

## **The Impact of Visible Differences Upon Intimacy: The Role of Healthcare Professionals**

Appearance altering conditions can have a negative impact upon an individual's psychosocial well-being. This may extend into the important sphere of intimate relationships and can affect existing relationships as well as the formation of new partnerships. Nick Sharratt from the Centre for Appearance Research discusses why this is a topic that is often not discussed with healthcare professionals and offers some initial suggestions as to how this may be redressed.

### **Four Summarising Key Points**

1. Visible differences can impact upon an individual's psychological health and well-being.
2. Those with a visible difference may experience difficulties and concerns both in forming new intimate relationships and within the context of more established intimate relationships.
3. These concerns and difficulties are often not discussed between healthcare professionals and patients.
4. There are several small steps that may be taken in order to incorporate a consideration of the potential impact of visible differences upon intimacy into the provision of comprehensive, patient centred care.

### **Four Key Words**

1. Psychology
2. Appearance
3. Visible difference / disfigurement
4. Intimacy

### **Abstract**

Looking different from the norm can be challenging in a society that attributes such importance to the way we look and subscribes to the poet's contention that "the good is always beautiful, the beautiful is good" (John Greenleaf Whittier 'Garden'). This article considers what we mean by the term 'visible difference,' looks at the potential impact of living with a visible difference and then examines this specifically within the context of intimacy and close relationships between actual or potential romantic partners. It goes on to contemplate what we know about the role of healthcare professionals and offers some initial suggestions as to what can be done for patients with visible differences who may have concerns about intimacy. It is hoped that the suggestions provided are capable of being incorporated into interactions with patients despite subsisting limitations on time and resources.

### **Article**

### **What are visible differences?**

Anything that distinguishes an individual's appearance from the norm may be considered a visible difference. This includes congenital (e.g. cleft lip and palate) and acquired conditions (Bessell and Moss, 2007). Acquired visible differences may arise in a variety of ways including accidental trauma (e.g. burn injuries), disease processes (e.g. psoriasis), and medical or surgical interventions (e.g. treatment for some cancers). A visible difference may therefore be present from birth, acquired later in life or fluctuate over time. It may normally be immediately visible or may not be if, for example, it affects an area of the body usually covered by clothing.

### **What impact can visible differences have?**

It is important to acknowledge that many people may live with a visible difference without it impacting negatively upon them. Others are less fortunate and visible differences are associated with a variety of psychosocial and behavioural difficulties including depression, social anxiety, reduced quality of life and social avoidance (Rumsey, Clarke and White, 2003). Furthermore, Rumsey and Harcourt (2004) describe how they may contribute to lowered self-perceptions and difficult social interactions via a spiral of negative emotions, maladaptive thought processes and sub-optimal behavioural patterns. An important point to note which challenges assumptions about the relationship between the physical manifestation of a visible difference and its bearing upon someone's life is that an individual's subjective appraisal of their appearance provides a more powerful indication of the likelihood of experiencing distress than an objective measure of the severity of their condition (Ong et al, 2007; Moss, 2005).

### **How can visible differences impact intimacy?**

Research shows that more attractive people tend to be assumed to possess a variety of positive traits (Swami and Furnham, 2008). Investigating this 'what-is-beautiful-is-good' phenomenon, Halioua et al (2011) found that those with a visible difference were considered less intelligent, trustworthy, attractive, optimistic and capable than people without a visible difference. These initial judgements mean that those with visible differences may be derogated in the eyes of others, subjected to stigmatisation (Goffman, 2000) and adjudged asexual by others rendering them invisible to those seeking a partner (Worthington, 1988).

As well as influencing the judgments of others, a visible difference may impact upon the individual's own capacity for intimacy. Magin et al (2010) spoke to people with acne, psoriasis and eczema and found that these conditions reduced self-perceived attractiveness, lowered self-confidence and led to participants fearing and avoiding intimate situations. Their participants expressed concern at the thought of removing clothing in-front of an intimate partner and experienced this as being qualitatively different and more personal to more public exposures at the beach or swimming pool. Shaban (2010) argues that intimacy requires self-confidence, trust and openness. Visible differences do not encourage the development of these qualities.

Interestingly, these difficulties were identified within the context of established relationships. Those with a difference may consider themselves a burden to their partner and experience their appearance as a barrier to achieving physical intimacy (Wahl, Gjengedal and Hanestad, 2002).

Similarly, Borwick (2011) references Changing Faces' SCARED acronym and argues that those with a visible difference may feel Self-conscious, Conspicuous, Angry/Anxious, Rejected, Embarrassed and Different and so act or appear Shy, Cowardly, Aggressive, Retreating, Evasive and Defensive. She contends that such feelings and behaviours may contribute to the breakdown of existing relationships as well as making new partnerships difficult to establish.

Difficulties in establishing relationships are commonly mentioned. Participants have reported concerns over beginning a new relationship, approaching potential partners and being immediately discounted because of their appearance (e.g. Mathias and Harcourt, 2014; Tindle, Denver and Lilley, 2009). Those with visible differences that are not immediately apparent are confronted with a dilemma when initiating a relationship: how and when to make their new partner aware of their condition. Griffiths, Williamson and Rumsey (2012) found that adolescents viewed concealment of their difference as helpful in the short term. They feared rejection if they disclosed their difference early in the relationship. In the longer term concealment was understood as increasing anxiety because participants felt compelled to reveal their condition once the relationship had developed. They worried that the revelation may make their partner appraise them negatively, end their relationship and make them feel guilty and deceitful.

### **Healthcare professionals, visible differences and intimacy**

Worthington (1988) argues that a program of treatment or rehabilitation is inadequate if it does not support sexual health and adjustment but this standard is rarely met (Sampogna et al, 2007). Some suggestions for appropriate practice exist within the research literature and it may be possible to adopt these within the context of a healthcare system operating with finite resources and within which referral pathways and access to psychological services may be limited.

One thing that can be done is to dispel any assumptions that psychological and social difficulties will necessarily be related to the nature, objective severity or location of a visible difference. Simply acknowledging that appearance may be a concern and that patients may approach intimate encounters with trepidation represents a significant step towards offering patient centred care. Penner (2009) suggests this should be done as early as possible to legitimise intimacy and sexuality as appropriate topics of attention and provide reassurance that such concerns will not remain wholly unaddressed. Speaking about such issues ensures they are not considered taboo, empowers the patient to discuss their fears and breaks the conspiracy of silence that exists between healthcare professionals and patients (Verschuren et al, 2013).

Dixon and Dixon (2006) claim that this is often not done, that healthcare staff may be apprehensive or embarrassed about discussing sexual issues and that the context of a hospital renders it difficult to view a patient as a sexual being. They offer the PLISSIT [model \(Annon, 1976\)](#), (in which Permission, Limited Information, Specific Suggestions then Intensive therapy are provided.) ~~model~~ as a framework within which these issues may be approached. For this to be effective, healthcare professional must feel confident in raising the issue. Verschuren et al (2013) worked with those who care for lower limb amputees and found that professionals often felt they lacked knowledge about and the ability to recognise sexual problems. Those who were more confident in their knowledge and ability were more likely to discuss the issue with patients. Professionals were also unsure whose

responsibility this should be and wanted sexuality to be addressed within a standardised protocol that defined which member of the team should take primary responsibility for discussing this with patients.

As well as a structured and organised approach, healthcare professionals also desired the creation of a brochure for patients (Verschuren et al, 2013). This should provide information and advice about difficulties with sex and intimacy and facilitate rather than replace a clinical discussion. Changing Faces has produced a two part guide entitled 'Intimacy, Love and Relationships' which is aimed at assisting those with a visible difference. This is available from their website and could be a useful resource for healthcare professionals and patients alike.

In summary, healthcare professionals can: equip themselves with some information about the experiences of those with a visible difference; acknowledge that neither being a patient nor having a visible difference renders someone asexual; view intimacy and sex as topics that should be discussed free from embarrassment; develop an organisational framework within which intimacy is addressed; allocate responsibility for this to specific team members; become aware of any relevant referral pathways, services or other organisations; and ensure helpful material that may be provided to patients is sourced. These initial steps may help to address the impact of visible differences upon intimate relationships, ensure this area is included within the clinical agenda and provide support to those in need.

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