh, it doesn't make any difference', and all my friends are the same. I suppose I need them to say, 'Yes you are all right'. I need other people to accept me before I can accept myself.

Living with vitiligo: A fragile acceptance of difference

Over time, and to varying degrees, the participants were able to put their altered appearance into some perspective. Acceptance of the reality of both the condition and others' behaviour as being uncontrollable but not necessarily devastating was an important cognitive change for participants. Specifically, some participants came to believe that their different appearance, though not ideal, was tolerable and could be lived with:

Zoe: I'd like to be like everyone else. I've got to accept that I'm different ... then again we are all different.

Debra: I think [the patches] are part of me. I've even got it written on my passport. I mean I do wish that I didn't have the patches sometimes. I mean you can worry about what others think, but what can you do. Everyone has something.

Here, though, maintaining this type of self-talk consistently could be difficult at times. As noted above, the core issue for the sample was an awareness of being different from others. Even when the participants showed what could be characterized as 'good' adjustment, having an unusual appearance continued to be a significant issue even many years after initial diagnosis. Acceptance of difference varied over time, depending on a several factors. These included the season (vitiligo is more apparent in summer when the unaffected skin tans making the patches more obvious), instances of stigmatization

(which reinforced the difference in appearance), times of transition (such as going to university and making new friends) and such factors as menstrual periods and general feelings of confidence:

Sara: I'm worse at different times of the month ... it bothers me more because of my monthly cycle.

Claire: Although I'm confident, I still think I need to cover up some of the time ... Some days I'll wear make-up, other days I won't. If I felt 100% confident all the time I wouldn't wear any make-up. It's about me feeling better about myself and I'm aware that contradicts a lot of what I say.

At such times the participants needed to engage in cognitive work in order to maintain the belief that the difference the vitiligo makes should not rule their lives:

Joanne: I just know that they can't really do anything for me personally. So I just have to tell myself that this is me and this is how it's going to be.

Zoe: People might say things, but you've got to be strong with them, not let them beat you. You have got it, it doesn't change you as a person, you've still got a life.

Thus, developing the adaptive cognition that being different was tolerable assisted the participants in their attempts to deal with the vitiligo as an important but nevertheless relatively containable aspect of their lives. But maintaining this belief was problematic and under certain circumstances it was easy for them to lose this ability to put their difference in appearance into a wider perspective.

Discussion

This study has demonstrated the value of taking a qualitative approach in this area. Unlike most previous research which has examined the nature of the relationship between the presence of a disfiguring condition and well-being using quantitative methods, the approach taken here has illustrated the complex nature of how individuals manage their behaviour and their concerns about appearance. It is likely that the interviewer's appearance (male and with no apparent skin disease) affected the nature and extent of the participants' accounts, but they nevertheless disclosed a wide range of feelings and reactions to their condition. It is also likely that this disclosure was facilitated by the interviewer's clinical training and past experience in helping people to talk about sensitive topics. The location of the interviews — a dermatology clinic — may have increased the salience of the condition for the participants and the accessibility of particular memories, but was unlikely to have had a substantial effect on the content of these memories.

The central recurring theme concerned perceived differences from previous appearance and from others. After an initial recognition of difference, and also recognition of it by others, the participants became preoccupied by its effects and on how they could manage to contain them. Various behavioural and cognitive strategies were used to achieve this containment, with some success, but the process was fragile and required psychological effort, so that it was difficult to maintain at all times.

The results have several theoretical implications. They indicate that a variety of psychological models can be used to understand the processes involved in living with vitiligo. Like previous work on both disfigurement and social anxiety, the participants reported that they often used avoidance and concealment as strategies to manage the

impression they made on other people (Leary & Kowalski, 1995), but there was much expressed ambivalence about their use. That these strategies were used despite this ambivalence illustrates the overriding concerns about social exclusion (Goffman, 1963). One important finding was that the choice of coping strategies varied over time, depending on social and physiological factors. Participants described how they could manage positive self-talk on some occasions but not others, and sometimes resorted to avoidance or concealment. Thus, these findings belie the idea that adjustment is a linear process and that the use of particular coping strategies is stable. The notion that the use of such strategies reflected a problem-solving process and that their choice varied over time depending on current events and context was supported. Thus, the models suggested by Leventhal *et al.* (1993) and Moos and Schaefer (1984) seem to apply to disfigurement as well as other chronic difficulties.

Social support may be particularly important in both encouraging exposure to feared situations and developing types of self-talk which facilitate the reduction of distress. By acting as sources of helpful self-statements, significant others may assist individuals who have a disfigurement to achieve a position where they can accept their difference in physical appearance. These types of support are complementary to Baumeister and Leary's (1995) position, in which social support is important because it involves acceptance into a social group. Direct or indirect experiences with others perceived as less fortunate than the participants were also important. Gilbert (1997) would argue that this is because such comparisons serve to increase self-esteem.

Therapeutically, these findings illustrate that formal interventions such as social skills training (Robinson *et al.*, 1996) and cognitive-behavioural therapy (Papadopoulos *et al.*, 1999) can mirror the kinds of help informally garnered from social networks. The social skills approach is helpful because it increases the repertoire of possible behavioural coping strategies to include self-disclosure and the verbal skills needed to deal with stigmatization. Cognitive-behavioural interventions combine these with challenges to unhelpful and debilitating self-statements. The participants in this study described how their friends and families were providing similar types of help.

Future studies could explore many of these issues in more depth. No claims can be made about the generalizability of these results. All of the participants here were female and Caucasian; it is probable that a sample from other racial and cultural backgrounds could face other issues, as might males. It would be helpful to know more about why people choose particular coping skills over others, the situations in which they are chosen, and the advantages and disadvantages of each. Future work could also be directed at understanding how premorbid personality characteristics, such as shyness and social anxiety, might interact with distress after the development of a disfiguring condition. These current results suggest that living with vitiligo with lower levels of anxiety and depressed mood involves an acceptance of difference and the use of particular cognitive strategies, hypothesizes which are open to testing through quantitative research. In all these ways, future studies could contribute to the alleviation of the high levels of distress reported by people with disfiguring conditions.

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