Marked Body Surface:

Lived experiences of women with non-facial scars

Dissertation

Presented in fulfilment of the requirements for the degree Doctor of Philosophy in School of Global, Urban and Social Studies of RMIT University

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‘For far too long the attention has been on denouncing “perfect” bodies. It’s time we turned to investigating the feelings, the experiences and the sheer diversity of imperfect ones,’

Elspeth Probyn 2004
Declaration

I certify that:

a) except where due acknowledgement has been made, the work is that of the candidate alone;

b) the work has not been submitted previously, in whole or in part, to qualify for any other academic award;

c) the content of the thesis is the result of work which has been carried out since the official commencement date of the approved research program;

d) any editorial work, paid or unpaid, carried out by a third party is acknowledged;

e) ethics procedures and guidelines have been followed.

Signed by Lee Kofman ______________________
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Abstract

This exploratory study examines the lived experiences of women with non-facial scars. The number of people living with scars is significant. In contemporary western culture scars are seen as disfigurements and having them can result in negative consequences for their bearers. However, while the psychosocial impact of facial scars have attracted some research interest, non-facial scars as a unit of analysis have rarely been investigated.

This study uses a mixed methods design that is predominantly qualitative and supplemented by quantitative measures where appropriate. It is underpinned by the constructivist grounded theory as developed by Kathy Charmaz. In-depth semi-structured interviews were conducted with thirty women with non-facial scars. The interviews were supplemented with other data collection methods: creative methods involving photography and writing, and two ordinal scales.

The main aim of this study was an open exploration of women’s experiences of their scars, which will also be reflective of the context in which participants live and the social processes involved in these experiences. The substantive theory that emerged conceptualises non-facial scars as marks that can be disfiguring, can be socially interpreted as shedding light on their bearers’ life stories and personalities, and can also contain personal meanings for their bearers, such as memories and being identity markers.

Findings show that, for some women, scars provide the positive identity of a resilient and interesting person with unusual life experiences. Scars can also trigger meaningful rumination about personal strengths and lessons learnt. However, taken together, the findings suggest significant distress exists within this population. This distress has four components: appearance concerns, stigma concerns, painful memories and concerns about future health. Most commonly, women felt that their scars marked them as unattractive and were painful reminders of suffering and vulnerability, yet were also positive metaphors for survival and resilience.

An integral part of having non-facial scars is dealing with social reactions. Most common and problematic responses to scars identified by participants were interrogations about the origins of scars, attention to their disfiguring effect, minimisation of scar-related concerns, and unsolicited urging to stop concealing their scars.
Women employed cognitive and behavioural strategies to deal with the negative impact of non-facial scars on their lives. However, beyond self-protection, some women also used their scars as tools to achieve social goals both for themselves and to help others. These goals included: bonding with people, seducing, validating past suffering and present health problems, getting practical help, helping people professionally and privately, promoting compassion in others, and warning people about health risks.

The impact of non-facial scars was found to be dynamic, with many women renegotiating meanings around their scars and their coping strategies over the years. Such fluctuations were affected by a complex interplay of physical, psychological, relational, social, demographic and cultural factors. Factors identified as most significant were certain appearance attitudes (subjective interpretations of scar locations, self-described modesty and critical awareness of dominant discourses around appearance), self-described personality traits (sociable, hardy and perfectionist), anticipated reactions to scars, negative changes in appearance, stage of life, relationship status and quality, occupation, the disfigurement degree of scars, aetiology, and health status.

Several unmet needs were commonly mentioned by women with non-facial scars. These were public visibility of women with non-facial scars; sensitivity about issues around non-facial scars amongst the public, health professionals and school staff; better access to peer support; better provision of information about the risks of scars embedded in medical treatments and more inclusion in decision-making around these treatments; and commensurate compensation in recognition of the negative impact of non-facial scars.

Overall, the experiences of non-facial scars can be viewed as complex and ambivalent. Non-facial scars can have a profoundly positive and/or negative impact on women’s identities, thoughts, emotions, social interactions and private behaviour. They can adversely affect women’s life choices and, to some extent, their life chances. However, women can also be creative at how they interpret, manage and utilise these bodily features which culturally are considered to be disfiguring.

This research adds knowledge to the previous scholarly work on disfigurements, and supports empirically some of the theories of the body, including extending this theorisation into the field of disfigurements. It also offers practice implications for the care and support of women with non-facial scars and serves as a foundation for future research on this topic.
Chapter One – Scars: a Disembodied Body?

‘We remember the time around scars.’

Michael Ondaatje

Conceptualising scars

The number of people living with scars is significant. Statistics are difficult to obtain, but it has been suggested approximately 100 million people in the developed world acquire scars each year (Sund, 2000). Despite their commonality, definitions of what constitutes scars can be complex, and sometimes even contradictory, as the following sections demonstrate.

Physical definitions

Scars result from the biological process of wound repair in the skin and other body tissues (Bayat, McGrouther & Ferguson, 2003). The causes of wounds that lead to scarring range from infections to trauma (such as burns and road trauma), self-harm, and surgical interventions for medical and cosmetic purposes. Scars can also result from the practice of scarification, which is done by branding (burning of skin), cicatrisation (skin cutting) or creating raised scars (Jablonski, 2008, pp.155-6). However, scarification is not included in this discussion, since such scars are deliberately made for the purpose of self-expression, whereas the focus of this thesis is on unintentionally acquired scars. Yet self-harm scars are included here, since while the act of self-harm is intentional, people engaging in it usually do not consider the resultant scarring. They may do this impulsively, without realising the long-term consequences, including the stigmatising nature of such scars.

Scars vary in size, colour, shape and texture, and can be broadly classified as ‘normal’ (fine and blended with skin), and ‘abnormal’ (altering the shape and texture of the skin) (Bayat et al., 2003). Abnormal scars include widespread (stretched) scars, scar contractures, atrophic (sunken) scars and hypertrophic (raised) scars; some hypertrophic scars can develop into keloid scars that grow beyond the wound boundary and may feel itchy and/or painful (Bayat et al., 2003; Jablonski, 2008). Scars, particularly keloid ones,
are usually resistant to cosmetic treatment, and never disappear completely (Bayat, McGrourther & Ferguson, 2006; Robles & Berg, 2007).

Recent technological developments in medicine have somewhat altered scar demographics in the contemporary west. For example, today keyhole and natural orifice surgeries are gradually spreading, reducing the number of scars resulting from medical treatments. However, such technological innovations do not necessarily reduce overall scar numbers, since other types of scars are currently on the rise - also due to the technological progress. Higher rates of survival from severe trauma, such as burns (Lawrence, Fauerbach & Thombs, 2006a), and the increasingly more sophisticated medical treatments for illnesses, such as cancer (Bonanno & Esmaeli, 2012; Wallace, Harcourt, Rumsey & Foot, 2007a) mean survivors often acquire disfiguring scars, even though surgeons are now more conscious of aesthetics and endeavour to produce finer scars. Sociocultural factors also play a role in the changing scar demographics, most prominently through the increase in scars resulting from caesarean sections, cosmetic procedures, self-harm and road trauma.

**Scars as disfigurements**

Although scars are common, in contemporary western culture they are seen as disfigurements (Austin, 1999; Rumsey & Harcourt, 2005). Rumsey (1998), a leading scholar of disfigurements, writes that the term ‘disfigurement’ has been defined by several key appearance researchers as “visible physical characteristic(s) perceived by the self and others as ‘different’ or ‘abnormal’ compared with societal and cultural norms” (p.576). In the literature on disfigurements the terms ‘physical disfigurement’ and ‘visible disfigurement’ are used interchangeably. Rumsey & Harcourt (2007) criticise this language, suggesting instead use of the term ‘visible difference’, which some researchers (e.g. Bessell & Moss 2007) have adopted. However, I believe this latter term is euphemistic, too vague and over-inclusive. In this thesis I use the term ‘disfigurement’ for its simplicity but also because, as is discussed later, with non-facial scars issues of concealment are as important as those of visibility, whereas the physicality of disfigurements is self-evident in my view and as such does not warrant a mention in the terminology.

Scholars (Featherstone, 1991; Jablonski, 2008; Rumsey & Harcourt, 2005; Shilling, 2003) suggest some of the main contemporary appearance prerequisites are to
look youthful, healthy and fit; these standards express current sociocultural values of autonomy, self-control, mastery and invincibility. These aspirations play themselves notably on the skin surface, which, ideally, should be smooth and not show signs of wear, experience, or even deep thought as in the case of wrinkles (Bundy, 2012; Jablonski, 2008).

This ideal image of skin may seem a natural preference. Yet, arguably, favouring unblemished skin is a socially constructed choice to some extent. In certain parts of Africa and Asia, for example, ritual scarification is practiced for beauty purposes and/or to indicate sexual maturity (Brain, 1979; Jablonski, 2008; Schildkrout, 2004). Many non-western cultures also prefer flawless skin and perceive scars as disfigurments. Iranian (Rahzani, Taleghani & Nasrabadi, 2009) and Bangladeshi (Mannan et al., 2006) studies, for example, show the existence of negative cultural attitudes towards people with scars. Still, it has been suggested by scholars of human skin (Benthien, 2002; Connor, 2004; Jablonski, 2008) that the western preference for perfect skin is unprecedented in its fervour, relegating scars to the realm of abnormality.

Having disfigurements can be a major disadvantage. People with disfigurements can be stigmatised in various ways, for example, through perceptions of being unhealthy or intellectually disabled (Rumsey et al., 2010). People with disfigurements often report experiencing insults such as staring, name calling, and unsolicited interrogations about their appearance (Kleve & Robinson, 1999; Rumsey et al., 2010). More particularly in relation to scars, studies in experimental psychology have demonstrated that observers rate people with facial scars (Bull & David, 1986; Rankin & Borah, 2003) and non-facial scars (Ogden & Lindridge, 2008) as less attractive than those without scars. Hypertrophic and keloid scars particularly correlate with appearance concerns (Jablonski, 2008, p.125).

**Scars as a ‘disembodied body’**

People with scars sometimes go to great lengths to conceal them, including covering them with elaborate tattoos (Spyropoulou & Fatah, 2009). But despite this and the fact that scars can convey negative meanings and reduce people’s attractiveness to others, their impact is often trivialised. In my observation, even the word ‘scars’ seems to have lost its physical dimension and become more of a metaphor for emotional problems. When I have mentioned the topic of this PhD, I have often been asked: ‘Are you writing about emotional scars?’ Such disembodied perception of scars is arguably reflected in the
lack of services for people with scars. There are few services catering to people with facial scars or with burns scars (the bulk of such services are concentrated in the UK) and no healthcare is provided specifically for helping people with non-facial scars. Health professionals too often underestimate the effects scars may have on people’s wellbeing (Bayat et al., 2003; Brown, McKenna, Siddhi, McGrouther and Bayat, 2008; Wallace et al., 2007b), which is somewhat paradoxical, considering the importance placed on appearance in contemporary culture.

**Scars within the existing research**

Scholarly interest in the psychosocial impact of scars on people’s lives has thus far been piecemeal, possibly reflecting the trivialisation of them. This is despite the current great interest social sciences have in the body, including its appearance (discussed in the following chapter), and despite the emerging evidence that scars may entail “a significant psychosocial burden” (Robles & Berg, 2007, p.26). The majority of studies examining the impact of appearance on lived experiences centres on such bodily differences as skin colour, disability, visible non-heterosexual sexuality, attractiveness, weight and shape, or on elective body modification (notably cosmetic surgery). But relatively little investigation has been conducted into the experiences of people with disfigurements generally, and scars in particular.

The only social scientists to pay systematic attention to disfigurements have been psychologists conducting research within the discipline of appearance research (other themes in appearance research are the study of social significance of attractiveness, the exploration of the impact of body image on individuals, and the expression of identity through appearance (Thompson, 2012)). The separate field of disfigurements is still relatively young, having gained impetus in the 1990s (Kent, 2002; Rumsey & Harcourt, 2005). The UK is the leader in this field, having established in 1998 the Centre for Appearance Research (CAR), dedicated to coordinating international research on appearance and disfigurements. To date, scars have been investigated chiefly within disfigurement research and even there - sparsely.

**Scars as a part of mixed disfigurement studies**

Scars have been included in aetiology-focused samples, such as in studies investigating the impact of a variety of cancer-related disfigurements (for example, Rasmussen, Hansen & Elverdam, 2010; Williamson, Harcourt, Halliwell, Frith &
Scars have also been included in mixed disfigurement samples (for example, Moss, 2005; Rumsey et al., 2010). However, researchers of disfigurements often rely on clinical samples. People attending clinics usually seek to improve their appearance and/or alleviate physical discomfort and health problems associated with their disfigurements. Those with scars, which as discussed are more difficult to treat cosmetically and often do not involve health problems, are arguably more likely to be absent from clinical samples. Besides, mixed research has not yielded consistent data. For example, a study (Rumsey et al., 2004) which recruited participants with both major and minor disfigurements, produced a great variability of findings. These findings present “a challenge in terms of designing appropriate... strategies for support...” (Rumsey et al., 2004, p.451) and the researchers’ conclusion was that “the levels of variability within this sample indicate that a broad-brush approach to assessment is likely to be ineffective, and an individual approach is needed” (Rumsey et al, 2004, p.451). There is growing recognition among researchers that people with disfigurements are not an homogenous group, and that “factors that predict distress in one condition are not assumed to be predictive in others” (Rumsey & Harcourt, 2005, p.35). Even when distress levels and symptoms are similar across some conditions, the everyday challenges and concerns people deal with can vary according to their different disfigurements.

Arguably, scars are a worthy unit of analysis in itself, having unique characteristics. Aetiology of scars is diverse, however non-facial scars share appearance-related characteristics. They can be concealed. They differ from congenital disfigurements in that they always signify an injury, a drama. They also differ from skin diseases, another locus of study in the disfigurement research, in that they do not trigger in others fear of contamination, neither do they ‘outbreak’ according to seasons. Scarred bodies also differ from visibly disabled bodies in that they do not necessarily involve a lack of function. Yet they can signify the limitations of our bodies: our physical vulnerability – including mortality – and, since they are resistant to treatment, the impossibility to achieve the cultural ideals of beauty. Thus, this unit of analysis is at once narrow and broad enough to test against findings from literature of disfigurements.

**Aetiological research focus**

When scars are investigated on their own, usually their sub-types are explored according to aetiology with these being chiefly burn scars (for example, Corry, Pruzinsky
& Rumsey, 2009; Lawrence, Rosenberg, Mason & Fauerbach, 2011; Thombs et al., 2008). Yet, insights into the experiences of people with burn scars may not be directly applicable to the experiences of people with other types of scars, particularly given that burns are often associated with pain and physical impairment (Noronha & Faust, 2007; Williams, Davey & Klock-Powell, 2003), whereas many other scars are not. Scars arise from a variety of causes and – if their impact is to be understood - require a rich aetiological snapshot.

**Facial scars as a unit of analysis**

Facial scars have also attracted some research interest as a part of the overall focus of disfigurement scholars on facial disfigurements, as the most visible ones. Several studies have been carried out into effects of facial scars on people’s lives (for example, Furness, Garrud, Faulder & Swift, 2006; Rankin & Borah, 2003) and they are often included in mixed facial disfigurement study samples (for example, Bonanno & Esmaeli, 2012; Shanmugarajah, Gaind, Clarke & Butler, 2012). Moreover, in mixed facial and non-facial disfigurement studies (for example, Moss, 2005; Moss & Carr, 2004), facial disfigurements – including scars - tend to dominate samples. Similarly, existing support organisations for people with disfigurements, such as the UK *Changing Faces* and *Let's Face It*, as well as published resources detailed in chapter three are usually oriented toward people with facial disfigurements.

However, the literature on disfigurements is inconclusive as to whether facial disfigurements correlate with more distress than the non-facial variety. Some studies (Kent and Keohane, 2001; Rumsey et al., 2010) show that less visible disfigurements are associated with lower levels of distress. Yet, evidence also exists that less visible disfigurements can cause suffering too (Hiatt, Collins, Pastorek & Bellows, 2009; Moss, 2005; Rumsey et al., 2010), sometimes as much as that from more visible disfigurements (Clarke, Hansen, White & Butler, 2012; Kleve & Robinson, 1999; Troilius, Wrangsjo, & Ljunggren, 1998). Thus, people with concealable disfigurements may require support too.

Existing insights into the experiences of people with facial scars may not represent the experiences of people with non-facial scars. Disfigurement research into the usefulness of coping strategies and interventions has so far focused mostly on examining the efficacy of social skills of people with disfigurements (Jenkinson, 2012; Rumsey &
Harcourt, 2005). This focus is based on research participants reporting the most
difficulties within social interactions. However, such findings are predominantly based
on, and most relevant to, the experiences of people with facial disfigurements, since non-
facial disfigurements are usually possible to conceal with clothing, jewellery and even
body language.

Although this relative ease of concealment can help avoid stigmatisation,
concealable disfigurements may still lead to secretive behaviour and generate guilt,
shame, feelings of being flawed and fear of evaluation by others when disfigurements are
revealed (Wittkowski et al., 2007). As Newell (1999) argues, when normally concealed
disfigurements suddenly become visible, social responses may be unpredictable.
Additionally, some concealable disfigurements are in locations important in sexual
interactions and their revelation can be particularly distressing. Therefore, although it is
plausible to assume non-facial disfigurements may have less impact on social
interactions, they are still likely to affect people’s self-concept and cause anxiety.
Arguably, the extent that the dilemmas around concealment, disclosure and secrecy may
affect people with non-facial scars warrants a separate investigation.

Mixed studies of facial and non-facial scars

Few studies conceptualised scars as a unit of analysis, and none focused on non-
quantitatively investigated quality of life of one hundred people with keloid and
hypertrophic scars who at the time were receiving treatment for their scars, mostly
because of the associated pain, itching and/or restrictions on physical functioning. Bock et
al. found that the highest psychological distress was associated with the greatest physical
suffering. Once again, this study sample was not representative of the vast majority of
people with scars that, particularly in the long-term, do not involve physical discomfort,
and can include normal, widespread and atrophic scars too.

Two later UK-based studies (Brown et al., 2008; Brown, Moss, McGrouther &
Bayat, 2010) also chose scars as a unit of analysis but without excluding any scars or
focusing on physical discomfort. The qualitative study by Brown et al. (2008)
investigated the impact of scars on people’s lives. Based on a sample of 34 participants
aged 14-70, Brown et al. concluded that the “effects of scarring have a major influence on
patients’ psychological morbidity and behaviour” (p.1056). The majority of the study’s respondents (76%) reported experiencing emotional difficulties, mainly low self-confidence, and feelings of depression, anger and anxiety. Just over half of the participants felt they looked abnormal. For many, the scars served as unwanted reminders of the suffering and trauma involved in the events that caused their scars. Brown et al. also found that two-thirds of the participants engaged in concealment (often laborious) of their scars, particularly at work. Some even concealed their scars from themselves by avoiding looking at mirrors. Many reported that because of their scars they were less sociable and avoided public spaces, and that their scars impacted negatively on their interactions with people of the opposite sex, particularly with regard to acquiring intimate partners. A fifth of the participants also reported that fear of exposing their scars interfered with their leisure activities, such as swimming. Some worried their scars may impact negatively on their career progression.

Later, Brown et al. (2010) quantitatively investigated the relationship between the physical aspects of scars and their impact on people’s lives. The study sample included 82 participants aged from 16 to 65. Brown et al. concluded that subjective, rather than objective, estimates of scar severity predicted the extent of distress. These findings are consistent with the cumulative findings from the research on disfigurements (Rumsey & Harcourt, 2005, 2007; Thompson & Kent, 2001). More surprisingly though, Brown et al. found that non-facial scars in locations more easy to conceal, such as the torso and upper limbs, were often associated with greater distress. Whereas Bock et al. (2006) showed that scars in visible, locations other than the face, such as the lower legs and arms, correlated with as much psychological distress as that arising from facial scars.

The aforementioned findings should be treated with caution because of the relatively small sample sizes. Still, taken together they indicate that non-facial scars are a worthy unit of analysis, since they can have a detrimental impact on people’s wellbeing, which needs to be understood further, particularly in respect to the issues of concealment, disclosure and secrecy. In this thesis I have expanded the area of scar study by introducing a new unit of analysis: non-facial scars.

**Scars and Gender**
Feminist scholars (for example, Bordo, 1990, 1993, 1997; Butler, 1990; Orbach, 1978) have highlighted the gendered nature of how people experience their bodies, including the different sociocultural expectations about female and male self-presentation, noting that the pressure to conform to cultural ideas about normality and beauty is particularly strong for women.

Feminist scholars exploring disability and illness argue that physically impaired women are located even more outside standards of normality and attractiveness. Wendell (1996), for example, herself a woman with chronic illness, maintains that for women, being ‘normal’ just as being ‘beautiful’ is not only a social but also an internal imperative, and that having a disfigured body profoundly challenges a woman’s sense of self. Miner (1997), in her gendered analysis of disability narratives, adds to Wendell’s argument by suggesting that women receive strong social messages about their ‘duty’ to hide their physical ‘abnormalities’ from the public view. If they dare not to conform to societal norms then, as the sociologist Inckle (2007) writes, “the non-normative female body… is intensified as the focus of hostile and intrusive public scrutiny, and is afforded none of the protections or pay-offs of normative femininity” (p.104).

A more detailed discussion of the contemporary pressures exerted on women is presented in chapter two. For introductory purposes, it should be noted that a bulk of appearance studies demonstrate that the effects of cultural expectations on women can be powerful. Although men, too, are increasingly becoming dissatisfied with their bodies (McCabe & Ricciardelli, 2004), women significantly outnumber them when it comes to appearance concerns (McCabe & Ricciardelli, 2004, 2006; McCabe, Ricciardelli, Mellor & Ball, 2005; Winham & Hampl, 2008).

Research on disfigurements is inconclusive as to whether gender correlates with greater disfigurement-related distress. However, female respondents tend to dominate studies with mixed gender samples (for example, Hill & Kennedy, 2002; Moss & Carr, 2004; Rumsey et al. 2010; Versnel, Duivenvoorden, Passchier & Mathijssen, 2010; Wittkowski et al., 2007). Although scars can be found with equal frequency in men and women (Shaffer, Taylor & Cook-Bolden, 2002), in the samples of studies of scars (Bock et al., 2006; Brown et al., 2008; Brown et al., 2010) the majority of respondents is also female. In a recent article (Spyropoulou & Fatah, 2009) presenting case studies of plastic surgery patients who concealed their scars with decorative tattooing, all the participants were female. Since most disfigurement researchers, including those studying scars, recruit
their sample from clinical populations (for example, Hiatt et al., 2009; Thombs et al., 2008), it is plausible to assume women seek treatment more often than men and are more concerned about their scars. Some limited evidence (Tartaglia, McMahon, West & Belongia, 2005) also suggests that women with disfigurements experience more discrimination in their workplaces than men with disfigurements.

Given the lack of research on scars and gender, poetry and fiction can be useful sources for speculating about the gendered nature of social meanings around scars. The Ancient Greek poet Homer set the scene, creating one of the most famous literary stories about male scarring. Odysseus’ is a heroic tale: he received the scar on his thigh in the course of his initiation into manhood, while killing his first bear. His scar is further celebrated as the visual representation of Odysseus’ ‘true’, heroic essence when he returns to Ithaca under a false identity and is recognised by his scar. Centuries later, in his novel Eucalyptus, Bail (1998) expresses a similar sentiment about male scars: “Scars are worn by men, almost as women wear jewellery” (p.101).

In fiction it appears male scars can be worn with pride, as glorious proof of masculinity and unique identity; the geography of male scars seems to be composed of phallic landscapes populated with dangerous mountains and jungles. In real life too, European men (particularly in 19th century Germany) inflicted ‘bragging’ facial scars on each other to showcase their bravery, which appealed to women (Kiernan, 1988). Similarly, a recent study (Burriss et al., 2009) showed that both male and female participants rated non-severe male facial scars as attractive – signposting risk-taking and aggression associated with masculinity.

But what about women? If theorisation of female disability and illness is applied to scars, then female body maps may look like lists of places to avoid or, at the very least, places housing self-consciousness and other anxieties. Women may have more to lose by revealing their scars, since these are likely to interfere with the acceptable notions of femininity. Anecdotally it seems even minor female scars can be perceived as disfiguring. While Harrison Ford’s chin scar is often incorporated into his cinematic roles, the actresses Sharon Stone and Catherine Zeta-Jones, for example, who both, coincidentally, have quite minor neck scars, conceal them meticulously with necklaces, make-up and clothes.

My initial personal and professional interest in female experiences of non-facial scars discussed in the next section was further reinforced when I consulted relevant
literature discussed above and in chapter two and realised that considerable research evidence exists demonstrating greater sociocultural pressures around body presentation exerted on women.

**Positioning myself as a researcher**

This section presents my rationale for this study, and situates this research on the scholarly map by explaining its cross-disciplinary approach and the methodological choices I made, including the approach to writing.

**My rationale for this study**

I have a long-standing interest in the impact of non-facial scars on women’s lives, both for personal and professional reasons. On a personal level, my body is inscribed with extensive scarring. By the time I turned eleven, I had undergone seven operations to repair congenital heart defects and a leg injured in a road trauma. These operations took place in the former Soviet Union in the early 1980s when - devoid of modern technology and sober staff - hospitals barely coped with providing basic care and would not ‘waste’ their time and resources on such ‘trivia’ as fine-skin suturing. I was already considered lucky for surviving so many operations and not ending up dead under the knife of an alcoholic surgeon, as some children I met on the ward did. But I acquired many scars. I have a long scar on my chest that ends with two dents where feeding tubes were once inserted. My left leg is utterly disfigured: between a keloid scar that runs to my knee and a large dent in place of the muscle torn by a bus wheel just above the ankle, the rest is an uneven tapestry of regrown patches of skin. My thigh, too, is a lax artwork of pale skin patches left after a skin graft. I also have several minor scars on my wrist and underarms.

Living in such a body negatively impacted my life in many ways. Dating, for me, was always bound with great anxiety about my body. I avoided school trips and, later, trips with friends, so as to avoid situations where my scars could be exposed. There were certain occupations, like acting or being a flight attendant, I felt I could never pursue because these could entail revealing my scars, for example through a uniform. The secrecy associated with having non-facial scars, which I still meticulously hide under my clothes, has affected my personality. Having a body imprinted with the stories of my childhood misfortunes has, paradoxically, both reduced my confidence and increased it. I have always felt like a freak, but also unique. It is possible I grew up to be a more resilient and adventurous person than I otherwise might have, because from a young age I
constantly had to deal with being different. I am a writer, and the story of my body has inspired some of my creative work too.

As a researcher, I agree with Frank’s (1991) suggestion that “if the body is the subject of sociology, theory becomes possible insofar as the theorist shares that embodiment” (p.92). Similarly, Inckle (2007) argues that “a position of embodiment facilitates empathic engagement with the lives and experiences of research participants…” (p.149). Therefore in the chapters presenting my findings I occasionally weave my own story in with the respondents’ narratives - to support, add to, and at times contrast, their insights into the experiences of living in a scarred body. The reasons for this approach are discussed further in chapter four that outlines the methodological framework of this thesis.

I am also a social worker. Social workers often work with people with poor physical and mental health, who are more likely to have scarred bodies because they are more likely to have undergone medical treatments, and to receive trauma and self-harm injuries. As a practitioner, I worked with some female clients who had non-facial scars, and learned that scars had a profound impact on their lives too. It was particularly then I began to ponder the lack of support services and adequate research in this area.

While some sociologists (for example, Berry, 2007; Rice, 2009; Shilling, 2003) recognise that appearance is an important factor in perpetuating inequality, appearance concerns (apart from weight issues) rarely feature in scholarship of helping professions, such as nurses. With some exceptions (Callahan, 2004; Tangenberg & Kemp, 2002; Thornton & Battistel, 2001; Williams et al., 2003; Williams et al., 2004), social workers, too, tend to overlook distress and inequality associated with appearance. Social work scholars focus on the socially constructed body, discussed in more detail in chapter two, while any focus on the physical body is often viewed as reactionary and reductionist (Cameron & McDermott, 2007). Cameron and McDermott’s (2007) book *Social work and the body* is the only major attempt to insert the physical body into the social work discipline, yet even this book does not engage with aspects of appearance. This is surprising considering how much impact appearance may have on people. As Orbach (2010) suggests, today appearance concerns are “far more serious than we first take it to be… [they] constitute a hidden public health emergency – showing up only obliquely in the statistics on self-harm, obesity and anorexia – the most visible and obvious signs of a
far wider-ranging body dis-ease” (p.12). This state of ‘emergency’ is discussed in detail in chapters two and three and is an important backdrop for this study.

A cross-disciplinary approach

So far, the main approach to investigating the impact of scars on people’s lives has been to conceptualise them as disfigurements. Researchers of disfigurements, mostly psychologists, usually investigate the cognitive processes involved in adjustment with the aim to help people improve their mental health. However, as Rumsey and Harcourt (2007), major researchers in the field, point out, the definition and measurement of adjustment are problematic.

Disfigurement researchers tend to define and measure adjustment – also referred to as ‘adaptation’ in the literature - in terms of the absence or presence of psychopathology (Thompson, 2012), such as symptoms of depression. The majority utilise quantitative methodology, often gathering data through standardised psychometric mental health measures such as The Hospital Anxiety and Depression Scale (for example, Fortune, Richards, Griffiths & Main, 2005; Ong et al., 2007), The Social Anxiety and Avoidance (Rumsey, Clarke & Mus, 2002) or Fear Questionnaire to measure a variety of phobias (Newell & Marks, 2000). Similarly, several measures particular to disfigurements for assessing mental health and behavioural dysfunction have been developed, the most notable of them being The Derriford Appearance Scale (Carr, Moss & Harris, 2005; Moss & Carr, 2004). Yet, as Thompson and Kent (2001) point out, such measures “tend to be generic and hence may be insensitive to the particular issues faced by disfigured individuals” (p.676). Thompson and Kent suggest measures such as checking for social participation and cognitive wellbeing need to be developed for measuring non-clinical distress.

Indeed, it is plausible to assume that the absence of mental health problems does not necessarily imply wellbeing. For example, a qualitative study into the experiences of people with facial disfigurements in the UK (Furness et al., 2006) found that the absence of positive emotions can be also an indicator of distress. In a study of people with facial disfigurements in Netherlands (Versnel, Duivenvoorden, Passchier & Mathijsen, 2010), while the results showed no significant differences in their self-esteem levels as compared to the general population, still the respondents expressed much more concern about their appearance. Similarly, the largest to date study of mixed disfigurements (Rumsey et al.,
2010) conducted in the UK found that even people who exhibited positive adjustment frequently experienced their disfigurements as strain; there was a significant discrepancy between psychometric scores and self-reported perceptions of wellbeing. This may have been because initially Rumsey et al. conceptualised adjustment as dichotomy: social anxiety and avoidance/isolation versus wellbeing. Consequently, Rumsey et al. concluded in their report that that “it is not sufficient, and may be even misleading, to rely solely on standardised measures” (p.199) to measure adjustment to disfigurements.

Another concerning trend around the definition and measurement of the impact of disfigurements on people (discussed in more detail in chapter three) is the widespread use of theoretical concepts derived from the psychology of appearance. Evaluating people’s experiences of disfigurements through such constructs as ‘body image’ (for example, Cory et al., 2009; Koo & Jensen, 2002) or ‘fear of evaluation’ (for example, Kent & Keohane, 2001) can actually limit understanding of the richness and complexity of their inner worlds, including meaning making processes. Meaning making around disfigurements and the ‘ordinary’ (non-clinical) distress remain at the periphery of existent research, just as the examination of people’s experiences within sociocultural context does. In summary, while some psychological research findings strike a chord with me, I feel uneasy about the stigmatising and pathologising potential of its conceptual focus and about the insufficient attention paid to the role of sociocultural context in people’s lives. My professional training as a social worker directs me to strive to understand people as embedded in their environments.

Scholarship that theorises the body - and comes mostly from the disciplines of sociology, anthropology, feminism, media and disability studies - usually pays more attention to ‘ordinary’ human experiences and to the role of society in shaping these. Such scholars note hierarchical system of valuing bodies in relation to gender, class, race, ethnicity and weight. In the last decade Berry (2007) and Rhode (2010) have published books where they argue for the recognition of what Berry terms ‘looksism’ and which Rhode calls ‘beauty bias’. However, even within this body of theory disfigurements - and scars in particular - remain underexplored.

Fraser and Greco (2005) argue that “experiences rooted in different forms of embodiment may be radically incommensurable” (p.3). Still, some insights of body scholars can be useful for understanding the experiences of women with non-facial scars.
From these theorists’ point of view, experiences of women with non-facial scars may be shaped as much by sociocultural context as by individual psychological characteristics and cognitive processes. For example, disability scholars working from the perspective of the social model of disability - who inform much of the thinking behind this thesis - show how barriers and constraints operate in a society against people whose bodies are deemed inadequate (Barnes, Mercer & Shakespeare 1999).

Some disfigurement researchers incorporate certain sociological concepts in their analyses of lived experiences. Goffman’s (1968, 1969) theories of stigma and presentation of self that have inspired much of the current thinking on the body are most commonly utilised. However, as argued in chapter two, Goffman’s theory needs to be supplemented by more recent theorisations of the body to fit contemporary conditions.

I argue that to understand the experiences of women with non-facial scars, psychological insights should be integrated alongside those from the body theory, particularly since this is an exploratory study, suitable to a broad-brush approach to the review of background literature. For this reason, I attempted to bring psychological and body theory perspectives together to inform this study with a particular focus on the theories of stigma, body and self-identity in consumerist society, and factors and processes integral in disfigurement research. It is a major undertaking, and a work-in-progress, of course. However, I hope in this thesis I already contributed to both research on disfigurements and theorisation of the body by using scars as a lens through which to examine what it is like to live in a supposedly abnormal body in a contemporary world. Qualitative insights from women’s narratives can be useful for also understanding the experiences of women with other disfigurements, which thus far have mostly been examined quantitatively. Moreover, scars are a fascinating crossroad from which to examine body discourses on beauty, normality, and assumptions about character and life experiences based on appearance. Thus, an analysis of the lived experiences of women with non-facial scars can also become a tool for furthering current thinking about the relationship between body, self-identity, and cultural anxieties and preoccupations.

This cross-disciplinary approach to studying experiences grounded in the body is also in line with the constructivist grounded theory (Charmaz, 2006) that guides the methodological framework of this thesis, and is discussed further in this chapter and in chapter four. As Charmaz (2006) writes, “rather than spotlighting… authors, grounded
theory places ideas and analytic frameworks on centre stage” (p.158) and “for grounded theorists, writing a thorough but focused literature review often means going across fields and disciplines” (p.166). My use of body theory (particularly works about dominant discourses on appearance) corresponds with the aims of constructivist grounded theorists to interpret the data while attending to “how people draw on socially constructed discourses” (Charmaz, 2009, p.142). After all, as Charmaz (2009) suggests, “participants’ meanings may reflect ideologies; their actions may reproduce current social conventions or power relationships” (p.131).

My professional standpoint as a social worker is also behind this choice of approach. Cameron and McDermott (2007, p.5) identify four central concerns within the profession: belief in human agency; recognition of social context as constraining and enabling agency; concern with inequality; assisting the marginalised and vulnerable. Similarly, I believe in helping people through making both personal and environmental changes. My aim in this study is to acknowledge and understand ordinary distress as well as allow for a broader conceptualisation of scars as more than just ‘disfigurements’. As the social model of disability postulates, by changing social perceptions about people with disability, it is possible to alter the notion of disability (Barnes, Mercer & Shakespeare 1999). I believe this can apply to disfigurements too. This approach will make space also for positive narratives, and suggest interventions aimed at both women and their environments.

A qualitative approach

The majority of studies of disfigurements to date have been quantitative. This approach has been useful in establishing an overall picture of the prevalence of problems and statistic associations, but not in clarifying the processes by which these associations occur. Nor has this helped to understand the individual meaning making, or relevant nuances. Consequently, one of the major shortcomings in disfigurement research is that quantitative results alone can lead to confusion between the cause and effect when examining factors mediating experiences of disfigurements (Kent, 1999; Thompson & Kent, 2001). For instance, as Versnel et al. (2010) highlight, while a positive correlation exists between fear of negative evaluation and disfigurement-related distress, it is difficult to determine whether predisposition to fear of negative evaluation causes more distress, or whether having disfigurements creates more fear of negative evaluation, or whether his
relationship is bi-directional. Key researchers of disfigurements (such as, Rumsey et al., 2010; Thompson & Kent, 2001) agree that qualitative research is necessary to complement and clarify quantitative findings.

A qualitative approach can help gain a more in-depth understanding of women’s experiences of non-facial scars than would be obtained from quantitative studies. This methodological framework focuses on the ways “individuals interpret their social world” (Bryman, 2004, p.20) and is therefore suitable to explore the deeper meanings women attribute to their scars, the intricacies of related social interactions, how women process the messages they receive from their environment about their scars and how these in turn influence their meaning making. In addition, because qualitative research methods are more open (Charmaz, 2006), they can allow for both negative and positive stories to emerge. The growing acceptance of the important role qualitative research plays in shaping the provision of care (Rumsey & Harcourt, 2005) also informs my choice of approach, since the rationale for this study is to find ways to support women with non-facial scars.

My choice to use a qualitative approach also reflects the overall dearth of research into scars. Qualitative methodology is valuable for exploring complex, sensitive issues in an under-researched area where the outcome is primarily unknown (Bryman, 2004). Through this methodology I aim to build a detailed snapshot of the experiences of women with non-facial scars.

The grounded theory approach

The research approach adopted in this thesis, which draws “on a range of concepts and theories as part of the analytic repertoire” (Charmaz, 2009, p.134), is prevalent amongst grounded theorists. Additionally, the inductive method of theory development in grounded theory (Glaser & Strauss, 1967) corresponds with my research preferences. Firstly, I believe in learning from lived experiences. I did not wish to be influenced by pre-conceptions of what the key aspects of participants’ experiences would be, and instead wanted to let a theory emerge from the data, which is what grounded theory methodology does. Secondly, I am interested in locating individual meaning making within the broader context, which is how constructivist grounded theorists approach research. Thirdly, grounded theory approach sits well with my position as a social work practitioner and educator, and a woman with non-facial scars who has often wished there
was some professional assistance on offer for helping me and my clients who had scars. I wanted to conduct a practice-oriented study and, as will be discussed in chapter four, grounded theory methodology is specifically designed with practitioners in mind (Charmaz, 2006; Glaser & Strauss, 1967, p.240) as well as aimed at bringing about social change (Corbin & Strauss, 2008, p.11).

**A writing approach**

Qualitative researchers have been increasingly contesting the neutral, impersonal language of academic writing, instead using the first person and a descriptive, narrative-driven style (Bryman, 2004; Charmaz, 2006; Denzin & Lincoln, 2003; 2008; Kvale, 1996). In this vein, Charmaz (2006) suggests that creative use of language “through word choice, tone and rhythm” (p.175) is suitable for conveying lived experiences, including their more tacit meanings. Charmaz endorses the importance of attaching a descriptive narrative to analytical findings in order to enable readers to better understand the context of the developed theory.

I, too, believe that such writing techniques enhance the understanding of studied worlds. Arguably, creative word choices can convey the mood of the experience. In line with this, throughout this thesis I use several terms I coined when I did not find existing language that conveyed what I wished to convey. I refer here to the term Body Surface I have coined - to signify the appearance of an unclothed body as the literature contains no suitable term (the prevalent term ‘appearance’ stands for naked, clothed and made-up bodies). I also refer to some of the theoretical concepts that emerged in the findings and which I will discuss in more detail in chapters five to eight. I also favour the use of emotional and biographic details when presenting data not only for the vividness they create but also as a respectful way of preserving women’s individuality by lifting them from the mass of undistinguishable research subjects whose main property is their non-facial scars. Therefore, in this study I have adopted a descriptive approach to writing when presenting the findings, and chose to write in the first person. I also illustrate findings with numerous direct quotes from interviews. The usage of participant voices is integral to grounded theory presentation, because it “allows our audiences to participate in our unfolding analytical arguments” (Bex Lempert, 2007, p.256). Yet, also in accordance with Charmaz, the focus in presentation of findings is on patterns and trends, rather than on comprehensive individual accounts. Additionally, I have deliberately used
accessible language where possible. This decision is in line with my personal and professional inclination to resist potentially exclusionary academic jargon (Charmaz, 2006, p.159), and also in line with my aesthetics as a writer and a reader. Like Cregan (2006, p.168), I do not believe complex thinking requires a specialised, often inaccessible, vocabulary.

**Study aims**

The overarching aim of this study is to explore the impact of non-facial scars on women’s lives, guided by the research question: **What are the lived experiences of women with non-facial scars?**

The objectives are:

1. To construct a grounded theory of women’s experiences reflective of the context in which they live and the processes involved in these experiences.

2. To generate insights for practice with women with non-facial scars and generally contribute to practice with people with disfigurements.

3. To contribute to research on disfigurements by furthering understanding of the lived experiences of women with disfigurements.

4. To contribute insights into body theory by exploring the relationship between body, self and society through the lens of the relationship between women and their scars.

**Organisation of the thesis**

This thesis is presented in nine chapters. I faced several choices as to how to structure this thesis, particularly in relation to where to place the literature review and how to weave it into the study findings. Often, in studies guided by grounded theory, the review of literature is conducted gradually: before, during and after data collection and analysis (Charmaz, 2006). I, too, worked in this way to ensure that the literature review informed my analysis without heavily influencing it. But while many grounded theorists

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1 Unless the researchers follow a ‘Glasserian’ approach, discussed in chapter four.
in their research accounts tend to either incorporate literature reviews within the findings or present them afterward, most of the literature review here is presented before the findings - in chapters two and three. I did this to maximise the clarity of presentation and to retain a narrative which, hopefully, captures readers’ attention. This choice is consistent with Charmaz’s (2006) recommendations. Charmaz suggests presenting key points from the literature review in the introduction and then continually weaving the literature review throughout the entire work. I have also highlighted key points in this introductory chapter. In order to continue a coherent narrative of current theorisation about the relationship between appearance and people’s lives, I chose to follow this chapter with two consecutive chapters that develop the literature review. As detailed below, I re-engage with the literature review again in the chapters that present this study’s findings and recommendations for practice and research.

To continue setting the scene for this study, in chapter two I introduce recent theories about the relationships between Body Surface, self-identity and society, particularly in how these apply to women’s lives. I discuss cultural ideas about what constitutes meaningful, beautiful and deviant female Body Surfaces, and the social rewards and penalties associated with such bodies. I also discuss the ‘bodywork’ women engage in to attain socially sanctioned bodies. Bodywork is a term coined by Shilling (2003), which stands for the effort, time and resources dedicated to grooming and even refashioning (for example, through surgery) Body Surface. I also examine the individual costs associated with cultural pressures around the body. The aim here is to create a context for understanding the lived experiences of women with non-facial scars, following on from my contention that women’s interpretations of their scars and presentations of them to others, plus the social responses to these scars, are frequently embedded within, or work against, dominant discourses around appearance. This chapter also further clarifies the position of this study on the scholarly map.

Chapter three provides a selective overview of disfigurement research. I first review the main findings on impact of disfigurements on people’s lives, factors that mediate adjustment, the coping strategies people with disfigurements employ, the evaluation of existing professional interventions, and the still-unmet needs. I follow this with a review of theoretical paradigms dominant in the psychology of appearance and used both in studies of the general population and those of people with disfigurements. The aim is to keep setting the scene for understanding the experiences of women with
non-facial scars, to position my study more specifically, and to clarify its potential contribution to the field of disfigurements. In that chapter I argue that insights from body theory can contribute to this field of scholarship.

**Chapter four** explains my methodological choices, including describing and justifying the use of constructivist grounded theory, and presents their application. It also includes the detailed outline of the study sample. In line with the constructivist grounded theory, I establish there a reflexive research stance, by acknowledging my inherent biases as a researcher and examining how I dealt with them in the research process. Finally, I describe the ethical considerations and evaluation criteria relevant to this study.

**Chapters five to eight** present the study findings, organised in the form of a grounded theory of women’s experiences of non-facial scars. One of the benefits I found in using constructivist grounded theory was that it helped me to organise and present my findings logically. Charmaz (2006, p.163) suggests using theoretical categories to organise thesis chapters by presenting one essential category in each. In this thesis each findings chapter presents one of the four essential categories of the grounded theory that emerged: *being marked, doing scar-work, travelling marked through life and unmet needs*. As Charmaz (2006; 2009) suggests, I have organised each theoretical category around a narrative that conveys the dynamic and interactive nature of experiences in women’s stories. In these four chapters I engage further with the literature. Firstly, I check my findings against the conceptual map generated from the literature of body theory and disfigurement research. Secondly, I add detailed findings from the existing research insofar as they reflect, or contradict, my findings. The thesis concludes with **chapter nine**, which summarises my arguments and main findings, and discusses how insights from body theory contribute to understanding the grounded theory that emerged and how the thesis, in turn, contributes to this scholarship. Next, possible study limitations are noted. The chapter concludes with practice and research recommendations as arose from this study.

**Conclusion**

This study aims to provide an exploration of the lived experiences of women with non-facial scars. It has been prompted by the dearth of research on this topic in the context of currently widespread appearance concerns among women in the general population and people with disfigurements in particular. I have argued here that non-
facial scars are a worthy unit of analysis in their own right and that exploring experiences of women with such scars can contribute to scholarship of disfigurements, and also shed light on the more universal theme of the relationships between women and their bodies in contemporary society. This latter theme is examined in the following chapter.
Chapter Two – The Rise of Body Surface

‘One cannot have any body that one wants – for not every body will do.’

Susan Bordo

This chapter sets the broader context for the lived experiences of women with non-facial scars by highlighting contemporary cultural pressures around female appearance exerted on women in western countries. Of course, the so-called ‘western countries’ contain various cultures and subcultures that may hold differing views on the body, especially its appearance. Not even a particular country can be thought of as homogenous in this, or any other, regard. For example, even though the female ideal of beauty in western countries is thinness (Berry 2007; Blood 2005), some ethnic communities view a more ample figure as attractive. But for the purpose of this thesis I name here dominant western discourses on the body rather than present an exhaustive list of existing attitudes.

In this chapter I also further clarify my research focus by reviewing literature in sociology, anthropology, psychology, and disability, feminist and media studies on the relationship between body and self-identity. The body at the locus of this chapter is what I call ‘Body Surface’. I have developed this term to signify appearance only, and exclude the movement, function or health of the body. Yet the term ‘appearance’, commonly used in scholarship, is unfit for my purposes for two reasons: I wish to distinguish my study from psychology of appearance studies; and to exclude clothing, makeup and other non-physical adornment that the term appearance usually encompasses (Falvey, 2012). Thus, Body Surface refers to the body most pertinent to this study, the visible flesh - face, skin, shape, wrinkles, tattoos, and scars, of course. This body impresses itself on audiences even before it speaks or moves. In short, this is the image that lies under the theoretical microscope here. Few would disagree that today much emphasis is placed on how people look.

The concept of self-identity needs to be defined too. Self-identity has been framed differently through various theoretical lenses. A comprehensive overview of the different positions is beyond the scope of this thesis. Instead, I have identified commonalities
between these positions on self-identity in order to compose a workable definition for this study. Ferguson (2009) claims that pragmatist and symbolic interactionist theorists of self, such as Cooley, Mead and Goffman, have provided the most detailed accounts of self-identity up until the last decades of the twentieth century, focusing on the role of social interactions in the formation. As Goffman (1969) argues, the “very structure of the self” (p.244) incorporates performances of various selves which people modify, depending on their audiences, and with the cooperation of these audiences. Similarly, as Ferguson argues, in contemporary thinking on self-identity, most scholars agree that self-identity is “neither fully a social, nor an existential, being” (p.158). Rather, self-identity can be broadly conceptualised as a set of personal characteristics by which a person defines, compares and differentiates herself to and from others (Jagger, 2000). In short, as Ferguson puts it, “self-identity is an assertion of the non-identical” (p.194). Such characteristics are understood, at least partially, to be continuously co-constructed within social interactions, and also embedded within the sociocultural context (Ferguson, 2009).

Whilst various contemporary scholars (e.g. Callero, 2003; Giddens, 1991) hold differing views about the extent to which external influences shape subjectivity, all agree that self-identity is not static but is subject to change. In this study, self-identity is indeed conceptualised as a dynamic, multidimensional and at times contradictory concept. It is also understood as inclusive of attributes and processes arising from a combination of individual tendencies and reflexivity, sociocultural context and interpersonal interactions. In my analysis I am also interested in how women’s framings of their scars are influenced by their social interactions, but also by their perceptions of how others might evaluate their scars, and in turn how all these are shaped by the sociocultural context.

This chapter first situates this study within the vast terrain of body scholarship. The aim is to tease out themes relevant for this thesis, rather than provide a complete review of this field of scholarship. Then theorisation and empirical studies on the role of Body Surface in contemporary women’s experiences - including cultural ideas about what constitutes meaningful, beautiful and deviant Body Surfaces, the social rewards and penalties associated with such bodies, the means women use to attain socially desirable bodies, and the individual costs associated with such cultural pressures – are examined. To discuss issues particular to scars, anecdotal stories from media, fiction, poetry and memoirs are occasionally used, not as a systematic analysis but rather for the purpose of illustration and speculation, because the scholarship in this area is so scarce. I conclude
by arguing that although theories presented in this chapter do not examine the specifics of scars, they direct us to thinking of them as disfiguring and to the assumption that in the current sociocultural context women with non-facial scars are likely to face difficulties and limitations.

The rise of the Academic Body

Body theory as a distinct area of study is considered to have developed following the appearance of the sociologist’s Turner’s (1984) seminal book *The Body and Society* (Csordas, 1994; Shilling, 2003). There Turner argues for the inclusion of the body within sociological theorising as a locus of social, philosophical and historical analysis. Since the late 1980s, the body has become the central focus of enquiry across a variety of disciplines (Peterson, 2007; Shilling, 2007). Scholars explore a variety of bodily aspects, such as movement, senses, health, reproductive functions and appearance. Despite the great diversity within this scholarship, both in analytical emphases and in conclusions drawn, body scholars share some similarities. They challenge the classical positivist view of the human body as an essentially ‘unproblematic’, purely biological phenomenon, which hitherto had dominated academy. Instead, they highlight the ways in which body, self-identity and society are interconnected.

Several academic and sociocultural developments have contributed to the explosion in theoretical preoccupation with the body. Hancock et al. (2000) attribute the rise of body scholarship to the following factors: coinciding feminist questioning of biological determinism; academic interest in consumerism and in increasingly sophisticated yet ethically challenging medical practices; the prominence of the body in everyday life; and the rapid ageing of western populations.

Although Turner was the first to explicitly suggest the human body as a unit of analysis, in his influential book *The Body and Social Theory* Shilling (2003) traces earlier influences on body scholarship, notably by Mary Douglas, Michel Foucault and Erving Goffman. Although none of these scholars explicitly position themselves as scholars of the body, their social analysis demonstrates the body’s social significance.

Douglas (1978; 1970) shows through her anthropological fieldwork how bodies can reflect cultures, serving as their symbols. She argues it is possible to ‘read’ human bodies, whether through tattooing, clothing or even body language, as coded representations of cultural values, customs, taboos and social hierarchies. Foucault’s
(1977) seminal work *Discipline and Punish* offers the concept of ‘docile bodies’, which has become central in body scholarship. Foucauldian analysis shows that the body plays an important role in how power is enacted on individuals: bodies can be constituted and disciplined through ideologies, discourses and daily practices, and can become sites of conformity, regulation and control. Goffman (1969, 1968) conceptualises the body as an individual vehicle to identity, a resource managed and utilised in social interactions for constructing impressions and achieving individual goals. All these ideas are pertinent to an understanding today of Body Surface that, as is discussed further in this chapter, can reflect our cultural aspirations, anxieties and values, be regulated, and used for personal purposes.

Of these three theorists, the work of Goffman is most relevant to this thesis, since it offers most insights into the relationship between Body Surface and self-identity. Goffman’s writing on the body is discussed further in the chapter. First though, the following sub-sections critically discuss various theoretical strands in body scholarship pertinent to the focus of this study.

**Social constructionist framings**

Notable scholars of the body, starting from Turner (1984) and continuing to such theorists as Bordo (1997; 1993; 1990), Baudrillard (2005), Butler (1990) and Featherstone (2007; 1991) have further emphasised the socially constructed aspects of bodily experiences, problematising even the most fundamental notions, such as desire, femininity and masculinity and redefining the body as a sociocultural and historical phenomenon. This social constructionist approach has formed the platform of the body scholarship (Orbach, 2010; Shilling, 2003). The central argument within this approach is that what we perceive in any given society in any era as the ‘natural’ body is, in fact, the result of specific discursive frameworks influencing how societies construct normative, desirable and abnormal bodies and, consequently, cultivate, nurture, discipline and exhibit the body. In short, body scholars hold the view that our bodies are “radically unfixed and historically contingent” (Atkinson, 2005, p.2).

These insights contribute to the thinking behind this thesis in two ways. Firstly, the notion that even the intimate experience of one’s body is invested with social meanings and shaped in many ways through dominant cultural discourses, thus becoming also an inter-subjective experience (Hughes, 1999), guides me to pay attention to the
discourses in which narratives of women with non-facial scars are embedded. Secondly, the understanding of the contingency of bodily experiences leaves scope for optimism that attitudinal change towards the body is possible and constitutes a part of my rationale for this study.

**Bringing the body into the Academic Body**

Several overviews of body scholarship from the last decade (Cregan, 2006; Evans, 2002; Peterson, 2007; Shilling, 2003) criticise the scholars of the body, particularly those working within the social constructivist paradigm, for their overemphasis on the socially constructed and metaphorical aspects of the body. Such a view, where “the body is named as a theoretical space, but often remains neglected as an actual object of analysis” (Shilling, 2003, p.10) is paradoxically based on estrangement from the body, in that it overlooks its physicality and pays little attention to individuals’ experiences of their bodies. Scholars often view bodies as the *outcomes* of the effects of power on one hand and a person’s ‘act’ on the other. As Orbach (2010) writes, “it had become a feature of postmodern thought... that the body can be anything we want it to be, with corporeality no more than a symbolic construct” (p.74). However, as Davis (2007) points out, such theorisation has “little to offer in understanding what it means to live with a disability or a chronic illness or even temporary [physical] discomforts” (p.55) - or with scars. Few would disagree that humans cannot completely control their bodies. Bodies menstruate, defecate, age, twitch and scar whether we wish them to or not, and this crucial part of human experience is overlooked by many influential body scholars. As Shilling (2007) writes, “the number of sophisticated theoretical works on embodiment has yet to be matched by sufficient substantive investigations of the significance of the body to people’s daily lives” (p.13).

Shilling (2003) offers a theoretical middle ground between positivist and social constructionist approaches, redefining the body as “an unfinished biological and social phenomenon which is transformed, within certain limits, as a result of its entry into... society” (p.12). In his view, both the physical and social aspects of the body exist in a complex relationship. Shilling, like some other body scholars (such as Blackman, 2008; Davis, 2007, 2003, 1997, 1995; Evans, 2002; Frank, 1991; Negrin, 2008; Orbach, 2010), directs his analytical attention not only to bodily possibilities but also to limitations. This phenomenological approach conceptualises the human body as dynamic, always “‘unfinished’ and in process” (Blackman 2008, p.83), and interacting with the
environment and with physical realities. It is both “’real’ and constructed” (Evans, 2002, p.8). Such a view of the body is compatible with this study, since scars are a physical response to wounding; it is a bodily reality. However, the circumstances of wounding and the aftermath of scar acquisition can differ amongst women, and can depend also on the social construction of scars and social interactions.

Scholars working from the phenomenological perspective share the ethical position that theorising about the body is impossible without empirical research into lived experiences (see for example Inckle’s (2007) contribution to body theory based on her empirical study of female scarification and tattooing practices). This bottom-up approach to generating theory, which is rooted in people’s experiences, is also at the locus of this study and – as discussed in chapter four – is in line with the grounded theory methodology that guides it.

The existing phenomenological scholarship encompasses a variety of lived experiences of the body, such as pregnancy (Marshall, 1996) and the clothed body (Hollander, 1999). The remainder of this chapter focuses on studies and theories most pertinent to this thesis in their examination of the relationship between Body Surface and self-identity in contemporary society, with the subsequent aim to set the scene for experiences of women with non-facial scars.

**Body Surface, self-identity and society**

**Preliminary influences: personal front and stigma**

Appearance - including the aspect of Body Surface - as a worthy topic for academic inquiry is an even younger field of study than that of the body (Negrin, 2008, p.1). Goffman’s seminal works *Presentation of Self* (1969)² and *Stigma* (1968)³ have been influential in inspiring this analytical direction. One of Goffman’s (1969) main contributions to contemporary theorisation of appearance is his suggestion that the management of what he defines as ‘personal front’ is central to everyday social encounters, where people play roles to communicate certain images of themselves. A significant part of this front is appearance: “as part of the personal front we may include...

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² First published in 1959

³ First published in 1963
clothing, sex, age, and racial characteristics; size and looks; posture... facial expressions; bodily gestures...” (Goffman 1969, p.34). According to Goffman, our management of our appearance plays a pivotal role in the formation of social impressions and our self-identities

Goffman’s (1968) theory of stigma has been equally significant for the contemporary theorisation of appearance. Goffman uses the term ‘stigma’ to refer to certain individual characteristics that are socially devalued and spoil people’s identities, rendering them socially unacceptable. Goffman argues that stigma is socially constructed: it is based on a shared belief system about what is normal and what is abnormal. He once again brings the body into an analytical focus, distinguishing between three types of stigma: spoiled character traits (such as mental illness or criminal activity), tribal stigma (ethnicity or religion), and physical deformity. In discussion of the latter type, Goffman shows how certain bodies can be socially disqualifying and as a result their ‘owners’ may be denied a variety of resources and be at risk of internalising stigma, thereby incorporating it into their subjectivity. Similarly, if the body is not managed appropriately during social interactions, people can experience shame and, possibly, stigmatising reactions. Later, Scrambler and Hopkins (1986) drew a distinction between enacted and felt, or anticipated, stigma. Felt/anticipated stigma refers to people’s internalised stigma and is associated with feelings of fear and shame; enacted stigma refers to social encounters where people discriminate against those with stigmatised attributes (Scrambler & Hopkins, 1986).

Goffman (1968; 1969) offers a useful model for the relationship between the body, self-identity and society. However, his writing focuses mostly on body language (particularly facial expressions) and clothing. He has little to say about more fixed appearance characteristics such as Body Surface, or about the specifics of how else people fashion their bodies to impress. Goffman (1969) does acknowledge the importance of sociocultural context, writing that “the cultural values... will determine in details how participants [in social interactions] are to feel about many matters and at the same time establish a framework of appearances that must be maintained” (p.234). Yet Goffman does not contextualise the processes of impression formation within specific discourses. Neither does Goffman consider the possibility of individual self-expression through the body unrelated to social interactions, just as he does not sufficiently explore self-reflexivity of individuals, which also governs the way they act.
As is shown in the remainder of this chapter, contemporary enquiry into Body Surface draws on Goffman’s notion of the embodied self within social interactions. A considerable number of psychological studies examining the role of appearance in people’s lives focus on judgements people make about others based on their looks and on people’s self-perceptions based on their looks (Rumsey & Harcourt, 2005, p.14). Whereas some body scholars (notably, theorists of consumer culture, such as Baudrillard, 2005; Featherstone, 2010, 2007, 1991; Shilling, 2007, 2005, 2003) fill in some of the aforementioned gaps in Goffman’s writings. They do so by building theoretically and empirically upon Foucauldian (1977) interest in the contextual specifics of how bodies can be socially regulated and on Giddens'(1991) understanding of people as self-reflexive. The major themes of appearance scholarship (excluding that of psychology of appearance), tend to be: appearance as a medium of self-expression; analysis of Body Surface norms with a focus on weight and shape; analysis and critique of bodywork based on consumerist critique; and analysis of social consequences for ‘bodies of difference’, usually focused on weight and shape, racial features, gender and queer characteristics, and visible disability. Yet, no matter what their analytical focus is, scholars (e.g. Baudrillard, 2005; Cregan, 2006; Featherstone, 2007, 1991; Rice, 2009; Shilling, 2007, 2005, 2003) seem to agree that in the contemporary west appearance carries great importance for individuals. The following sections discuss this claim.

The world of Body Surface

“There was also this about Mona’s body – it was constantly changing... Each change registering her inner transformation, her moods, longings and frustrations,” wrote Miller (1965, p.174) in his novel Nexus. Often ahead of his time, Miller’s description of Mona seems to foretell the story of the body’s relationship to self-identity in the twenty-first century. Since the publication of this novel and Goffman’s books in the 1950s and 1960s, the western world has undergone a rapid transformation: part of this change is that Body Surface has become not just important - as Goffman posited – but almost central in social interactions. In the past, people fashioned and displayed their bodies primarily to convey their social roles (Negrin, 2008, p.17). However, during late modernity, as Giddens (1991) famously argues, people started investing in their bodies to enhance their self-identity. More recently, Negrin (2008) suggests that now the fashioning of Body Surface supersedes all other sources for forming self-identity, appearance being thought of as “the mirror of the soul” (p.58). While Negrin’s may be an extreme position, still - as
discussed further in this chapter – people seem to treat various Body Surface characteristics like clues to others’ histories and personalities (Shilling, 2003). Moreover, Hughes (1999) argues that we do not only ‘read’ people through their bodies, but also create “a hierarchy of bodies” (p.163).

In such a climate, prominent body scholar Featherstone (1991) suggests a new, ‘performing’ self has been born which places a great emphasis on appearance. Featherstone distinguishes between two bodily domains significant to contemporary individuals: an inner body that encompasses health and functioning, and an outer body that refers to “appearance as well as to the movement and control of the body within social space” (p.171). Featherstone argues that “the prime purpose of the maintenance of the inner body becomes the enhancement of the appearance of the outer body” (p.171).

Body Surface has become an important vehicle for creating social impressions. People are also increasingly resorting to Body Surface for self-improvement and self-expression purposes. Moreover, Body Surface now takes central stage in mass culture and commerce. In short, today looks are often highly important in both how people are perceived by others and how they perceive themselves. International psychological research on appearance supports these theoretical assumptions by showing that how people feel about their looks influences greatly their self-concept and self-esteem (see for example Choma et al., 2010; Mellor, Fuller-Tyszkiewicz, McCabe & Ricciardelli, 2010). This is not to say that all people experience, and succumb to, cultural pressures around appearance. However, the literature on appearance, as is shown further, suggests that having Body Surface that deviates from the cultural norms can be associated with social and personal difficulties.

Factors that have, and continue to, influence the current cultural focus on Body Surface, which are cited most commonly by scholars, are: the decline in religious and state authority; changes in the labour market; consumerism and popular culture; and technological advances (Baudrillard, 2005; Featherstone, 2007; Hancock & Tyler, 2000; Negrin, 2008; Peterson, 2007; Shilling, 2003). Although some of these social processes have their roots in the more distant past, arguably it was in the last decades of the twentieth century that they accelerated.
Decline in religious and state authority

Scholars (Baudrillard, 2005; Shilling, 2003) suggest that the decline in institutional (religious and state) authority and the resulting process of individualisation, have encouraged people to resort to Body Surface as a means for articulating who they are. In the past, people tended to ground their sense of self in their social roles and in a transcendental mode of self-expression, with many believing that their individual worth, and consequently the pathways to achieve a good life and salvation, depended on their piety and state service. Arguably, today, at the absence of grand narratives the world appears increasingly fragmented and therefore likely to induce anxiety, and the body is viewed as a more reliable marker for providing the sense of ontological security (Baudrillard, 2005; Ferguson, 2009; Giddens, 1991; Shilling, 2003). Some critics (Connor, 2004; Negrin, 2008) view the rising popularity of permanent body marking, such as tattooing, as a more extreme expression of this desire to establish one’s identity through the body.

Body scholars (Baudrillard, 2005; Featherstone, 2007; Shilling, 2003) draw our attention to the current widespread popularity of bodywork, such as physical exercise and dieting. They argue that bodywork allows people some sense of control and note its somewhat religious undertones, reminiscent of the devotions of religious ascetics. They suggest that by engaging in bodywork, which is often rigorous and demanding, we demonstrate discipline, endurance and restraint against the temptations of hedonistic society. Through media and other means of social pressure, western culture encourages us to take responsibility for our bodies, be watchful and to work hard on them (Baudrillard, 2005; Berry, 2007; Negrin, 2008; Orbach, 2010; Shilling, 2003). An article in *The Age* captures how even the governing sections of western societies are susceptible to the pressures of bodywork:

President Barack Obama is known for his fruit, pistachios, and Fiji-water refuelling, basketball prowess, sadistic cardio sessions, and a body shape to put Russian Prime Minister Vladimir Putin to shame. Meanwhile, his good lady is notorious for hitting the gym at 4:30am and never missing the opportunity to brandish those steely upper arms. In Britain, Tory leader David Cameron is a committed cyclist, and even the reassuringly beanbag proportioned Gordon Brown is rumoured to have taken up Pilates (Betts, 2009, October 10).
Paradoxically, though, bodywork is often driven by the consumerist culture it is meant to negate. Instead of paying for chocolates, bodywork devotees consume gym memberships and Botox procedures.

*Consumerism and popular culture*

Featherstone (2007) and Baudrillard (2005) concur that contemporary consumer culture, which includes popular media with its ubiquitous advertisements, plays a significant role in the formation of self-identity for many people. One of the chief ideas consumer culture promotes is that one’s essence can be distilled from the goods one possesses and displays. In short, individual worth has become often tied to images. In this context, Body Surface has been turned into a profitable commodity. Scholars (Featherstone, 1991; Orbach, 2010; Peterson, 2007) draw attention to the dependence of the global economy on many people’s willingness to continuously ‘improve’ their bodies through purchasing various body-related products and services, and to the strategies used to encourage people to consume. Many scholars (Adams, 2009; Featherstone, 2010, 1991; Gillen & Lefkowitz, 2009; Marwick, 2010; Urla & Swedlund, 2000) suggest that advertisements, television shows, websites, magazine articles, Hollywood films and other avenues of popular culture and commerce position Body Surface in the locus of the individual pursuit of happiness. The idea that having an attractive Body Surface secures personal and socio-economic success, particularly for women, is being increasingly promoted. Already at a young age girls are encouraged to associate happiness with attractive appearance and to regard grooming as an important activity through engaging with Barbie dolls (Urla & Swedlund, 2000).

But Barbie, traditionally, is seen as beautifying herself for her partner Ken. Lately - in a savvy response to the feminist ethos of our times – body-related products and services are increasingly being promoted to women not as something they should purchase to please men, but for personal self-improvement (Blood, 2005; Negrin, 2008). In popular culture and commerce, having the ‘wrong’ body is often presented as the source of all our problems rather than ‘just’ an obstacle to finding love. As Marwick (2010) demonstrates in her analysis of the American reality makeover show *The Swan*  

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4 See *The Biggest Loser* and *Extreme Makeover* for examples.
popular in many countries, the low self-esteem of the show’s contestants is framed as “caused by a non-ideal body” (p.257). Marwick argues that there is currently an entire stream of “body culture media” (p.252) dedicated to promoting bodywork and related consumption as appropriate ways to solve personal problems, the equivalent of psychotherapy. Even the more extreme bodywork practices, such as elective cosmetic surgery, are often framed as a lifestyle choice, and an acceptable means either for revealing or improving the ‘real’ self (Adams, 2009; Davis, 1995; Gilman, 1998; Marwick, 2010). Furthermore, Featherstone (2010) argues that such self/body transformation has come to be seen as our moral duty of self-care.

In order to increase profits, new markets are continuously identified and new desires are invented. Pre-teen girls are offered g-strings and men – steroids and masculine-oriented diet products. To entice even further spending, beauty standards are set higher and new ‘problems’ are discovered (Orbach, 2010; Peterson, 2007). For example, now the vagina is under aesthetic examination, with the recently introduced practice of labiaplasty gaining in popularity (Stark, 2010, November 6). Indeed, consumerist messages about Body Surface seem to work for many. In recent decades, the beauty and fitness industries have become more profitable and powerful than ever (Orbach, 2010; Petersen, 2007). Marketing scholars Eisend and Moller (2007) even go as far as to argue that “the beauty industry is one of the most prosperous sectors in today’s developed economy” (p.101) in the western world.

Changes in the labour market

Hancock and Tyler (2000) point out the changed nature of work in contemporary society, where the tertiary sector and front-line customer service have become major sources of employment, thus bringing appearance to the forth. According to Hancock and Tyler, western labour market is particularly predisposed for attractive women, pointing out that in “a whole range of servicing occupations, women are employed for their sexually attractive bodies” (p.96).

Technological advances
One of the defining characteristics of our age is the prominence of images enabled by sophisticated technology, or what Jablonski (2008) describes as ‘visual obsession’. Images of beautiful people are everywhere – in ubiquitous advertising, the booming film industry, the use of digital communications, video games, and other media (Featherstone, 2007; Orbach, 2010; Rhode, 2010; Peterson, 2007). Moreover, people frequently form impressions of others based on visual clues of photos and videos in the era where the Internet has become crucial for social interaction and virtual social networks proliferate (Wang, Moon, Kwon, Evans & Stefanone, 2010). This visual culture is closely tied to body-related consumerism. A German study (Eisend & Moller, 2007), for example, demonstrates that television viewing increases women’s dissatisfaction with their bodies and consequently their consumption of body-related products and services. Similarly, a recent meta-analysis of international research on media influences on appearance-related attitudes and behaviour in women (Lopez-Guimera, Levine, Sanchez-Carracedo & Fauquet, 2010) found a positive correlation between women’s exposure to visual media and their dissatisfaction with their bodies.

Featherstone (1991) argues that the popularity of photography also contributes to people’s concerns with their looks, since they are constantly bombarded with images of models and other celebrities (made even more beautiful through technologies, such as Photoshop), and possess photographs of themselves where they are younger and often better looking. Thus, arguably, persistent exposure to beautiful Body Surface encourages self-scrutiny and a tendency to judge others quickly, based on their looks (Featherstone, 1991; Jablonski, 2008; Peterson, 2007; Rumsey & Harcourt, 2005). For example of the latter, an American study of speed-dating with 108 participants (Luo & Zhang, 2009) demonstrated that the strongest predictor of interest for both sexes was the prospective dating candidate’s attractive Body Surface.

Paradoxically, while ubiquitous displays of beautiful people make it increasingly difficult for most to resemble cultural ideals of Body Surface, other technological developments seduce some people into believing that bodily perfection is now possible. At a time when scientists are experimenting with creating human skin for robots and cloning (Jablonski, 2008), and when the notion of designing babies is already beyond science fiction, flesh is increasingly presented as plastic, as a “phenomenon of options and choices… a project which should be worked at… as part of an individual’s self-identity” (Shilling, 2003, pp.3, 5). This is another contemporary paradox: the dominant
discourses at once direct us to see the human body as the mirror of the Self and as an external object to be manipulated.

Increasingly sophisticated technologies are enabling people to ‘work hard’ on their bodies, darkening and lightening skin, eliminating varicose veins, sculpting noses and buttocks. In the US, for example, the rate of cosmetic surgery increased by 77% between 2000 and 2010\(^5\) (American Society for Plastic Surgeons [ASPS], 2010). This increase in the consumption of costly, risky and painful cosmetic procedures may be influenced by the aforementioned discourses of self-improvement and self-expression, but also a manifestation of the simultaneous feelings of bodily alienation and omnipotence. As Shilling (2003) writes, recognising that “the body has become a project for many modern persons entails accepting that its appearance, size, shape, and even its contents, are potentially open to reconstruction in lines with the designs of its owner” (p.5).

The normalisation of complex cosmetic procedures in turn raises expectations about how people should look. Research suggests that, increasingly, healthy, average-looking bodies are pathologised (Marwick, 2010). For example, people may feel pressure to spend money on procedures such as teeth braces for their children to ensure they do not stand out amongst their peers. This rise in beauty standards renders sharper the gaps between those who can afford to perfect themselves and those who cannot (Negrin, 2008, p.94; Peterson, 2007, p.14). Women with non-facial scars too might be negatively affected by such high Body Surface standards, particularly given that scars are often resistant to cosmetic improvement.

**Gendering, imagining and making Body Surface**

So as to express, improve and impress themselves on others, many people nowadays monitor, groom, modify and exhibit their Body Surface in a variety of ways. A distinction can be made between bodywork that renders Body Surface beautiful, and that which makes it unique and meaningful to others and to oneself. In short, people often aspire to appear attractive both externally and internally through their bodies.

Negrin (2008, p.16) suggests that a contradiction often exists between these aspirations and one of the challenges facing people today is to negotiate the tension

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\(^5\) National statistics are not collected in Australia, but anecdotally here too cosmetic surgery is becoming popular.
between wanting to conform to sociocultural ideals of appearance and to fashion uniqueness (inner qualities, interests, talents) through their bodies. In this section I examine what constitutes meaningful and beautiful Body Surfaces in contemporary society. Then I discuss how these tensions can be negotiated by people, while considering the body as a “deeply gendered phenomenon” (Shilling, 2003, p.38).

**Making gendered Body Surface**

Body scholars note repeatedly that expectations as to what constitutes self-identity based on Body Surface differ for men and women, both in content and in intensity. Historically, women have been identified with their bodies significantly more than men (Negrin, 2008). Arguably, body still remains one of the more important sites for women to negotiate their self-identity (Baudrillard, 2005; Negrin, 2008; Peterson, 2007; Reischer & Koo, 2004).

Much recent international research shows that increasingly men, too, are dissatisfied with their looks and succumb to pressures to undertake bodywork (for example, see Atkinson, 2008; McCabe & Ricardelli, 2004; Rysst & Klepp, 2012). Still, several recent literature reviews of studies from a variety of countries (Fawkner, 2012; Thompson, 2012; Tiggemann & Slevec, 2012) show that appearance concerns are consistently more widespread amongst women than men across all age groups.

This latter finding is not surprising considering that literature shows cultural messages about the importance of Body Surface are more frequently directed at women. Adams (2009) has analysed American media framings of bodily modifications and found that women experience more social pressure to undergo elective cosmetic surgery. Another American study (Markey & Markey, 2012) demonstrated that both sexes viewed these and other body-improvement media messages aimed at women positively, endorsing the female pursuit of beauty even when it involves risky procedures. In Australia McCabe and Ricciardelli’s study (2006) showed that the positive messages adolescent girls received about their bodies from family and friends were largely to do with appearance, whilst those for boys were mostly about their physical performance. Another example of gendered differences was found in the New Zealand study (Boyes & Latner 2009) which showed that while men’s weight did not affect the quality of their relationships, overweight women were judged more harshly by their partners. The
parameters of attractiveness seem to differ according to gender, with international literature (for example, see Fawkner & McMurray, 2002; Rumsey & Harcourt, 2012) consistently demonstrating that sociocultural representations of attractive masculinity allow more diversity and imperfection than those of attractive femininity. Even advertisers, according to Australian newspaper *The Age*, have moved from preferring male models sporting “classic good looks to more unusual ones – from androgynous types… to the kind of guy you might expect to bump into in a grungy Collingwood pub” (Wells, 2012, January 14). There is also some limited evidence from the US that women with disfigurements experience more discrimination in their workplaces than men with disfigurements (Tartaglia, McMahon, West & Belongia, 2005).

Objectification theory suggests that since women’s bodies are often treated as objects for the consumption and pleasure of others, some women may internalise this attitude and self-objectify, critiquing their bodies through the eyes of others (Fredrickson & Roberts, 1997). Indeed, a study of 209 American adolescents (Polce-Lynch, Myers, Klimartin, Forssmann-Falck & Kliwer, 1998) showed that appearance was more salient to girls’ self-esteem. Similarly, a meta-analysis of research on gender differences across various domains of self-esteem (Gentile, Grabe, Dolan-Pascoe, Wells & Maitino, 2009) showed that one of the most significant differences was in the appearance domain, with women scoring much lower than men. Another American study (Franzoi et al., 2012) showed that women tend to be significantly more self-critical when it comes to their appearance than men, and also less optimistic about achieving appearance that adheres to cultural ideals. Research from Australia (Mellor et al., 2010) and Germany (Eisend & Moller, 2007) suggests that women dissatisfied with their bodies may experience more severe emotional consequences than men and are more prone to engage in excessive bodywork. Similarly, in the US statistics indicate that in 2010 91% of plastic surgery patients were women (ASPS, 2010), while in a recent UK study that examined 502 applicants for cosmetic surgery (Clarke et al., 2012), 87% were women, with most participants exhibiting high appearance-related anxiety and risky coping strategies. Taken together, these are important findings. While not all women are affected by appearance concerns, many do. The following sections explore in more detail the gendered nature of sociocultural pressures around Body Surface, with a particular emphasis on skin as the most pertinent bodily feature to this thesis.
**Imagining and making attractive Body Surface**

What is an attractive Body Surface? The answer lies, at least in part, with the place and time of our birth. Hughes (1999, p.164) writes that philosophers Benjamin Walter and Maurice Merleau-Ponty suggest even our sensual perceptions are to some extent socially constructed, expressing social values and beliefs. Research shows that many beauty criteria vary across societies and within the same societies throughout time. The social anthropologist Robert Brain (1979) showed in his work that even erogenous bodily zones are not universal, but enmeshed with sociocultural discourses. Another example is skin colour. In the west, for centuries light skin was associated with belonging to the upper class and therefore held to be more attractive (Jablonski, 2008, pp.158). Yet since mid-20th century, when the rich began vacationing in the sun, tanned skin has become a desirable bodily feature (Jablonski, 2008, pp.159).

Messages about what is attractive are conveyed through artistic, scientific, political, and media discourses. Over the last few decades, in the context of globalisation and the consequent exporting of Hollywood-inspired beauty, the range of what is considered beautiful in women has significantly narrowed down, now excluding most bodily types. For women today, the main beauty prerequisites are symmetric facial features, flawless skin, ultra-thinness, a toned figure, slim hips and large breasts. The imperative is to look youthful, healthy and fit (Bartky, 1997; Featherstone, 1991; Negrin, 2008; Orbach, 2010; Rysst & Klepp, 2012; Siebers, 2000; Urla & Swedlund, 2000). Critics (Bordo, 1993; Peterson, 2007) point out that such a carefully shaped, controlled and unblemished Body Surface symbolises the currently dominant vision of selfhood associated with autonomy, self-control, mastery, toughness and with contemporary aspirations for eternal youth. The latter aspirations play themselves out particularly on the skin’s territory (Bundy, 2012; Jablonski, 2008).

The preference for unblemished skin (Bundy, 2012) may seem natural. Yet, arguably, even this beauty aspect is, to some extent, a construct. Flawless skin is not necessarily a highly valued attribute in some non-western countries, particularly in those parts of Africa and Asia where tattooing and scarification are practised for beauty purposes (Brain, 1979; Jablonski, 2008; Schildkrout, 2004). As Jablonski (2008) reminds us, scarification and branding “are widespread practices found in indigenous cultures on all continents” (p.1530). And while many non-western cultures also prefer unblemished skin, it has been suggested by scholars of human skin (Benthien, 2002; Connor, 2004;
Jablonski, 2008) that the western preference for perfect skin is unprecedented in its fervour. This attitude can be traced back to Ancient Greece, where the human body was thought to symbolise divinity and skin marking equated to corruption of the sacred (Negrin, 2008, p.54). According to Fraser & Greco (2005), Plato in particular associated what he considered the *natural*, meaning unmarked, body, where the “surface is closed and smooth, from which all ambiguity has been purged” (p.70) with divinity. For Plato, divinity and beauty are interchangeable. Such a conceptualisation of the natural body, though, is in fact unnatural, since it is hardly possible to go through life without experiencing health problems, accidents and/or ageing, which all mark the skin. In its natural state, the body, if anything, can never be divorced of ambiguity. Still, an idealised body with a flawless skin, which resembles Plato’s ideal, is constantly replicated in contemporary entertainment and media industries (Davis, 2005).

Today, many men and women aspire to appear healthy and fit, and therefore beautiful (Berry, 2007, p.19; Shilling, 2003, p.5). Still, Balsamo’s (1996) suggestion that the female body “comes to serve as a site of inscription, a billboard for the dominant cultural meanings” (p.78) feels relevant today too. It has been argued that the ideal of an unblemished body that does not show wear, life experience or deep thought applies more to women (Townsend & Wasserman, 1997), and seems particularly unattainable for women with non-facial scars.

**Imagining and making meaningful and unique Body Surface**

Jablonski (2008) describes human skin as “the centrepiece of the vocabulary of personhood” (p.3). In order to forge unique self-identities people are increasingly resorting to their skin, modifying their bodies through piercing, tattooing and scarification (Negrin, 2008). This section focuses on the role of two latter practices in the construction of self-identity. Arguably, tattooing and scarification (hereafter referred to as *body marking*) are the most pertinent bodily modifications for understanding experiences of women with non-facial scars. Unlike piercing, which can be removed, tattoos and scarification, like scars, mark the skin permanently, leaving little room for manipulation. Also, the tension of negotiating the self through bodywork is particularly apparent in these two practices, since they mark the skin permanently in the context of a cultural preference for flawless skin. Scars, like bodily modifications, also render our bodies as unique, albeit unintentionally.
In western societies in the past permanent body marking was done mostly to signpost an, often deviant, social membership (for example, criminals) or to stigmatise and punish (Jablonski, 2008), such as in the case of Nazi tattooing of camp prisoners. Nowadays increasingly, body marking is practiced to emphasise one’s uniqueness (Jablonski, 2008; Negrin, 2008; Swami, 2011). Jablonski (2008) describes contemporary tattoos and scarification as “permanent reflections of personality, carefully calculated representations of core beliefs and sentiments that can make a uniquely powerful statement of individuality” (p.150). This can explain why today self-customised tattoos have become more popular than standardised ones (Negrin, 2008).

What kind of self-identities do people want to communicate through marking their skin? Most commonly, contemporary body marking has been understood to symbolise an adventurous and non-conformist self; to commemorate autobiographical highlights; to signal our interests and values; to manifest our desires (Negrin, 2008; Schildkrout, 2004). Recently, inspirational quotes have become the fashion (Karnikowski, 2012, May 27). Body marks can also be seen as testimonies of endurance, and of the mastery of pain (Schildkrout, 2004; Siebers, 2000). In the last decade or so, tattoos have also come to be viewed - at least in some circles - as beautifications, yet only when they are ‘light’ (Koch, Roberts, Armstrong & Owen, 2010; Swami, 2011). In short, tattoos and scarification are often heroic narratives of self and, occasionally, aesthetic endeavours.

Yet while both men and women are increasingly practising body marking, studies from Canada (Hawkes, Senn & Thorn, 2004), the UK (Inckle, 2007) and Germany (Wohlrab et al., 2009) demonstrate that female marks are commonly ‘read’ by the public in a stigmatised way - as indicators of deviant, unhealthy lifestyle and sexuality. Female tattoos are framed similarly in American media (Adams, 2009). In contrast, male tattoos are increasingly promoted in the fashion industry as part of a trendy masculine aesthetic (Negrin, 2008, p.7). Swami’s (2011) study of 82 recently tattooed people in the UK shows that, although both men and women experienced an enhanced sense of uniqueness, women were significantly more socially anxious about their bodies, because they anticipated negative evaluations. Similarly, Inckle (2007) shows that only a narrow range of ‘light feminine’ tattooing is socially acceptable. Women tend to have smaller tattoos and in more discrete locations, such as on the breasts and shoulders (Fisher, 2002).
Based on this discussion, it is plausible to assume that women who wish to express their uniqueness through their Body Surface experience more tension than their male counterparts. This is because women’s bodies are still expected to look beautiful (in accordance with cultural ideals) rather than unique and thus women have more limited options to render their Body Surface meaningful. Similarly, women whose skin is marked by scars might be more stigmatised than men, whose scars may be viewed as heroic narratives, signs of adventurous, unique character.

The remainder of this chapter reviews literature on the individual implications for women living in contemporary western society where the question of Body Surface is, arguably, always on the surface, particularly for women.

**Body Surface panic**

Few would disagree that beauty is valued in every culture, and that throughout human history people everywhere have strived to look good. Yet international research (for example, Carr, Moss & Harris, 2005; Mellor et al., 2009) consistently demonstrates that the prevalence of appearance concerns in the new millennium is unprecedented, possibly an ‘epidemic’ (Rumsey & Harcourt, 2005, p.xv). Orbach (2010), too, argues that in the west the human body “is becoming a site of serious suffering and disorder... a constant fretfulness and vigilance take hold for many” (pp.2-3). In short, what I term ‘Body Surface panic’ is on the rise.

As Rumsey (2008) writes, international research repeatedly shows that Body Surface panic affects great numbers of women. A study of 3300 women and adolescent girls from ten countries (Etocff, Orbach, Scott & D’Agostino 2006) found that only one in ten participants was unconcerned with her weight and shape. This is not surprising considering that women’s bodies are routinely subjected to public scrutiny (Bartky, 1997; Wolf, 2002). Many women, in turn, engage in self-scrutiny (Mellor et al., 2010), objectifying themselves or, as Orbach (2010) puts it, engaging in ‘hyper-criticism’ (p.69). Literature (Choma et al., 2009; Lee & Johnson, 2009; Rumsey, 2008) shows that bodily dissatisfaction, self-objectification and self-scrutiny have been associated with lower wellbeing and mental health problems, namely depression, sexual dysfunction, eating disorders and self-harm. The frequency of these problems, particularly eating disorders, among women is continuously growing while the age range of sufferers has decreased to encompass even elementary school-age children (Orbach, 2010; Smolak, 2012).
Non-clinical distress around appearance is even more widespread (Lamarche, Kerr, Faulkner, Gammage & Klentrou, 2012; Orbach, 2010; Rumsey, 2008). Women often experience shame, guilt and anxiety, and overall low well-being because they ‘fail’ to attain ideals of beauty (Calogero & Pina, 2011; Choma, Shove, Busseri, Sadava & Hosker, 2009). Self-objectification, body shame and self-scrutiny can also interfere with women’s sexual desire and pleasure (Woertman & Van Den Brink, 2012). To ‘improve’ their looks, many engage in bodywork that sometimes can be risky and endanger their health (Etcoff et al., 2006; Lee & Johnson, 2009; Markey & Markey, 2009; Muise & Desmarais, 2010; Rudd & Lennon, 2000). For example, in an American study conducted by Rudd and Lennon (2000), more than half of the female participants reported abusing laxatives and/or undergoing liposuction procedures.

In summary, international research suggests that the pressure to look good for contemporary women seems to be high, Body Surface panic is widespread and many women today spend much time, energy and resources on bodywork. Yet I am not suggesting that Body Surface panic has become the absolute mode for how women relate to their bodies. More plausibly, such a panic affects most women intermittently (Blood, 2005), and the minority of them - more permanently.

Rice (2009) suggests that ambivalence about their bodies is the more prevalent mood among women. Findings from a Canadian study of 304 women (Muise & Desmarais, 2010) support this suggestion by showing the prevalence of a paradoxical attitude among women who at once use anti-ageing products, and also express scepticism about their usefulness and critique media messages encouraging women to look youthful. This paradoxical attitude may correspond with another appearance-related anxiety arguably common among contemporary women. Blood (2005) and Orbach (2010) concur in their analyses of the popular culture as at once promoting the importance of beauty and being dismissive of women’s appearance concerns. Arguably, as a result women can be often torn between wanting to be attractive and not wanting to appear susceptible to messages about beauty. Thus, in addition to experiencing appearance concerns, women may also accuse themselves of vanity. Still, the degree of agency women exercise in their pursuit of beauty remains debatable.
The question of agency

Although most body scholars accept social constructionist arguments about the influence of sociocultural context on the constitution of our bodies, opinions vary about the extent people exercise agency in this area. Postmodernist feminism has been criticised for highlighting the discourse in shaping women’s practices and rendering women largely as compliant (Davis, 2007). For example, such influential feminist critics as Bartky (1997), Bordo (1997, 1993) and Wolf (2002) tend to perceive women’s attitudes to their bodies and their practice of bodywork, as a submissive and uncritical acceptance of dominant discourses. Other scholars, focus on the subversive, agentic, potential of the human body, arguing that people ‘appropriate and manipulate the body’s symbolic capacities for their own ends, though this project is not necessarily a conscious endeavour’ (Reischer & Koo 2004, p.308). Notably, Butler (1990) suggested that the practice of drag has the potential to destabilise gender stereotypes.

On the question of agency this study draws upon scholars who take the middle ground (Davis, 2007, 2003, 1997, 1995 and Shilling, 2007, 2005, 2003 among others). These thinkers conceptualise the body as a dynamic, flexible but also contested territory where social and individual actions and meanings intersect, and struggles between social control and individual interest ensue. Thus, the body can be viewed at once as a site of conformism and agency. Feminist scholars such as Davis (2007, 1995), Hollander (1999) and Rice (2009) follow such a more nuanced conceptualisation of women’s relationships with their bodies. They believe women differ vastly in their responsiveness to cultural messages, can enjoy their bodies, and also employ them to resist social customs. Studies too show that various people, and even sub-groups, vary in their susceptibility to cultural norms of female appearance. For example, a meta-analysis of international research on the effects of media on women’s body image (Holmstrom, 2004) showed that women varied in their acceptance of media messages about thinness. Similarly, Jefferson and Stake’s (2009) study of 169 European American and African American women showed that the latter group was less worried about their appearance and less influenced by the media.

Moreover, such scholars (for example, Budgeon 2003; Davis 2007, 2003, 1995; Hollander 1999; Rice 2009) see bodywork as a multifaceted endeavour, acknowledging that many women engage in it for self-expression and enjoyment. They distinguish between more and less harmful or pleasurable bodywork practices and note its
empowering aspects. Davis (2003), for example, argues based on her research on women who underwent cosmetic surgery that such surgery often stands not only for “the constraints and limitations of femininity [but also] allows some women to renegotiate their relationships to their bodies, and through their bodies, to themselves” (p.83). In this view, women’s relationships with their bodies can be conceptualised as ambivalent and dynamic.

However, the phenomena of Body Surface panic and bodywork can be understood beyond the debates of submissiveness versus self-expression. What if the ‘panic’ and the pursuit of beauty by some women are also practical responses in the face of tangible disadvantages women who fail to attain a beautiful, or at least ‘normal’, Body Surface, can face?

**Body Surface as capital**

Popular wisdom posits that beauty is only skin-deep. However, some theorists and researchers disagree with this notion, arguing that our bodies can bring us both gains and losses. The remainder of this section discusses these ideas.

**Capital gain**

One of the more influential writers to highlight the concrete benefits the body can provide us was Bourdieu (1978), who included *physical* capital in his theory of social life as being influenced by distribution of different forms of capital. Bourdieu argued that the body “can also be converted to attain other forms of capital – economic, social and cultural” (cited in Jagger 2000, p.53). Bourdieu’s physical capital covers a variety of bodily aspects, including taste, physical abilities and Body Surface. More recently, sociologist Hakim (2010) presented her controversial theory of ‘erotic capital’. Hakim’s erotic capital is a multidimensional concept, “a combination of aesthetic, visual, physical, social and sexual attractiveness” (p.501), yet Body Surface is at its locus. Echoing Bourdieu, Hakim argues that in the sexualised contemporary world erotic capital “is just as important as economic, cultural and social capital for understanding social and economic processes, social interaction, and social mobility” (p.499). According to Hakim, erotic capital is a highly important individual asset useful for socio-economic success.

Hakim’s (2010) theory has been criticised by some scholars, particularly for its gendered focus: Hakim argues that erotic capital is a major source of women’s power. However, a considerable body of empirical studies discussed below suggests there is
some element of truth in Hakim’s argument - that Body Surf is an important factor not only in how people construct their self-identities, but also in terms of the life chances available to them.

International research suggests that attractive people of all ages reap more social rewards. A meta-analysis of the relationship between attractiveness and life opportunities (Langlois et al., 2000) concluded that beautiful people experience more positive social attitudes towards them, such as receiving more attention, respect and support. They also enjoy better sexual and romantic opportunities, and quality relationships (Asendorpf, Penke & Back, 2011; Luo & Zhang, 2009; Perilloux, Cloud & Buss, 2013), better social mobility, employment and promotion opportunities (and consequently higher incomes) (Hosoda, Stone-Romero & Coats, 2003; Watkins & Johnston, 2000) and even better health and greater life expectancy (Henderson & Anglin, 2003; Langlois, et al. 2000). Attractive people are also more likely to receive more lenient judicial sentences, (Rhode, 2010) and be admitted more into virtual social networks (Wang, et al. 2010). The tangible benefits for attractive people seem to be gendered too, just as Hakim (2010) suggests. While more attractive men seem to fare better than other men, as many of the aforementioned studies indicate (see the meta-analysis by Hosoda et al., 2003 for example), for women Body Surf is far more crucial. For example, Ha, Berg, Engels and Lichtwarck-Aschoff’s (2012) study of 1586 people in The Netherlands showed that heterosexual men value attractiveness in their choices of dating partners significantly more than heterosexual women do.

Various theories have been posited to explain the link between beauty, and personal and socio-economic success. For example, some scholars (Becker, 1994; Hughes, 1999) suggest that attractive people enjoy more social validation, because people read their Body Surf as a sign of success. A comprehensive overview of such theories is beyond the scope of this thesis. However, it is important to mention one of the most prominent and empirically supported theories, which explains many of the benefits good-looking people enjoy. This explanation relates to the long standing tradition of western association between beauty and virtue, which – as mentioned earlier - dates back to the ancient Greeks, and later re-emerged in Christian values through Saint Thomas Aquinas’ similar belief that the beautiful and the good are identical (Langlois et al., 2000; Rumsey & Harcourt, 2005; Russell, 2000; Synnott 1989). Studies support the notion that attractive appearance is often interpreted as indication of moral goodness, and of other positive
character traits. International literature reviews (Jackson, 1992; Langlois et al., 2000) and studies from Sweden (Rohner & Rasmussen, 2012) and Israel (Segal-Caspi, Roccas & Sagiv, 2012) concur that attractive children and adults are judged more positively by both strangers and those who know them as being intelligent, conscientious and kind. In order to explain how this judgement reinforces itself, Jackson (1992, p.40) describes a dialectic process whereby people tend to attribute positive qualities to attractive people and consequentially behave towards them in a more favourable way; in turn, attractive people internalise these favourable perceptions and respond accordingly.

Theories are abundant. However, what stands clear is that today, possibly more than ever, attractive Body Surface is a highly valuable asset with empirical findings showing the considerable privileges beautiful people often enjoy. From this perspective, Body Surface panic and vigorous bodywork can be also understood as rather practical responses. The other side of this phenomenon is that a socially devalued Body Surface – of the unattractive, ungroomed, unhealthy, unfit, disabled or disfigured - can be associated with social sanctions, particularly when it belongs to women.

**Capital loss**

Baudrillard’s (2005) wry observation that “if you don’t make your bodily devotions, if you sin by omission, you will be punished” (p.278) seems to reflect reality to some extent. Arguably, people with bodies that deviate from cultural norms inhabit an “under-privileged and disadvantaged world” (Evans, 2002, p.3), enjoying lesser opportunities across social, intimate and professional domains. An American study (Commissio & Finkelstein, 2012) showed that unattractive women are viewed as less desirable employees, whereas according to a study from New Zealand (Boyes & Latner, 2009) such women can also be evaluated by their partners as having a lower mate value. Moreover, virtual social network users are disinclined to befriend members displaying unattractive photos (Wang et al., 2010).

Yet while, arguably, all people with a ‘deviant’ Body Surface may face social sanctions, different types of such Body Surface may attract different negative reactions. In a time when our bodies appear to be more controllable than ever, the bodies with ‘amendable’ problems, such as excessive weight, may be held to account as personally responsible for such deviation and be accused of having a flawed self (Bordo, 1993; Becker, 1994; Featherstone, 2010, 1991; Negrin, 2008; Orbach, 2010; Peterson, 2007).
On the latter point, such a Body Surface is often read as an indicator of overindulgence, laziness, poor self-control, ‘mere’ incompetence, or a rejection of social values. This view is evident in popular culture. For example, in Australian article about women’s bodywork in *The Age* (Gibbs 2011), three out of four women interviewed held people who look prematurely older responsible for their ‘unacceptable’ appearance, assuming they caused it through smoking and consuming greasy food. This attitude is in line with the currently operating neo-liberal discourse on health which, as Heyes (2006) argues, assigns individuals with responsibility for their wellbeing “as a necessary condition of effective citizenship” (p.139), shifting much of the health-related financial responsibility onto the individual, saving governments money. But does this mean those with less amendable Body Surface ‘abnormalities’, who have been touched by some kind of ‘misfortune’ – in short, the disabled and the disfigured – are absolved of social sanctions?

**Disabled and Disfigured Body Surface**

This section discusses dominant discourses on visibly disabled and disfigured bodies and the social barriers facing people with such bodies. It is argued here that these bodies commonly evoke simultaneous fear and fascination in the public which, in turn, either others them or renders them invisible.

**Fear and fascination**

People today, as previously discussed, often respond to bodies cerebrally by ‘reading’ and assessing them. In a society where a beautiful and healthy looking Body Surface has a capital value and can signify success, morality, good citizenship and even salvation, and where many women scrutinise and work on all possible bodily features, disabled and disfigured Body Surface may evoke discomfort, and even fear.

Scholars of illness and disability (Barnes, Mercer & Shakespeare 1999; Davis, 1997; Frank, 1991; French, 1994) have argued that reading such bodies can be frightening, since their existence challenges profoundly contemporary belief in individual mastery and our growing sense of death-defiance, signposting the limits of human control over the body and the fragility of humans. Particularly in the context of how removed illness and death are now from the public sphere (Davis, 2005; Frank, 1991; Shilling, 2003), visible disabilities and disfigurements serve as powerful reminders that the human body can “come apart at the seams” (Davis, 1997, p.55). Studies from the UK that examined responses to disfigurements (Kleyn et al., 2009; Shanmugarajah et al., 2012)
similarly show that disgust people often feel about disfigurements is associated with fear – fear of contamination and oral incorporation of the ‘disgusting’ object as well as fear evoked from being reminded of our ‘animal’ nature.

Possibly such a reading is particularly relevant to scars, since, unlike many visible disabilities and congenital or developmental disfigurements, scars always signify a rupture in an initially ‘whole’ body. Slattery (2000), one of the few scholars to mention scars in their work and himself a scarred person, also suggests scars to be the “physical and psychological emblem of one’s mortality, one’s limits” (p.54). Scars, being resistant to cosmetic improvements, may be also potent reminders of the limits of bodywork, challenging our narratives of self-improvement. In this context it is hard not to think about the phonetic similarities between the words *scar* and *scare*.

As much as disabled and disfigured Body Surface can trigger fear and disgust, it can also evoke simultaneous fascination bound with voyeurism. Hughes (1999) suggests that people with disabilities often become subjects of intense public curiosity and are “transformed into a spectacle in which ‘abnormality’ becomes the visual feast” (p.163). Similarly, Wardle and Boyce (2009) show that when people with disfigurements are featured on the UK television they are usually positioned as voiceless objects of voyeurism with viewers responding to them with great curiosity.

Anecdotal evidence exists that people with scars also terrify and fascinate the public. A striking example would be that of the actress Sharon Stone whose neck scar became an obsession of her fans. The more Stone hid her scar with clothes and jewellery, the more they strived to uncover it. The intensity of inquiry peaked with the appearance of a website dedicated to photos of Stone’s scar and speculation about its origins (the website has been shut down since 2009). Whereas American writer Resnick (2009), exemplifies the mixed nature of reactions to scars when in her memoir she describes her feelings about the burn scars on her lover’s chest:

> The first time Eddie strips down I am horrified... Across his alabaster chest runs a thick band of rumply-rough dark skin. He looks like... a fricasseed warrior on a

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6 Interestingly, in Africa where infectious diseases are common, scars are sometimes seen as signs of good health - a properly functioning immune system (Jablonski 2008).
day-pass from hell... I will write in my journal about the ravaged splendour of his body (p.76).

Arguably, to deal with the intense feelings a disabled and disfigured Body Surface evokes in the public, they other or render such bodies invisible, as the following section shows.

**Invisibility and Othering**

Scholars of disability show that people with visible disabilities are frequently cast as The Other, as deviant, by the communities in which they live (Barnes, Mercer & Shakespeare 1999). Similarly, cultural commentators (Austin, 1999; Berry, 2007; Davis, 2005, 1997; Hevey, 1992; Lloyd, 2011) have argued that people with bodies bearing signs of misfortune rarely feature in public representations, such as media or art, in a normalised context and unrelated to stories of pathology and trauma. “Images of diseased, disfigured or disabled bodies are largely deemed a private atrocity, the province of the personal and domestic space” Lloyd (2011, p.213) eloquently writes. Indeed, Davis’s (2005; 1997) scrutiny of contemporary art and visual media demonstrates the near absence of disabled bodies from these spheres, whereas Wardle and Boyce’s (2009) analysis of the UK primetime television shows that disfigurements (particularly female ones) rarely feature.

The social taboo of showing bodies inscribed with suffering is occasionally breached when such bodies stand for something outside of the norm, either in their heroism or monstrousness. Then, the disability or disfigurements have become the main markers of such people, reducing them to their ‘abnormality’. As Lloyd (2011) suggests, “images of wheelchair users are more acceptable if they belong to muscular Paralympic athletes who are trumpeted as having ‘defied the odds’” (p.212). Similarly, film characters with disabilities tend to be cast in roles that are heroic in their endurance and achievements, or grotesque, tragic and helpless (Berry, 2007; Davis, 2005). On television, having disfigurements is usually associated with evil, reclusiveness and/or bitterness (Wardle & Boyce, 2009). A dialectic relationship possibly operates here. While fascinated yet threatened by disabled and disfigured Body Surface, western society either exorcises such bodies from the public sphere or puts a safe distance between the ‘normal’ people and the ‘unfortunate ones’ by othering them. According to this logic, if the disabled and the disfigured are either heroes or monsters, then what has happened to
‘them’ cannot happen to ‘us’. In turn, the distance put between ‘them’ and ‘us’ results in a lack of familiarity, and may trigger even more fear and fascination.

Anecdotally speaking, even though scars are so common in the population, they are rarely represented in the public domain. If characters in cinema and television do have scars, most commonly they signify otherness and take over the character’s identity (Partridge, 2012). Usually scars signify villains: Freddy Krueger from A Nightmare on Elm Street, the Joker from The Dark Night and a long line of gangster characters count amongst the famous examples. In real life facial scars in men also can be associated with aggression and criminality, and a study of Ong et al. (2007) shows that sometimes people fear and avoid individuals because of their scars.

The few artists who depict scars tend to have them themselves. Mexican painter Frida Kahlo and British photographer Jo Spence both created self-portraits exposing their scarred bodies. Spence (1995) in particular put herself on display for political reasons, writing that “people can discover how to relate to themselves and to others more positively when armed with images of themselves – images which counteract the stereotypes usually seen in the mass media” (p.35). American fashion model Lynn Kohlman had a similar intent when she showcased her scarred body through revealing photography.

However, even when some people are willing to show their scars, the public may not be willing to allow such displays. For example, several American art galleries refused to exhibit artist Ted Meyer’s collection of monoprints of scars until Washington’s National Museum of Health and Medicine took in the exhibition (Kennedy 2006). Similarly, when in 2009 the model Tahlia Brookins appeared on the reality TV show America’s Next Top Model, the show’s crew offered her outfits to conceal the burn scars on her stomach and legs (Bracchitta 2009). Brookins refused them though, and her revealing TV appearance caused much discussion. Still, the story of Brookins is a one-off story.

**Conclusion**

It has been shown in this chapter that in the contemporary west Body Surface has become significant to many women’s sense of self and can affect their life choices and chances. Literature presented in this chapter mostly does not directly engage with the
specifics of scars, however its focus on the cultural norms about what constitutes attractive, meaningful or deviant Body Surface highlights the potential pressures women with non-facial scars are likely to face in contemporary society. It has been argued that current dominant discourses on female appearance potentially pose risks to all women, but particularly to those whose Body Surface is deemed ‘deviant’, a definition which encompasses scars too. The next chapter focuses on the particular issues people with disfigurements face, as examined by psychologists of appearance and some other healthcare professionals.
Chapter Three – Disfigured Body Surface: Psychological Framings

‘I consider ugliness a kind of malady, and illness and suffering always inspire me with revulsion’

_Oscar Wilde_

This chapter provides a selective review of empirical findings and theoretical framings from disfigurement research with the aim of setting a further context for the experiences of women with non-facial scars. The majority of this research has been conducted by health psychologists working within the psychology of appearance field, but several studies come from other health areas – namely, from the nursing discipline (as discussed in the preceding chapter, almost none are conducted by social work researchers). As discussed in chapter one, most of the significant studies in this field were conducted in the UK. A bulk of American studies of disfigurements exists too, as well as some European and Australian studies. All this literature is reviewed in this chapter.

I begin by reviewing the main findings about the individual consequences of having disfigurements, including the effects on self-identity, mental health, life choices and life chances, while also considering factors mediating these consequences and the coping strategies people with disfigurements employ. I then critically review notable theoretical models that guide both disfigurement research and intervention design in order to position this study more specifically and to clarify its potential contribution to the existing literature on disfigurements. This review contains three arguments: 1) that psychological framings of disfigurements alone are insufficient to understandings such experiences; 2) that insights from body theory, highlighting the importance of sociocultural context in the relationship between body and self, can complement psychological insights; 3) that conceptually and methodologically this thesis addresses several research gaps in the field. I conclude with a discussion of existing professional interventions for people with disfigurements, and their still-unmet needs.

**Experiencing disfigured Body Surface**

Individual costs of living with disfigurements when people face the dual challenge of managing their own response to their appearance and dealing with the responses of others have been documented extensively as this section shows. Taken together, studies
exploring the impact of disfigurements indicate “the presence of higher than average levels of psychological distress” (Thompson, 2012, p.92). According to Rumsey (2008), one of the leaders in disfigurement research, literature shows that between 34% and 51% of those affected by disfigurements experience significant psychosocial difficulties. The largest to-date study of mixed disfigurements conducted in the UK (Rumsey et al., 2010), which is one of the most important points of references in this thesis, shows an even higher prevalence of distress amongst the 1265 participants (60%), with a small majority showing clinical rates of anxiety and depression, and that the negative impact can extend into numerous life domains. The following sections discuss in more detail what is known today in the field of disfigurement research about the consequences of having disfigurements.

Dealing with social responses

Negative social reactions, such as harassment and avoidance behaviours, are cited as some of the most acute problems for people with disfigurements. Great difficulties with social interactions have been reported by people with a variety of disfigurements, including those resulting from cancer, burns, congenital abnormalities, scleroderma and dermatological diseases (for example, see Hill & Kennedy, 2002; Kent, 1999; Kleve & Robinson, 1999; Rumsey et al., 2010; Rasmussen et al., 2010). Those whose disfigurements are visible in public often report experiencing insults, such as staring, name calling, derogatory jokes and unsolicited interrogations about their appearance from both strangers and people they know (Kleve & Robinson, 1999; Krille et al., 2012; Tartaglia et al., 2005; Williams et al., 2004; Williamson et al., 2010). Some even experience an ongoing bullying (Rumsey et al., 2010). Others report that strangers and people who know them may avoid them in social situations (Bull & Rumsey, 1988; Rasmussen et al., 2010). Sometimes people tend to be less helpful towards those with disfigurements (Lansdown, Rumsey, Bradbury, Carr & Partridge, 1997) and listen to them less attentively (Stevenage & Furness, 2008).

Beyond actual social rejection, and often following such experiences, many people with disfigurements anticipate negative responses (Kent & Keohane, 2001; Rumsey et al., 2010; Rasmussen et al., 2010). As a result, self-imposed social withdrawal – at times even profound social isolation - features in self-reports (see for example, Hawkesworth, 2001; Wahl, Gjengedal & Hanestad, 2002). Others, in anticipation of stigmatisation, may display negative body language, anger or defensiveness during social
interactions, in turn eliciting negative reactions that reinforce anticipation of rejection (Thombs et al., 2008). Still, limited evidence exists to show that sometimes people, both acquaintances and strangers, show support and willingness to help those with disfigurements (Krille et al., 2012).

**Psychological impact**

The impact of disfigurements on emotional wellbeing and quality of life can be pervasive and profound. Studies (Benrud-Larson et al., 2003; Hiatt et al., 2009; Krille et al., 2012; Steinmann et al., 2011) show that in comparison to the general population, people with disfigurements have a more negative body image. Some other commonly reported difficulties are low self-esteem and self-confidence (for example, Kent & Thompson, 2002; Newell & Marks, 2000; Robert et al., 1999; Rumsey et al., 2010), high self-consciousness and vigilance, and social anxiety (for example, Hagedoorn & Molleman, 2006; Rumsey et al., 2010; Rasmussen et al., 2010; Williamson et al., 2010). People also report grieving for their lost looks, feeling anger, shame, and even self-hatred (Callahan, 2004; Jafferany, 2007; Partridge, 2006; Rumsey et al., 2010; Taal & Faber, 1998; Wahl et al., 2002; Wittkowski et al., 2009). Some participants in Rumsey et al.’s (2010) study said they felt pessimistic about their lives and that their disfigurements inhibited them from achieving life goals. Some also report feeling guilty of vanity because of their disfigurement-related distress (Kent, 2000; Williamson et al., 2010). Distressing disfigurement-related thoughts can become intrusive, and some people attribute various negative experiences they have had solely to having a disfigurement (Kent, 2000). For some, their disfigurements become a defining feature in their self-concept (Williams, Reeves, Cox & Call, 2004). Psychopathology is also prevalent. Research shows high rates of clinical levels of anxiety, depression, post-traumatic stress disorder (PTSD) and social phobia amongst people with disfigurements (see literature reviews by Jafferany, 2007; Noronha & Faust, 2007; Rumsey & Harcourt, 2004; Wisely & Gaskell, 2012) and sometimes even suicide attempts (Bundy 2012).

It feels apt to finish this discussion of the gravity of the psychological impact by quoting from the personal account of Partridge (2006), a burns survivor, who describes eloquently the aftermath of his accident: “The euphoria of being alive… slid away into years of rarely expressed anger, sadness, and barely concealed depression” (p.956).
Significant others

Significant others can also be affected negatively as they deal with the disfigured appearance of their loved ones and/or witness the latter’s distress (Brown et al., 2008; Chamlin, 2006; Phillips, Fussell & Rumsey, 2007; Troilius et al., 1998; Williamson, 2010). For example, in a study of families of people with burns (Phillips et al., 2007), a majority of siblings, children and partners reported experiencing distress, particularly in dealing with the sight of scars and with the negative social responses these attracted. However, more research is needed to comprehend the impact on, and needs of, the significant others (Wisely & Gaskell, 2012).

Variations in impact

While the impact of disfigurements can be profound and lasting, and can extend onto many life domains, research also demonstrates great individual variation in the impact severity. For instance, Feragen’s (2012) literature review of people with congenital disfigurements shows that some also report positive outcomes because of their appearance: self-understanding, character strength and good emotional regulation. Several studies (Feragen, Kvalem, Rumsey & Borge, 2010; Lawrence, Rosenberg & Fauerbach, 2007; Robert et al., 1999) show levels of self-esteem among people with disfigurements to be similar to, or even higher than, in those without disfigurements. Although self-esteem is not always a reliable measure of wellbeing, and these findings (plus those about positive outcomes), are based on relatively small samples, still they point out differences in adjustment among people with disfigurements. These differences highlight the importance of understanding factors that influence the impact. The next section discusses what is currently known about these factors.

Mediating factors

Research into factors mediating the impact of disfigurements on people’s lives is relatively recent and inconclusive (Rumsey & Harcourt, 2007). So far studies have investigated differences in physical, psychological, relational and sociocultural (demographic and cultural) variables, and also adjustment7 to disfigurements over time.

7 The problematic nature of the term ‘adjustment’ as it is currently used in the literature on disfigurements was discussed in chapter one and will be elaborated on further later in this chapter.
Major literature reviews in disfigurement field (Moss & Rosser, 2012; Rumsey et al., 2010; Rumsey & Harcourt, 2005) concur that although research shows that individual adjustment is affected by a complex interplay of all these factors, the majority of investigators to date have focused on psychological factors, particularly on cognitive processes. The following sections discuss the mediating factors that disfigurement research has examined.

**Physical factors**

Physical factors include the overall disfigurement degree and its more specific aspects (e.g. size or colour), bodily location and associated physical discomfort, and aetiology. Research findings about the importance of these factors are not conclusive. According to several literature reviews (Moss & Rosser, 2012; Rumsey & Harcourt, 2012; Thompson & Kent, 2001), cumulative research shows that the physical aspects of disfigurements are not strong predictors of adjustment to living with disfigurements in contemporary society. However, some contrary evidence exists too, as outlined in the remainder of this section.

Studies of paediatric (Lawrence et al., 2007) and adult (Fauerbach et al., 2000; Thombs et al., 2008) burns survivors demonstrate that the extent of total body surface area (TBSA) covered by burns and objective scar severity correlate positively with the severity of distress. Similarly, in his review of literature on breast cancer surgery, Pruzinsky (2002) argues that empirical evidence exists to show that lumpectomies are associated with less distress than mastectomies. Yet a study of mixed disfigurements (Moss, 2005) shows that moderate, rather than mild or severe, disfigurements were predictive of distress. Moss (2005) explains these somewhat surprising findings by suggesting that social responses to moderate disfigurements are less predictable and therefore less manageable.

Reviews of paediatric (Noronha & Faust, 2007) and adult (Van Loey & Van Son, 2003) burn literature identify the visibility of body location as a significant variable in predicting the nature of adjustment. For example, according to Van Loey and Van Son (2003), more visible burns were most predictive of depression and post-traumatic stress disorder. Similarly, Kent and Keohane (2001) and Wahl et al. (2002) found that people with more visible psoriasis – on their hands and faces – exhibited higher social anxiety. In
contrast, Brown et al. (2010) showed that less visible scars predicted greater distress. This finding possibly shows that, as argued in chapter one, hidden disfigurements entail unique challenges, such as managing concealment and disclosure. Moreover, people whose disfigurements are less concealable may have more opportunities to develop skills for dealing with social responses (Wisely & Gaskell, 2012). Gender may also matter in explaining the inconsistency of the findings about the importance of disfigurement location. For instance, Rumsey et al. (2010) found that for women the location most associated with distress was a less visible one - the torso. This may be so, because women can associate this area with sexual attractiveness.

Most researchers concur that aetiology plays some role in experiences of people with disfigurements, yet its salience in adjustment and coping is debatable. The major aetiological distinction in the field is made between congenital (manifested at least to some extent in birth) and acquired disfigurements (Rumsey & Harcourt, 2005). According to Rumsey and Harcourt (2007), acquired disfigurements include those caused by trauma, surgical intervention, illness, genetic conditions that manifest themselves later in life (such as some skin diseases) and abnormal developmental processes.

Rumsey and Harcourt (2005) argue that the severity of distress cannot be predicted according to whether disfigurements are congenital or acquired, particularly given that both groups include many different conditions. For example, some congenital disfigurements can be amended, whereas others intensify with time (Rumsey, 2002; Rumsey & Harcourt, 2005). Whilst it remains unclear whether distress in either the congenital or acquired group is higher, lived experiences often differ qualitatively. For example, some congenital disfigurements can be passed genetically and may generate distress around deciding whether to have children (Rumsey, 2002). Also, people with congenital disfigurements are at risk of having problematic relational and social experiences which may negatively affect their development from infancy (Papadopoulos, Bor & Legg, 1999; Rumsey, 2002). Whereas the circumstances of disfigurement acquisition may matter in the adjustment. Also, people who acquire disfigurements later in life may experience a loss of identity (Partridge, 1990).

Some researchers studied some condition-specific effects. Broadly speaking, aetiologies that have so far received most attention are cancer, burns and skin conditions. Physical aspects particular to certain conditions can affect adjustment. Burns often
involve pain, physical impairment and severe disfigurement (Wisely & Gaskell, 2012; Williams, Davey & Klock-Powell, 2003). Skin diseases have their unique challenges too. They can flare unpredictably or fluctuate cyclically; their outbreaks may be triggered or exacerbated by stress; they can increase in scope over time and be associated with physical discomfort such as itchiness (Bundy, 2012; Jafferany, 2007; Kent & Keohane, 2001; Koo & Yeung, 2002).

Different types of disfigurements also have different sociocultural meanings attached to them, which in turn affect the experiences of people with disfigurements. Skin diseases may evoke fear of contamination and disgust, and people often associate these conditions with sexual promiscuity and/or poor hygiene (Kent, 2000; Kent & Keohane, 2001; Koo & Yeung, 2002; Wittkowski et al., 2007). On the other hand, amputations are less associated with stigma but may trigger visceral repulsion (French, 1994).

Aetiology can also impact people’s meaning making around their disfigurements. Some people with skin diseases can internalise stigma, experiencing their bodies as unclean and infectious (Koo & Yeung, 2002; Wahl et al., 2002). People with disfigurements resulting from life-threatening illnesses, such as cancer (Furness et al., 2006; Wallace et al., 2007a) or meningococcal septicaemia (Wallace et al., 2007b) often report that their joy at surviving, or health concerns, override appearance concerns. However, cancer-related disfigurements can trigger a different distress, serving as visible reminders of past suffering and possible recurrence of the cancer (Furness et al., 2006; White, 2002). Burns can remind people of the trauma associated with their acquisition (Rumsey & Harcourt, 2005, p.112). Moreover, a study of people with vitiligo (Papadopoulos, Bor, Walker, Flaxman & Legg, 2002) showed that their meaning making around the causes of vitiligo affected their adjustment to their appearance.

Despite the aforementioned aetiology-related differences in people’s adjustment, the role of aetiology as a mediating factor has not received substantial attention in the literature. Furthermore, the overall significance of aetiology in adjustment to disfigurements is subject to debate, with leading researchers Rumsey and Harcourt (2005) arguing that “there are more similarities than differences in the experiences of those affected, regardless of aetiology” (p.116). Yet differences exist, even within relatively homogenous conditions. For example, in the literature review of skin diseases, Papadopoulos et al. (1999) showed that their impact differed according to their specific
nature with people with psoriasis rating the worst, possibly due to the severely disfiguring nature of this condition which causes dry, flaky skin.

In summary, arguably the inconsistency of findings on the role of physical factors in adjustment does not show their unimportance, but rather that they may affect adjustment qualitatively rather than be predictive of the amount of distress. More qualitative research is needed to better clarify these relationships.

**Psychological factors**

In their reviews of disfigurement research, Rumsey and Harcourt (2007; 2005) argue that the most significant predictors of adjustment belong in the cognitive domain. These are the extent of appearance investment\(^8\), perceived social support, and a level of preoccupation with evaluation from others. High levels of appearance investment and preoccupation with evaluation from others, and perceived poor social support correlate with higher distress. More recent studies of factors mediating the impact of disfigurements (Feragen et al., 2010; Moreira & Canavarro, 2012; Rumsey et al., 2010; Thombs et al., 2008; Versnel et al., 2010) also found the aforementioned factors to be important. Other cognitive factors highlighted in the literature as predictive of distress are: felt or anticipated stigma (Kent, 1999; Thompson & Kent, 2001), negative interpretation of social responses to disfigurements (Rumsey et al., 2010), a high subjective rating of disfigurement degree, and its perceived visibility and stigmatisation (Brown et al., 2010; Lawrence et al., 2006; Moss, 2005; Ong et al., 2007; Rumsey et al., 2004). In short, negative cognitive biases in processing appearance-related information have received the most attention from researchers (Moss & Rossner, 2012) and are most associated with poor adjustment.

Certain personality traits and dispositional styles can also mediate disfigurement-related impact. Optimism, sociability and hardiness (resilience to stress) may ameliorate this impact, while trait anxiety and introversion are associated with distress (Furness et al., 2006; Rumsey et al., 2010; Taal & Faber, 1998; Thompson, 2012). Such psychological constructs as self-esteem (Rumsey, 2004) and self-efficacy (Hagedoorn &

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\(^8\) this term refers to the extent to which people’s self-worth depends on their perception of their appearance (Williamson & Wallace, 2012) and is a part of the body image construct discussed later in the chapter.
Molleman, 2006) have also been found to be important. Self-esteem is “the self-appraisal of one’s significance, worth, competence and success as compared with others” (Coopersmith cited in Rumsey & Harcourt, 2005, p.130). Self-efficacy can be defined as the degree to which people “believe that they capable of influencing the reactions and openness of others” (Thombs et al., 2008, p.210). High self-efficacy and self-esteem are associated with better adjustment to disfigurements.

**Relational factors**

Relational factors refer to the availability and quality of support from friends and family. Several studies (Feragen et al., 2010; Furness et al., 2006; Lawrence et al., 2006a; Phillips et al., 2007; Robinson, 1997; Rumsey, 2004; Rumsey et al., 2010; Williamson et al., 2010) have considered the role of such support in mediating the impact of disfigurements and found that good support is associated with better adjustment. The importance of intimate relationships was highlighted in some studies. For example, a study of adult burns survivors (Lawrence et al., 2006a) showed that being in a committed relationship had a modest yet significant correlation with lesser depressive symptoms. Yet significant others can also pose risks. Poor support, and even casual negative comments about disfigurement made by partners were experienced as highly distressing (Furness et al., 2006; Rumsey et al., 2010). Overall, it is still unclear what aspects of social support and from whom are most effective. More research is needed in this area (Feragen, 2012).

**Demographic factors**

Literature reviews by Rumsey and Harcourt (2012, 2007, 2005), and Thompson and Kent (2001) suggest that demographic factors (gender, age, ethnicity and socio-economic status) are not strong predictors of adjustment. Yet some research discussed in this section does show these to have a significant effect. Possibly, this inconsistency in findings stems, at least partly, from the paucity of research in the area (Wisely & Gaskell, 2012) and from certain methodological difficulties as discussed in the following sections.

**Gender**

Rumsey and Harcourt (2007, 2005) argue there are more similarities than differences between people with or without disfigurements in terms of their appearance concerns and, as discussed in chapter two, research demonstrates that gender does play a
significant role in how people experience their bodies, with women exhibiting more concerns. Indeed, a significant number of studies on disfigurements (for example, Feragen & Borge, 2010; Kleve & Robinson, 1999; Thombs et al., 2008; Troilius et al., 1998; Van Loey & Van Son, 2003) show that appearance concerns are more severe for girls and women. Similarly, Austin (1999, p.81) cites a poll conducted by Rejuveness, a company that markets scar treatments, which showed that 65% of women, as opposed to 35% of men, were concerned with their scars. A recent literature review of head and neck cancer-related disfigurements (Williamson & Wallace, 2012) also showed that women experienced more distress than men.

Rumsey et al.’s (2010) findings about gender, drawn from respondents with mixed disfigurements, are more ambiguous: they show that women experience more distress than men, but also that the differences are small. Yet even those women who did not experience high levels of clinical symptoms reported greater difficulties in their daily lives in comparison to men (Rumsey et al., 2010). There is also evidence (Burriss, Rowland, & Little, 2009; Gardiner et al., 2010) to suggest that social responses to female disfigurements are more negative than to male ones, which is likely to mean that women are affected more severely.

One of the possible reasons for the inconsistency of the findings about gender may be due to methodological issues with measures and sampling. Feragen et al. (2010) argue that there are few studies investigating the role of gender and these are usually based on small samples. Also, often the majority of respondents in mixed-gender studies are women. For example, in Rumsey et al.’s (2010) study, women (n=867) constituted two-thirds of the participants. Thompson and Kent (2001) and Rumsey (2002) concur that having disfigurements may mean different things to men and women and that their coping strategies may differ (for example, women are more likely to use makeup as camouflage, and generally resort to concealing). Therefore, using the same measures of adjustment for both sexes may produce misleading findings.

Age

Research about the relationship between age and adjustment to disfigurements is also inconclusive. The prevalent assumption in the field is that no significant relationship exists, since evidence of high levels of distress can be found across all age groups (Mellor...
et al., 2010; Rumsey & Harcourt, 2012). However, it is plausible to assume that different life stages pose different challenges for people with disfigurements.

According to Thompson and Kent’s (2001) literature review, having a disfigurement as a child can disrupt the resolving of Erikson’s trust-mistrust crisis and interfere with developing healthy attachments. Children with disfigurements are also likely to be teased and bullied at school and so be more at risk of developing psychological difficulties (Feragen & Borge, 2010; Frances, 2000; Lawrence et al., 2011; Rumsey, 2002; Rumsey & Harcourt, 2007).

During adolescence the vulnerability of those with disfigurements seems to be particularly high. Body image at this stage of life is the principal predictor of psychological wellbeing and disorders (Stice, 2002; Verplanken & Velsvik, 2008). At this time appearance is intrinsic to the developmental milestone of identity formation and the social pressure to look good is particularly high (White, 2002; Williamson et al., 2010). Adolescent peers tend to judge disfigurements the harshest (Crystal, Watanabe & Chen, 2000; Krille et al., 2012), with sustained teasing and bullying being as salient and prevalent as in childhood (Rumsey, 1998; Williams et al., 2004; Williamson et al., 2010).

Little is known about unique challenges in adulthood, possibly because of the sheer diversity of life pathways then. However, one of the most contentious topics in the literature about age and disfigurements is the relationship between growing older and adjustment. Here, too, thus far findings have been inconclusive. While some studies (Benrud-Larson et al., 2003; Feather et al., 1988; Rumsey et al., 2010) show a certain decrease in disfigurement-related distress in old age, considerable individual variation still exists. These findings echo the research into appearance concerns and age in the general population, which is also limited and has produced inconsistent results (Armstrong et al., 2009; Pruis & Janowsky, 2010). Some appearance researchers tend to think that appearance concerns may decrease in older age because while older adult women may be as dissatisfied with their appearance as the young ones, possibly other priorities, such as health, become more important (Tiggemann & Slevec, 2012). However, while studies indicate that rates of eating disorders and body-related anxiety decline in older age, they also show that non-clinical dissatisfaction with one’s looks is common, and that many older women still engage in a variety of bodywork (Armstrong et al., 2009; Pruis & Janowsky, 2010).
Ethnicity

To date, in the listerature on disfigurements there has been no adequate investigation into the ways in which different ethnic groups respond to disfigurements (Naqvi & Saul, 2012). However, two studies among South Asian UK residents (Hughes et al., 2009; Papadopoulos et al., 2002) highlight the need to understand such attitudes, showing that these ethnic groups express many stigmatising attitudes. In South Asian communities stigma can be linked with blame and can extend to the entire family of the person with disfigurements. These attitudes have roots in spiritual beliefs, where disfigurements are often viewed as punishment for sins committed by the person or her parents. Consequently, in a study of vitiligo sufferers (Papadopoulos et al., 2002), South Asian participants reported more distress than Caucasian and African-Caribbean respondents.

Socio-economic status

The role of socioeconomic status in mediating adjustment to disfigurements has so far remained underexplored in disfigurement research. However, there is some evidence to suggest that better educated people with disfigurements are less distressed about their appearance (Versnel et al., 2010), while low socio-economic background is associated with poorer adjustment (Blakeney, Rosenberg, Rosenberg & Faber, 2008).

Cultural context

Negative responses to disfigurements, as previously discussed, are prevalent and can be highly distressing. Still, the role of cultural context in coping with disfigurements has not been given much attention in research on disfigurements. This literature (e.g. Kent, 2000) often refers to distressing social situations as ‘triggering events’ (meaning they trigger distress), rather than conceptualising these as part of the broader context within which people with disfigurements live. Similarly, few studies exist on the influences of media on the experiences of people with disfigurements, even though this topic has been a salient feature in appearance research among the general population. Also, little is known about the importance of institutional factors in people’s experiences of disfigurements and whether positive social messages about disfigurements can ameliorate distress.
Adjustment over time

The process of living with disfigurements is occasionally framed in literature in terms of positive adjustment. Thompson and Kent (2001) and Partridge (2005) offer theories of staged adjustment. They concur in suggesting the existence of an initial period when people become progressively distressed about their appearance, then later on cope by either withdrawing from social activities or hiding their disfigurements, and finally gradually develop the skills to cope with unpleasant social encounters and an (often fragile) sense of acceptance. Partridge, whose theory focuses on burns and is therefore more applicable to other acquired disfigurements, includes another, earlier stage, when the focus is more on physical recovery than on appearance concerns, and a further later stage when some people become advocates for others with disfigurements.

Some studies (Hill & Kennedy, 2002; Wallace et al., 2007a) demonstrate, in line with the aforementioned theories, that disfigurement-related concerns decrease over time. For example, Wallace et al. (2007a) investigated appearance changes resulting from meningococcal septicaemia, concluding that: “while participants struggled enormously with an altered appearance, overall it would seem that they have come to accept their new appearance and have adapted satisfactorily” (p.130). However, empirical research does not always support such progressive trajectories. Some studies (Kleve & Robinson, 1999; Lawrence et al., 2006a; Moreira & Canavarro, 2012) show no correlation between the passage of time and the degree of distress. Whereas Rumsey et al. (2010), after following 360 participants with mixed disfigurements for nine months, conceptualised the experience of disfigurements as often being a permanent stressor that “can be an ongoing strain on resources and, at times of particular stress and change may be an ‘Achilles heel’ becoming the focus of distress” (p.200). At other times this stressor can be less salient, depending on people’s developmental stages, concurrent life events and daily stressors (Rumsey et al., 2010). As shown, the findings about adaptation over time are inconclusive. This can be partly explained by the fact that most existing data comes from cross-sectional studies.

Summary

As discussed, research is still inconclusive as to the precise nature of the mediating processes involved in living with disfigurements, particularly given that causal
directions are difficult to ascertain (Rumsey & Harcourt, 2007). The disparity of findings may indicate the complexity and multifactorial nature of adjustment, the difficulty of measuring it and the lack of systematic research. Arguably, how people choose to cope with disfigurement-related difficulties, whether these are social or emotional ones, is somewhat easier to assess.

**Coping with disfigured Body Surface**

How people cope with the impact of disfigurements is highly significant in their adjustment. Coping has been theorised in psychology as a dynamic process where a variety of behavioural and cognitive strategies are employed to manage effects of stressful situations (Folkman & Moskowitz, 2004; Papadopoulos, Bor & Legg, 1999). Robinson (1997) and Rumsey (2002) concur that having a broad coping repertoire to pick and choose from is the most useful. The following sections explore the main coping strategies identified in disfigurement research. These are divided into other-oriented and internal (affective and cognitive) strategies.

**Other-oriented strategies**

*Proactive coping*

Many researchers (for example, Furness et al., 2006; Partridge, 1990, 2006; Robinson, Rumsey & Partridge, 1996; Rumsey & Harcourt, 2005; Thompson & Kent, 2001) suggest sound social skills are most helpful for people with disfigurements, in particular being proactive in social situations when disfigurements are visible and taking responsibility for how these unfold. Partridge (2006) argues that when people take control over interactions around their disfigurements by talking openly about these and educating people about their conditions, they are likely to elicit positive feedback, which in turn will reinforce future confident behaviour. Empirical studies (Rumsey et al., 2010; Williamson et al., 2010) support Partridge’s contention. However, the use of such strategies is mostly reported among people with the most visible (usually facial) disfigurements. People whose disfigurements are easier to conceal often choose to hide them as the following sub-section shows.
Concealment and Avoidance

Concealment and avoidance strategies, aimed at minimising the exposure of disfigurements, are common amongst people with disfigurements (Brown et al., 2008; Clarke et al., 2012; Kent, 2000; Rumsey et al., 2010; Troilius et al., 1998; Wahl et al., 2002; Williamson & Wallace, 2012). However, these two strategies are also most associated with adverse outcomes.

Concealment can be done through the use of clothes, jewellery, makeup (including camouflage makeup), hairstyle, body language and dim lighting. This strategy can alleviate distress and help people participate in social interactions (Kent, 2002). However, while concealment may alleviate social anxiety, it can generate new distress in several ways. Concealment entails anxiety about a possible ‘discovery’ of disfigurement (Kent, 2002; O’Donnell, Sell, Rauso & Goode, 2001). Finding suitable clothing and applying makeup can be laborious and can also be associated with significant expense (Brown et al., 2008; Rumsey et al., 2010). At times people go to great lengths to conceal their disfigurements even from significant others, including their intimate partners and children, and forgo disclosure to medical practitioners, endangering their health (Lanigen & Cotterill, 1989; O’Donnell et al., 2001). Concealment devices too can stigmatise. For example, covering disfigurements during hot weather with unseasonable clothes may attract attention (Brown et al., 2008; Newell & Marks, 2000; Rumsey et al., 2010; Wallace et al., 2007; Williams et al., 2004). Also, the act of concealing can impact on people’s sense of self, making them feel inauthentic and secretive (Kent, 2000; Wahl et al., 2002).

Avoidance strategy can include avoiding being photographed and looking in mirrors, avoiding intimacy, dating and social events (particularly those requiring bodily exposure, such as pool parties), with the latter behaviour sometimes developing into self-imposed isolation (Furness et al., 2006; Hawkesworth, 2001; Kent, 2000; Rumsey et al., 2010; Williamson et al., 2010). This coping strategy is particularly associated with long-term mental health problems, such as heightened anxiety, and with poorer quality of life (Kent, 2000; Newell & Marks, 2000; Rumsey et al., 2010). Avoidance also has secondary negative effects, such as the loss of valued activities, reluctance to develop intimate relationships, loneliness and feelings of guilt about letting others down (Kent, 2000; Williamson et al., 2010). This is not to suggest that avoidance is always a poor choice.
Furness et al. (2006), for example, found out that this strategy can be useful when it is employed short term. However, when avoidance becomes the main way of coping, it can prevent people from developing additional coping strategies and from facing possible disconfirmation of anticipated rejection (Thompson and Kent, 2001). Generally, when people stop concealing their disfigurements and/or avoiding situations where these disfigurements can be exposed, such behaviour is associated with positive coping (Kent, 2000).

**Internal strategies**

People with disfigurements employ a range of affective and cognitive strategies to manage the impact of their disfigurements on their self-concept and self-esteem. One of the most common such strategies is making social comparisons (Furness et al., 2006; Rumsey et al., 2010; Thompson & Kent, 2001). According to social comparison theory, people engage in a relatively continuous self-evaluative process on various attributes in order to contextualise and understand themselves in relation to others (Festinger, 1954). Upward comparison is the tendency to compare oneself to people perceived to be better off and is associated with negative feelings and low self-esteem (see for example a study by Franzoi et al., 2012). Downward comparison is comparing oneself with those who are worse off; it has been considered to be a useful coping strategy (Major, Testa & Blysma, 1991; Wilson & Ross, 2000). Social comparison has been demonstrated to be an important component in how people feel about their appearance (Franzoi et al., 2012). Studies of disfigurements (Rumsey et al., 2010; Thompson & Kent, 2001; Wahl et al., 2002; Wallace et al., 2007a) show that people employing appearance-related upward social comparisons cope worse than those employing downward social comparisons.

Pragmatist approach to coping, perceived efficacy at coping with disfigurement-related difficulties, positive thinking, taking things day-by-day, acceptance and taking responsibility for engaging with difficulties are all associated with positive coping with disfigurements (Furness et al., 2006; Rumsey et al., 2010). Ability to critically evaluate dominant discourses on appearance (Rumsey & Harcourt, 2007) and humour (Furness et al., 2006; Williamson et al., 2010) can also help. Whereas continuous emotional preoccupation with disfigurement is associated with greater distress (Furness et al., 2006; Hill & Kennedy, 2002).
So far research findings about the factors and processes involved in living with disfigurements were explored. The next section discusses the theoretical underpinnings that direct such research and help to explain findings.

**Theoretical underpinnings in the field**

A comprehensive overview of all models relevant to disfigurement research is beyond the scope of this thesis, however this section reviews the most influential paradigms informing this field of study.

**Symbolic interactionist framings**

Goffman’s (1968) and Scrambler and Hopkins’s (1986) works on stigma have been salient in early attempts made by researchers to explain the impact of having disfigurements on self-identity and interpersonal interactions. The theory of stigma is particularly central to research into skin conditions (for example, Kent, 1999; Wittkowski et al., 2007)

According to Goffman (1968), the overriding anxiety among people with stigmatising characteristics is exposure, and their central concern is to be socially accepted. As discussed in chapter two, Goffman also argues that when people encounter someone with stigmatised appearance they often feel discomfort, since they have no guidelines on how to interact with such persons. They may fear offending them and worry that the people with the stigmatised appearance may in turn react aggressively. They may be also concerned that these people have some other, non-visible differences associated with the visible ones. In turn, people with stigmatised appearance may sense and/or anticipate this unease and subsequently act defensively in social situations.

While Goffman (1968) focused mostly on interpersonal encounters, Scrambler and Hopkins (1986), as mentioned in chapter two, distinguish between enacted and felt stigma, viewing both as profoundly distressing. According to Scrambler and Hopkins, people who experience felt stigma expect to be socially rejected and engage in avoidant behaviours, often without testing whether their fears are grounded in reality. This latter model helps explain many of the avoidant and concealing behaviours of people with disfigurements (Thompson, 2012).
Psychological framings

Particularly since the mid-1990s, models and concepts derived from psychology have been applied to explain the personal and social consequences for people with disfigurements. Most notably, researchers have used theories of shame (Leary, Rapp, Herbst, Exum & Feldman, 1998; Thompson & Kent, 2001), social anxiety (Kent, 2002; Newell, 1999; Newell & Marks, 2000), self-concept (Moss & Carr, 2004; Rumsey et al., 2010), and the cognitive-behavioural model of body image (Cash, 2002). These theories have arisen predominantly from cognitive-behavioural approaches, highlighting how people interpret their appearance and related social interactions. This section critically appraises such theorisation and how it has shaped research and interventions aimed at helping people with disfigurements.

Shame

Shame-based theorisation has also been influenced by Goffman’s (1968) work, which positions shame at the locus of the stigma experience. Similarly, Leary et al. (1998) argue that shame and social anxiety are the main mediating factors on the impact of disfigurements. According to Leary et al., people with disfigurements who are prone to feel shame and fear negative evaluation experience more social anxiety and tend to avoid social activities. Thompson and Kent (2001) elaborate on this theory, which is focused on the individual’s internal world, offering a more comprehensive model by acknowledging that negative social responses to disfigurements contribute to shame development.

Social anxiety

Thompson and Kent (2001) suggest that shame and social anxiety are closely interrelated in disfigurement-related concerns, because both experiences involve self-evaluation and resulting protective behaviours. However, it is Newell (1999) who places social anxiety as being central to understanding why some people with disfigurements cope poorly. He proposes a fear/avoidance model of social anxiety to explain why avoidance strategy is widespread among these people. In Newell’s view, the fear of social situations and the anxiety felt then, which often lead to avoidant behaviours, are central to mediating the experiences of people with disfigurements. Consequently, Newell suggests placing the behaviour of these people on a continuum of confrontational and avoidant responses, arguing the former are healthier responses. In a later study of facial disfigurements, Newell and Marks (2000) found that participants exhibited a high ratio of
social avoidance, similar to that amongst people with phobias. This finding led Newell and Marks to suggest that avoidant behaviour following disfigurement is phobic in nature, and to recommend using the same cognitive behavioural interventions with people with disfigurements as used with people with phobias.

Kent (2002) also places anxiety and avoidance at the locus of his model. Yet he makes additional links between appearance anxiety, social anxiety and Goffman’s theory of stigma. Kent suggests that whenever people with disfigurements encounter stigmatisation, they interpret it as related to their appearance, in turn becoming even more vigilant and self-conscious. In order to manage this anxiety, people often resort to avoidance and concealment strategies. Yet Kent acknowledges that this anxiety may be, at least in part, triggered by real experiences of stigma. Still, arguably, the focus on anxiety, as well as on shame, narrows down the experiences of people with disfigurements, and emphasises an individual pathology. The centrality of shame and fear in the aforementioned theoretical works may possibly be due to the predominance in the study samples of facial disfigurements, which draw the most attention.

**Self-concept**

Moss and Carr (2004) and Rumsey et al. (2010) theorised adjustment to disfigurements through the lens of self-concept organisation theory. This theory is based on the assumption that people possess a cognitive representation of themselves, including their appearance. Self-concept construct describes how people process and organise information about the various aspects of their selfhood, and is considered to be predictive of wellbeing (Moss & Carr 2004). Moss and Carr, and Rumsey et al. argue that people with disfigurements for whom appearance is more salient in their self-concept exhibit poorer adjustment. This is because these people access appearance-related information more frequently, and compartmentalise more between their appearance and other aspects of themselves. They are also more likely to attribute negative social interactions to their disfigurements. As Rumsey et al. write, people with appearance attention bias “perceive the world in a way that reinforces and exacerbates their distress” (p.65).

*The cognitive-behavioural model of body image*

Body image theorisation is closely related to that of appearance-related self-concept. Body image is a multidimensional construct that signifies people’s attitudes to
their appearance (Woertman & van den Brink, 2012). According to Cash (2002), people develop an internal representation of their appearance (self-schema) following sensory experiences, socialisation and social interactions. Appearance-related self-schema, or body image, influences how people process information about their looks and how they evaluate social responses to their appearance. It is generally agreed that body image construct is a dynamic concept that can change both throughout a person’s life and on a short-term basis (Newell, 1999).

Since the mid-1990s, body image construct has become central in appearance research, generating numerous studies, predominantly on body shape and weight issues (Blood, 2005; Rumsey & Harcourt, 2005). Researchers of disfigurements, too, often employ this construct to examine the role of people's self-perceptions in their adjustment to disfigurements. They do so quantitatively, using body image measures, such as The Satisfaction with Appearance Scale (see Benrud-Larson et al., 2003; Fauerbach et al., 2000; Hiatt et al., 2009; Lawrence et al., 2007). As the literature review by Thombs et al. (2008) demonstrates, high levels of body image dissatisfaction have been found across a wide spectrum of disfiguring conditions.

The theoretical work of Cash (2002) is notable in the body image field and informs much of the disfigurement research. Cash offers a cognitive-behavioural model of body image that includes the following dimensions: body image evaluation, investment and affect⁹. Evaluation is the degree of satisfaction with appearance, including the perceived discrepancy between an internalised ideal and one’s appearance. Investment has two components: self-evaluative salience, or the extent to which a person cares about their appearance, and the perceived impact it has on their life; and motivational salience, or the effort one is prepared to put into appearance maintenance and/or improvement. Affect refers to people’s emotions as they relate to their appearance. According to Cash, body image develops in the context of the cultural pressure to look good. When this pressure is combined with negative social responses to a person’s appearance, people can develop a negative body image. People with disfigurements can be particularly vulnerable to this. Social events, such as bodily exposure, can activate the negative body image schema, resulting in hyper-vigilant behaviour, negative interpretation of social

⁹ In the literature these terms can be interchangeably referred to as either appearance evaluation, investment or affect.
interactions, and avoidant and concealing coping. Additionally, according to Cash people with high appearance investment experience more disfigurement-related distress, and negative responses to their disfigurements are likely to reinforce any beliefs about the close relationship between their appearance and self-worth.

Cash’s (2002) theory provides a more comprehensive description than other aforementioned models, because it recognises sociocultural influences on formation of body image attitudes and provides the sequence of reactions from triggering events to the emotional states of people with disfigurements. Yet Rumsey and Harcourt (2005) criticise this theory as being “an amalgam of complex processes” (p.55), which is difficult to utilise in practice. The following section continues exploring this and other problematic aspects of dominant theoretical framings of disfigurements.

**Issues in psychological framings**

The psychological framings of experiences of people with disfigurements are mainly concerned, as already discussed, with “the relationship between cognitions and behaviour” (Kent 2000, p.118). Even theories of stigma employed by some field researchers share certain aspects with the psychological constructs of self-concept and body image dominating research of disfigurements. They all locate “anxiety about exposure and vigilance to others’ behaviour” (Kent 2000, p.118) and social interactions encouraging a negative body image as central in experiences of disfigurements.

Doubtlessly, such framings contribute to understanding important processes embedded within lived experiences of people with disfigurements. Yet, as Thompson (2012) and Rumsey et al. (2010) concur in their reviews of the theoretical underpinnings of disfigurement research, none of the current models is sufficiently sophisticated to provide a comprehensive picture of the dynamic and diverse nature of living with disfigurements. More recently, Rumsey et al. offered a more inclusive theoretical framework that integrated findings from their study with other notable research findings. The model includes three components: predisposing factors (sociocultural, visibility of disfigurements, dispositional personality style), intervening cognitive processes centred on appearance-related cognitions and self-concept, and outcomes (adjustment). Yet this model excludes people’s lived context in the intervening stage, as if a life is a static phenomenon. The following sections discuss this gap around the context and other gaps in current dominant framings.
The missing context

Theoretical models in the literature of disfigurements acknowledge that sociocultural context matters in lived experiences. Still, the theoretical focus in this field, as discussed, “is placed on the individual, his/her characteristics, and efforts to adapt to his/her condition” (Bonanno & Esmaeli, 2012, p.141). From this perspective, people’s perceptions of their appearance are assessed as either healthy or not. Consequently, constructs such as body image problems, dissatisfaction or even disturbance, which stand for problematic cognitive processes, are seen as the principal causes of poor adjustment and the locus for solutions.

Such a paradigm has been critiqued by some (notably Blood, 2005; Orbach, 2010) for placing the responsibility for adjustment primarily within the individual: their cognitions, emotional responses and personality. It is likely that for some their disfigurement-related distress may be symptomatic of underlying psychological problems. Yet as Gleeson and Frith (2006) argue, individualising body image formation reduces the complexity of lived experiences. After all, as Miner (1997) suggests in her analysis of narratives of people with disabilities, “we are shaped from and by relatives’ stories, commercial narratives, medical interpellations, and countless other tales in which we find ourselves” (p.183). Similarly, Cameron and McDermott (2007) argue that “human bodies are sites and places where we witness the effects of society” (p.18). Meanings people attach to their bodies are not only subject to individual differences, but are also influenced by the context in which we exist.

Critics (Blood, 2005; Gleeson & Frith, 2006; Orbach, 2010; Peterson, 2007) suggest that the dominance of the body image perspective in research of appearance obscures another possibility. That is, that often disfigurement-related distress is not pathological, but a normal response to living in a highly visual and consumerist world where non-realistic images of Body Surface are promoted as attainable, and bodily self-scrutiny and improvement are framed as a moral duty. The focus on the individual obscures the tangible sanctions that having disfigurements may entail. Disfigurements, as discussed in this, and the preceding, chapter may affect a person’s position within the social hierarchy. Viewed through such lenses, people’s adjustment and coping choices may be evaluated differently. For example, coping strategies of concealment and avoidance that appear problematic according to the psychological discourse may at times
(for instance, when hiding one’s scars during a job interview) be adaptive. The role of ongoing life events in influencing people’s cognitions and behaviour is also largely missing from current theorisation. Researchers perceive such factors as less amenable to intervention (Rumsey et al., 2010; Rumsey & Harcourt, 2005) and therefore tend not to include them in their theoretical models. However, arguably, some life events are possible to amend. For example, one can change one’s social networks. Also, it can be possible to lobby for anti-discrimination legislation with regards to appearance where such laws are not in place.

Arguably, even when unhelpful appearance-related cognitions are clearly present it is still important to acknowledge the role sociocultural factors may play in shaping these cognitions, and the overall adjustment, particularly when planning interventions. Yet interventions for people with disfigurements, discussed further in the chapter, are usually designed within the psychological paradigm and “focus on changing the erroneous individual rather than the problematic society” (Gleeson & Frith, 2006, p.88). Not surprisingly, there have been few research attempts to examine which sociocultural factors are amenable to interventions.

**Construct-based theorisation**

Constructs such as self-concept and body image, are central to current framings of lived experiences of disfigurements, as discussed. Yet relying predominantly on such variables can be problematic. Psychological constructs, particularly ones as complex as body image, have been criticised as being difficult to assess and measure (Rumsey et al., 2010; Rumsey & Harcourt, 2005). Furthermore, treating such constructs, or even their dimensions, as self-contained, as researchers tend to do, arguably can lead to even more misrepresentation of the complexity of the experiences of people with disfigurements. For example, studies of body image often examine only its evaluative dimension (Woertman & van den Brink, 2012). Rumsey and Harcourt (2012) eloquently critique this research fragmentation, noting that:

Psychologists talk of social comparison processes, internalisation, cognitive biases, discrepancy theory, and schemas as discreet constructs and processes, and parcel them up separately in order to understand them fully. Yet the reality is
more a combination of processes that work in parallel and are not mutually exclusive… (p.445)

Unsurprisingly, such fragmentation can lead to difficulties to establish how various factors and processes important in lived experiences of disfigurements relate to each other.

(Mis)understanding relationships between variables

Existing theories on lived experiences of disfigurements are predominantly grounded in quantitative findings. Such an approach is important for establishing the big picture. Yet, as discussed in chapter one, this is unsuitable for capturing the nuanced nature of the processes involved. The exploration of complex correlation issues can be particularly difficult. For example, as mentioned earlier in this chapter, quantitative data shows a high subjective rating of disfigurement severity correlates with higher distress. However, as Moss (2005) suggests, it is unclear whether the negative evaluation of one’s body is what causes distress, or whether less adjusted people tend to judge their appearance more negatively, or whether the relationship is bi-directional. Context plays an important role in understanding correlational relationships (Corbin & Strauss, 2008). For instance, when social anxiety is measured, the specifics of the social situations that cause distress to various people usually remain unknown. Context is captured best in qualitative research (Corbin & Strauss, 2008). This is where this study can potentially contribute, clarifying further correlational links.

Adjustment definitions

Theories seeking to make generalisations about the nature of adjustment to disfigurements share no consistent and comprehensive definition of adjustment. This can be problematic, particularly since - as Feragen et al.’s (2010) study of facial disfigurements highlights - people may show positive adjustment in some areas but not in others.

Some studies (e.g. Bock, et al. 2006; Brown et al., 2008) explore adjustment through the lens of quality of life or wellbeing, or through self-reports as in the qualitative component of Rumsey et al.’s (2010) study. More often though, as described in chapter one, researchers conceptualise adjustment in terms of the presence or absence of clinical symptoms, using standardised mental health measures. Yet the absence of symptoms does
not necessarily indicate wellbeing. As Wisely and Gaskell (2012) suggest: “An over-reliance on standardised measures… as a barometer of psychological state may hide genuine problems. While a person… may be bitterly unhappy, angry, and distressed about their appearance, they may not score as clinically depressed on a recognised measure” (p.379). Thus, ‘ordinary’ suffering may not always be captured in existing data.

Some researchers, as discussed, evaluate adjustment by assessing the nature of people’s coping strategies. However, this measure is not always reliable either. It is difficult to ascertain from quantitative data alone which coping strategies are adaptive or not without knowing the context in which they are employed. Also, the presence of coping capacity does not always indicate wellbeing, as a Netherlands study of burns survivors (Taal & Faber, 1998) shows. There, most respondents did not report major changes in their activities after being burnt, yet many experienced shame during social interactions. Rumsey et al. (2010) similarly argue that “even when adjustment is positive over long periods of time, coping with a visible difference can be an ongoing strain on a person’s psychological resources” (p.200). Once again, it is the ordinary distress that often remains unaccounted for in such instances. This study’s qualitative design is aimed at capturing the everyday experiences involved in living with non-facial scars alongside the more extraordinary ones and inform subsequent research and interventions offered to people with disfigurements described in the next section.

**Existing professional interventions**

Current healthcare provision for people with disfigurements is still focused on medical interventions at the expense of psychosocial assistance (Corry et al., 2009; Thombs et al., 2008). Yet many disfigurements, including scars, are resistant to cosmetic treatment. Even though in recent years the US and UK have made some progress in national initiatives for providing psychosocial support for people with disfigurements, particularly burns survivors, most are still left to cope on their own (Bessell & Moss, 2007; Corry et al., 2009; Harcourt & Rumsey, 2012). In order to fill these gaps, a variety of interventions have been designed by psychologists of appearance, with the UK-based CAR being the leader in this area. Other UK-based organisations, notably the charities *Changing Faces* and *The Healing Foundation* have all been driving forces in providing individual and group support and education for professionals, and disseminating self-help information.
Based on the previously discussed assumptions that cognitive factors are most predictive of adjustment, the most common existing interventions for people with disfigurements are guided by cognitive-behavioural therapy (CBT) for social anxiety, and/or focused on social skills training programs (Clarke, 1999; Jenkinson, 2012; Moss, 2005). These programs challenge people’s beliefs about the connection between their disfigurements and self-worth, and teach skills to cope with social reactions. CBT-based interventions particularly address social anxiety (Lawrence et al., 2006; Newell & Clarke, 2000). Peer support and provision of self-help information also exist, but none of these interventions are offered extensively. These interventions, as well as education for professionals, are usually provided by the few existing organisations supporting people with disfigurements. The following sections provide more details about these interventions and discuss their effectiveness, as evaluated by a limited number of studies.

**CBT-informed interventions and social skills training**

CBT-informed interventions are aimed at changing cognitions and behaviours associated with disfigurement-related distress (Moss, 2005; Rumsey et al., 2010). This approach is based on the assumption that there are many similarities between the cognitive processes of people suffering from social anxiety and social phobia and those with disfigurements. Such processes include unhelpful schemas about the self and others, plus fear-avoidance in social situations (Newell & Marks, 2000; Thompson & Kent, 2001). Some interventions are designed to challenge these negative cognitive processing and interpretive biases, particularly beliefs about the connection between appearance and self-worth, and about others’ hypothetical focus on their disfigurements, by offering alternative interpretations (Rumsey, 2002b; Thompson & Kent, 2001). Many of the strategies used in such programs are borrowed from social anxiety therapy, for example: gradual exposure and response prevention (Lawrence et al., 2006; Thompson & Kent, 2001).

Recently, some CBT-based interventions have been offered via CD-ROM and on the internet, such as the Face IT program aimed at reducing anxiety and depression, and increasing the social skills of people with disfigurements (Bessell, 2012; Jenkinson, 2012).

The existing evaluations of CBT-based programs (Kleve, Rumsey, Wyn-Williams & White, 2002; Robinson, Rumsey & Partridge, 1996) showed their effectiveness in decreasing anxiety, depression and social avoidance, and increasing confidence during
social interactions. CBT-based therapy is known to be effective in helping people with disfigurements who are suffering from social phobia and anxiety (Newell & Clarke, 2000). However, it is unclear how helpful such programs are for people without these symptoms, particularly for those whose disfigurements are less visible, as is the case with many non-facial scars.

Social skills training programs are aimed at helping people with disfigurements manage social interactions. The programs teach such skills as initiating contact and diverting people’s attention away from disfigurements through instruction, modelling, role play, feedback and discussion (Rumsey, 2002b). They are also often guided by the CBT framework.

In summary, despite the popularity of CBT-based approaches and social skills training programs among organisations and professionals supporting people with disfigurements, to date there is no substantial research evidence to show their effectiveness. The existing evaluation studies are often methodologically problematic, particularly because they investigate small intervention effect sizes and with no consistent measures (Bessell & Moss, 2007; Jenkinson, 2012). Also, it is unclear how helpful such interventions are for people whose disfigurements are not publicly visible.

Peer support

Peer support programs foster connections among people with disfigurements, enabling them to share experiences and give and receive information plus emotional and practical support to each other (Bessell, 2012; Jenkinson, 2012). Role modelling is central to these interventions (Williams et al., 2004). The charitable organization Changing Faces provides peer support for people with facial disfigurements, but usually condition-specific support organisations provide peer support10, mostly in the form of support groups and residential camps for rehabilitative and recreational purposes (Jenkinson, 2012; Wisely & Gaskell, 2012). More recently, on-line support groups for various conditions have become popular (Bessell, 2012). Yet as with any other interventions, peer support does not suit everyone. Some people fear that attendance at such programs can stigmatise them further (Rumsey & Harcourt, 2004).

10 Some Australian examples of such organisations are Limbs 4 Life which caters to amputees and the Burns Foundation
Bessell and Moss (2007) and Jenkinson (2012) concur in their literature reviews that there is little evidence of quality to show the effectiveness of peer support, however some findings exist about its usefulness. Studies (Clarke, 1999; Robinson et al., 1996) indicate that peer support can play a valuable role at normalising people’s difficulties around their disfigurements. Similarly, qualitative evaluation of three American burns camps for adolescents (Williams et al., 2004) showed that participants found the camps to be valuable, because there they felt normal and accepted, were less vigilant about their bodies and thus enjoyed summer activities without concealing their scars. Participants also reported feeling that their confidence and self-esteem increased and that they developed more empathy (Williams et al., 2004).

Self-help information

Written and multimedia-based information about coping with disfigurements, such as self-help booklets, leaflets and CD-roms, is distributed through organisations which support people with disfigurements, such as Changing Faces. The CBT approach is also central in shaping these materials. For example, some information helps people replace their anticipation of negative social responses to their disfigurements with more positive beliefs (for example, see Clarke, 1999; Newell & Clarke, 2000). These materials also often introduce role models to foster beliefs that positive prospects exist for people with disfigurements. Once again, the effectiveness of self-help information has not been sufficiently evaluated (Jenkinson, 2012).

Educational interventions

Several UK organisations, notably Changing Faces and CAR, provide resource packs and training workshops to health professionals so as to help them improve their practice with people with disfigurements or those about to acquire disfigurements through medical treatments. Changing Faces also offers resources to schools for promoting acceptance of students with disfigurements (Diedrichs & Halliwell, 2012; Frances, 2000) and workshops for employers to promote the acceptance of customers, staff and job applicants with disfigurements. Recently, a manual was developed for psychosocial specialists following a CAR-led study (Rumsey et al. 2010). Limited evidence exists to show that working with schools reduces bullying and increases the confidence of students with disfigurements (Diedrichs & Halliwell, 2012). However, little else is known about the effectiveness of educational interventions.
In summary, the predominant CBT-based intervention approach is chiefly informed by research of, and practice with, people with the most visible (usually facial) disfigurements (for example, Newell & Clarke, 2000; Robinson et al., 1996). For such people, distress can be particularly severe, with some refusing to leave their homes (Clarke, 1999). Therefore it is not surprising that the existing service provision for people with disfigurements is aimed chiefly at helping those exhibiting clinical symptoms, such as depression and social anxiety (for example, Kleve et al., 2002). Thompson & Kent (2001) suggest that understanding stereotypes around different disfiguring conditions is important in informing interventions. Potentially, some of the needs of those whose disfigurements are concealable (for example, learning to manage disclosure) remain unmet. The following section discusses other unmet needs among people with disfigurements as identified in the literature.

Unmet Needs

Little research has been conducted into the needs of people with disfigurements. Still, some unmet needs have been identified in studies on the perspectives of people with disfigurements and their families, and on the attitudes of health professionals.

Studies of people with disfigurements and their families (for example, Kleve & Robinson, 1999; Phillips et al., 2007; Rumsey et al., 2004; Wallace et al., 2007b) repeatedly highlight the need for psychological help. People report being reluctant to approach generic services when seeking out therapy for their disfigurement-related concerns. Instead, they wish for specialist therapists who are appropriately trained (Bundy, 2012; Rumsey et al., 2010). A need was also identified for programs to support family members of people with disfigurements (Phillips et al., 2007) and for peer support (Wallace et al., 2007a; Williamson et al., 2010). Yet, as discussed, such specialist therapists and programs are scarce.

There appears to also be a need for more education of healthcare professionals about the impact of disfigurements on people. Studies from patient perspectives (Callahan, 2004; Kleve & Robinson, 1999; Lawrence et al., 2004; Rumsey et al., 2010; Wallace et al., 2007a; Wallace et al., 2007b; Williamson et al., 2010) and from nurse perspectives (Clarke & Cooper, 2001; Konradsen, Kirkevold & Zoffman, 2009) indicate that health professionals tend to focus on physical treatment and need to learn more about the psychosocial impact of disfigurements. For example, Konradsen et al. (2009) found that nurses working with head and neck cancer patients often view appearance concerns
as a ‘luxury’ that should be given secondary priority to physical concerns. Whereas people with disfigurements in Phillips et al.’s (2007) study expressed a wish for specialists to offer more information and support before and after disfiguring medical treatments. Rumsey (2008), too, notes that the problem of insufficient information about appearance-related risks of medical interventions is common. Unfortunately though, specialists, such as dermatologists (Koo & Yeung, 2002) or oncologists (White, 2002), typically do not even include appearance concerns in their assessment of the impact of an illness. General practitioners, too, need to be better informed, since they are often the gatekeepers to existing support services for people with disfigurements (Rumsey & Harcourt, 2005). It is plausible to assume that health professionals are particularly likely to dismiss relatively mild disfigurements, such as non-facial scars.

Conclusion

This chapter has demonstrated that beyond the ‘ordinary’ Body Surface panic widespread amongst the general population, people with disfigurements may experience the additional stress of being stigmatised as ‘abnormal’. Consequently, although many show resilience, psychological distress and even mental health problems are relatively high in this population. It is plausible then to assume that distress may be common also among women with non-facial scars. Yet while research shows that having physical disfigurements can cause significant difficulties, literature is inconclusive as to why some people adjust better than others and who is more at risk. This may be, at least in part, because most studies are quantitative. Qualitative inquiry, like that done in this study, is more equipped to examine how the intricacies of individual meaning making and context shape adjustment (Denzin & Lincoln 2008, p.14) and thus clarify the processes involved in living with disfigurements.

Another methodological issue is that researchers tend to draw their samples from people with facial disfigurements. Consequently, disfigurement theorising focuses on such difficulties as social anxiety and social avoidance. Interventions informed by these framings prioritise the development of skills to distract others from disfigurements and to reduce social anxiety about their visibility. While important, these strategies may not always be most helpful for people with less visible disfigurements, such as non-facial scars.
Moreover, most existing research and theories of lived experiences of disfigurements unfold primarily within the psychological paradigm which has a cognitive focus. While this is an important area for research and intervention design, arguably it is insufficient on its own. One problem here is that cognitive factors are often grounded in difficult-to-assess psychodynamic constructs. Also, when explanations of variations in adjustment focus on how people process, internalise and formulate ideas about their appearance and its effects on their lives and on others, the influence of the outer world on people’s lives can be overlooked. The assumption that shifting unhelpful cognitions and improving people’s social skills is sufficient for helping them adjust is arguably unrealistic in a society that stigmatises disfigurements. Interventions designed with such assumptions in mind may place undue pressure to cope well on affected individuals, and may also forgo offering some practical coping strategies.

Effective interventions need to consider the social rewards and penalties that are distributed according to people’s appearance, and the processes of individual meaning making and coping in this context. Researchers need to examine how and why people interpret their disfigurements, and what life choices and chances are available to them. Integrating the insights from body theory discussed in chapter two may be useful in order to build a more comprehensive theoretical framework of disfigurement experiences. As Kent (2000) writes, “the sociological literature places disfigurements in a social context that is largely lacking in the psychological literature” (p.119). Accordingly, my analytical attention, discussed in the following chapter, encompasses women’s interpretations of their scars, what they perceive as being helpful in their coping, and the specifics of internal and external factors affecting their meaning making. To this end, I investigated the experiences of non-facial scars qualitatively by asking my participants: what does it feel like to live with scars? This approach is compatible with Charmaz’s (2008) suggestion that researchers have to let people whose experiences they are exploring explain in their own words what matters to them.
Chapter Four – Investigating Body Surface

‘With flexible guidelines, you direct your study but let your imagination flow.’

*Kathy Charmaz*

In this chapter I continue the discussion woven throughout the first three chapters about the methodological choices informing this study. As mentioned, this study is exploratory and employs a qualitative approach. It is guided philosophically and methodologically by grounded theory as modified by Charmaz (2000; 2006) according to a constructivist research paradigm. Consistently with Charmaz’s framework, my research approach is reflexive and I acknowledge my inherent research biases.

In this chapter I initially outline the exploratory and qualitative nature of this study design, then provide a brief overview of grounded theory as a methodological framework, while discussing in detail constructivist grounded theory, including its philosophical underpinnings and methodological guidelines. Next I explain how I applied this research methodology to this study and what methods I employ. I conclude with a description of ethical considerations I undertook and evaluation criteria to which I adhered.

**Exploratory qualitative design**

According to Babbie (2009), social exploratory research is concerned with discovery: the goal of such research is to learn about social phenomena without explicit expectations, generating key variables and theory from the data itself, rather than verifying hypotheses. This research framework is usually applied when the chosen topic is new and/or when data is difficult to collect (Babbie, 2009). As previously discussed, an exploratory design was the best choice for this study in order to address the lack of data about lived experiences of women with non-facial scars.

Qualitative methodology “emphasises words rather than quantification” (Bryman, 2004, p.266) and is particularly suitable in exploratory research (Babbie, 2009). Other reasons for choosing a qualitative approach have already been highlighted in preceding chapters. Chiefly, the framework for this study reflects the dearth of qualitative data about physical disfigurements. This choice is also in line with the contemporary theorisation of
the body as complex, nuanced and contextual, as described in chapter two. A qualitative approach fits this conceptual framework, because it views social reality as “a constantly shifting emergent property of individuals’ creation” (Bryman, 2004, p.20). This approach is also useful for clarifying correlational links between variables, since it is suitable to exploring contextual subtleties, such as processes embedded in social situations and individual meaning making, and how these shape each other (Bryman, 2004). Qualitative methods enable researchers to access people’s perceptions of their lived experiences and to understand how they construct them (Skeat & Perry, 2008, p.96), something which is difficult to obtain through quantitative research (Corbin & Strauss, 2008). This emphasis on people’s own words is also compatible with my concern with giving voice to the experiences of women with non-facial scars. As notable sociologist of the body Arthur Frank (cited in Fraser & Greco, 2005, p.31) argues, it is impossible to theorise about people’s bodily experiences in abstract and/or ‘objective’ ways. Similarly, Rumsey and Harcourt (2005) argue that “some of the clearest descriptions of the problems faced by people who are visibly different are found in self-report data” (p.40).

Another advantage of qualitative research lays in its flexible design, which can be altered even as late as the data analysis stage (Bryman, 2004). This flexibility sits well with my preferences for dynamic work processes. In research I enjoy “serendipity and discovery” (Corbin & Strauss, 2008, p.13) that are the essential ingredients of qualitative processes. The grounded theory paradigm, which informs this study, extends this flexibility even further, as discussed in the following section.

**Grounded theory paradigm**

Grounded theory methodology is thought to be particularly useful for exploratory research. Grounded theory is always developed in an exploratory spirit, since researchers working within this framework allow themes to emerge from the data (Heath & Cowley, 2004). Grounded theorists “discover rather than test variables” (Corbin & Strauss, 2008, p.12) and their analysis “shapes the conceptual content and direction of the study” (Charmaz, 2006, p.178). In fact, as Babbie (2009) writes, “exploratory studies are the source of grounded theory” (p.93). In what follows I first define the term ‘grounded theory’, identifying commonalities between all the approaches fitting under this umbrella term, then trace the origins of this framework and its later major developments. Finally, I discuss the constructivist grounded theory as modified by Charmaz (2000; 2006) as is my rationale for choosing this methodological framework.
Grounded theory: definitions and origins

Grounded theory is a term referring to both a research methodology and its end theoretical products (Glaser & Strauss, 1967; Weed, 2009). This research paradigm was first developed by sociologists Glaser and Strauss, and introduced in 1967 in their book *The Discovery of Grounded Theory: Strategies for Qualitative Research*.

**Aims of grounded theory**

Grounded theory was considered revolutionary at the time of its inception, when the social science research landscape was dominated by quantitative experimental research and by increasing scepticism towards qualitative research, which was seen as insufficiently rigorous and scientific (Charmaz, 2006; Glaser & Strauss, 1967). Still, both quantitative and qualitative researchers at the time strived to ‘know’ the world objectively and were mostly preoccupied with the verification, modification and reformulation of various ‘grand’ theories, which attempted to explain and predict human behavior (Charmaz, 2006; Glaser & Strauss, 1967).

Glaser and Strauss (1967) resisted the dominant assumptions of their time, arguing that such scholarly practices resulted in a disparity between theory and the studied realities. They believed in the dynamism of social reality. For Glaser and Strauss, the purpose of theory was to explain specific realities, including their variations and exceptions. They aimed at generating, rather than testing, theory. Glaser and Strauss studied social processes in order to produce middle range theories grounded in the empirical world. They focused on people’s perceptions of their situations as the basis for understanding their actions, while also acknowledging that these perceptions are dynamic and can be re-defined through social interactions (Glaser & Strauss, 1967; Glaser, 1978; Strauss & Corbin, 1998). The core question grounded theory posits about the empirical world is focused on the process: ‘What is happening?’ (Glaser, 1978). The end theory should conceptualise meanings that people, experiencing similar circumstances, share.

**Grounded theory methodology**

Grounded theory, a primarily qualitative research approach\(^\text{11}\), stood then, as it still does, for a systematic but flexible, largely inductive inquiry with an analytical stance.

\(^{11}\) Glaser and Strauss’ methodological framework is often referred to as qualitative approach. They argue that qualitative data is more suitable for studying complex phenomenon (Glaser & Strauss, 1967). However,
towards data. Glaser and Strauss (1967) perceived qualitative methods as “the most ‘adequate’ and ‘efficient’ way... to contend with the difficulties of an empirical situation” (p.18). To counter the perceived lack of academic rigour in qualitative research at the time of their book’s release, the authors provided researchers with a framework that allowed them to defend their methods - a careful, systematic approach with detailed, practical guidelines. According to Charmaz (2006, p.6), such methodology was unusual in the 1960s, when most qualitative researchers were implicit about their methods.

The building blocks of grounded theory analysis and theory building are codes and categories. Both emerge from a close engagement with data. Codes are descriptive labels denoting what the data is about. The term ‘category’ refers to theoretical concepts that name patterns in the data and enable researchers to explain and predict behavior. Each category has properties - conceptual elements that define or elaborate the meaning of the category (Glaser & Strauss, 1967).

Glaser and Strauss (1967) proposed the following sequence of generating theory:

The discovery of important categories and their properties, their conditions and consequences; the development of such categories at different levels of conceptualisation; the formulation of hypotheses of varying scope and generality; and above all the integration of the total theoretical framework (pp.168-9).

In such research process, theory was formulated through a constant comparison and theoretical categories were gradually delimited and saturated until the theory was reduced to its essential components and centred around a ‘core category’, meant to explain the studied social phenomenon (Glaser & Strauss, 1967; Glaser, 1978). The following sub-sections detail the central principles and concepts of grounded theory methodology as presented by Glaser and Strauss (1967).

An iterative research design: the phases of data collection and analysis are blurred together and inform each other.

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the authors thought their approach could be useful also for those wanting to generate theory from quantitative data, but were not clear on how to execute this. More precisely, this has always been a rather Glaserian vision, not shared by Strauss. In practice, only a few researchers have applied grounded theory to quantitative research, and mainly in mixed methods studies (Charmaz, 2006; Kennedy & Lingard, 2006).
Data collection: one of the key components to generating a valid theory diversity was having a diversity of categories and to achieve this, Glaser and Strauss (1967, p.66) encouraged diverse data collection methods. Glaser and Strauss’s notion of what constituted suitable data for social scientists was innovative for their times, since beyond official documents and data produced during fieldwork- this could also include fiction, media, memoirs, letters, self-help books, photographs, researchers’ personal experiences and other anecdotal data.

Theoretical sampling: the driving force behind the concurrent process of data gathering and analysis is theoretical sampling. Such a sampling approach is aimed at advancing theory by uncovering similarities and differences in data, rather than accurately representing a particular population. In theoretical sampling, the initial decisions are based loosely on the study subject, but as data collection and analysis progress, selection of additional data is governed by the theoretical relevance for furthering the development of emerging categories (Glaser & Strauss, 1967, p. 45). The aim of theoretical sampling is to maximize the diversity of theory produced by generating “as many properties of the categories as possible and that will help relate categories to each other and to their properties” (Glaser & Strauss, 1967, p.49). For this purpose, Glaser and Strauss (1967) suggest researchers first minimise and then maximise differences between units they compare. Collection of similar data about the same category allows fine differences between each category’s properties to emerge, verifies categories and establishes conditions under which they emerge or vary; maximising differences helps to spot patterns in studied phenomena and expands the scope of theory (Glaser & Strauss, 1967, pp.55-58). Grounded theory researchers continue sampling until they reach theoretical saturation, which is when no additional data emerges for essential categories (Glaser & Strauss, 1967, p.61). This means the category properties are well developed and demonstrate variation in their dimensions.

Coding: this is the process of assigning codes to data units, thus allowing researchers to generate categories based on their understanding of the empirical world. Glaser and Strauss (1967) suggest two types of coding: substantive and theoretical. Substantive coding conceptualises the data, at first rather descriptively, then generating more theoretical categories, subsequently elaborating their properties and clarifying relationships between categories. Eventually researchers reduce the categories to the essential ones, which conceptualise the studied phenomenon. Theoretical coding shows
how substantive codes relate to each other by organising them into theoretical coding families and delineating the relationships between them (Glaser & Strauss, 1967).

**Comparative analysis**: data analysis is done through the systematic method of constant comparison within a data unit, across data units, and comparison of data with developed categories, between categories, plus comparison of categories with the relevant literature. The aims are to increase abstraction of analysis and generate as broad a theory as possible which includes variations of categories and their properties. As Chen & Boore (2009) write, in such a process “the researcher is constantly redesigning and reintegrating theoretical notions as [data] materials are reviewed” (p.2255). This analytical process is intended to increasingly reduce categories and their properties to the essential ones, and generate more abstract theorising of the social issues under study.

**Memoing**: Glaser and Strauss (1967) suggest accompanying the data analysis with memo-writing, or - memoing. Writing memos means recording researchers’ ideas about the meanings of data throughout the entire research process, using text, graphics, diagrams, tables or any other aids. Glaser and Strauss argued that memoing is an essential link between data collection and analysis, and theory emergence, because memoing encourages increasingly more abstract thinking and allows theory to develop progressively.

**Theoretical sensitivity**: this is the researchers’ ability to identify theoretically relevant information in the data, detect alternative meanings, choose the most plausible meanings and construct a theory. Glaser and Strauss (1967) argued that researchers develop theoretical sensitivity through training and practice, but also through their life experiences. They suggest that memoing helps hone theoretical sensitivity.

**Theory products**: grounded theorists aim to produce an analytical scheme of empirical relationships between a core category and other categories essential to the studied phenomenon, and create conditional statements about these relationships. They then locate these findings within the existing literature to find out whether there are any relevant pre-existing concepts for furthering the emerging substantive theory. According to Glaser and Strauss (1967), this latter step also becomes “a comparative analysis that delimits the boundaries of the existing theory while generating a more general one” (p.255). This recommendation that researchers conduct a literature review towards the end of the study is one of the more controversial aspects of grounded theory (Charmaz,
Glaser and Strauss’s reasoning was that the literature could interfere with researchers’ exploration of empirical reality, impairing their theoretical sensitivity.

Nevertheless, and despite the general controversy surrounding the emergence of grounded theory, this methodology soon became popular. Although initially grounded theory was developed within sociology, since the 1990s it has been widely used in qualitative inquiries across a variety of disciplines (Morse et al., 2009). The appeal of grounded theory is largely rooted in its relatively clear but flexible analytical guidelines and pragmatist orientation towards research dealing with social problems and offering theory useful for practice (Denzin, 2007; Kennedy & Lingard, 2006). The practicality of this theory is also in line with the rationale behind this study, as discussed in chapter one. Of particular appeal to me is the fact that this method “warns against an unexamined or too briefly considered application of extant ideas and theories and instead urges… open-mindedness” (Bryant & Charmaz, 2007b p.49).

**Major modifications**

Today most grounded theorists do not precisely follow the initial grounded theory framework, instead using Glaser and Strauss’s (1967) invitation to use their guidelines flexibly. Grounded theory is now an umbrella term for several approaches with differing epistemological underpinnings (Mills, Chapman, Bonner & Francis, 2007). Still, a number of key ideas are common to all grounded theorists. Overall, research informed by grounded theory always generates theoretical concepts from the empirical data and favours analysis over description (Corbin & Strauss, 2008). The guidelines for data collection and analysis are flexible yet with a focus on social processes, including on the intentions and strategies of participants (Denzin, 2007; Dey, 2007). Weed (2009) identifies eight methodological elements common to all grounded theory approaches: 1) an iterative, non-linear research design with phases of data collection and analysis being blurred; 2) theoretical sampling; 3) theoretical saturation; 4) codes, memos and categories; 5) theoretical sensitivity; 6) constant comparison; 7) fit, relevance and modifiability that mean the theory reflects the empirical world; 8) substantive theory products (theory that deals with a limited area of inquiry). The remainder of this section focuses on the differences in the main grounded theory approaches.
The main methodological debates among grounded theorists (for example, Charmaz, 2008; Clarke, 2005; Corbin & Strauss, 2008; Mello & Flint, 2009; Glaser, 1978; 1992; 2001; Seldon, 2005) centre around the degree of structure required for data analysis, the role of coding, the nature of theoretical sensitivity and saturation, and to what extent research design and theory development should be informed by prior scholarly knowledge. A comprehensive overview of these issues is beyond the scope of this thesis. What follows here is a discussion of three major modes of grounded theory: Glaserian (Glaser, 1978; 1992; 2001), Straussian (Strauss & Corbin, 1990; 1998), and the constructivist grounded theory (Charmaz, 2006), with a focus on the latter approach as the one informing this study.

The split: ‘Glaserians’ and ‘Straussians’

The initial departure from the ‘classic’ grounded theory occurred when Strauss (1987) developed a distinct approach to conducting grounded theory research often referred to as ‘Straussian’. Yet most of this approach was formed in collaboration with Juliet Corbin. Their influential text Basics of Qualitative Research: Grounded Theory Procedures and Techniques (Strauss & Corbin, 1990) and its second edition (Strauss & Corbin, 1998). Glaser (1978; 1992; 2001; 2003; 2007) continued to adhere to classic grounded theory, with his later writing expanding on, and even somewhat modifying, its various elements, as discussed below.

The initially different ontological and epistemological positions of Glaser, who came from Columbia University where sociologists mainly employed quantitative methodology, and Strauss who was schooled at the University of Chicago in symbolic interactionist thought, became more evident after the split and are discussed further. However, Glaser and Strauss’s principal dispute, also discussed later, can be summarised, in Glaser’s (1992) words, as “emergence versus forcing” (p.101). The theorists disagreed about the extent of prior knowledge necessary for researchers and the extent of structure in data analysis. The following sub-sections discuss the major differences between Glaserian and Straussian approaches.

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12 This third edition of Corbin & Strauss’s methodological text was edited by Corbin after Strauss’s death and also includes Corbin’s modified use of grounded theory.
**Research focus:** Strauss (1987; Strauss & Corbin, 1990; 1998), being influenced by a symbolic interactionist perspective, focuses on context, human agency, action/processes and the causal relationships between these elements (Dey 2007, p.178; Mills et al., 2007, p.74). Glaser’s focus remained narrower for a long time, centring on uncovering a *single* social process related to participants’ *main* stated concern. Later, though, Glaser (2001; 2003) discarded the search for one basic social process, claiming this forced data analysis into a preconceived framework.

**Theoretical sampling:** Strauss and Corbin (1990; 1998) elaborated upon the process of theoretical sampling, distinguishing between three sub-types: *open, relational and variational*, and *discriminate*. These matched their elaboration on the coding phase, which is detailed later. In an *open* phase, researchers collect data systemically and flexibly (so as not to exclude anything). In *relational and variational* sampling, researchers move from situation to situation, gathering data on theoretically relevant categories (e.g. re-interviewing people to clarify major categories). In *discriminate* sampling, data units are chosen purposefully in order to maximise opportunities for verifying relationships between categories, filling in underdeveloped categories, and identifying and elaborating properties of key variables (Strauss & Corbin, 1990; 1998).

**Coding and comparative analysis:** in order to focus on context and process, Strauss and Corbin (1990; 1998) formulated a complex, structured approach to data analysis, based on a *coding paradigm*. Ironically, despite the symbolic interactionist bent of Strauss, this approach to coding moved his methodology further into positivism. A detailed discussion of this paradigm - which is significantly more prescriptive and less inductive than classic grounded theory in its requirement for asking numerous, pre-planned questions about data - is beyond the scope of this study. Overall, the Straussian approach places action at the centre of analysis and includes detailed guidelines for naming concepts and their properties, and for considering their conditions, actions and consequences (Strauss & Corbin, 1990; 1998). In a further departure from classic grounded theory, Strauss and Corbin recommended researchers look beyond the properties and dimensions of categories in order to identify the causal and intervening conditions of the core category (including contextual and individual factors), as well as identifying actions people undertook to deal with the core category. The Straussian coding process also is more structured, containing three overlapping phases: *open, axial* and *selective*. *Open coding* is coding line-by-line, then by sentences or paragraphs, and
finally by perusing the entire document, in order to group data into conceptual categories. Axial coding develops relationships between these emerging categories and their sub-categories, and specifies their properties and dimensions, assembling them into a theoretical framework. In selective coding researchers identify the core category and establish how other categories relate to it, creating a descriptive narrative of the studied phenomenon (Strauss & Corbin, 1990). According to Glaser (1992) though, such an approach forces researchers to code for preconceived categories, betraying grounded theory’s principles of constant comparison and theory emergence. Glaser also considers Straussian theory products to be descriptive rather than analytical. Yet Glaser, too, eventually modified classic grounded theory coding procedures, discarding the line-by-line coding in favour of an incident-by-incident to avoid fracturing of the data.

Theoretical sensitivity: to stimulate theoretical sensitivity during coding, Strauss and Corbin (1990; 1998) devised various analytical strategies, such as far-out comparisons, where researchers compare the studied phenomenon with other, unrelated phenomena, and a conditional matrix that helps “to consider the wide range of possible conditions and consequences that can enter into context” (Corbin & Strauss 2008, p.87). Glaser (1992) maintained that these aids were too technical and forced researchers into coding for pre-conceived categories. Yet Glaser (1978), too, provides researchers with strategies to stimulate theoretical sensitivity by identifying 18 theoretical coding families. He suggests using this tool in the theoretical phase of coding, and applying it loosely, rather than coding for a particular family (Glaser, 1978, p.73). The aim of this tool is to help establish “how the substantive codes may relate to each other as hypotheses to be integrated into a theory” (Glaser, 1978, p.72).

Literature review: another key difference between the two approaches was in how Strauss and Corbin (1990; 1998) perceived the role of literature review in research. Whilst, as discussed, Glaser (1978; 1992; 2001; 2003) saw existing literature as merely additional data, for Strauss and Corbin literature informed both the research process and theory development. They disagreed with Glaser’s argument that pre-existing knowledge can prejudice the analytical process, positing that if not overdone initially, knowledge of literature only enhances theoretical sensitivity. Strauss and Corbin suggested conducting a preliminary literature review at the onset of study and reviewing the literature again, more extensively, once a grounded theory began to emerge.
Theory products: both approaches are aimed at producing hypotheses about the relationships between categories and their properties, but each approach shapes the kind of knowledge produced differently. Straussian grounded theory is more likely to consider the context, social interactions, and strategies of participants and their consequences, aiming not merely to understand, but also to manage the issue under investigation. Straussian researchers also utilise concepts from other fields (using far-out comparison strategies). Glaserian theory may, or may not, comprise all these elements, but its range of categories is likely to be wider; Glasserian theory pays less attention to context and to the conceptualisation of phenomena in terms of action.

These two approaches to grounded theory are not without their limitations. Mello and Flint (2009) argue that the Glaserian approach risks producing a rather unfocused theory. Charmaz (2006) criticises Glaserian theoretical coding families for being too restrictive in the analytical process and for overlooking “agency, and action, power, networks, and narrative and biography” (p.66). Some critics (Cutcliffe, 2005; Heath & Cowley, 2004; Selden, 2005) join Glaser in arguing that the Straussian approach is too rigid, and as such may compromise scholarly creativity, overlooking important categories embedded within the data if they do not fit the coding paradigm. Axial coding in particular has been criticised by some as being limiting and cumbersome (Charmaz, 2006). Moreover, comparative analysis is less prominent in the Straussian approach, while its paradigm may not be applicable to every research topic (Charmaz, 2006; Chen & Boore, 2009).

Today both approaches are often criticised for being dogmatic and lacking in reflexivity, in other words, having a positivist focus on verification and technical procedures, and a positivist belief that a researcher can produce objective, ‘unproblematic’ knowledge (Charmaz, 2006; Chen & Boore, 2009; Clark, 2005; Kennedy & Lingard, 2006; Skeat & Perry, 2008). The irony here is that grounded theory was initially conceived as a response to the dominance of positivism in social science research.

Today grounded theorists, influenced by postmodernism, constructivism and critical theory, tend to agree that research can only ever produce incomplete knowledge (Bryant & Charmaz, 2007a). They consider the coexistence of multiple socially constructed realities, the influence of discourses on subjectivity and social worlds, and
identity politics, and often incorporate emancipatory intent within their research (Bryant & Charmaz, 2007a; Charmaz, 2008). Contemporary grounded theorists tend to avoid the more prescriptive elements of Glaserian and Straussian guidelines, such as axial coding or theoretical coding families (Bryant & Charmaz, 2007a). Increasingly, these researchers are moving beyond taking sides, instead synthesising various grounded frameworks (for example, Chen and Boore (2009) have developed a framework that builds on the works of Glaser, Strauss and Corbin, and Charmaz). Some bring into grounded theory aspects from other theoretical frameworks, such as narrative analysis (Dey, 2007) or discourse analysis (Clarke, 2005). Most notable grounded theory modifications can be attributed to Schatzman (1991), Clark (2005) and Charmaz (2000; 2006). A comprehensive discussion of such modifications, though, is beyond the scope of this paper. The following section discusses the work of Charmaz, since her framework informs this study.

**Constructivist grounded theory**

The sociologist Charmaz utilises elements from both Glaser’s and Strauss’s approaches in her grounded theory framework, which is also inspired by the constructivist research paradigm. Her approach was first introduced in a chapter in the second edition of *Strategies of Qualitative Inquiry* (Denzin & Lincoln, 2000) and later elaborated upon in the book *Constructing Grounded Theory* (Charmaz, 2006). This section describes theoretical underpinnings of Charmaz’s approach, her emphasis on reflexive research and her methodological guidelines and ends by acknowledging some criticisms of her approach.

**Ontological and epistemological underpinnings**

Charmaz’s methodological framework shares an “inductive, comparative, emergent and open-ended approach” (Charmaz, 2009, p.137) with classic grounded theory and with Glaser. Yet, like Strauss’s methodology, Charmaz’s is influenced by the symbolic interactionist focus on action as a basis for analysis, since it “assumes… social life as processual” (Charmaz 2006, p.126). Thus, similar to Strauss, Charmaz (2006) suggests focusing the analysis on people’s actions, and the processes and meaning making that underlie them, in order to “conceptualise relationships between experiences and events” (p.136). Constructivist grounded theory does not strive to uncover one basic social process or one core category as Glasserian researchers do (Charmaz, 2006, p.132).
Charmaz’s approach is also situated within the constructivist-interpretive tradition of research inquiry (Charmaz, 2000, p.521; Charmaz, 2006), thus moving grounded theory further towards more situated knowledge. According to the constructivist paradigm, the “real world exists but is never separate from the viewer” (Charmaz, 2009, p.130). This means reality is neither objective nor singular, since – in order to make sense of their lives - people actively interpret events and construct realities in which they then participate (Charmaz, 2006). Constructivists believe people may alternate at once, or during various phases of their lives, between different (even contrasting) positions (Charmaz, 2000). While this paradigm recognises human agency, it also supposes that subjective meaning making is enabled and constrained by social conditions and discourses. Thus, the researcher’s role is to study individual meaning making processes while locating these within the broader context (Charmaz, 2009; Holstein & Gubrium, 2008).

The philosophical framework and methodological guidelines of constructivist grounded theory inform this study. In line with Charmaz’s suggestions, I approached data collection and analysis assuming that women’s narratives would not represent the ‘truth’, but rather a more or less honest rendering of how they view their lives, and that these views will be influenced by the sociocultural context in which their lives are embedded. I also assumed that inconsistencies in individual narratives are a natural occurrence.

Grounded theorists working from a constructivist-interpretive perspective share the belief that they should try to understand but also interpret, how participants define their experiences, as well as their explicit and implicit assumptions (Charmaz, 2006, p.32). These researchers “examine the standpoints of the participants, their historical locations, and social circumstances” (Charmaz, 2009, p.143). This is a departure from classic grounded theory which aims at representation of participants’ stated concerns (Glaser, 2003). Instead, these researchers “try to understand but not necessarily adopt or reproduce... [participants’] views as our own” (Charmaz, 2006, p.19) in order to “avoid reducing grounded theory research to studies of overt behaviour or interview accounts taken at face value” (Charmaz, 2006, p.184).

In line with this thinking, my research focus was on meaning making, actions, processes and context in women’s lives. This focus is also consistent with grounded theory’s concern with social phenomena that are potentially problematic for participants
and with the social processes of how people deal with their problems (Glaser, 1978; Mello & Flint, 2009). I explored how women conceptualised their scars and coped with having them, and how this evolved over time. I also studied contextual factors in women’s lives (including the sociocultural context within which their lives are embedded) that shape their meaning making and actions. I also aimed at developing an “integrated theoretical model” (Skeat & Perry, 2008, p.101) to conceptualise the experiences of women with non-facial scars. I was open-minded to the possibility that more than one core category would emerge. Yet as shown later in the thesis, the integrated theoretical model includes one core category and three essential categories.

In summary, constructivist grounded theory is ontologically and epistemologically situated between positivism and postmodernism (Bryant & Charmaz, 2007b). Such research “does not seek truth – single, universal, and lasting. Still, it remains realist because it addresses human realities and assumes the existence of real worlds” (Charmaz, 2000, p.523).

**Reflexive research approach**

Charmaz (2009) turns constructivist-interpretive underpinnings also “back on the research process rather than only outward to the empirical world” (p.129), assuming that researchers and participants interpret each other’s meanings and actions, and therefore “co-create understandings” (Denzin & Lincoln, 2008, p.32). Therefore, Charmaz (2006) recommends taking a reflexive stance towards research process and outcomes.

Reflexive research is becoming increasingly popular amongst qualitative researchers (Denzin & Lincoln, 2008; Olesen, 2007). Reflexive researchers consider how their biographies, worldviews, behaviour and presentations may affect how “data, analysis, and methodological strategies [authors’ emphasis] become constructed” (Bryant & Charmaz, 2007a, p.10). The assumption here is that, rather than discrediting the entire endeavour of social research, bias awareness may result in self-scrutiny, potentially becoming a productive site for study. Also, as Inckle (2007) argues, reflexivity “offers some protection to the participants in that a self-aware, reflexive and ethically orientated researcher is perhaps less likely to cause harm to them” (p.22).

Still, even reflexive researchers cannot completely avoid bias in their work. For example, in-depth interviewing which is the principal data collection method in this study, always produces knowledge that is “contextual and negotiated” (Charmaz, 2006,
p.27) between researchers and participants. Who researchers are and how they interact affects what people tell them (or don’t) (Taylor & Bogdan, 1998, p.101).

Charmaz (2006) suggests that data collection and analysis can be particularly influenced by researchers if researchers share the experiences under investigation. I followed her warning to try and deal more effectively with my biases and really listen to participants. My own experience of having disfiguring non-facial scars, as discussed in chapter one, had a great impact on me. I initially approached this study believing that non-facial scars mark other women as profoundly different in positive and negative ways, also limiting their life choices and chances, as I felt was in my case. Once I realised my biases, I was careful to ensure that my experience was not projected during the interviews, or onto the data analysis and theory development. I was also mindful that having disfiguring scars could influence my evaluation of other women’s scars. To ensure I did not minimise women’s concerns over scars that seemed to me minor, I utilised several strategies discussed further in the chapter. I also hope that photos of participants’ scars I present in chapters five to eight speak for themselves.

Rather than pretending to be objective, Corbin and Strauss (2008) suggest that researchers “consciously use experience to enhance the analytic process” (p.85). Kvale (1996) similarly writes that “a recognised bias or subjective perspective, may... bring new dimensions forward, contributing to a multiperspectival construction of knowledge” (p.286). I believe that my experience of scars was often helpful to the research process, since I could understand, and relate to, many of women’s concerns and appreciate the strategies they used to ‘manage’ their bodies. Sharing what Rice (2009) calls “experiential experience” (p.252) with participants also meant I was comfortable having deep conversations about scars and I was ‘finely tuned’ to detect any ambivalence in women’s stories. After all, my own experience, too, reveals scarred Body Surface may entail positive and negative consequences at once. I drew on my experience also that a when designing the interview guide, and during the data collection and analysis, as discussed further. Also, as mentioned in chapter one, in line with Kvale’s (1996) suggestions, I added snippets of my story to the findings presentation when something in the data particularly resonated with my story, or when I could add to, or contrast, participants’ insights. Thus I added to the chorus of participants but without taking the central stage.
The disciplinary perspectives of researchers can also have an impact on the research process (Charmaz, 2006, p.16). This study design was influenced by my professional background. My interest in the practice-oriented research rooted in my social work training was discussed in chapter one. As a writer, I am also a believer in writing as a stimulant for deeper thinking beyond the clichés, closer to the visceral experience and, as discussed further, I included writing techniques in my data collection methods. A more reflexive examination of how I possibly influenced this study and how I dealt with my biases is woven throughout the remainder of this chapter.

**Constructivist grounded theory methodological guidelines**

This section describes how Charmaz’s research guidelines differ from those of the Glaserian and Straussian approaches. Most significantly, Charmaz (2000; 2006) steers away from the Straussian emphasis on methodological rules and, as discussed below, somewhat simplifies analytical procedures. Overall, Charmaz (2006) suggests a theory development process that includes four stages: 1) creating and refining research questions; 2) developing codes into concepts; 3) asking more conceptual questions; 4) using the writing stage as an opportunity to make more theory discoveries and refining. The following sub-sections discuss Charmaz’s modifications.

**Data collection and theoretical sampling:** Charmaz’s (2006) guidelines for the initial data collection are simpler than in the Glaserian and Straussian approaches; they contain only the directive to adhere to the primary research criteria. Charmaz’s later stage of data collection is in line with the theoretical sampling as suggested in classic grounded theory. However, she problematises the notion of theoretical saturation, important in the Glaserian and Straussian approaches. Glaser (1978; 2001) posits that the amount of data is irrelevant to the credibility of a study as long as a theory emerges, while Charmaz argues that studies with small samples lead to superficial analysis. Instead, she suggests continuing the collection process, even if categories are saturated, until rich data is collected, and coding it until researchers feel that a credible theory has emerged. During data collection, Charmaz also advocates for more detailed questioning than Glaser allows.

**Data analysis:** Charmaz’s (2006) approach to analysis is less structured than in the Straussian approach, or even in some of the later, synthesised, approaches. Charmaz rejects the Straussian axial coding matrix and Glaserian coding families, arguing that such strategies may “force data into preconceived frameworks” (p.115). Charmaz’s method
includes two types of coding: initial and focused. Initial coding is reminiscent of classic grounded theory: during this phase data is coded closely, by short segments, with descriptive codes gradually becoming more abstract. At this stage, researchers should remain open to any analytical directions (Charmaz, 2006, p.46). Focused coding “requires decisions about which initial codes make the most analytic sense to categorise your data incisively and completely” (Charmaz, 2006, p.57). During this phase new codes may be generated through combining initial codes; categories and sub-categories are developed and linked among one another. Following these selected codes, data is then re-analysed as researchers “compare data with data and then data with codes” (Charmaz, 2006, p.42) and raise selected categories to theoretical concepts that will form the final theory.

**Literature review:** Charmaz (2006) sides with Strauss and Corbin (1990; 1998) (and with most contemporary grounded theorists (Selden, 2005)), against Glaser, in their view that conducting a preliminary review of the literature is essential to theoretical sensitivity. However, unlike Strauss and Corbin, Charmaz suggests that literature be read continuously through all stages of the research.

**Theory products:** constructivist grounded theory is meant to show “how meanings, actions, and social structures are constructed” (Charmaz, 2006, p.151). For this purpose, Charmaz (2006) allows for the possibility that more than one core categories may emerge. In line with the Straussian approach, Charmaz also argues for theory that accommodates as many social processes as are pertinent to the findings.

Like many grounded theorists (for example, Clark, 2005; Corbin & Strauss, 2008; Mills et al., 2007), Charmaz (2006) favours diagrams illustrating relationships between categories for theory presentation. Yet Charmaz is also a great believer in the power of description when presenting theory. In this, she steers away from classic grounded theory’s approach of identifying variables, deducing testable hypotheses, and describing these rather concisely (Charmaz, 2006, p.141). In Charmaz’s view, theoretical discussion that involves description and narrative minimises the fragmentation of data and adds context. Similarly, the theory that emerged in this study is presented descriptively and with the aid of diagrams.

**Critique of constructivist grounded theory**

Glaser, who objects to most modifications of grounded theory, is one of Charmaz’s major critics. Chiefly, Glaser (2003) disputes constructivist beliefs in the
dynamism of meanings and in knowledge co-construction between researchers and participants. Glaser maintains that perceiving people’s meanings as constantly shifting runs the risk of ignoring their voiced concerns and argues that “the constant comparative method discovers the latent pattern in the multiple participant’s words” (p.168). In Glaser’s view, data entails ‘correct’ views of participants, and researchers’ job is to discover them. Therefore, Glaser objects to Charmaz’s emphasis on reflexivity. Glaser also argues that her analytical guidelines produce over-descriptive findings. According to Chen and Boore (2009, p.2257), some scholars also criticise Charmaz’s approach for having insufficiently detailed analytical guidelines.

Despite the aforementioned objections, Charmaz’s approach has been increasingly used in research design (Chen & Boore, 2009; Weed, 2009). As discussed in preceding chapters, I share the constructivist belief in the dynamic nature of the social world. For the purposes of this study, I find the reflexive approach to research useful. I also like the flexibility and simplicity of Charmaz’s guidelines which allow for open-ended exploration of experiences of women with non-facial scars. The remainder of this chapter discusses my application of Charmaz’s, and some other researchers’, methodological suggestions to this study.

Methodology

Inductive and iterative research process

In line with inductive principles of grounded theory, I wanted to capture women’s own perceptions of their experiences, rather than test pre-existing assumptions or theoretical models. As a result, although my initial interest was in appearance-related distress, after nine interviews I realised that women harboured also other concerns related to scars and began gathering data and coding for these too. This change of direction is also indicative of the iterative research process pertinent to grounded theory. In line with this methodology, in this study the phases of data collection, data analysis and theory development were concurrent and informed each other. Figure one, ‘The Research Process’, demonstrates the iterative process of this study.
Sampling

In Charmaz’s approach, as aforementioned, initial sampling adheres - with maximum variation - to the research criteria established before the fieldwork, so that at the start “analytic directions emerge without being forced” (Charmaz, 2000, p.520). Once findings begin emerging, researchers proceed to engaging in theoretical sampling. Theoretical sampling is a more focused sampling approach, aimed at “seeking and collecting pertinent data to elaborate and refine categories in your emerging theory” (Charmaz, 2006, p.96) by confirming, challenging or expanding the categories and their properties. I began implementing theoretical sampling after the first five interviews, by making adjustments to the interview guide and sampling for particular participants.
(Charmaz, 2006; Draucker et al., 2007). More detailed discussion of theoretical sampling in this study is woven within the sections on data collection and analysis.

For initial sampling, in order to capture a range of experiences within the constraints of my selection criteria, which is described below, I attempted to recruit as diverse as possible a range of women in terms of their demographic characteristics, scar causes and scar physical properties. For this purpose, I reached out broadly into the community, using a range of recruitment strategies described in the following section.

*Initial recruitment criteria*

The study sample was drawn from adult women aged between twenty and sixty years of age who have permanent non-facial scars not associated with any ongoing health issues (based on the women’s reports), and which have been present for at least four years (see Appendix one for recruitment advertisement).

The focus on adult women is consistent with the existing literature on disfigurements discussed in chapter three, which suggests that disfigurements affect people in different ways according to their developmental stages. Women whose scars are associated with ongoing health concerns were excluded on the assumption that such women are likely to focus in their narratives on their health conditions rather than on issues around the scars. As the literature discussed in chapter three shows, health concerns can override disfigurement-related concerns. Finally, a minimum of four years of lived experience with scars was required following findings drawn from the literature about the psychosocial adjustment of people with burns. This research (Lawrence et al., 2006; Noronha & Faust, 2007; Robert et al., 1999) demonstrates that experiences of one to two years after sustaining burns - when the memory of trauma is still fresh and the physical impact (pain and/or loss of physical function) is most acute - differ qualitatively from later years. In line with my interest in scar-related concerns, I wanted to ensure respondents had some distance from scar acquisition and a considerable experience to narrate.

*Recruitment strategies*

In previous studies, as discussed in chapters one and three, samples were mostly drawn from clinical populations. In this study participants were recruited from the general population. As Rumsey et al. (2010) note, “this type of recruitment is more challenging”
Therefore I used a variety of recruitment strategies both for the initial and theoretical sampling, drawing upon them before and during the phase of concurrent data collection and analysis, as necessary:

1. I placed recruitment advertisement in RMIT electronic newsletters.
2. I left leaflets advertising the study in two GP clinics in Melbourne.
3. I distributed recruitment advertisement electronically through organisations working with burns survivors: Burns Support Foundation and Kids Foundation.
4. I gave an interview in the *Australian Jewish News* about my research, including a call for participants.
5. I distributed recruitment advertisement electronically to my personal and professional contacts, asking them to forward the advertisement on to their networks.
6. I advertised for participants electronically through professional networks I am involved in: Australian Poets’ network and Victorian Freelance Writers’ network.
7. During presentations related to this study in various conferences and seminars, I called for volunteers for participation.
8. I used other public speaking engagements and my teaching work as opportunities to seek recruits.
9. I networked during any social events I participated in to find participants.

Although this study sample was initially gathered with a certain bias since I was drawing on some of my networks, the sample ended up including mostly women unknown to me who were either acquaintances of acquaintances, or complete strangers, and thus included women from a variety of backgrounds, as discussed later.

**Recruitment issues**

At the study’s onset, I naively assumed women who would volunteer would self-select in accordance with the recruitment parameters. However, the self-selection process proved to be less straightforward. Apparently, the recruitment criteria for this study could be interpreted in several ways. Three issues arose during the recruitment process.

Firstly, what constitutes a ‘scar’ proved not to be so clear cut. Women with moles, amputated limbs, scleroderma, mastectomies, birthmarks and skin diseases approached
me, self-identifying as having scars. After meeting one woman and finding out during the interviews that she had a different disfigurement, I began asking volunteers for descriptions of their scars prior to setting interviews. Secondly, some women who contacted me had very minor, barely noticeable scars, which therefore – according to women – did not feature in their lived experiences. After interviewing two such women, I wanted to ensure I only interviewed women who had stories to tell me. For this purpose, I modified the initial recruitment advertisement (see Appendix two), adding: ‘Do you feel that having scars has had some impact (positive, negative or mixed) on your life?’ Thirdly, four women who contacted me had disabling, lasting health conditions (life-threatening in one case) and therefore did not fit the study’s focus. However, when women with cancer-related scars contacted me, decision on whether they fitted the criteria was more difficult, since cancer may or may not recur. I decided that in this case, particularly that I have no medical background, I would trust the process of self-selection and interviewed women who felt their cancer belonged to the past.

Overall, as the recruitment process progressed, I learned to check more carefully with women who contacted me whether they fitted the study criteria. While in discussions of sampling and recruitment I have alluded to some of participants’ characteristics, the following section elaborates on the final composition of this study’s participants.

Composition of participants

This research, as discussed, aims to foreground the diversity of experiences of women with non-facial scars. My sample included 30 women aged between 22 and 58 from a variety of life situations and ethnicities, and various scar types. I spoke to single mothers and childless women, students in their twenties, businesswomen and poetesses. Most women (n=23) were born in Australia either to Anglo-Australian or migrant parents, four women were from a Jewish background and three were born overseas (Singapore, Malta and Colombia) but spoke good English. The vast majority (n=26) lived in Melbourne’s many inner and outer suburbs. I also interviewed three women from interstate: Western Australia, Queensland and New South Wales. Participants’ self-described socio-economic status and relationship status were diverse too. Description of this diversity is provided in table one, ‘Participant characteristics’ (30 participants in total).
<table>
<thead>
<tr>
<th>Demographic characteristic</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>20-29 years old</td>
<td>4</td>
</tr>
<tr>
<td>30-39 years old</td>
<td>8</td>
</tr>
<tr>
<td>40-49 years old</td>
<td>9</td>
</tr>
<tr>
<td>50-59 years old</td>
<td>9</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>Anglo-Saxon</td>
<td>19</td>
</tr>
<tr>
<td>Jewish</td>
<td>4</td>
</tr>
<tr>
<td>Second generation Italian</td>
<td>3</td>
</tr>
<tr>
<td>Second generation Sri Lankan</td>
<td>1</td>
</tr>
<tr>
<td>Chinese</td>
<td>1</td>
</tr>
<tr>
<td>Columbian</td>
<td>1</td>
</tr>
<tr>
<td>Maltese</td>
<td>1</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
</tr>
<tr>
<td>Postgraduate</td>
<td>11</td>
</tr>
<tr>
<td>Undergraduate</td>
<td>13</td>
</tr>
<tr>
<td>Diploma</td>
<td>5</td>
</tr>
<tr>
<td>High school</td>
<td>1</td>
</tr>
<tr>
<td><strong>Self-stated socioeconomic status</strong></td>
<td></td>
</tr>
<tr>
<td>Wealthy</td>
<td>8</td>
</tr>
<tr>
<td>Middle class</td>
<td>20</td>
</tr>
<tr>
<td>Working class</td>
<td>2</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>5</td>
</tr>
<tr>
<td>Arts</td>
<td>4</td>
</tr>
<tr>
<td>Student</td>
<td>4</td>
</tr>
<tr>
<td>Research</td>
<td>3</td>
</tr>
<tr>
<td>Medical</td>
<td>2</td>
</tr>
</tbody>
</table>
Overall, the variation in characteristics provided useful points of contrast in analysis.

The diversity of scars was also considerable. Several women had single, neat scars. At the opposite end of the scar severity continuum was a woman with burns to 70% of her body. Overall, seven women had what can be considered ‘severe’ scarring with the others having ‘mild’ to ‘minor’ scars. The age of participants’ scars ranged from 4 to 48 years, with the majority of women having had them for at least 10 years. The causes of scars included: systemic infection, trauma, medical and cosmetic procedures, cancer and self-harm. Scar locations included: limbs, pubic bones, chest, back, shoulders and abdominal scars, which constituted the majority (n=16). Chapter five provides more information on scar breakdown according to the degree of disfigurement and the causes, whereas chapter seven shows scar breakdown according to the age of the scars. Table Two, ‘Scar locations’, shows scar breakdown according to locations (some participants

<table>
<thead>
<tr>
<th>Field</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marketing</td>
<td>2</td>
</tr>
<tr>
<td>Finance</td>
<td>2</td>
</tr>
<tr>
<td>Social work</td>
<td>2</td>
</tr>
<tr>
<td>Bureaucracy</td>
<td>2</td>
</tr>
<tr>
<td>Law</td>
<td>1</td>
</tr>
<tr>
<td>Alternative medicine</td>
<td>1</td>
</tr>
<tr>
<td>Science</td>
<td>1</td>
</tr>
<tr>
<td>Volunteer</td>
<td>1</td>
</tr>
<tr>
<td>Relationship status</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>12</td>
</tr>
<tr>
<td>De-facto</td>
<td>7</td>
</tr>
<tr>
<td>Single</td>
<td>11</td>
</tr>
<tr>
<td>Children</td>
<td></td>
</tr>
<tr>
<td>3 children</td>
<td>3</td>
</tr>
<tr>
<td>2 children</td>
<td>10</td>
</tr>
<tr>
<td>1 child</td>
<td>3</td>
</tr>
<tr>
<td>No children</td>
<td>14</td>
</tr>
</tbody>
</table>

Table one: Participant characteristics
had scars in more than one location and so the total number of scar locations exceeds the 30 study participants).

<table>
<thead>
<tr>
<th>Scar location</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdomen</td>
<td>16</td>
</tr>
<tr>
<td>Legs</td>
<td>12</td>
</tr>
<tr>
<td>Chest</td>
<td>6</td>
</tr>
<tr>
<td>Arms</td>
<td>6</td>
</tr>
<tr>
<td>Back</td>
<td>2</td>
</tr>
</tbody>
</table>

**Table Two: Scar locations**

**Data collection**

Consistent with grounded theory, which, as discussed, advocates for creativity in generating sources of data, I collected data through a variety of methods. Data for this study included 34 interview transcripts with 30 participants (four participants consented to a follow-up interview); 10 writing exercises completed by 10 participants (one in the form of a poem) \(^{13}\); 90 photographs of scars from 22 participants; demographical data; ordinal scale ratings of scar severity by participants and myself, and scar-related level of distress by participants. The following sub-sections describe data collection methods: in-depth, semi-structured interviewing; a demographical questionnaire; an ordinal scale; photo elicitation; photography of scars; elicited texts.

*The in-depth, semi-structured interviewing method*

In total, 33 in-depth semi-structured interviews with 30 participants were conducted for this study, with three of these interviews being follow-ups on an elicited text component (discussed further in the chapter).

In-depth interviewing is suitable for exploratory studies where there exists a clearly defined research focus and interest in a variety of lived experiences (Taylor & Bogdan, 1998). This method provides access to individual experiences and meaning making underlying people’s worldviews and actions (Kvale, 1996, p.291; Taylor &

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\(^{13}\) Hereafter writing exercises are referred to as ‘texts’ and interview transcripts as ‘transcripts’
Bogdan, 1998), which is in line with my aim of listening to how women develop meanings around their scars. In-depth interviewing is particularly compatible with the interpretive inquiry informing this thesis, because it is “open ended but directed, shaped yet emergent, and paced yet flexible” (Charmaz, 2006, p.28).

Semi-structured interviewing furthers more the aims of the study. This method, which keeps the structure to a minimum:

enhance[s] the opportunity of genuinely revealing the perspectives of the people you are studying... aspects of people’s social world that are particularly important to them, but that might not even have crossed the mind of a researcher... are more likely to be forthcoming (Bryman 2004, p.280).

At the same time, semi-structured interviewing contains enough structure to allow comparison between interviews (Franklin & Jordan, 1997). To provide some structure to interviews, I developed an interview guide which initially included 24 questions. Later in the research process, I added new questions following issues that emerged in interviews and data analysis (see Appendix three - italicised questions were added later). These additions are discussed more later in the chapter.

In line with constructivist grounded theory, I included open-ended questions that reflected my interest in how women talk about their scars, and generally about their bodies; as well as to better elicit meanings participants attach to their scars, and how scars enter their social worlds and impact on their lives. Other questions were concerned with how women deal with scar impact, and what their subsequent needs may be. Additionally, in line with the emphasis of constructivist grounded theory on how context shapes individual experiences, I was interested in women’s life circumstances and included a demographical questionnaire within interviews (see Appendix three) as well as questions examining the role of cultural context in women’s experiences (for example: ‘How do you think scarring is perceived in our society?’). I also drew upon my experience of having scars. For example, the question ‘Do you think if you didn’t have scars, your life was different in some ways? Or would you be a different person?’ is based on my experience discussed in chapter one.

To test the interview guide, I conducted a pilot interview with a consenting friend who has an abdominal scar, using the pseudonym ‘Maria’. Over one and a half hours,
Maria responded to questions and provided me with feedback. Overall she found the interview concise and unobtrusive, but she felt that three questions were too leading. Following Maria’s feedback, I reworded the questions she pointed out to make them more neutral and open-ended.

Since the interviews concerned potentially sensitive issues, I followed the suggestion of Yeandle (cited in Reinharz & Davidman, 1992, p.25) that answering demographical questions empowers interviewees by placing them in a ‘knowledgeable’ position. To put women at ease, I began most interviews with the demographical questionnaire. Afterwards I followed Charmaz’s (2006, p.26) recommendation that in order to maximise research discovery and be open to learning about participants’ lives, researchers should first ask broad, open questions and only later focus them for clarification. After the demographical questions were completed, I usually asked women to tell me anything they wished about their scars so as to find out what was meaningful to them. Afterwards, each interview took its own direction, guided loosely by the interview guide. Towards the end I would check the interview guide to ensure I covered all important topics. I ended most interviews (n=22), using the photo elicitation method, which is also discussed later. This semi-structured interviewing (as opposed to unstructured interviews) proved to be useful. Most respondents said they had hardly ever discussed their scars before. Having specific questions helped stimulate conversation. Overall, participants had the freedom to talk about their experiences in a way that was meaningful to them while, particularly in the later stages of interviews, I also provided some direction to the process.

So as to empower study participants further, in line with Reinharz and Davidman (1992), I offered women the choice of selecting the locations for our interviews. The majority of participants chose to meet in their natural surroundings: in their homes and workplaces. This choice was also beneficial for the research since, as Kvale (1996, p.293) posits, such interview locations enable researchers to place the data within an individual context and so understand it better. However, in accordance with participants’ wishes, several interviews also took place in cafes, an office at RMIT and at my home. An interview with an interstate participant was conducted over the telephone and another via Skype. One interview was conducted at a writers’ retreat, another in a bar. Even interviews conducted in public places were done as privately as possible while sitting in rather hidden locations away from the public.
Also for empowerment purposes, I advised participants that they controlled the
duration of the interviews and could terminate them at any stage. None of the
interviewees, however, exercised this right. Taylor and Bogdan (1998, p.97) argue that an
interview shorter than an hour is unlikely to address a research topic in depth. Interviews
for this study ranged between one to three hours in length. Additional time was frequently
spent in informal conversation either before or after interviews to build rapport and
address potentially sensitive topics that occurred, or were likely to occur, during
interviews such as sexuality, body image, body shame and bullying.

There is a growing recognition of the methodological benefits of a more intimate
and reciprocal mode of interviewing with researchers expressing their feelings and, at
times, revealing some aspects of their lives. Such an approach to interviewing can
minimise the distance between researchers and participants, producing a richer, more
honest data (Charmaz, 2006, p.19; Corbin & Strauss, 2008; Fontana & Frey, 2000,
p.658). However, it is often a dilemma for researchers to decide where, on the continuum
of ‘stranger’ and ‘friend’, to position themselves in relation to participants (Kvale, 1996;
Reinharz & Davidman, 1992). I, too, grappled with such decisions.

Attempting to appear neutral is, in my view, not only inauthentic, but also
unhelpful for advancing the study. Arguably, reserved, formal behaviour on the part of
researchers is likely to stifle interviewees’ responses, particularly when the research topic
is personal and sensitive. Instead, I believe in being what I term a ‘passionate listener’. In
my view, a crucial task for interviewers is to be attentive and respond to information
imparted with empathy, deep interest and curiosity. Like Inckle (2007), I tried to be “fully
present [during the interviews]… [and respond] emotively and emphatically” (p.25).
Moreover, in my responses I tried to show a (genuine) passion for the women’s stories
through my body language and verbal responses. I believe that listening passionately is an
ethical stance, since by doing so researchers can, at least to some degree, reciprocate
participants’ generosity with their time and disclosure. Indeed, participants responded
positively to my expressions of interest in what they said and to my assurances of the
value of their stories, often becoming encouraged to talk further.

Passionate listeners may occasionally share an insight or experience. Yet this
should be done critically, since a researcher’s self-disclosure is potentially a problematic
act. Arguably, people often volunteer for research because they want to be heard and to
feel someone is taking an interest in their lives. In such instances one of the main rewards for volunteers is a researcher’s undivided attention, something they are less likely to experience in usual social interactions. Researchers’ self-disclosure may sometimes not only shift the focus from the research topic and/or influence stories of respondents, but may also feel unrewarding for participants (Rice, 2009).

For self-disclosure to be useful for research purposes, finding the right timing is crucial (Reinharz & Davidman, 1992, p.33). Additionally, Rice (2009) distinguishes between ‘ethical accounting’ and ‘confessional accounting’ of a researcher’s experiences. I always conceal my scars and unless I told participants about them they did not know I too have scars. During the interviews I kept reflecting (in order to avoid confessional accounting) about whether to disclose my scar-related experiences, and if so, when and for what purpose. I disclosed my scars mostly when women told me about particularly difficult experiences. Yet, rather than telling my own story in detail, I would only briefly mention I have scars to intimate that I could relate to the women. By doing so I hoped to express empathy more effectively and make participants feel understood, particularly given that, as discussed in chapter two, we live in a paradoxical culture where appearance is highly important, but admitting concerns and preoccupation with it is considered vain. Many interviews reflected this tension and by disclosing that I too had scar-related concerns I was able to reassure some women that I was not judging, but rather empathising, with them. To use Rice’s (2009) words, in these instances if I kept silent about my scars, this “may have rendered… [these women] vulnerable to my ‘normalised gaze’” (p.253). Sometimes I also tried to introduce hope by sharing my positive experiences, and some of the preliminary findings about other women’s positive stories.

I always disclosed my background as a social worker to participants, knowing this had encouraged some to participate in this research. Several women told me they felt more comfortable sharing their concerns with me knowing I was used to listening to people’s problems. I also used this professional experience to deal with those interviews which touched on particularly sensitive issues, such as appearance concerns, difficulties in relationships, traumatic memories and health concerns. Additionally, I knew from my experience of working in the mental health sector the crucial role of proper closure of sensitive conversations, that even high levels of distress can be ameliorated by closure that builds on strengths of people and positive aspects in their lives. In this way conversations ended with a sense of hope. Therefore I always finished interviews on a
positive note. As interviews would draw to an end, I would use the following three strategies (separately or in combination): 1) I would gradually steer an intimate discussion towards more general questions (for example, about cultural attitudes towards scars) to give women a sense of mastery and control in expressing their opinions, and shift the focus away from their own lives; 2) I would note how women’s insights had contributed to this study; 3) I would reiterate positive aspects that had come through in participants’ narratives, such as their hobbies, art, children.

My social work background was useful in the process of probing too. I borrowed techniques I have used during my work with people with mental health problems who also often needed probing to talk about themselves. I used gentle but frequent questioning, reflective statements and summarising to get participants talking. I also listened carefully and, following up on their stories, would ask them to elaborate on some statements and/or clarify these. Sometimes I compared various statements they made. These techniques proved to be useful in eliciting richer, deeper and more reflective stories from participants.

Researchers (Rice, 2009; Sharma, Reimer-Kirkham & Cochrane, 2009) suggest that in reflexive research practice it is important to consider how the embodiment of researchers affects their research process, particularly when they are studying body-related issues. During the fieldwork, I experienced ”heightened awareness of our physical selves” (Sharma et al., 2009, p.1642) and not only because of my scars. Since a variety of appearance concerns featured during interviews, I grew self-conscious about my own appearance and its potential impact on the data produced. I am a woman in my late thirties who looks younger than her age, and I am of average weight and height. I appear fit and healthy, and have a flair for fashion. During interviews I deliberately dressed more casually than usual and used no makeup, as I felt it would be insensitive to draw attention to myself during conversations where distress about appearance was often present and, occasionally, stories of grave health issues were told. I was also mindful of my youthful appearance and concerned that this might lead participants to not take me seriously, or make them less inclined to share sensitive aspects of their stories. In order to deal with this issue, I always found a way to mention my age in the early stages of the interviews to establish my credibility.

*Ordinal scale*
Sometimes qualitative researchers include minor quantitative components within their data collection (Charmaz, 2006; Glaser & Strauss, 1967; Seale, 2003). To obtain a greater structure and clarity in the exploration and comparisons of women’s perceptions of their scars, and to compare my perspective with those of the respondents, I included two ordinal scales in the interview guide (see Appendix three). These scales allow for a ranking order by which data can be sorted, though the distances between its categories are not always equal (Babbie, 2008; Bryman, 2004).

I used a five-point ordinal scale to measure three aspects: 1) participants’ rating of disfigurement degree of their scars; 2) my rating of disfigurement degree of participants’ scars; 3) participants’ rating of their scar-related distress. The rating parameters for aspects one and two were identical: the scale ranged from 1 (very minor) to 5 (very significant), including 0.5 categories. The third item was measured from 0 (none) – to avoid the assumption that distress always exists - to 5 (very significant).

However, in practice none of these elements were easy to define and measure. Some qualitative researchers of disfigurements (for example, Brown et al., 2010; Furness et al., 2006) employ an ordinal scale to measure subjective disfigurement degree. In this study, I asked women to rate the disfigurement degree of the total of their scars (19 respondents had more than one scar). However, some wished to rate their scars separately, particularly when these had resulted from different causes and/or looked different. This finding contributed to the development of properties in the sub-categories ‘scar aetiology’ and ‘disfigurement degree’ described in chapter five.

My own rating of disfigurement degree was also fraught with issues. As discussed earlier, I had to put in place strategies to address my biases. For this purpose, I based my ratings on existing parameters for determining the disfigurement degree of scars. The Manchester Scar Scale (Brown et al., 2010) considers the following scar dimensions: colour (red scars are considered to be most disfiguring), finish, contour, shape distortion and texture. I rated scars in line with these dimensions. According to the literature (Moss & Rosser, 2012; Robles & Berg, 2007), it is also possible to measure how disfiguring scars are through the size and quantity of scars, and I also considered these elements in my rating. To increase objectivity further, I re-rated the scars of each participant several times: following the interview, some weeks later, and again by comparing them with
those of other participants. I also used memoing, discussed in more detail later, to reflect on my rating process.

Participants’ ratings of their scar-related distress were not straightforward either. I initially conceptualised such distress as the sum of the lifelong impact, a fixed variable. However, some women wanted to distinguish between distress levels in the past and present, giving a rating for both. In accordance with grounded theory principles that a theory should emerge from the data, I included two different ratings where was applicable. This finding was important in developing the essential category ‘travelling marked through life’ discussed in chapter seven.

Photo elicitation

Despite the many advantages of in-depth interviewing, some researchers (Gauntlett & Holzwarth, 2006; Harper, 2002; Taylor & Bogdan, 1998) point out the difficulties in eliciting data beyond conventional responses through interview questions. On the other hand, there is a growing recognition amongst social researchers of the benefits of including photo elicitation in data collection methods. Photo elicitation means using existing photographs supplied by researchers and/or participants in discussions about the studied topics in order to stimulate conversation (Frith & Harcourt, 2005; Harper, 2002). Proponents of this method (Gauntlett & Holzwarth, 2006; Harper, 2002; Hurworth, 2003; Williamson et al., 2010) argue that photo elicitation can facilitate deep insights into meaning making processes, and produce more nuanced information and even new perspectives that conventional interviews might not. This is because images “mine deeper shafts into a different part of human consciousness than do words-alone interviews” (Harper, 2002, p.23).

As an interpretive tool to stimulate reflective conversation, I used photolanguage cards. Photolanguage cards are a worldwide recognised communication tool, first devised in 1968 by French psycho-sociologists Pierre Babin, Claire Belisle and Alain Baptiste, and used in a variety of education, research, therapy and community settings (Cooney & Burton,1986). The photographs can be described as metaphorical and are aimed at stimulating people’s memory, imagination and emotions through “the language of symbol” (Cooney & Burton, 1986, p.12). The goal is to help people become “aware of the… resonances that are awakened by the photograph, and thus to know himself or herself better by trying to put this inner life into words” (Cooney & Burton, 1986, p.2).
Through my work as a social worker and educator I was familiar with the Australian version of these cards, created by Jan Cooney and Kevin Burton, which features iconic Australian images such as the bush. I found these cards useful in stimulating meaningful conversations with clients and students, and therefore thought them a good choice for this study.

I used photo elicitation in most interviews (n=22) unless both the participant and I felt that the interview was sufficiently exhaustive. Naturally, I could not use the cards during telephone and Skype interviews. As aforementioned, I used photo elicitation towards the end of interviews. I would present participants with 65 photolanguage cards, asking them to pick those that made them think about their scars. Afterwards we discussed their choices and the insights the photographs generated. In most cases these discussions added depth to the data.

*Scar photos*

Rumsey and Harcourt (2005, p.59) recommend expanding the use of photography in studies of people with disfigurements. Some researchers (Frith & Harcourt, 2005; Frost, 2003) already use visual representations of disfigurements in their practice. I, too, included images of participant scars within my research for two main reasons: 1) to explore and compare the relationship between the physical aspects of scars and the impact these have on women’s lives; 2) as some researchers (Firth & Harcourt, 2005; Radley & Bell, 2007) argue, visual data engages and draws the attention, particularly that of non-academic readers, to the issue at stake.

Additionally, in my view, producing a ‘disembodied’ study of scars would be unethical, since it would reinforce the invisibility of scars in our culture discussed in chapter two. The creation and presentation of images of disfigurements, over which participants have control, can help contribute to promoting acceptance of diverse appearance (Radley & Bell, 2007). My professional experience also shows that some women want to break the invisibility barrier. When I worked in mental health, I found that female clients, who told me about their non-facial scars often volunteered to show them to me. Similarly, Gila Kozma, who contributed to an anthology of writings by people with mental health problems which I edited (Kofman, 2007), explored her altered appearance in the aftermath of mastectomy through revealing poetry and self-portraits. ‘The breasts were/the favourite parts of my body.../now there is a deep indigo hole/on my
left side’ wrote Kozma (2007, pp.96-7). She supplemented her words with striking drawings of her body. Similarly, I aimed to present this study’s findings as a landscape of narratives and images.

I collected 90 photos from 22 women: I photographed the scars of 20 women during the interviews (one of these women provided me with an additional, pre-existing photo), and 2 respondents photographed their scars after the interviews and emailed them to me. Three participants did not permit photography of their scars and five women offered to photograph their scars and email the photos after our interviews, but did not follow up on their offers.

I photographed the scars using a digital camera. This technology enabled me to immediately show the photos to participants for their approval. Only one participant requested alterations, asking me to delete those photos where her tattoos were visible. In some instances, the act of photographing during interviews turned into collaboration, with the women taking an active role in orchestrating the photoshoots. The willingness of women to show and photograph their scars further reinforced my initial assumption that exposing scars can be a positive, normalising act.

**Elicited texts**

Elicited texts are produced by participants upon researchers’ requests, with the aim of generating data (Charmaz, 2006, p.35). Writing is generally considered to be a more refined form of thinking, which – like photo elicitation - helps stimulate deeper reflection and can be an optimal medium for articulating complex ideas and emotions (Bolton, 1999; Chandler, 1999; Klauser, 2003). Therefore, writing techniques are utilised in research in social sciences (Durgee, 1987; Richardson, Mallen & Burrell, 2008) either as the main or supplementary methods. In order to further deepen data insights, I asked participants to write about their scars either prior to, or following, interviews. I used this method in addition to photo elicitation, because in contrast to the latter method, writing allowed access to women’s thoughts and feelings formed in solitude. Additionally, some people respond better to writing than visual stimulation.

Participants were asked to do three writing entries over one week, each time for the duration of seven minutes, using the technique of free-flow writing (interchangeably termed in literature ‘free intuitive writing’). This technique means writing in short bursts without stopping, editing or self-censoring, with the aim of recording any immediate
thoughts (Malchiodi, 1998, p.13; Siporin, 1988, p.178). Free-flow writing can be particularly helpful for gaining greater, often unexpected, insights into one’s life (Bolton, 1999). I provided participants with three optional prompts for writing, one for each entry, and with an explanation of the free-flow writing technique (see Appendix four).

Ten women agreed to create texts. Nine of them used all three prompts, and one wrote a poem. Six women elected to write before interviews (because of time constraints) and we discussed their texts during the interviews. Four participants wrote following the interviews and participated in a second, shorter, follow up interview to discuss their texts. In line with the research cited above, most women who agreed to create texts (n=7) said writing about their scars helped them gain more in-depth insight into their lives.

**Transcription**

All interviews were audio-recorded, then transcribed. I transcribed interviews myself following the advice of researchers (Charmaz, 2006; 2008; Fingerson, 2005; Fontana & Frey, 2000) who suggest that researchers should do the transcription in order to listen again to such nuances as silences, verbal fillers (such as *hmm*...), laughter, sighs, changes in speech rhythm and tone. According to these writers, such conversational elements can indicate ambiguity, discomfort, inability to express one’s experiences, taken-for-granted assumptions or attempts to control the information being imparted. Therefore, these elements should be considered during analysis. In accordance with these recommendations, as I transcribed I immersed myself in re-experiencing the moods of the interviews and in listening to the conversational dynamics. I included in my transcripts silences, sighs, laughter, tears and verbal fillers. I also indicated when the rhythm of the interviews or the tone of respondents’ voices changed. This process allowed for a subtler interpretation of emergent patterns and themes in the data.

**Data analysis**

This section describes all the steps, tools and processes involved in developing a substantive theory for this study. Substantive theory, as discussed, deals with a limited area of inquiry, close to real-world situation and producing it is the goal of grounded theorists (Charmaz 2006).

*Computer-based technology*

Many qualitative researchers use computer software programs to assist with analysis. I used NVivo, a computer-aided analytic software package, for organising data.
and presenting it clearly, but not to assist me in analytic processes per se. Such an approach was taken in accordance with the recommendations of numerous grounded theorists, discussed in Hesse-Biber (2007). NVivo provided me with facilities for track searching, coding and re-coding, for sorting transcripts, texts and participants according to some of their characteristics; and for writing memos.

Initial coding

Following the constructivist grounded theory approach, the coding in this study involved two stages: initial and focused. During the initial coding phase, I studied the data closely, conceptualising it line-by-line. At the start “the codes are active, immediate and short. They focus on defining action, explicating implicit assumptions, and seeing processes” (Charmaz, 2008, p.216). I coded for actions and processes rather than topics. In order to stay close to the experiences of participants and identify their main concerns, I asked questions such as: What did the participants describe? What did they care about? What were they worried about? How did they deal with their situations? What explained their different behaviours, thoughts and actions? Consistent with the principle of constant comparison, I also asked: How does what this participant says relate to other narratives? Additionally, I looked closely at the language (Charmaz, 2006, p.46) and other aforementioned conversational elements. In line with the reflexive approach, I also re-read several times those parts of the data that made me feel uncomfortable, or contained contradictions and tension, in conjunction with memos where I recorded my instant responses after those interviews.

The primary focus of the analysis was on identifying participants’ main concerns. However, in accordance with Charmaz (2006), I also conceptualised data as being embedded within sociocultural contexts. I examined possible assumptions underlying participants’ meaning construction and their actions, paying particular attention to how women articulated their attitudes to cultural norms and coding not only for meaning and action, but also for context.

Many of the codes that later became categories and sub-categories in the resulting substantive theory are in vivo codes - named using participants’ language. For example, the sub-category ‘damaged goods’ emerged after several women referred to themselves as such. In vivo codes anchor researchers’ “analysis in… research participants’ worlds” (Charmaz, 2006, p.57). Some other categories and sub-categories were named after terms
I invented (for example, ‘self-revealing body’). Several more categories and sub-categories were based on pre-existing theoretical concepts, such as ‘passing unmarked’, where these were applicable to empirical reality (Charmaz, 2006; 2008; Dey, 2007). Chapters five to eight provide more information about those categories and sub-categories inspired by the literature.

This analysis was done inductively, using the constant comparative method (Glaser & Strauss, 1967). Transcripts and texts were re-read several times to search for similarities and differences, both within and between them (Charmaz, 2006; Corbin & Strauss, 2008), and were subsequently re-coded. The analysis of later data and its comparison with earlier transcripts and texts helped to refine the coding of first sets of data, while re-coding of early data sometimes led to new insights in later data analysis. Such multiple readings are likely to have led to a more complex conceptualisation of the data.

**Theoretical sampling**

As discussed, after initial findings emerge grounded theorists progress to the theoretical sampling stage. In this study, too, several analytical findings directed the later data collection as the following sub-sections show.

**Adjustment to the interview guide:** during concurrent data collection and analysis, and in line with emerging findings, I added an extra nine interview questions. For example, after several interviews I noticed that women frequently discussed their scars within the context of their overall feelings about other aspects of their appearance. In pursuing this theoretical direction, I started coding for women’s overall attitudes towards their appearance, and added the following 2 questions: *How do you feel about your overall appearance?* and *Has your appearance always been (un)important to you?* Another example was when initial analysis revealed the complexity and diversity of social reactions to scars. I then added two questions to delineate the properties of the category ‘dealing with social responses’: *Is it more difficult to show your scars to people you know or to strangers?* and *Do women react to your scars differently than men?* These and other questions increased the complexity of my analysis.

**Sampling for particular participants** 1) An early analysis revealed that some women worried less about their scars as they grew older. At that stage of the interviewing
process only 1 respondent was in her twenties, with the rest being older. In order to further explore the age factor I sampled for more respondents in their twenties. 2) Initial findings showed that disfigurement degree of scars mattered in women’s lived experiences and warranted a sub-category. My initial sample consisted mainly of women with minor to mild scars and so I then recruited more women with severe scarring to develop this category. 3) When the category of ‘scar aetiology’ emerged, I sought to diversify scar causes in the participant sample. 4) Early findings indicated that the ‘status and quality of intimate relationship’ was an important code. In order to verify and elaborate this finding I sought to interview more women who were single, since in my initial sample the majority of respondents were in relationships.

I kept collecting data until theoretical saturation occurred, which is when “gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of your core theoretical categories” (Charmaz, 2006, p.113), a rich enough pool of data was collected, and a credible substantive theory to describe the experiences of women with non-facial scars had emerged. After 28 interviews saturation was achieved, but I conducted two more interviews to ensure that my impression of saturation was accurate.

Focused coding and theory development

As the codes grew more abstract, they formed the basis for the focused coding stage. During this phase I selected what appeared as the most frequent and/or pertinent codes to categorise my data “incisively and completely” (Charmaz, 2006, p.58), simultaneously looking for “cumulative patterns” (Bex Lempert, 2007, p.258). I collapsed “categories that lack power” (Charmaz, 2006, p.159). Then I re-read and re-coded the data, comparing it with the selected codes. During this process several new codes emerged. Finally, codes were developed into categories and a substantive theory of the lived experiences of women with non-facial scars emerged with one core category (being marked) and three essential categories (doing scar-work, travelling marked through life and unmet needs). Then I refined these categories, their sub-categories and properties, and further clarified their relationships, making the developed theory diagrammatic.

It is important to note, though, that the initial and focused coding phases are usually not entirely successive (Charmaz, 2006, p.58). Indeed, during the analysis in this study these stages occasionally overlapped. Charmaz (2008) argues that such an iterative
approach is beneficial: it allows for a prompt refining of analysis and a more sensitive subsequent data collection.

Memoing

During the entire research process I wrote memos for the purpose of “discovery and theory development” (Bex Lempert, 2007, p.262). Most of my memos formed the basis for the findings presentation. Memoing “prompts researchers to analyse their data and to develop their codes into categories early in the research process... and helps them to increase the level of abstraction of their ideas” (Charmaz, 2006, p.72). As discussed, grounded theorists use text, graphics, diagrams, tables and any other aids they find useful during the memoing process. In line with grounded theorists’ (Bex Lempert, 2007; Charmaz 2006) suggestions, I memoed using text, tables and diagrams, and compared memos.

Grounded theorists (Corbin & Strauss, 2008; Charmaz, 2006) stress the importance of honesty in recording what researchers see and how they feel during the interviews, including how interviews have affected them, and treating this as data for coding. After each interview I recorded my impressions of the context and process: the interview surroundings, the visual and psychological descriptions of participants (including their body language), the mood of the conversation, my emotions, our interactions prior and sometimes after the interview, and comparisons with other interviews. This side of memoing was helpful with reflexivity too, enhancing my awareness of my responses to the data and therefore my ability to consider these during analysis. Memoing after each interview helped me realise that I sometimes felt frustration when participants claimed their scars did not have much impact on them. This emotion stemmed both from a fear that this study’s findings would not be significant, and also because my own experience is that scars have had a major impact on my life. Initially I also felt frustrated when women stated they had large scars that distressed them, then showed me scars I considered small. At first I had difficulties understanding these participants because of my own experience of having disfiguring scars. Yet memoing was helpful for separating these emotions from data analysis and gaining a more balanced stance.

I also wrote memos about codes and about each participant’s story as a whole, summarising the context of the women’s lives, their key attitudes to scars, the actions
they undertook to solve scar-related issues, and the relationships between all these. Then I compared these memos. As codes were refined and subsumed under categories and sub-categories, I wrote memos about these (Charmaz, 2006, p.72), articulating the meanings, properties and conditions under which these categories and sub-categories varied. I also recorded ideas about the emerging theory that encompassed the relationships between all these categories, incorporating insights from the literature I reviewed.

Once I had conducted eight interviews, I also began creating tables to sort data according to the various characteristics of participants, such as age or causes of scars. Additionally, I used diagrams in memoing to visualise each woman’s life trajectory in terms of her experience of scars. At the theoretical integration stage, I used diagrams to visualise and sort out each category with its sub-categories and properties, and to tease out relationships between essential categories.

*Theoretical sensitivity*

Theoretical sensitivity can be enhanced, as discussed earlier, through pre-existing professional knowledge and the lived experiences of researchers (Glaser & Strauss, 1967), as well as through preliminary and concurrent reading of relevant literature (Charmaz, 2006). As discussed in chapter one and in this chapter, I utilised my experience of living with scars by comparing and contrasting my story with participants’ narratives during coding, and by generally being sensitive to nuances in the data. I had some pre-existing knowledge of a variety of social science theories following my training and practice as a social worker, and my subsequent work as a social work educator for undergraduate and postgraduate students.

I did some preliminary reading about theories and empirical reports about body, self and society, and about appearance research, before I began fieldwork, in order to form some broad analytical directions of inquiry. I then kept consulting relevant literature progressively during the entire research. I read research on disfigurements, but I also read widely across the fields of psychology, sociology, philosophy, anthropology, social work as well as cultural studies about theorisations of the body (including health and disability), coping and resilience, and theorisations of identity. This broad reading helped to avoid becoming biased through assumptions embedded in disfigurement research and to be more receptive to new ideas as these emerged from the data. I also kept in mind Charmaz’s (2006) suggestion to “treat concepts as problematic and look for their
characteristics as lived and understood, not as given in textbooks” (p.210). As the analytical process proceeded, and categories, sub-categories and their dimensions started emerging, some concepts from the readings came forth in participants’ stories. This led me to further explore these theoretical frameworks for informing the data analysis, thus expanding my research in an iterative process.

**Ethical considerations**

Contemporary ethical concerns in research are located in “the practices, politics, and presentation of research results” (Lincoln & Denzin, 2003, p.5), with particular attention paid to the power relationships between researchers and research participants (Charmaz, 2008; Lincoln & Denzin, 2003). Some ethical considerations implemented in this study have already been explored in this chapter. This section furthers this discussion by introducing several more ethical considerations that ensured the rights of respondents were recognised and protected.

**Participant consent**

Ethical approval for conducting this study, including taking photos of scars, was secured through the RMIT Human Research Ethics Committee in 2008. The purpose of the study was explained to prospective participants through a written plain language statement that specified the project’s outline, aims and participation requirements (see Appendix five) and which was forwarded by email. Prospective participants were also offered the option of talking to me on the telephone if they needed further clarifications. Respondents then completed a consent form (see Appendix six) stating clearly that they retain the right to withdraw from the research at any time (yet no one exercised this right). A separate consent form was signed by those participants who agreed to create photos of their scars (see Appendix seven), as will be detailed in the following sub-section. Participants were also informed about the RMIT Human Research Ethics Committee whom they could contact should they have any concerns about the conduct of the research project.

**Confidentiality**

The identities of participants, in most cases, are known only to me. Pseudonyms were assigned to 27 participants. Three participants chose to reveal their real first names, and one of them provided me with photos revealing her face. Yet participants’ real names (or in the case of the aforementioned three participants – full names) will not be used in
any official documents included this thesis nor in any other publications which may arise from this study.

All interviews were audio-recorded with the consent of the participants, who were also informed that, if at any stage they changed their minds, the recording would be stopped and deleted (even in the aftermath of the interview). Yet no one declined to be recorded nor changed their mind. Data from those interviews and from texts was kept in a locked cabinet in a secure location at RMIT. Names were removed from the transcripts and texts, which are instead numbered. The coding sheet was kept in a separate locked cabinet to the interview data. This data will be kept for a period of five years following the completion of the research and then destroyed in accordance with the National Statement on Ethical Conduct in Human Research requirements.

Prospective participants were also informed in the plain language statement emailed to them before the interviews that as an optional component of research participation they would be asked to have a photo-image of their scars taken. If they were interested in this, they could tick the ‘yes’ box on the consent form. They were also informed that just as with their overall participation, they could withdraw from this option without compromising their research participation up until (after sighting the photo) they signed a separate consent form for including the photos in research findings for presentation and publication. Thus, those women who consented to having their photos taken and used in presentations of the study findings, had the time to reflect about that before the interview and were therefore able to make an informed decision.

Those participants who gave consent for the use of their photos in the dissemination of the research findings, might potentially be identified. However, they had full control over the content of their photos and could make an informed decision whether to give their consent after viewing the photo. Also, their names will not appear on the photos in any presentations. If, at a later date, any of these women want to withdraw their images, the latter will not be used in any further publications or presentations and, where possible, any publicly available images will be removed.

**Interviewing about potentially sensitive issues**

During the interviews, as discussed earlier, I drew upon my skills and experience as a social worker with expertise in mental health. I endeavored to be sensitive to participants’ needs and checked periodically whether they were comfortable continuing
our conversation. I maintained respect for each woman’s privacy by refraining from exploring those sensitive topics participants did not wish to address. I also ensured not to pursue lines of questioning which might cause major distress. Furthermore, I stopped interviews where necessary to provide participants with immediate support. I was also prepared to refer them further for professional support if the need arose, however such concerns did not present themselves with any of the participants.

Overall, though, I believe the benefits to participants of partaking in this study outweighed the risks. As Taylor and Bogdan (1998) argue, “by virtue of being interviewed, people develop new insights and understandings of their experiences” (p.98). As discussed in chapter eight, some women testified to the therapeutic benefits of having been interviewed about their scars.

**Eliciting texts about potentially sensitive issues**

Creating texts was also an optional-only component of the research participation. Writing about scars can be a potentially emotionally taxing endeavour. However, as a social work practitioner I am experienced in using writing techniques to discuss sensitive issues. I have used writing techniques widely in individual counselling and therapeutic group work, trained other health practitioners to use writing techniques in their work in sensitive ways, and presented my creative practice in various conferences. Besides, there is research evidence to suggest that writing can be beneficial for the physical and emotional wellbeing (Fox, 1997; Joplin, 2000; Robinson, 2000). Consistently with the literature on free-flow writing mentioned earlier, most women who created texts said doing so was helpful because it stimulated their thinking about their scars, often bringing unexpected insights. Three women said this exercise was cathartic for them.

**Evaluation criteria**

In qualitative research, controversy still exists as to what constitutes sound evaluation criteria (Corbin & Strauss, 2008; Rolfe, 2004; Seale, 2003). In this study, I chose to focus on three of the standards commonly applied to grounded theory studies.

Coffey and Atkinson (cited in Bryman, 2004, p.407) argue the grounded theory approach to data analysis is overly fragmenting and may cause a disconnect between the resulting theory and meanings embedded within the participant narratives and the context. In order to increase the fit of the findings - which is to ensure that a connection exists between theoretical products and data (Charmaz, 2006) - Charmaz (2006) suggests to
collect “rich-detailed and full-data” (pp.10-11) and consider the context in which the meanings and actions occur (Charmaz, 2008, p.225). As discussed earlier, several methods were utilised in this study for collecting as rich data as possible from 30 participants. I also recorded the women’s life circumstances as they were revealed during our interactions to explore what might be relevant to the women’s experiences of their scars. I particularly considered material and social resources available to participants.

To further ensure fit, I also implemented, as discussed, Charmaz’s (2006, p.54) instructions for careful initial coding of the data line-by-line. Additionally, I followed Dey’s (2007, p.182) advice for treating the coding procedures not as the primary analytic tool, but as the ‘preliminary means of managing and organising data’ and thus avoid fragmentation. After the initial coding phase, I re-read each interview transcript as a whole to trace any social processes pertinent to each, thus refining the emerging categories.

Respondent validation was also conducted to ensure fit. Respondent validation is a process whereby researchers share their findings with participants to ensure these capture respondent perspectives (Bryman, 2004, p.274). Fifteen study participants received by email a summary of the substantive theory generated in this study as well as excerpts from the findings featuring their quotes for comment. Thirteen of these women approved of the findings and the use of their words. Two respondents never replied.

Internal validity measures whether “there is a good match between researchers’ observations and the theoretical ideas they develop” (Bryman, 2004, p.273). In order to increase the internal validity of this study, as Glaser and Strauss (1967) suggest and as discussed in chapter one, findings presented in the following four chapters are supported with participant quotes and excerpts from elicited texts. Such a method of presentation enables readers to evaluate the interpretation of the data themselves (Bex Lempert, 2007). While it is recognised that the analysis of the same data may differ among researchers (Charmaz, 2006), this practice assists in increasing the transparency of analysis. Additionally, to increase the validity of my disfigurement degree ratings, during three public presentations of this research, I asked the audiences to rate the scars and compared their ratings with mine. In three cases I readjusted my ratings in line with audience reactions. I also incorporated the photos within the chapters presenting findings and the readers can evaluate them too. Also, in line with Draucker et al.’s (2007) suggestion that
grounded theorists show an audit trail as to how they implement theoretical sampling in response to emergent findings, I wrote the theoretical sampling section presented earlier in this chapter. An additional audit trail of the research process was provided through continuous memoing and through interview recordings and their transcripts.

Constant comparison, which is a necessary component of grounded theory methodology, is another method that serves to evaluate the research, because its purpose is to determine how data elements fit together as well as “stand up to such scrutiny” (Strauss & Corbin, 1998, p.24). Within this study, as discussed, I employed various methods of constant comparison: I compared data within each transcript and text; between transcripts and/or follow up interview transcripts and/or texts from the same participant, if available; between texts; between transcripts; between memos; between my findings and perspectives of thirteen participants; between participants’ ratings of their distress; between participants’ ratings of their scars, my ratings and those of outsiders. I also employed constant comparison within the codes, between emerging codes and data, and between categories and sub-categories.

In summary, the grounded theory that emerged in this study meets the evaluation criteria in terms of fit, internal validity and constant comparison. These criteria served as guidelines throughout the entire research process

**Conclusion**

This chapter demonstrated the rationale behind, and the application of, exploratory qualitative research design as informed by grounded theory, in this study. The ontological and epistemological underpinnings of the constructivist-interpretive paradigm that frame this study were explored. In line with the reflexive approach taken in this thesis, researcher biases were made explicit and strategies for minimising these biases were discussed. The participant sample, comprised of 30 women, was presented, including demographical and scar characteristics. Ethical considerations were discussed, including the ethics of recruitment, interviewing about sensitive issues, creating data using photography and free-flow writing methods, creating photos of scars and their use in the presentation of findings, consent and confidentiality. The processes involved in creating a substantive theory of the lived experiences of women with non-facial scars were made transparent. The remainder of the thesis presents this theory and discusses its potential contribution to existing scholarship.
Interlude

Introducing Substantive Theory of Lived Experiences of Women with Non-facial Scars

In describing the results of this study, I first introduce, in this interlude, the substantive theory which emerged, including a figure showing the major categories and the relationships between them. Substantive theory, as discussed in the preceding chapter, is the standard product of research guided by any grounded theory framework – a model that describes closely the empirical world under investigation by identifying major processes and factors pertinent to it and the relationships between them.

The theory grounded in this study identifies variations in the lived experiences of women with non-facial scars through four categories: a core category and three essential categories. It shows how women frame these experiences, including how the experiences may evolve over the time, as identified in this research. The theory also describes the strategies women use in managing their scar-related problems, women’s unmet needs, and the main factors influencing variations in the lived experiences of non-facial scars as has emerged in this study.

A core category is supposed to tie “the emerging concepts together, explain a lot of the data and represent the main concern of participants” (Skeat & Perry, 2009, p.104). The common refrain in the participants’ narratives was the notion that scars hold visible meanings, both social and personal, which mark women as different and/or as having gone through some potentially problematic experience, and that being marked had a varying degree of impact on their identities and lived experiences. The core category ‘Being Marked’ encapsulates these notions and their consequences. It also describes the processes of how women come to frame their scars as embedded within a sociocultural context, as well as the psychological and scar-related factors mediating these framings and experiences.

The essential categories ‘Doing Scar-work’ and ‘Travelling Marked through Life’ delineate more processes integral to the experience of being marked. The Doing Scar-work category shows how women solve problems integral to being marked, chiefly by passing as unmarked, gaining some control over others’ interpretations of their scars and trying to accept their scars. This category also describes the context for women’s choices
of coping strategies and the consequences these entail. The Travelling Marked through Life category captures the fluid nature of the being marked experience, showing how often this evolves over the years. This category also includes ‘fluid’ (i.e. subject to change) factors which influence women’s experiences, meaning making and actions, such as relationship status and life stage. The third essential category Unmet Needs encapsulates that which women felt they needed to experience their scars more positively, but which was not available to them.

Overall, results suggest that non-facial scars can be deeply integral to both how women think of themselves in terms of their appearance, and their overall identity. The findings also show that scar experiences can be multifaceted and are processes that can evolve over time, though not necessarily in a linear fashion (for example, scar-related distress may decrease after some years, then increase later). Scar experiences evolve in response to what else is occurring in women’s lives and depend on the resources available to them at the time. Scar experiences are also influenced by more permanent internal and external factors in women’s lives. It is important to note though that, consistently with grounded theory, this substantive theory only includes those factors which were specifically addressed by participants. Additional factors may exist that have an impact on the lived experiences of women with non-facial scars.

Results also show there is coping work involved in having scars, and that how women cope and which of their needs remain unmet depends on both how women frame their scars and on the context of their lives. In turn, how women choose to cope and the consequences of these choices can reshape their meaning making around their scars. Throughout life stages unmet needs of women and their coping strategies can change more than once, and these changes can influence again how women think about and experience their scars. Figure two, ‘The Grounded Theory of Lived Experiences of Women with Non-facial Scars’, illustrates these relationships between the core category and essential categories:
It is important to note, though, that these relationships are exploratory by nature, rather than being predictive with suppositions of an ‘if, then’ process. Instead, this substantive theory is intended to be viewed as fluid and adaptive according to the unique processes by which women interpret and narrate information about their bodies.

The next four chapters explore these major categories and their relationships and link the study findings with existing literature, highlighting the unique contributions of this thesis. As discussed in chapters one and four, each of these chapters focuses on one category and illustrates its theoretical points with participant quotes.
Chapter Five – Being Marked

‘The body itself is indeed a narrative to be marked by the world... In the markings of the body are the tracings of that person’s mythology.’
Dennis Slattery

‘Being marked’ is a term inspired by the words of a participant who said she felt she was no longer ‘a fresh canvas. You’re marked’. Broadly, the way participants framed being marked can be classified into two sub-categories: ‘being damaged goods’ and ‘having a self-revealing body’ which tells others something about their lives and/or character. While the former sub-category connotes only negative feelings about scars, the latter includes both negative and positive ones. But for the majority of participants being marked involves multiple concerns. This finding is consistent with the literature on disfigurements discussed in chapter three.

The experience of being marked means also that when scars are in public view, they are likely to attract (not necessarily desired) attention. Even those participants who said they accepted their scars as a part of their bodies (with the exception of a woman with a well-hidden caesarean scar) reported that they could not escape the feeling of being marked because of the social attention their scars warranted. Most frequently, as this chapter shows, scars evoke questions. Thus, a big part of the being marked experience involves explaining one’s scars and, generally, to be ‘dealing with social responses’, which is the sub-category covering scar-related interactions. These social interactions, in turn, affect how women frame their scars.

Several ‘permanent mediating factors’, the last sub-category within the core category denoting the psychological characteristics and physical aspects of scars, also affect how women experience their scars. It is important to note, though, that while such factors as personality traits or scar locations are arguably not amenable to change, other factors discussed here can be defined as semi-permanent. For example, appearance attitudes can change. Still, such changes are usually not as drastic as those that can occur in fluid factors discussed in chapter seven.
Figure three, ‘Being Marked core category’, shows the internal structure of the core category:

![Diagram of core category](image)

**Figure three: Being Marked core category**

This figure captures the fact that not only do marked bodies attract social attention, but also that how people respond to scars affects women’s framings of their scars. It also shows that the physical aspects of scars influence the nature of social responses to them. The latter point is also the reason why permanent mediating factors did not warrant a separate essential category. As will be discussed further in more detail, one of the major findings in this study is that physical scar characteristics are integral to the experience of being marked. They affect how people respond to scars, and how women think and feel about them, including what life choices are available to them. Similarly, some psychological factors affect how women perceive their bodies. My decision to incorporate these mediating factors within the core category reflects these relationships. The following sections discuss the core category, including all its variations.
and the factors shaping them, as emerged from the data. These findings are illustrated with participant quotes and discussed with reference to existing literature.

**Being Damaged Goods**

The ‘being damaged goods’ sub-category encompasses appearance concerns and is named after three participants’ references to themselves as damaged goods. The participants who experience themselves as such feel their scars mark them as unattractive, even ‘disgusting’, as some said. In this study, many women (n=21) experienced themselves as such. This is consistent with the only existing qualitative study of scars (Brown et al., 2008), where 56% of respondents (total n=34) had appearance concerns.

As discussed in chapter two, for women in particular, having scars can be viewed as a significant departure from the cultural ideals of Body Surface. Wendell (1996) puts it succinctly, writing that for many women ‘our proximity to the standards of normality is an important aspect of our identity and our sense of social acceptability’ (p.88). Shanty, an attractive 30-year-old lawyer with scars from chicken pox on her chest, says in a similar vein:

If it wasn’t for my scarring, I think I’d be average prettiness. But because of my scars I’m just… average.

Consistent with other disfigurement studies (Brown et al., 2008; Hawkesworth, 2001; Rumsey et al., 2010) where some participants felt ‘ruined’, ‘freakish’ or ‘abnormal’, in this study women who felt they were damaged goods also used emotionally highly charged language in their descriptions of themselves. Candice, a 25-year-old postgraduate student with four fine scars on her stomach, described her body as ‘hideous’, saying she used to feel:

so ugly and disgusting... It [scars] really had an impact on my confidence.

**Photo one: Candice, 25 years old, with four abdominal scars**

Joanne, a 55-year-old mother of two with numerous abdominal scars from various causes, said her scars were:

livid, ghastly, ghastly… Every so often I catch sight of myself in the mirror and I just... I almost feel physically sick.
Joanne, like some other women who feel like damaged goods, felt alienated from her body, saying her scars made her hate it forever:

I just think that it’s [her scarred abdomen] not really me… This isn’t mine. I can’t own it.

As scars are usually resistant to cosmetic intervention, they can be perceived as a disruption of the cultural ideal of the body-as-a-project. Indeed, the contemporary quest for the perfect body and the obsession with ‘fixing’ imperfections were central to some participants’ narratives, particularly those in their twenties and thirties. Candice, a good looking woman, exemplifies this preoccupation with perfection:

Maybe I’m obsessed with looking perfect… So when the scars came it’s like oh, God… imperfection… It’s like I always have to be perfect… I think I fixate on my appearance.

Integral to the experience of being damaged goods is the tension discussed in chapter two between the pressures on women to be perfectly beautiful and the pressures for self-acceptance. The fear of appearing vain was a constant thread running through the interviews in which women expressed scar-related appearance concerns, with this fear often leading to women blaming themselves for such concerns. Michelle, a 31-year-old naturopath whose thigh scar resulted from a dog bite, typifies movement between the contradictory desires to self-improve and to self-accept. Throughout the interview she kept fluctuating between wishing her leg was 'perfect' again, or at least 'normal', to emphasising the importance of self-acceptance and 'looking deeper than skin'. Similarly Michaela, a 43-year-old marketing professional with scars on her legs from a childhood burns accident, spoke about her lifelong internal conflict. She had always felt ashamed of her scars yet at the same time berated herself:

It’s the whole thing of being ashamed and also ashamed that you can’t be bigger than that, that you can’t let it go. So it’s a compound feeling and it’s really stressful having those feelings.

Lora had the critical awareness to place her conflicting feelings within a larger context:

It’s probably hard not to be self-conscious… The women in the media are portrayed as perfect. I’ve always been concerned about my appearance, but at the same time not wanted to care too much…

Some other women emphasised a pride in not minding their scars while blaming other women for vanity. Sophia for example, was proud that she had not chosen a keyhole surgery that would have resulted in no scars. This finding on conflicting feelings echoes Kent’s (2000) and Williamson et al.’s (2010) studies of people with disfigurements, where respondents similarly experienced shame about both their appearance and their supposed vanity.
For women who experience themselves as damaged goods the scar-related impact can be grave and multidimensional. The intensity of distress can be enormous for some participants. Candice described a time when she was ‘fixated’ on her scars. Karen, a 46-year-old accountant with scars from third degree burns over 70% of body, said that up until recently her scars used ‘to rule’ her life to the point where:

A couple of times I took some tablets. I just didn’t want to be alive anymore... No one ever is going to love me, you know, that sort of stuff.

Karen’s story lies at the more extreme end of the experience continuum. Yet other respondents who felt like damaged goods also reported a range of adverse consequences. Those who had acquired their scars in adulthood grieved over their lost looks. Candice, for example, said that when she’d go to the beach:

I’d be looking at other women’s stomachs… I’d wish I had my old stomach.

Participants also frequently worried about anticipated social reactions and were highly self-conscious when their scars were publicly visible. Bronwyn, a 40-year-old teacher who has five melanoma scars on her leg and back, and a scar near an armpit from a childhood burns accident, spoke about feeling awkward in public, particularly when her arm scar was visible:

I’m conscious of the fact that my [arm] scar is showing... I did athletics in summertime, and of course athletic uniforms are all singlet tops. So I couldn’t hide it… Whether people were actually looking at it, or I thought they were looking at it, I don’t know. But because you can see where the eyes are, you imagine, or you do see, that their eyes are wandering there... It was embarrassing...

In her examination of narratives of women with physical disabilities Miner (1997) writes that women tend to see their disabled bodies as personal failings, hold themselves responsible and feel shame. Research cited in chapter three also shows that shame features in reports of people with disfigurements. In this study, too, more than half of the respondents mentioned feelings of shame, worry that people may find them disgusting, and fear of disappointing others if their scars were revealed. Michaela, for example, said:

I felt ashamed about it [her scars] for years, really embarrassed… it was about disappointing people. You’ve got that preconceived notion about someone being the way they are, but when you have the scar it’s a tangible thing that makes you different to everyone else and… takes away from that perception. It’s really, really distressing.

As Michaela describes, this anxiety can be debilitating:

It could be really paralysing, the anxiety, the knots in the stomach. I used to get cramps in my foot… and heart palpitations. I to be so worried and nervous, particularly every time I’d go on holidays. I didn’t want to be with a group of people and swim at the beach… Tennis, swimming, dating could trigger this anxiety.

After acquiring scars, some women may also feel more self-conscious about other bodily ‘faults’ that previously had not worried them much. For example, Lora, a 31-year-old
social work student with numerous scars on her torso and limbs from self-harm and a road trauma, became distressed after getting red marks from sandfly bites:

When you already have so many imperfections, all these scars, every time something else happens it becomes a bigger deal than perhaps it should be… I just felt so bad about myself, I felt so disgusting, like I have all these red bites and then the scars, whereas if it was just the bites I wouldn’t be so worried about it.

These feelings of loss, anxiety over anticipated social responses, shame and self-consciousness about scars are consistent with the previous research on disfigurements discussed in chapter three. However, heightened self-consciousness about other appearance aspects is a new finding.

Some participants said that after acquiring scars their personalities changed. Namely, they became more introverted, less outgoing and less confident. As Shanty said:

If I didn’t have the scarring I’d be more confident, really. Confident in terms of the way I dress, how I act around men… I’d have had less inhibitions about myself and I think it’d have translated into being more confident.

Joanne, too, felt she lost confidence:

Before [the scars] I was a really out there person, very confident, didn’t have a problem entering a room full of people, always found something to talk to people about… Usually I wore all sorts of unusual, arty-farty clothes. And afterwards, I was much less outgoing, much more suspicious of people and much less open. I dressed in black and grey.

However, others told stories of positive changes, when they developed some appealing personality qualities to ‘compensate’ for their appearance or became more compassionate. Michaela, for example, attributes being and over-achiever, her sense of humour and her compassionate nature to having scars:

I feel my scars have affected me psychologically and I’ve developed an over-achieving attitude in most areas of my life as compensation… Also, people who were victimised at school, I used to stick up for them and that was the best thing about how my character shaped. I have a really strong sense of justice and I’m against ageism and accept people in all shapes and sizes.

Loss of confidence is a common theme in the literature on disfigurements, however few studies (usually qualitative) show people making positive attributions to their disfigurements. Such attributions are usually framed as ‘finding benefits’ and described as association of ‘personal growth’ with disfigurements. For example, in Wallace et al.’s (2007b) study of 6 adolescent girls with cancer-related disfigurements, some said they learned to place less importance on their looks. Similarly, in Williams et al.’s (2003) study of 8 women with burn scars, some constructed their becoming scarred as “an opportunity to define themselves differently and more meaningfully” (p.67). Several respondents from a study of 52 adolescents with burns (Williams et al., 2004) and
a study of 11 adolescents with appearance changes from meningococcal septicaemia (Wallace et al., 2007a) said that having disfigurements made them feel more empathy towards others.

Another recurring theme in the narratives of women who feel like damaged goods is that they think men must be feeling better about their scars. Michaela’s husband also has a scar (on his chest) and she said that he thinks ‘it’s very glamorous.’ Whereas Karen, who draws both on her own experiences and on her work with other burns survivors, thinks that:

Women are more conscious of scarring than men. Women are more into ‘what do I look like’, and presenting themselves nicely, whereas men just want to be blokes... ‘It doesn’t bother me’, that sort of thing… I think it’s an ego thing really.

Such subjective accounts from women with scars can contribute to debates in the literature on disfigurements about the importance of gender.

The impact of scars on respondents’ romantic and sexual lives (here, the terms ‘sexual’ and ‘sexuality’ include any form of physical intimacy) was a particularly strong theme. Women who felt like damaged goods often said scars had a negative effect on their confidence in this area. Manuela, a fashion design student with abdominal scars from complications after a cosmetic surgery, felt significantly less sexually attractive because of her scars:

I’m 25 and I’ll never wear sexy lingerie, it’s not sexy because of the scars on me.

Manuela, like some other single participants, felt that her romantic prospects might be affected because of her scars and felt anxious about dating:

Now I’m dating all the time. You meet people, go for coffee… and you think, what would they say [if they knew she had scars]… like if they wouldn’t care, or think it’s terrible… And I don’t want guys to ask me questions and to explain myself. It’s almost like I have to apologise for the way I look before I have sex. Every time I’ve started dating someone new it’s been really, really stressful. I’m very self-conscious about my scars.

Similarly, Meg, a 43-year-old divorced poetess with a caesarean scar, said:

I wonder about men [she dates]… What would they think? Would they find my scar unattractive? So I’m self-conscious about it.

Several participants also talked about compromises they made in their romantic choices by partnering with men they were not excited about, because they assumed no one else would want them. Karen said this was one of the reasons why she married her second husband:
I just sort of took whatever I got. I took second best with my second marriage... He loved me, no matter my burns, and I think I married him for the wrong reasons...

Three women said that, to compensate for their scars, they chose good-looking partners at the expense of other qualities. Michaela, a pretty woman herself, made such choices several times:

> It was a self-esteem thing... If I didn’t have scars, I think I wouldn’t have been that preoccupied with seeking someone beautiful to make me feel better. I’d be more looking at the person.

Existing intimate relationships can also be negatively affected. Participants who feel like damaged goods often reported decreased sexual satisfaction: they felt non-sexual and were distracted during sex with thoughts about their scars or with attempts to conceal them. Often women refused to have sex in lit places or during the day, were reluctant to be nude around their partners and refused to be touched in the locations of their scars. Joanne said that since she had acquired her scars:

> I never show my body to my husband anymore... I don’t feel desirable. Every time I see it [her scars] I get such a shock and I think he must too...

Several participants said they were less physically affectionate with their partners, because they felt bad about their bodies. Karen felt that such behaviour damaged her two marriages which both ended in divorce:

> My first husband... I just stuffed it up big time. I wouldn’t let him see me naked... The first thing men go for is boobs and that’s where I feel protective, because this is where I got burnt. I’ve got no nipples. And I feel like ‘don’t go there’, that sort of thing... Fortunately I didn’t get burnt in my private bits [laughs].

Women who feel like damaged goods also tend to be less sexually ‘promiscuous’, because they do not want to disappoint lovers by revealing their scars and face sexual rejection.

Several existing studies (Jafferany, 2007; Porter et al., 1990; Rumsey et al., 2010; Van Loey & Van Son, 2003; Wahl et al., 2002) mention the intimate difficulties of people with disfigurements, and scars in particular (Brown et al., 2008), namely difficulties interacting with members of the gender to which they are attracted, beginning sexual intimacy with new partners and maintaining satisfactory sexual life with existing partners. However, overall, little is currently known about the impact of disfigurements on intimate behaviour (Rumsey et al., 2010; Wisely & Gaskell, 2012). Nor do these issues feature much in existing interventions for people with disfigurements. This lack of attention to intimacy is surprising, particularly given the established importance of how women in the
general population feel about their bodies with regard to their sexual functioning (Pujols, Meston & Seal, 2010; Woertman & Van Den Brink, 2012).

Summary

Most of the negative consequences embedded in the experiences of participants who feel like damaged goods correspond with existing research on disfigurements, including Brown et al.’s (2008) study of scars. As discussed in chapter three, negative body image, low self-confidence, social anxiety, self-consciousness, feelings of loss and shame and personality changes have been previously noted in other studies. Self-accusations of vanity are a less noted feature in the literature; this study lends support to this emerging finding, but also a more detailed examination of it. This study also provides more detail about positive psychological changes that can be associated with disfigurements. Additionally, this thesis identifies the negative impact of disfigurements in intimate domains as one of the central concerns raised by participants and adds a new finding about feelings of romantic compromise. Other new findings here concern scars exacerbating other appearance concerns and the comparisons women make between their experiences and those of men.

Having Self-revealing Body

The ‘having self-revealing body’ sub-category encompasses women’s framings of their scars as related to their self-identity. ‘Self-revealing body’ is a term I coined inspired by the current theorisation of the body, which - as discussed in chapter two – directs our attention to bodies increasingly becoming vehicles for self-expression and for impression formation.

Being marked by scars means that the marked person has endured at least some discomfort in an event that was likely to be ‘out of the ordinary’ and that a degree of adaptation, and perhaps resilience, was required in the aftermath of such an event. Thus, scars provide potent grounds for speculation about their bearers’ biographies and even character. This theme was reflected in almost all participants’ stories. Respondents experienced their scarred bodies as texts which reveal true or false information about who they are: stories they are proud or ashamed of; stories that do, or do not, reflect their versions of themselves. As Lora said:

If you see someone overweight, you just see someone overweight. But if you see someone with scars, then it’s ‘where is this scar from?’ What’s upsetting for me is this idea of people looking at me and trying to work out what’s the story and judging me.
This study also reveals the significance of scars as embodied memory. In this fashion, being marked means scars can communicate information about the self also to their bearers. Even when women do not want to recall what they have endured, the scars are there to remind them (although sometimes scars can also physically fade and be forgotten). Yet some memories can also validate lived experiences and even become sources of pride rather than distress. The following sub-sections discuss three types of self-revelations scars may provide: spoiled identity, reminder to self and enhanced identity.

**Spoiled Identity**

The ‘spoiled identity’ code is derived from Goffman’s theory of stigma discussed in chapter two. This term refers here to the social process whereby people read scars in stigmatising ways and to participants’ concerns that their scars can assign them a stigmatised identity. Predominant spoiled identities mentioned were: being mentally unstable, a victim and a patient.

Women with self-harm scars were usually most concerned about how people ‘read’ their scars, fearing these mark them as mentally unstable, even if they have harmed themselves in a distant past and/or in a one-off incident. As Sarah, a 24-year-old arts student who during one depressive episode made slashes on her thighs, said:

> Those scars, they’re extremely loaded. There will always be the assumption: this person is a fruit cake, this person is insane… I don’t think there is anyone whom I could explain what they are to... Like, you become the crazy person. You become the self-harmer… So even if now I’m better, I still have these marks on me.

Self-harm scars can often be easily recognised for what they are, as in the case of Lola, a 32-year-old social work student with raised scars on her wrists and several slashes on her ankle:

> I feel that because of where they [scars] are it’s quite obvious what they are. It’s a quite revelatory thing to show to someone, like it tells a lot about me without me having a say in it... I want to appear to other people as normal, but my scars won’t let me do this.

Thus, self-harm scars can betray what women want to keep secret, revealing a past they are ashamed of and potentially rendering them as ‘unstable’ even in the present. As Lola’s story shows, women with these scars often feel they lose control over disclosure of sensitive information. Lola describes feeling self-conscious because of this:

> If I put my hand up, I’m conscious that someone might see them [scars]... Even just sitting with my wrist up is quite weird.

Potentially such scars can also interfere with the development of intimate relationships by revealing difficult information when the relationship is just beginning. Even when the
scars are concealed or are in naturally hidden locations, they may be discovered in intimate situations and women may have to disclose their past difficulties before they are ready. As Lola said:

My boyfriend would notice the scars and say, “What the hell is that?”... You get vulnerable with your partner at some point, but to have to do it earlier on, or maybe at a time I am not in control of... This way I lose control of when I discuss it.

Women with self-harm scars also worried that their scars could potentially discredit their professional competence in the eyes of their colleagues, clients or during job interviews. Lola had such concerns:

[clients would] think, “What’s wrong with that girl? She hasn’t got the answers”... Also in a job interview I’d be very self-conscious and that’s about wanting to look professional, wanting to present as a competent person who has got their shit together. So it affected me in terms of my confidence and how I want to present myself as a professional.

The fear and shame can be so great that Sara and Lora, who both had scars from self-harm and from other causes, disclosed to me their self-harm scars only at a late stage of their interviews.

Some participants worried that their scars, particularly if they were acquired in traumatic circumstances, might render them as victims. They wanted to avoid pity and, as in Bronwyn’s case, avoid people interpreting how they acquired their scars in more negative ways than they felt about that. Bronwyn received her arm scar when she was eleven during a woodwork class when a classmate accidentally dropped a hot nail into her shirt. Bronwyn said she forgave the boy but whenever she recounted this story, people got angry with the boy, which made her feel a victim.

Among women who acquired their scars through treatments for medical conditions, only those with cancer-related scars were concerned about being identified as ‘patients’ and being pitied. As Rosa, a 55-year-old speech therapist, said:

When I was meeting people... I wanted to meet them normally, not ‘I’m Rosa and I’ve had a melanoma, this is my story.’ I’d rather have attention somewhere else.
Possibly this difference with scars from cancer-related treatments arises because of the possibility of its return, and women’s attempts to normalise their lives despite this. Participants did not want to be ‘forced’ into an identity they felt was not theirs. Bronwyn, for example, did not feel she had a ‘proper cancer’, because her melanoma was treated quickly and she did not have chemotherapy:

I find it funny when people say to me ‘You’re a cancer survivor’ and I go, ‘Well, I didn’t even know I had it...’ As far as I knew, I didn’t even have cancer. So to call me a cancer survivor, I don’t think so!

Some respondents also worried their scars marked them with a false spoiled identity. Helen, a 57-year-old bureaucrat with a chest scar from heart surgery, described feeling distress when a stranger misinterpreted the cause of her scar:

I was in Bali, and an Australian tourist made some assumption that I’d had an adult heart operation, which I associate with having a bad lifestyle. So I said ‘No, no. This was a childhood congenital heart condition. I haven’t led a dissolute life.’

This finding is consistent with other studies (Brown et al., 2008; Rumsey et al., 2010), where participants feared they would be falsely judged as criminals, self-harmers, unhealthy or contagious.

In summary, consequences for women with spoiled identity concerns can be distressing: they can feel self-conscious, shame and anxiety in anticipation of interrogations, pity and stigmatisation. They may worry about being defined by their scars and the stories attached to them, and some are concerned about their intimate and professional prospects.

Reminder to Self

The ‘reminder to self’ code refers to the memories attached to scars and the rumination these memories may trigger in women. This rumination can be meaningful or even positive, but more often it is distressing. Michelle, for example, wanted to release her anger at the owner of the dog that bit her, but her scar served as a continuous reminder of what had happened:

He [the owner] was awful. The trauma came a lot from this... So sometimes when I look at my scar I think this came from that bastard.

For Nellie, a 52-year-old teacher, her scars bring up memories of trauma and pain, and rumination about her thwarted dream to make a new life for herself. Nellie was enjoying living in Indonesia, teaching English, when she had a motorbike accident that resulted in numerous injuries, including a shattered pelvis. The amount of care Nellie needed following the accident meant she had to return to Australia to live near her family:
I was just getting settled and organised, and getting on with my life… It [the accident] cut it off completely.

**Photo three: One of Nelly’s numerous scars**

These findings are consistent with Wallace et al.’s (2007a) study of adolescents with appearance changes resulting from meningococcal septicaemia, who also reported that their scars reminded them of their illness, and are also consistent with Brown et al.’s (2008) findings that scars reminded people of the trauma of their causation.

For some participants, their scars reminded them of their physical fragility and mortality, thus triggering distress not only about the past and present, but also about the future. For example, Michelle said her scar reminded her daily that she was ‘made of flesh and could be damaged’. Cancer-related scars particularly evoke such fears, since they remind women of the potential recurrence of cancer. Stacy, a 43-year-old poet with two large melanoma scars on her limbs and many small scars all over her body from mole removals, eloquently said her scars made her think of her body as ‘treacherous’, as capable of turning on her any time:

> You think you’re okay and in actual fact you’re not. You don’t know what lies dormant inside you.

Stacy expressed these concerns in a poem she wrote in lieu of an elicited text:

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Somewhere below the surface
In the depth of darkness
As dense as granite rock
As surreal as any dream
Lies the unknown, biding time
Buried deep within
The skin you’re in
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This finding corresponds with previous research into impact of cancer-related appearance changes (Harcourt & Frith, 2008; Wallace et al., 2007b), where respondents also reported their changed appearance interfered with their efforts to get over the illness and move on, because it could “act as vivid, constant reminders” (Frith & Harcourt 2005, p.2) that cancer may recur.
Scars can also be experienced by women as important records of their lives, marks of their resilience and endurance. Sophia, a 53-year-old journalist with an abdominal scar from a kidney removal sees her scar as a reminder of her victory over her illness and is fond of her scar:

I’m actually so pleased with it [her scar] that I have a fantasy that if my other side ever goes, I’d have a matching scar.

Scars can assist with women’s personal growth, which is in line with the literature cited in chapter three, by triggering meaningful rumination about participants’ life priorities, how the women have changed for the better since the scar acquisition, or what they have learned as a consequence. For example, Gemma, a 55-year-old researcher with two scars from complications of breast reduction surgery, said scars make her think of lessons she learned from that experience: to not blindly trust doctors and not alter her body for the wrong reasons. In her text she wrote:

On my body they [scars] are skin deep but etched into my conscious mind is the wisdom they’ve helped me to acquire… the self-confidence which transcends the image of the body… They have toughened me up… If I should lose sight of my scars, I’d grieve their loss… They are a part of me, acknowledgement that a change has taken place.

Such framings of scars correspond with Rumsey et al.’s (2010) study where some participants reported personal growth resulting from disfigurements, such as becoming more resourceful and resilient, being calmer, improving relationships, understanding other people more, being able to deal with difficulties and trying new things.

For some respondents, their scars became visual metaphors of who they are in the present. For Meg, her caesarean scar reminds her that she is a mother and she finds this disturbing. She wrote in her text:

Since I got my scar... my body is… no longer the body of a young woman. It is the body of a mother… Integrating being a mother into my identity was very difficult for me and the scar is a real mark of it. Our culture has very negative images about motherhood, very traditional images… You know how men find it difficult to be attracted to their wives after they’ve had a baby, because now they’re mothers. Being attracted to a woman who is a mother is a taboo.

But usually when participants associated their scars with their current identity the metaphors were more positive as the next sub-section shows.

In summary, scars mark women with memories that are sometimes disturbing, yet cannot be forgotten because of the scars. Thus, scars can trigger painful rumination about past trauma, bodily suffering, unresolved anger and disappointment. This study also supports the theoretical argument discussed in chapter two that scars can disrupt our
claims of invincibility. However, scars can also trigger positive rumination about their bearers’ strengths and assist self-growth.

Enhanced Identity

The ‘enhanced identity’ code is derived from Goffman’s concept of spoiled identity, signifying its antonym – a socially valued identity. Some respondents (n=6), albeit only those with non-stigmatising and relatively minor scars, felt their scars marked them positively by rendering them unique and/or interesting. Liz typifies such a framing. A 58-year-old academic, she is a good-looking woman with a pale, smooth and straight scar on her lower abdomen from an appendicitis removal. The story of the surgery includes complications, but her scar, she said, is ‘good’:

If anything, I’m a bit more interesting, because I have a written story… it [the scar] causes me no grief. On a baseline it can only go up, because it gave me something interesting.

Similarly Haya, a 35-year-old doctor with a single long and pale abdominal scar from a gallbladder removal, thinks her scar enhances her:

It does give you some character to your body, like something is different about you… Maybe not the scar itself, but the fact that I had a really big operation at 16… I had a story to tell. In that way it probably had a positive effect.

Lynne, a 58-year-old bureaucrat with a single, medium-sized, smooth scar on her thigh from a childhood accident, always felt ’special’ because of her scar:

I suppose once I survived it [a tree stump piercing her thigh], and had the stitches, it was… something to show off about: ‘Look at my scar! None of you have a scar like that’… So at school I was the centre of attention because I had to have a crutch for a while and I had this scar… I never felt embarrassed about it, or have seen it as a disfigurement… My scar is an important part of my body in the sense that it is… something distinctive about me and you always look for things that might make you stand out.
Such framings of scars make sense in a cultural climate where women, as discussed in chapter two, are often stigmatised for making their bodies unique through tattoos and scarification while for men these can be viewed as heroic or even aesthetic endeavours. Scars, if they are not stigmatising, are seen as involuntary marks. Thus they can mark women as unique and heroic (not beautiful though) without the social stigmatisation associated with body modification.

Layers and Ambivalence of Being Marked

Despite the distinct sub-categories I created to identify experiences of being marked, for most respondents being marked is a layered, ambivalent, and, at times contradictory experience that can encompass several of these sub-categories simultaneously, or fluctuate between them. As discussed in chapter two, this finding is consistent with women’s overall relationships with their bodies that are often complex and ambivalent.

Most commonly, respondents’ narratives showed that scars at once marked them as damaged goods and served as painful reminders of suffering and vulnerability, but were also positive metaphors of survival and resilience. Rosa exemplifies such an attitude:

It [scars] was about what it looked like, in my vain years, but it was also about the mortality... and the last eight years... it’s been a badge of honour.

Whereas Lynne who, as discussed earlier, does not see her scar as disfiguring, but thinks it makes her interesting, sometimes also experiences her scar as a painful embodied memory of her traumatic childhood accident. At other times, Lynne sees her scar just as a natural part of her body.

In more than a half of the interviews women expressed ambivalence about their scars. For example, Rivka, a 49-year-old yoga teacher with two abdominal scars and a chest scar from various causes, fluctuated between saying her scars, which once upset her greatly, did not matter anymore to saying they still bothered her. Similarly, Stacy said of her leg scar:

The scar is what saved my life. I don’t hate it. I just don’t... show it around.

Manuela, too, perceived her scars as ‘disgusting’, but also said ‘sometimes I think they look good.’ Moreover, although Manuela’s scars have caused her much emotional pain, she also experienced them as an integral part of her identity, a reminder of her near-death experience following complications from surgery:
I don’t want not to have them [scars]. I just don’t want them to be so big… Those four to five weeks [of hospitalisation] were so bad, I was like sometimes ‘Mum, I want to die’. So after that I was proud of my scars, proud of everything I went through. But now sometimes it’s hard… Still, with the scars, I always felt like this is me.

Whereas for Shirley, a 53-year-old teacher with six scars on her body from road trauma, her feelings about her scars fluctuated daily between 2 to 5 on the ordinal scale:

I have days when I feel okay, and there are days when I feel sick to actually see them... I don’t feel like this about all my scars. I know some of them are fine and the doctor did a good job... but other times I look at them and I think: they’re horrible.

Yet regardless of whether women felt distressed, ambivalent about their scars, or accepted them, they all had to deal with social responses to their scars which were beyond their control.

**Dealing with Social Responses**

As discussed in chapters two and three, bodies that deviate from cultural norms are likely to draw social attention. Indeed, for the vast majority of participants, dealing with social responses to their scars was the most significant element in the being marked experience. This sub-category describes the social processes embedded in being marked through capturing trends in responses to non-facial scars as reported by respondents. Additionally, this sub-category describes how these responses shape women’s feelings and thoughts about themselves. As chapters two and three show, people’s perceptions of their bodies are shaped and modified through their social interactions. Orbach (2010) describes this eloquently: “It is hard to separate out the ways bodies are seen, talked about and written about and the effect of that on our personal perception of our own bodies and other bodies” (p.4). Indeed, the data from this study indicates that how women perceive their scars is bound with how others react to the scars. Overall, women’s narratives featured four main (sometimes contradictory) responses to their scars: confessional discourse, minimisation, scar fuss and liberation discourse. The following sub-sections describe these responses.

**Confessional discourse**

The term ‘confessional discourse’ was developed by me. Confessional discourse refers to the most common social response identified in the data - curiosity about the stories behind scars and subsequent attempts to elicit a confession (here ‘confession’ refers to information people are more likely to release under pressure than to volunteer).
According to participants, many people, whether acquaintances or strangers, felt entitled to query them about how they received their scars, if these were visible in public. Bronwyn described strangers asking her about the scar on her arm:

They’d go: ‘Oh, love, how did you get this? What happened there?’ Like, in a shop or something… It’s just another thing you have to explain. You know, you get sick of telling the story all the time… It’s like if she’s comfortable with showing it, she must be okay talking about it. I’d never ask somebody about their scar, because I know what it’s like. Just because you have something on display, doesn’t mean you need to talk about it.

Karen, too, said that strangers approached her in places such as shopping centres or her children’s school. Shanty, whose scars are usually hidden, said people could be vigilant in spotting them:

If somebody catches a sight of this [scar], if something [her clothes] moves, they say ‘What’s that?’

Confessional discourse from lovers can be also hurtful, as Bronwyn’s story demonstrates:

Over the years I’ve been with guys who actually asked me about it [her scars] and you just think ‘Oh my God, I don’t want to be talking about my scars when we’re supposed to be doing something else…’ And I had a guy saying, ‘Oh my God, what happened here? You have scars all over the place.’ And if you’re becoming intimate with someone, you don’t really want to be rehashing war stories.

Small children in particular tend to ask about scars, but – possibly because they are less socially conditioned - they tend to be more compassionate about scars than adults. For example, after Shirley recovered from her accident and returned to work at school, her nine-year-old students were interested in her scars but without judgement. They even asked to touch them. Similarly, Shirley’s grandson was fascinated by her scars and volunteered to anoint them with oil.

However, adolescents can be cruel. Karen endured much bullying at her high school:

In my school kids were very cruel… I was pretty well isolated with all the geeky people, or people who were different... and it affected my self-esteem a lot. To the point that I tried to take my life a few times in high school. It’s hard, because unfortunately kids back in those days judged what you looked like and they didn’t really care what they called you. So yeah, growing up at a high school was the hardest… I sort of remember being called ‘inferno’… The name calling, the teasing, it pushed me to the point where I couldn’t cope anymore.

Some women said they did not mind answering questions and three women even reported enjoying such attention. But most found enquiries about their scars distressing and intrusive, and spoke of feeling self-conscious. Women often felt a loss of privacy and control over disclosure. As Karen said, ‘I’m in defence mode since I was burnt.’
Answering questions about scars may mean revisiting difficult experiences. Whereas women with cancer-related scars, as discussed earlier, did not want to bring the illness into their consciousness, but people’s questions made them aware of it again. Rosa is one of those women who wanted to forget they had had cancer:

And I remember sitting there [in a resort] in front of the fire and somebody saw it [her scar] and said, ‘Oh, what’s that? Is that a burn?’… It sort of made me aware of it. You know, when you are trying to forget something, you don’t give it oxygen. You pretend it doesn’t exist. And I guess I just wanted to block it. But I had to think about it, and I did a lot of thinking about it and my own mortality… I didn’t want to talk about the melanoma, about the fact that it was potentially fatal, about my dad who died from it. I didn’t want to think about it.

Dealing with confessional discourse reactions led many women to conceal their scars, as is discussed in chapter six.

These findings about confessional discourse are compatible with the research on disfigurements discussed in chapter three, which shows that unsolicited interrogations are common. The findings are particularly fitting with Brown et al.’s (2008) study of scars, which found that “when meeting new people the inevitable questions and explanations about the scar were found to be exasperating, awkward and often recalled bad memories” (p.1053).

Scar Fuss and Minimisation

‘Scar fuss’ and ‘minimisation’ are codes I have developed and discuss together, because both describe social attention toward the appearance of scars rather than to the stories behind them. The codes signify two contradictory yet co-existing discourses. Scar fuss refers to a collection of responses which indicate that scars turn women into damaged goods. Minimisation refers to responses that downplay women’s appearance concerns about their scars, urging them to accept themselves. This study’s findings indicate that it is equally common for women to encounter people who fuss over their scars and those who minimise them.

Scar fuss responses can often come from strangers. Some women reported people staring, pointing at them, or making derogatory comments. Karen recounted many distressing incidents, such as the following:

I was at Target at the checkout and I could hear this girl behind me: ‘Oh, look, she has these burns on her arms, oh yuck!’… My whole body just felt clammy straight away. I knew she was talking about me. I turned around to say something and this girl was about 12 or 13. And I said: ‘You know, it’s rude to stare’. And her mother grabbed her arm and said: ‘She wasn’t staring, she was actually commenting on how smooth your skin was.’ These exact words… I felt like it was a lifetime there in that checkout. I couldn’t wait to get through. I got out of the shop, I went to my car and burst into tears… I just felt like I was going to die. I just wanted to die.
Such responses to scars can leave a lingering impact on self-identity, as Karen can testify:

When you get called names, like freak and inferno, over and over and over again, you sort of start to think, ‘Well, maybe I am a freak. Maybe I’m not normal’…

Photo five: Karen who has burns on 70 per cent of her body.

Fussing responses can also come from friends, family and various professionals. Often these would be well-meaning suggestions for women to cover or ‘fix’ their scars. However, even such well-meaning fuss can be experienced as painful, since it suggests scars are something to be ashamed of and also because most scars are resistant to ‘fixing’.

Manuela was not even concerned with her scars in the first months following her cosmetic surgery until she encountered scar fuss. Initially, she just felt grateful to be alive and for her new, slimmer, body:

I didn’t care at the start… I never thought about scars as disgusting. I myself always found scars cool. But that’s me, that’s not the general concept. I went to a massage therapist and she was like ‘Oh my God, you had a surgery! What scars! That’s so bad!’ and I was feeling at that time amazing, because I’d had the surgery and I was thinner. I just had fun. And my mom… she really wanted me to do something about the scars, fix them, but there wasn’t much to do. My mom was stressing about it. She obviously didn’t mean bad. Sometimes my friends too… Like, one friend was talking about a girl and he said, ‘Look at her, she has this ugly scar…’ and I felt really bad - that could be me.

Following such responses, Manuela came to feel she was ‘damaged goods’ and became ‘obsessed’ with her scars.

Several women with disfiguring scars said they felt disturbed when people referred to their scars as ‘big’ or ‘serious’, since such responses accentuated their own concerns. My experience is similar. Once, for example, a beautician saw my leg scars during a treatment and, possibly to show her sympathy, referred to my leg scar as ‘shocking’. Her response validated my fear that I may appear revolting to others. However, women with less disfiguring scars can find scar fuss comforting in their

14 As discussed in chapter four, Karen - an experienced public speaker on issues pertinent to burns survivors - did not wish to remain anonymous and created this photo specifically for this study.
validation of their distress, as in Michelle’s case. Even though Michelle’s leg scar is not that disfiguring, it concerns her:

My other leg is all normal and perfect… I do feel like I’m damaged. It’s always nice when people acknowledge that yes, I have this big chunk [of flesh taken out]… It’s kind of nice when they actually see it and go: ‘Oh, my God, it’s a big scar, you poor thing.’

Some of the most painful instances of scar fuss participants reported were from either existing or potential lovers. Although such stories were few, women seemed to be deeply affected by them, even if these happened years ago and were followed by positive intimate experiences. Michaela, for example, who had many committed relationships and was happily married at the time of interview, was still affected by what happened to her at 17:

My brother-in-law’s friend was flirting with me, an older man, and he was very good looking. And I remember we went to the beach and I was trying to be true to who I am [she exposed her scarred legs], and he didn’t talk to me. So that was a tangible moment, very humiliating. He’d flirted with me for days before … I didn’t regret it [showing her scars], because I thought, ‘You’re a dick if you are… How absurd that you can’t see me as a person if I had some burn scars.’ And he couldn’t look at me and wouldn’t even talk to me… You feel you’re being diminished.

Manuela also told a story of a failed courtship:

There was this guy I started dating. He cared about his body and had the most amazing personal trainer. When we started being close, I said: ‘I have scars.’ And he said: ‘If this had happened to me, I’d have killed the guy [the surgeon].’ And I was just like, ‘Don’t talk to me!’

However, more often participants recounted positive intimate experiences, where men did not make a fuss about the scars. As Rivka pointed out, if anyone fusses over her scars during intimate situations it would be her, not her partners:

More my own self-consciousness. Probably in terms of leaving the lights off… I sometimes think that men don’t actually look anyway. They are not interested in scars… They just want to touch and feel.

Rivka’s, and stories similar to hers, resonated with my own experiences of intimacy, where I cared about my scars more than my partners did.

If anything, the women’s stories revealed that partners were more likely to minimise scars than fuss over them. Madeleine, a 40-year-old finance clerk with an abdominal scar from a road trauma, said whenever she tried to discuss her scar-related distress with her two former husbands, they accused her of vanity. With friends and family, according to participants, if they did not fuss over the scars they often minimised them. Respondents described such attitudes as unhelpful, blaming the victim and making them feel guilty. Shanty, for example, said that when friends told her not to worry about her scars, she felt they blamed her for her distress:
When people say ‘Don’t be silly, don’t be silly, don’t be silly, just ignore it’, I think: ‘What’s wrong with me? I need to just ignore it’. But it’s hard…

Michaela described similar experiences:

This is another thing people with scars deal with, like, ‘Get over it, you aren’t disabled. Are you just being vain? Are you just preoccupied with something that in the big scheme of things is not that important?’ But the reality is it [scars] is enormously damaging because we live in a world where it is seen as completely awful. And particularly in western culture. I felt I just had to suck it up, not to be pathetic.

These findings about minimisation echo in some ways findings from a small study (=15) of people with facial disfigurements in Denmark (Kondrasen, Kirkevold, McCallin, Caye-Thomasen & Zoffmann, 2012) where respondents reported an unwillingness of their loved ones to acknowledge their appearance-related difficulties. The findings about scar fuss correspond with negative social responses noted in the literature discussed in chapter three, and they provide more nuances by distinguishing between the responses from strangers, friends, family and intimate partners, and the differing impact of such responses.

Liberation discourse

‘Liberation discourse’ is a code I coined. It relates closely to minimisation, since it is also about people (usually family and friends) urging respondents to accept their scars, in this instance by asking them to liberate themselves by stopping concealing them. Women usually felt such advice came from a good place, but that those who gave them did not grasp the bearers’ reasons for concealment, how challenging it can be to face the world from within a marked body. Such responses made women feel judged for not being more ‘courageous,’ and misunderstood. Stacy, for example, concealed her scars because she abhorred the idea that someone might pity her and found her friends’ liberation urgings unhelpful. For example, a friend said to her:

‘You should be proud of your scar, you should show this off… It’s something you’ve been through’. And I said, ‘Yeah, I can see what you’re saying, but no’. Once you’ve seen something it’s on your mind and I don’t want people to think of me: ‘Oh, here is Stacy with a scar’… Because if you know something about someone that is not nice, you feel sorry or whatever. And I don’t feel sorry for myself, because I wouldn’t have been alive if I hadn’t had this scar.

Summary

It seems that scars are a body loaded with social meanings on which surface contemporary anxieties play themselves with gusto. The main responses to scars identified in the data support empirically some theorisation of the relationship between the self and body, discussed in chapter two, by showing fear and fascination to be
underlying responses to scars. People also seem to view scars as the key to women’s characters and/or as an opportunity to hear an interesting story that is out of ordinary and, as such, is unlikely to happen to them. It also seems that the coexisting attitudes of scar fuss, and minimisation and liberation discourse are symptomatic of the paradoxical contemporary expectations that women should at once perfect their bodies and accept them.

The effects of the aforementioned social interactions can have a lasting impact on women. This study seems to support Inckle’s (2007) argument, based on her research of women with self-harm scars and tattoos, that women with ‘non-normative’ bodies are often policed and shamed by society. But while the literature focuses on insults and interrogations as affecting negatively people with disfigurements, this study uncovers also more subtle yet problematic discourses operating in our society. It appears that policing and shaming are often grounded in good intentions: the desire to ‘liberate’ women, minimise their concerns or help them ‘fix’ their ‘problem’. Consequently, this study’s findings showing that some types of support may do more harm than help add nuances to the existing findings in disfigurement research about the positive importance of perceived social support from family and friends. This research shows not any support will do.

The intensity of the negative impact of scars

Scar-related distress, as discussed so far, can be summed up as being often profound and lasting. Yet it is not always static or constant. Rather, living with non-facial scars can be best conceptualised as a dynamic process with women experiencing their scars intermittently as salient or not, and in a variety of ways: as disfiguring, stigmatising, meaningful or enhancing. As discussed earlier, most participants had mixed feelings about their scars, whereas their distress varied in intensity. While some reported little distress, others said scars profoundly reduced their wellbeing. Shanty, for example, said:

I feel as though the impact has been huge, huge… Every week it’ll come into my head. If I could change one thing about myself, it would be scars at the top of the list.

Overall, scar-related distress was prevalent, and it was not unusual for women to burst into tears during our interviews. As discussed in chapter four, I evaluated participants’ distress through interview and text analyses, and also by using a five-point ordinal scale. On this scale, more than two thirds of respondents (n=22) rated their distress as being 2 or higher either at present or during some past years, with ten women
rating their levels of distress as 3 or higher. Such changes in the intensity, and sometimes also in the nature, of the impact will be discussed in chapter seven. The next section discusses some of the factors that influence the nature and intensity of scar impact.

**Permanent Mediating Factors**

It is difficult, if not impossible, to infer causal links between women’s lived experiences of their non-facial scars and other factors in their lives. For example, the distress participants attributed as arising from their scars can sometimes, at least partially, stem from other sources, such as participants’ quest for perfection as Candice said about herself, or their overall satisfaction with their lives. Still, disfigurement research and this study show some factors to be more significant in shaping women’s adjustment. Chapter seven explores in detail fluid factors, whereas this section introduces more permanent factors in women’s lives, which participants’ narratives revealed as most important. These can be divided into the physical (disfigurement degree and scar aetiology) and the psychological (appearance attitudes, anticipated stigma and personality traits) factors. Most codes in the ‘permanent mediating factors’ sub-category are derived from the literature on disfigurements. Code names derived from other sources are indicated in the text.

**Disfigurement degree**

As discussed in chapter four, participants’ and my impressions of the severity of scar disfigurement were measured using a five-point ordinal scale. These did not differ much. In eight cases I rated the disfigurement higher than respondents did, and in nine cases lower. Apart from in three instances, the rating differences were minor, ranging between 0.5-1. All other ratings (n=13) were identical. It is possible that the similarity between our ratings was partly due to the qualitative study design, where meanings can be co-produced. However, I took care not to share with participants my impressions of their scars so as not to influence their self-ratings.

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15 Three women reported no negative impact – Beth, a 33-year-old social worker with a neat caesarean scar, and Helen and Liz who both, as aforementioned, have neat single scars from successful surgical procedures. Five women rated their degree of distress as 1.
To distinguish between degrees of disfigurement, scars rated 2.5 or higher by both me and the participant, or by me only, are defined here as ‘severe’. This group comprised nine women. Scars rated 1.5-2 by me and the participant, or by me only, are defined as ‘mild’, with 12 women having such scars. Whereas nine participants had ‘minor’ scars, meaning they were rated by me and the participant, or by me only, between 0.5-1. Thus, the sample numbers for the three identified disfigurement levels were distributed almost equally.

Some women in the minor category had a single, smooth, pale scar. Such scars did not usually distress them much, even if the scars were quite large. As Lynne said about her thigh scar:

I don’t think it attracted a lot of attention, because it’s just a straight scar.

Other women with minor scars had several small, smooth and pale scars. Such scars were less predictive of distress. So were those in the ‘mild’ category. Women with severe scarring experienced the highest levels of distress even when many ameliorating factors discussed further were present.

Photo six: An example of severe scarring

Consistently with the literature discussed in chapter two, for women with severe scarring, distress usually extends beyond appearance concerns, since such scarring is acquired in difficult circumstances and is often associated with painful memories. Interestingly, though, in terms of appearance concerns, women perceived scars with abnormal shape and texture as the most disfiguring and therefore most distressing, even when these were small. As Michelle said:
If I just had the little triangular scar [on her thigh], no problem… But it’s also having this dent [on the same scar], having a hole, this is what I don’t like.

Similarly, Joanne was most distressed about the shape of her abdominal scars:

When I was younger, people used to think I was pregnant because of the bulge, which is pretty humiliating. When I look down on it, it’s like a bum… It looks like a bottom. So horrible...

Whereas Lora, like some others, saw the quantity of her scars as the most distressing aspect:

I feel tired of my body... Maybe one or two cuts are okay, but I have so many. I basically have no part of my body I’m happy with. My arms, my legs, my stomach, they all bear scars.

In summary, this study’s data indicates that most minor and mild scars (but not the single pale and smooth ones that were usually predictive of low distress), were not predictive of distress levels, and their impact is varied and dependent on various other mediating factors. Whereas severe scarring is predictive of higher levels of distress. Additionally, abnormality in the shape and texture, and large numbers of scars, are the most upsetting disfiguring aspects for participants. These findings contrast much of the research discussed in chapter three, including that of Brown et al. (2010), the only study to investigate (quantitatively) the relationship between disfigurement degree of scars and scar-related distress, which showed that disfigurement degree does not matter. The data from this thesis shows this does matter to some extent. This difference may be attributed to the qualitative design of this study which allows for finer nuances in data to be captured. Also, as discussed in chapter three, often samples of people with disfigurements are drawn from clinical populations (Brown et al. (2010) too sampled from patients of a specialist scar service). Such respondents actively seek to treat their disfigurements or related conditions, which means they are likely being more distressed than the general population, regardless of the objective disfigurement severity. Most realistic people with scars do not attend such services because, as discussed, scars usually cannot be improved considerably with cosmetic treatment. Indeed, in Brown et al.’s study, participants’ and researchers’ scar ratings differed significantly at times, but not here. Another reason for the incompatibility between findings from this study and some other studies of disfigurements may be that many researchers, as discussed in chapter three, measure distress with clinical symptoms. It is possible that people who exhibit clinical symptoms appraise their scars less realistically, and that the physical aspects of scars are more significant in predicting ordinary rather than clinical distress.
Scar aetiology

The importance of how scars were acquired in mediating adjustment featured prominently in the data. Table three ‘Aetiology of scars’ shows, in alphabetical order, the breakdown of the 30 participants according to their scar aetiology (five women had scars from several causes and are counted more than once).

<table>
<thead>
<tr>
<th>Aetiology</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cosmetic surgery – with complications</td>
<td>3</td>
</tr>
<tr>
<td>Medical procedure</td>
<td>13</td>
</tr>
<tr>
<td>Medical procedure - cancer</td>
<td>4</td>
</tr>
<tr>
<td>Medical procedure – with complications</td>
<td>2</td>
</tr>
<tr>
<td>Self-harm</td>
<td>4</td>
</tr>
<tr>
<td>Systemic infection</td>
<td>1</td>
</tr>
<tr>
<td>Trauma</td>
<td>8</td>
</tr>
</tbody>
</table>

Table three: Aetiology of scars

The next sub-sections show how these aetiological groups mediate women’s experiences.

Trauma scars

Scars acquired through traumatic injuries tend to be more disfiguring. Six out of eight study participants with trauma scars rated them as relatively disfiguring (ranging between 2 and 5) and reported significant appearance concerns.
Also, as discussed in the ‘having self-revealing body’ section, trauma scars are usually acquired suddenly, with no preparation or choice in regard to the scar acquisition. Such scars may trigger feelings of anger and powerlessness, and also painful memories. Nelly, for example, said her scars remind her:

that I was in an accident that I didn’t cause and didn’t ask for and wasn’t doing anything particularly dangerous, you know. Wasn’t doing anything I shouldn’t be doing.

Other women with trauma scars may associate feelings of guilt and self-blame with the sight of their scars. Karen, for example, used to blame herself for her burns accident as a 5-year-old resulting from playing with matches, believing this triggered the subsequent separation of her parents. In short, participants often perceived trauma scars as something they should not have received in the first place.

*Cancer scars*

Similarly to trauma scars, scars resulting from cancer tend to be disfiguring. For example, melanoma removal often results in dented scars. Melanoma scars can also involve physical discomfort, such as numbness and pain. For example, Stacy experienced phantom pains in her leg she described as ‘stabbing’, while Rosa described feeling ‘agonising’ pain, which was later replaced with numbness. Both Rosa and Stacy said the physical discomfort exacerbated their awareness of their scars and the unpleasant thoughts these trigger.

Additionally, as discussed, cancer scars remind participants of their mortality and the possibility of the cancer recurrence. Yet respondents also tended to see these scars as having occurred ‘for a good reason’, since the medical procedures that caused them also saved their lives. As Anne, a 48-year-old business manager with an abdominal scar from the removal a cancerous kidney, wrote in her text:

My scar is a blessing and I am grateful to our Lord/key spiritual Leader for the opportunity to have a second chance at a better life.

On the other hand, as discussed, participants were concerned that their scars may stigmatise them as ‘cancer patients’. In short, ambivalence prevailed in the accounts of cancer scars. This may explain the contradictory nature of existing findings about cancer-related disfigurements, with some studies (such as Williamson et al., 2010) showing appearance to be one of the major concerns while others (such as Furness et al., 2006) find health concerns to override other appearance concerns.
Self-harm scars

As discussed earlier in this chapter, self-harm scars can often be recognised for what they are and there is a strong stigma attached to them. Also, such scars were potent reminders to participants of the emotional suffering they had endured and could trigger feelings of guilt and shame. To Lora, who made scars on her arms during teenage years, the scars are reminders of:

How I felt and how horrible it was … I feel like my story is written on my body and it’s a constant reminder to me. I don’t necessarily want to look at them [scars], and I find them confronting… [they are] always there, at the back of my head, as a body memory. Therefore self-harm scars, even when not disfiguring, were associated with distress.

Medical and cosmetic procedures with complications

Scars acquired through medical complications are also often highly disfiguring. For example, Joanne who has abdominal scars from various causes, received her most disfiguring scar from an ovary operation that went wrong. This scar sinks in the middle of her lower abdomen, creating a deep dent to which Joanne referred as a ‘bum shape’. Scars from complications also usually involve physical suffering and, like trauma scars, were framed by participants as preventable and acquired ‘for no good reason’. Also similarly to trauma scars, these scars raise questions of blame and injustice. Often the women blamed not only health professionals but also themselves, for their supposedly ‘poor’ decision making or lack of assertiveness. Joanne’s story is representative here. In the aftermath of her surgery, which was even, in retrospect, unnecessary, Joanne suffered significant pain and acquired irritable bowel syndrome. During the interview, nine years after the surgery, she still experienced much anguish and anger:

I just feel as though I’ve been maimed... I willingly went to have the surgery, thinking that it was a good thing to do… [the scars are] a visible sign of the way I was mistreated. They’re always going to be there to remind me of the pain. I’m a completely different person these days.

Again, as with trauma, scars from medical complications are acquired unexpectedly, with no preparation for or choice over them and thus, as Joanne testified, were experienced negatively. Joanne said her other abdominal scars, from fertility treatments, did not distress her as much since it was her decision to get the treatments and the outcome was two successful pregnancies:

I could own the scars that came from baby making dramas… It’d be the same if I had breast cancer. Any of those things where there was a purpose and a positive outcome are okay. And so when you’re balancing this out, you think – it was definitely worth it.
Whereas scars resulting from cosmetic complications, as in the case of Gemma, can trigger additional guilt for supposed ‘vanity’ related to deciding to do such surgery, and also a ‘failure’ to improve appearance where the surgery leaves disfiguring scars. Overall, participants found it harder to accept scars arising from medical and cosmetic complications.

**Routine medical procedures**

Scars from treatment of medical, non-cancerous conditions were experienced by participants more positively. Partly this was because such scars tend to be neater. But even when these scars were disfiguring women felt better about them, because they perceived them as occurring ‘for a good reason’.

![Photo eight: A scar from gallbladder removal](image)

Participants with scars from appendicitis removal said these did not worry them, because they are *common* scars, not marking them as different. Rivka, for example, felt much more positively about her the scar from appendicitis removal than about the chest scar acquired from complications during a cosmetic surgery:

> I wasn’t alone with the appendicitis. There were a lot of people out there with appendicitis scars and so it wasn’t something that was unusual. I don’t think anyone I know was particularly bothered by them. It was something people know what it is. It never particularly bothered me… [but with the chest scar] I’ve never met anyone who has had the same operation... so it’s not relatable to anybody.

Women also usually knew in advance that their surgeries will result in scars and sometimes they also had a choice about it. For example, Sophia could have chosen to have her kidney removed through keyhole or traditional surgery. She opted for the latter
option as the safer, even if it meant receiving a large scar and felt proud she had decided to prioritise her health:

I knew I made the right decision. I’d rather the inside of me be really looked after, not the outside.

She even, as discussed earlier, grew fond of her scar.

Summary

The research discussed in chapter three acknowledges that aetiology plays a role in the lived experiences of people with disfigurements, yet its salience in adjustment and coping is debatable. Overall, little investigation into aetiology as a mediating factor has occurred. In contrast, disability researchers pay more systematic attention to this matter, finding aetiology an important mediator of adjustment to appearance. Rybarczyk and Behel (2002) sum up these findings in the disability field:

The cause of a disability can have a substantial impact on the individual’s response to, and ultimate ability to cope with… the changes in body image… Disabilities that are incurred during accidents, through medical mismanagement, or due to personal neglect are likely to be seen as random, unnecessary and unfair… people may blame themselves or someone else. Body image changes… may be closely associated with unresolved feelings of anger, resentment and self-blame… [whereas] those incurred during the course of medically necessary, life-saving interventions… may be viewed as the price of being saved… such [the latter] adaptive responses… are typically associated with positive rehabilitation outcomes (p.389).

The findings in this study indicate that aetiology is a significant mediating factor in the experiences of women with non-facial scars. Specific physical effects (including present and future health concerns), cause-related memories, and sociocultural meanings around certain scars all can affect women’s experiences (and also their coping, as will be discussed in chapter six). Participants’ interpretations of the circumstances of scar acquisition were also important: whether the acquisition was sudden or planned, whether participants felt they had a choice in what happened, whether issues of blame and injustice existed, and whether women perceived their scars as acquired for a good, or not, reason. Thus, scars acquired through trauma, cancer, self-harm and medical or cosmetic
procedures with complications can cause distress even when they are minor, whereas scars resulting from routine medical procedures might be experienced more positively.

**Appearance attitudes**

Investment in appearance, as discussed in chapter three, is commonly cited by researchers as one of the most important mediating factors in adjustment to disfigurements, and correlates with greater distress. Findings from this study show a more nuanced relationship between the importance of appearance and adjustment. Participants who considerably cared about their appearance were not always concerned with their scars more than other participants. Some of them cared more about other body ‘faults’. For example, Haya was more concerned with the shape of her ears than with her abdominal scar. The most common ‘faults’ which overrode scar-related concerns were those of weight, shape and visible signs of ageing. As Sarah said:

> I have cellulite and I’m a bit overweight... I’ve got quite poor body image problems. So a scar is not something, on the scale of things, to worry about.

Overall, in this study the importance of appearance was not predictive of scar-related appearance concerns. What did, though, appear to mediate scar-related concerns were other, less commonly studied, appearance attitudes: how women framed scar locations, the extent of their modesty and their capacity for critical awareness.

**Scar locations**

Women framed the locations of their scars as ‘lucky’, ‘invested’ and ‘compromising’. The code ‘lucky’ was coined following several participants referring to their scar locations as ‘lucky’. ‘Invested’ and ‘compromising’ are terms I have coined.

Lucky locations are body parts, which participants viewed as ‘convenient’ for having scars. Perceptions of what is ‘lucky’ varied between participants. Locations can be lucky because the women perceived them as ‘hidden’. As Sophia said about her abdominal scar:

> It’s in a lucky location, because you can wear a one-piece bathing suit and no one knows it’s there. It’s quite a private scar... The public doesn’t have any access to it.

Such estimates were subjective, since what one woman may consider as a hidden location another may not. For example, the thighs were hidden locations for some participants, but not for those who liked wearing short skirts or swim. Locations were also considered ‘lucky’ if before scar acquisition they were already perceived as being unattractive; thus
scars did not spoil valuable body parts. Shirley, for example, framed her foot as a lucky location for both the aforementioned reasons:

I have a big one [scar] on my foot, but you don’t see the foot, and feet are ugly anyway in my opinion. So it didn’t bother me that my foot was scarred.

Invested locations are body parts that prior to scar acquisition participants invested with pride, exhibited and enjoyed. Sometimes women did considerable bodywork to maintain these parts. Acquiring scars in these places was associated with a sense of loss and high distress even if the scars were relatively minor. Such locations are often associated with femininity and sexuality. For example, five out of six participants with scars on their chests felt like damaged goods.

Shanty, who has keloid scars on her chest spoke about this:

It’s harder when the scarring relates to you as a woman… It’s very personal. You’re horrified when you aren’t normal.

Other invested locations were subject to more subjective judgement. While some women with abdominal scars, like Sophia, considered such locations as hidden and therefore lucky, for others they were invested. Before she got scars, Candice, for example, used to take pleasure in displaying her toned and tanned abdomen, which she also decorated with piercing. For Meg, too, her abdomen, and generally her body, were important:

I always thought my body was attractive to men, not so much the face, but about my body I was confident. So this is why the image of the body is so important to me. The actual scar, and what it’d done to my body image, it did a lot… It’s [abdomen] a central part of your body. It’s not like having a scar on your arm or leg which is a bit peripheral… The other thing for me is that this part of the body is a very erogenous zone and being touched there is one of the things I really like.
Compromising locations were locations where the scars can be interpreted in stigmatising ways. For example, Lola’s scars are on her wrists, which can be associated with self-harm.

In summary, inconclusive findings about disfigurement locations in existing literature may also be explained by the findings from this study, which shows that locations matter more in a psychological than physical sense. It is also important to note that participants’ framings of their scar locations were not as clear cut as this section may indicate, but were rather characterised by ambivalence. The same location could be viewed as lucky in some respects, but invested in others. For example, Stacy considered her lower leg to be an invested location because she used to enjoy wearing three quarter pants before she got a scar there, but she also considered this location as lucky, since she did not think it was intrinsic to her sexual relations with her husband.

**Modesty**

The ‘modesty’ code is based on the words of four participants who described themselves as ‘modest’. These women disliked exposing their bodies in public, dressing modestly. For such women scars tended to be less concerning, since most of their bodily locations were considered as ‘hidden’ and therefore ‘lucky’.

**Critical awareness**

The ‘critical awareness’ code is a term I used to describe some women’s capacity to critically evaluate dominant discourses on appearance. Several women described themselves as holding strong feminist views or being left-wing political activists. These women appeared to have greater resistance to appearance ideals. Helen, for example, described herself as being modest for political reasons and unconcerned about her chest scar:

> I have a feminist critique about women exposing their bodies... Often the politics of women’s dress design is to be seductive and alluring to men, and I don’t like it. So I’ve always tended to dress only modestly and I cover not only my chest, but also my legs and my upper arms... Because if you look at men, they don’t often walk around half naked.

Similarly Ophelia, a 40-year-old social worker with numerous self-harm scars on her limbs, reported having few scar-related concerns and attributes her attitude, in part, to her political convictions. Ophelia is committed to promoting social justice, including diversity of appearance. She also has tattoos and piercing, which she is reluctant to remove, even for professional purposes:
For a long time I wouldn’t change my rings for a job interview, I wouldn’t transform myself… It’s a part of my philosophy, also with clients I work with, that we judge so much by appearance and I wanted to challenge that stereotype so that people got to know me for who I was. They’d go ‘Ah, someone with piercing and tattoos isn’t that harsh’…

Critical awareness as an ameliorating factor in adjustment was noted in several other studies of disfigurements, notably in that of Rumsey et al. (2010).

**Anticipated stigma**

Consistent with research findings cited in chapter three, how respondents imagined people would react to their scars affected their levels of scar-related distress. Those who believed their scars would be perceived negatively, like Shanty who said that if people saw her scars ‘it detracts from the rest of you’, experienced more distress. Almost two-thirds of the women held such beliefs. Participants who felt people accepted, or did not care about, their scars usually experienced less distress. However, there were three exceptions where the latter women still perceived themselves as damaged goods. Shirley had such an attitude:

> I think it’s more me, I don’t think it’s other people. So I don’t think it’s [her distress about her scars] a matter of what people are saying… It’s just the fact that when I see it, I don’t like the look of it.

Drawing on theorisation of the body discussed in chapter two and on participants’ stories, it is possible that anticipated stigma was often a realistic response, drawing on real-life precedents. Whereas the absence of anticipated stigma may have stemmed from internalised cultural messages about female appearance, and the three respondents may have engaged in self-objectification and self-scrutiny, viewing their bodies as projects, but blaming themselves for disliking their scars.

**Personality traits**

Respondents who described themselves as sociable and hardy said these characteristics helped them feel better about being marked. Haya saw herself as having both of these qualities and believed they accounted for her low scar-related distress:

> I do have confidence, and I have… naturally an outgoing, strong personality. So I think that philosophy of ‘just go and get on with it’ helps a lot.

Four women described themselves as high-achievers and perfectionists, and said the latter trait exacerbated their scar-related distress. Shanty was one of them, and described herself as juggling a happy marriage, motherhood and a busy law career. She felt that her scars were one of the few aspects in her life not under her control. However, she also said:
If I didn’t have the scarring, I’d be focusing on something else in terms of what I don’t like about myself.

The finding about perfectionism as exacerbating distress adds to the existing research, whereas the correlation of sociability and hardiness with less distress corresponds with the findings discussed in chapter three. However, it should be noted that in this study personality traits were established based on participants’ self-descriptions and no attempt was made to measure these traits formally.

**Conclusion**

Findings presented in this chapter indicate that bodies marked with non-facial scars can trigger significant appearance concerns and are loaded with social meanings. The philosopher Alfonso Lingis (1984, p.34) argues that the western eye reads scars cognitively. Indeed, people often read scars as biographical evidence. This makes sense, since, unlike congenital disfigurements or skin diseases, scars arise out of wounding and as such are usually signs of suffering, fright and/or violation, promising a dramatic narrative. Thus, scars mark women with stories to be uncovered (or covered). Such stories, in turn, evoke strong social responses ranging between curiosity, judgement, compassion, fascination and disgust. Having a marked Body Surface also may mean one’s life story is on display, but possibly marked with errors. It also means memories related to scar acquisition, be this through childbirth, accidents or illness, often persist. In short, scars can have a profound impact on women’s lives both in negative and positive ways.

Being marked may sometimes limit life choices and chances, as illustrated by some stories about intimate relationships, stigmatise women, make them vulnerable to social harassment, evoke painful rumination on both past suffering and future health concerns. Consequently, scars may have an impact on women’s mood and self-concept, and be associated with excessive self-consciousness, self-alienation, social anxiety, tendency toward being less affectionate and more secretive, and in some cases even with suicidal attempts. On the other hand, scars can be positive identity markers: they may inscribe women with uniqueness, render them more interesting, trigger meaningful rumination, and even assist in personal growth and self-improvement.
In keeping with the interpretive paradigm informing this research, which directs us to see the world as dynamic, the way participants interpreted and experienced their scars was found to be dynamic, contingent, layered and ambivalent. Respondents could hold at once several, sometimes opposing, views about their scars, and oscillate between these. Some of the factors affecting these perceptions - the social, physical and psychological ones - were discussed here. In particular, social interactions, disfigurement degree, scar aetiology, some appearance-related attitudes, anticipated stigma and certain personality traits were found to be significant in mediating women’s experiences of their scars. Other mediating factors mentioned by participants as important are described in chapter seven. The next chapter describes how respondents act to solve some of the problems discussed here, but also how they sometimes capitalise on their scars.
Chapter Six – Doing Scar-Work

‘I became a student of the way people reacted to me and a researcher of ways to influence them.’

James Partridge, burns survivor and activist

This chapter describes the essential category ‘doing scar-work’, which conceptualises actions women undertake in order to solve problems arising from having scars and sometimes also to positively utilise these scars. The term ‘doing scar-work’ is inspired by the term ‘bodywork’, popular with theorists of the body and discussed in chapters one and two.

For many women, the experience of living in a marked body includes doing at least some interpersonal and intrapersonal work - usually in order to minimise the negative impact of being marked, but sometimes to capitalise on such a difference. Figure four ‘Doing Scar-Work category’ shows the three major types of scar-work as developed from data analysis:

![Diagram of Doing Scar-Work category]

The sub-categories ‘passing unmarked’ and ‘managing mark readings’ encompass a range of actions concerned with social interactions. The ‘doing acceptance work’ sub-category describes the intra-personal work that women do. Each of these sub-categories includes several cognitive and/or behavioural strategies discussed in the following sections. Also discussed is the variation in participants’ choices of scar-work, and the dilemmas and consequences some of these choices entail. Links between doing scar-work and other categories constituting the substantive theory of this thesis captured in figure two are explored. Findings presented here are also linked with the existing research.
Passing Unmarked

‘Passing unmarked’ is a term inspired by Goffman’s work around stigma and self-presentation discussed in chapters two and three. As noted in chapter three, according to Goffman (1968), the overriding anxiety among people with stigmatising characteristics is about exposure and their central concern is with being socially accepted. According to Goffman (1969), such a person “tends to conceal or underplay those activities, facts, and motives which are incompatible with an idealised version of himself” (p.56). Goffman (1968) terms this activity ‘passing’. The aim of passing is to present a socially acceptable version of oneself to the public. Passing has become a popular term in social sciences, particularly in race and queer theories, and is also used by some disability theorists (for example, Wendell, 1996). I developed this term into passing unmarked to reflect the experiences of women with non-facial scars. Data from this study indicate that participants with disfiguring and/or stigmatising scars were usually keen to pass as unmarked. Two thirds of participants were concerned, at least at some stage of their lives, with passing unmarked, and for various reasons as discussed below.

Reasons for passing unmarked

Cultural ideals of female appearance played a big role in participants’ motivations. All but two participants, whose scars were rated as moderate to severe, were concerned with passing unmarked at least for some years in their lives. As chapter five shows, many participants felt shame about their scars and feared disappointing others, particularly potential or new lovers, by revealing them. Michaela, an attractive woman who was burnt when she was three-year-old had such concerns for most of her life. To deal with them, she chose to conceal her scars:

Maybe if you’re not fit, not looking after yourself, not particularly attractive, then it might be easier to some degree, because you’re not dealing with that contrast. It [scars] makes you feel less adequate. That contrast has been an issue since I was a teenager… On the beach, I’d choose not to go to the water. Stupid, I know… and because I had a fabulous upper body, I was in a bikini top. I kept the sarong so that that image was maintained, because if I’d have taken off the sarong, it’d have gone.

Moreover, some scholars (Goffman, 1969; Miner, 1997) argue that for women, concealing their aesthetic ‘flaws’ can also be a social imperative. As Goffman (1969) suggests, “there are many social contexts in which it would be improper for a woman not to misrepresent herself as being more youthful and sexually attractive than is really the case” (p.68). It seems not that much has changed since Goffman wrote his seminal books. Some women felt it was unacceptable to show their scars in public. As Rivka, who covers her chest and abdominal scars, said:
You don’t see many people around wondering around the beach with scars on their stomach.

Whereas Liz for years was content to wear bikinis that revealed her abdominal scar until her teenaged daughter asked her to wear one-piece bathing suits - to appear ‘normal’. Liz’s story was typical of several other mothers’. Other women said they wanted to be ‘normal’ for their own sakes.

Other reasons for why women may choose to pass unmarked may be bound with shame over the information their scars may reveal about them, particularly when they bear self-harm scars. Respondents with scars from complicated and/or unsuccessful medical or cosmetic procedures also often wished to conceal their scars (also from themselves) so that to forget what they tended to perceive as a personal failure and/or undeserved misfortune.

But not all participants tried to pass unmarked out of shame. Michelle often concealed her leg scar resulting from a dog bite because she did not want to discuss that incident:

> Often people would ask questions and I’d have to re-tell the story of how I got the scar. So that was one reason why I wouldn’t wear short skirts in public.

Also, as discussed in chapter five, women may pass unmarked to avoid a spoiled identity, pity, interrogations, being defined by their scars or revisiting memories and thoughts related to their scars. Rosa, for example, did not want to see her scar in order to forget she had melanoma. Karen covered her many burn scars partly to protect other people:

> I don’t want to scare people. People can get shocked by burns... I’m aware that there are people, especially little children, who would find it very confronting if I went to shops like that [with exposed arms and neck]. So a part of me wants to protect the public as well. I don’t want to show too much.

For many participants, their desire to pass unmarked arose from a combination of the aforementioned reasons and they utilised a range of strategies to do so.

**Strategies for passing unmarked**

In order to pass unmarked, participants employed three chief strategies: they concealed their scars, and avoided physical and/or verbal disclosure of them.

**Concealment**

Most commonly, respondents concealed their scars with clothes. Clothing is a powerful tool that allows individuals to creatively construct and project desired self-images (Hollander, 1999). Yet, as discussed in chapter two, it can also be used for self-disciplinary purposes. Clothing offers women with non-facial scars a practical and socially acceptable means of concealing the “abominations of the body” (Goffman, 1963,
Three participants also mentioned using tanning lotion and jewellery to conceal their scars. Several women modified their body language. Lola, for example, crossed her legs to conceal the scars on her ankle, and kept her scarred wrists down.

Michelle used to put her hand on her thigh scar if it was visible when she sat down. Whereas Shanty used several methods to hide her chest scars: she wore high-cut tops, scarves and jewellery, and arranged her hair to cover her scars. Some women went to great lengths to conceal their scars during sexual intimacy, through body language and dimmed lighting.

While concealment can be an effective strategy to preserve a more ‘normal’, and desirable, image, it also has negative consequences. Firstly, summer is the most difficult time to pass unmarked since it is when the body is most on display, particularly in the Australian outdoor and beach culture. Participants who concealed their scars with long clothes often then suffered from overheating. Stacy, who concealed her lower leg and arm scars with long pants and sleeves, said:

> I’m probably more likely not to like summer, because... I’m dressed for winter almost. People are out there when it’s warm, and here is I am all curled up in my long sleeves and my pants.

Similarly, Lora said:

> Every time the weather gets warm, I feel jealous of people for feeling so comfortable in their bodies.

This finding is compatible with Brown et al.’s (2008) study of scars, where respondents also reported hiding their scars during summer at the price of overheating.

In summer women are also more likely to be subjected to interrogations about being ‘overdressed’. For example, women with abdominal scars who wore one-piece
bathers said they were routinely asked why they did not wear bikinis. Ironically, ‘overdressing’ to prevent scar-related stigmatisation may attract almost as much attention and assign stigmatised identity. Lora’s mother, for instance, thought Lora wore long sleeves in summer because she injected drugs. Thus, this strategy sometimes may even exacerbate women’s sense of being negatively marked. It is of little surprise then that participants who sojourned in conservative countries, where modesty was the norm, or in countries with a colder climate, often felt relieved. In those places their ‘covered’ self-presentation drew little, if any, attention.

Another inherent difficulty in concealment is that it can take considerable time and effort to find fitting clothes. Rivka spoke of her struggle to conceal her chest scar in summer, when many clothes being sold are cut low at the front:

The scar had affected how my breasts would move so I couldn’t sort of fit in and make my breasts look nice in the top… That was the most difficult thing: to find shirts, to find bras, to find bathers, it was just always so difficult.

My experience is similar to Rivka’s: I often struggle during summer to find high tops to conceal my chest scar and opaque stockings to conceal my leg scars. These findings are in line with Rumsey et al.’s (2010) study where many participants also mentioned such concerns.

Concealing practices, particularly with clothing, were also often associated with feelings of loss. Participants felt that their clothing choices resulted in a more conservative and less attractive self-presentation than they wanted. Lora felt this, and also felt she had become less tolerant towards women who wore revealing clothes:

I’m just becoming more and more like: ‘Oh my God, I can’t believe they’re wearing this!’ I think a part of it is just getting older. And a part of it is a jealousy thing. It’s not that I want to wear it [revealing clothing], but I want to be able to wear it if I want to. It’s this choice… Then I see people wearing all these tiny clothes and I think: they shouldn’t be [laughs].

Other participants talked about envying women clad in revealing clothes, such as short dresses. For some, like Shanty, this feeling was pervasive:

I feel sad that I can’t wear something that looks nice on other women… Like, every week this thought will come into my head.

Whereas Stacy, who even before acquiring her scars felt ashamed of many aspects of her appearance, such as her weight and the bumpy skin on her arms, said that her scars had ‘robbed’ her of the few body parts she felt she could expose. Stacy particularly grieved over no longer feeling comfortable enough to wear three-quarter pants in hot weather, after acquiring a scar on her lower leg. Yet in my experience, sometimes concealment can
actually coexist with a more revealing self-image. This can result from overcompensation. For example, once I realised I could conceal my chest scar with necklaces, I began wearing tops and dresses with deep cleavage to make up for what I could not expose. This theme, though, did not come through in any interviews.

*Physical avoidance*

Considering these difficulties associated with concealment, but also in circumstances where scars are difficult, or even impossible, to conceal, some participants chose to avoid altogether those (often valued) activities where their scars might be exposed.

Some women avoided the beach and pools, like Joanne who lamented giving up swimming:

> I used to swim, but won’t go anywhere near [water], because you can actually see the line of the scarring through my bathing suit. It sort of bulges...

Whereas Lora went to less populated beaches, and during times when people were less likely to be around.

Participants also might avoid being fully or partially nude in social situations. Many avoided changing clothes in shared changing rooms. Gemma would not join her friends for skinny dipping. Some avoided sports activities, which required revealing uniforms.

Some women avoided sexual intimacy and dating. The study sample was relatively homogeneous, in that most women did not have a history of many lovers. Women said that when they were single they sometimes avoided sexual experiences and dating out of fear of being rejected because of their scars, or to avoid, in Manuela’s words, ‘explaining’ or ‘apologising’ for their scars. Thus, they would often choose not to date in the first place. Once Manuela stopped a contact with a potential lover who did not know about her scars, because she suspected he would not accept them:

> We got along very well. And I said I hurt my knee, and he said, ‘Be careful, scars are disgusting’. And when he said that… I said, ‘Don’t talk to me! Bye!’ [cries].

Some women disliked their scars so much that they avoided looking at mirrors or being photographed. Rosa tore up her honeymoon photos because they showed her scars.

Several women said that the cost of their avoidant behaviour was that they tried fewer new things and had become less adventurous. Michaela felt this way:

> I haven’t put myself out there enough… it [her scarring] clipped a lot of my experiences. Clipped is a good word because I’ve still done them, but haven’t done them to the full extent. I have a passionate nature and I look back and think: what a shame, what a shame that I didn’t just go ‘stuff it!’ But I couldn’t… I could have been more adventurous. For
example, swimming. On the beach, I’d choose not to go to the water… And I wasn’t particularly promiscuous. It’s not a bad thing now in hindsight, but it definitely restricted me.

Rivka, too, felt she:

put a lid on myself... I couldn’t enjoy myself and my body. I got so used to not being able to do things I wanted to do... that I think it’s sort of suppressed me for quite a period.

Similarly, Manuela said that if she had the opportunity to participate in a reality show, she probably would not do it because of her scars:

I’d certainly have to show myself… I’m afraid people might say something that will hurt me [cries].

Avoiding verbal disclosure

Some participants concealed their scars from public view, but could mention that they had them in the context of a conversation. Others who wanted to pass unmarked would not disclose such information even verbally. Gemma, for example, had only several trusted friends who knew about her scars. Some women resorted to active deception. For example, Joanne, whose abdominal scar as mentioned bulges and can sometimes be visible even through clothes, preferred to say to people who enquired that it was ‘fat’. Women talked about the stress embedded in keeping their scars secret and the accompanying guilt about not being honest and authentic.

Adverse consequences

As previous sub-sections demonstrate, the practice of passing unmarked entails its own problems, such as alternative stigmatising identity, feelings of loss and loss of valued activities, missed opportunities and practical difficulties. Beyond this, there is the underlying anxiety behind this practice. Goffman (1968) indicates that the potential for stigma weighs heavily on people regardless of whether others are privy to their conditions. Similarly, those respondents who successfully passed unmarked still felt self-conscious and vigilant as they policed themselves. They felt anxiety about being ‘caught’ - exposed for not being who they seemed to be. Shanty described such feelings and behaviour:

I’ll wear something and it’ll move and I’ll be like, ‘Quickly, cover it up!’ If it’s borderline, like if I’m wearing a top and it keeps moving, I might put my name tag or a security pass, or hair over it, or I’ll keep fiddling with it.

Similarly, Manuela described how she got:

obsessed at times. I think, what if my top lifts?… It’s this thing [her scars] I constantly have to hide.

The tension between the imperatives to be beautiful and to accept yourself is powerfully present in the stories of participants who pass unmarked. Sometimes these
women would experience their desire to pass unmarked as a moral failure, proof of their ‘vanity’. Michaela, for example, said she ‘beat’ herself up ‘all my life’ for this.

The continuous practice of passing unmarked can mark women internally too. It may leave them feeling they are ‘frauds’, whose bodies harbour ‘dirty secrets’. Michaela has a sister who has a facial scar she cannot hide and she said they discussed the differences in distress concealable and non-concealable scars can generate:

We saw pros and cons in both. My sister always feels self-conscious of her scar, so she was forced to accept it more readily. Mine… I was able to disguise it, so I had a public persona very different to my scars. And this meant for me dysfunction later in life, whereas my sister was forced to be ‘the scar’. She was forced to talk about it and accept it. And I suppose she had better clarity about who she is… You’d think the non-facial scars would be less traumatic, but the trauma when you can actually create a persona you can hide, this made me more dysfunctional. You do this denial thing, then there is the shame because you are not frank and open… People who have an obvious scar can have access to instant sympathy, because it’s something that people see. Whereas when you have a scar that can be easily covered, you can be dealing with this duality of personality. You become this person who looks nearly-perfect, but you’re flawed in your mind…

This sense of being secretive extends onto other domains of respondents’ lives. Shanty explained how this could happen:

It’s like you’re subconsciously hiding a part of yourself. The other person would never know what’s going through my mind and that’s what I’m worried about. It must have affected my communication on some level…

This wish to appear normal at the expense of one’s wellbeing is reminiscent of Bordo’s (1993) analysis of women’s practice of dieting, mentioned in chapter two. Bordo writes that “denying oneself food becomes the central micro-practice in the education of feminine self-restraint” (p.130). Passing unmarked, which is bound with personal discomfort, can be also seen as an exercise of female self-restraint for the purpose of the common good by removing ‘offending’ body parts from public view.

Yet although the practice of passing unmarked is associated with many negative outcomes, for participants the benefits often outweigh any potential negative consequences. Passing unmarked can mean appearing more desirable, and provide relief from standing out and/or from problematic social responses discussed in chapter five. Participants valued the fact that while they had little choice in being able to ‘fix’ their scars, they had choices in self-presentation. This felt empowering. Many, like Rosa, were also relieved that they could exorcise their scars, and all they stood for, from their own awareness. Thus, participants’ choice to pass unmarked can be viewed both as adherence
to dominant social discourses on appearance, as Bordo (1993) argues, but also as an expression of agency, or rather – as being positioned somewhere between the two.

**Intensity of passing unmarked**

Respondents differed in how strict they were about passing unmarked. Those who avoided even verbal disclosure were consistent in always trying to pass unmarked. For them, concealment was an ongoing act that dominated their daily lives. As Shanty said, she hid her scars ‘365 days a year, seven days a week’. Shanty, though, did not conceal her scars from her family, whereas Joanne, like some other participants, did not show her body even to her husband and children.

Given the potential social penalties for having one’s scars exposed, a strict practice of passing unmarked can be seen as a natural response, however this is also a difficult practice to maintain. Some women occasionally relaxed this practice when they felt that the negative aspects of passing unmarked outweighed the advantages. For example, some women decided they wanted to resume swimming even if this meant exposing their scars. Michaela describes such a decision:

> Although I don’t walk confidently at the beach in a pair of bathers I do confidently swim and play with my kids in a pair of board shorts. I don’t dwell on my scars, however my ability to fully embrace opportunities – particularly social ones related to the beach or pool – has always been thwarted with fear and anxiety that on some occasions I have managed and others I have simply withdrawn from.

Those who practised passing unmarked intermittently often needed to make decisions about how to present themselves. Bronwyn, who during the last decade had begun to occasionally exposing her upper arm scar, spoke about such choices:

> I acknowledge the fact that when I do put a singlet on these days I take the risk of being asked questions.
Such decision-making can be distressing as Lora’s story shows:

Wearing long trousers on a 40-degree day is not very nice. So there is this anxiety about what I’m going to wear. It’s kind of this long thing about what pants I’m going to wear, then what top…

However, many of the participants, who usually pass unmarked, find it liberating being away in foreign places, whether interstate or overseas. There they suspend their practice of passing unmarked. Shirley, who is usually quite meticulous about covering her leg scars, said:

When I went over to Fiji, I wasn’t conscious [of her scars] at all. I wore bathers, I wore dresses with no stockings and I wore dresses above the knee and I didn’t care… I just had a different outlook while I was there and it never bothered me and I never even noticed it [scars]. I was in a holiday mood, I was in the sun and I was relaxed. I’d get dressed and sometimes I wouldn’t even look in the mirror to see [if the scars show]. Whereas when I’m at home, I usually look.

Some other women, like Shirley, attributed not caring about their scar exposure during holiday travels to a changed frame of mind, to feeling happier. For those women who were mostly concerned with strangers and distant acquaintances seeing their scars, foreign places were particularly liberating.

Some respondents interrupted their practice of passing unmarked only in special circumstances. Such an interruption might occur as a subversive gesture, as in Michelle’s case:

Sometimes I deliberately wear short skirts in public. It’s like, this is my leg and I love it, even if it has a hole in it… I kind of push through my fears.

Other participants might expose their scars as a one-off experiment, not to be repeated because of the associated emotional costs, but to nevertheless be remembered with pride. Stacy, for example, told such a story about participating in a group photoshoot at her workplace, where everyone wore only underwear. Stacy, who otherwise always conceals her scars, viewed her participation alongside her colleagues as significant and empowering, and kept retelling the story throughout the interview. This incident made her feel good about herself, even if she said she would not do something similar again. Similarly, as a gesture of love towards her husband, Shanty agreed at his urging to wear a wedding gown that exposed her chest scarring:

I wore a v-neck just to show him: look, I don’t care about them [scars].

These examples demonstrate the complex relationships women often have with their bodies, where the scars can at once be a site of conformism and agency, and also the difficulties women experience in their attempts to accept their scars.
Summary

This study’s analysis shows that women with non-facial scars are concerned with passing unmarked. This is consistent with the existing research on disfigurements, discussed in chapter three, which shows that concealment and avoidance are among the most common coping strategies. In Brown et al.’s (2008) study of scars, too, 68% of respondents employed such strategies. However the distinction made in this thesis between physical and verbal avoidance is not a feature of the literature on disfigurements.

This study supports the existing literature that shows while concealment and avoidance can alleviate disfigurement-related distress, they also generate their own problems by potentially stigmatising people, depriving them of valued activities, impacting negatively on their sense of self, and on their sexuality and intimate relationships, and are associated with practical difficulties. Most adverse consequences from passing unmarked that emerged in the data (vigilance, anxiety about being ‘caught’, self-consciousness, guilt and becoming secretive) are also consistent with the literature cited in chapter three. Yet participants’ concerns that passing unmarked can give them other types of unwanted identities – conservative and less adventurous ones - are new findings.

The cyclical nature of distress related to passing unmarked is consistent with existing findings about disfigurements, particularly from skin diseases (Kent, 2000), which also indicate that during hot weather distress is likely to increase. Yet this study adds to the existing research by highlighting that the intensity of passing unmarked can vary in some circumstances, particularly that while being away from home some women suspended this practice.

An examination of women’s motivations for passing unmarked warrants attention in terms of its contribution to current theorisation on disfigurements. Scholars tend to view concealment and avoidance as ‘poor’ coping strategies stemming from feelings of shame, with such shame often understood to arise from anticipated stigma regarding appearance and/or stigmatising reactions. Indeed, shame was found to be an important psychological mechanism in respondents’ decision making about passing unmarked. Yet shame was not the only factor for explaining the choice of passing unmarked. Some women wanted to avoid pity or being interrogated. Others wished to conceal their scars from themselves. Some respondents were concerned with distressing other people. The latter reason is consistent with Miner’s (1997) analysis of the narratives of women with
visible disabilities, which found that many of these women wanted to conceal their ‘faults’ in order to protect the public eye. The choice to pass unmarked can be viewed as a self-disciplinary practice in the face of social pressures to appear ‘normal’. Still, the practice of passing unmarked can be empowering and adaptive in the current sociocultural context. This argument is in line with the work of the cultural commentator Kroeger (2004), who claims that passing can be agentic, because people may “pass in order to bypass being excluded unjustly in their attempts to achieve ordinary, honourable aims and ambitions… [and in order] to be more truly themselves” (p.2).

While the sub-category ‘passing unmarked’ captures women’s practices of hiding their scars, the following sub-category describes the other side of the coin - how women deal with social readings of their marks, when these are revealed verbally and/or physically to others.

**Managing Mark Readings**

‘Managing mark readings’ is a term inspired by insights from body theory, discussed in chapter two, that suggest people ‘read’ bodies to form impressions. This sub-category describes participants’ attempts to have some influence over how their scars are read. Like memoirists who pick carefully which aspects of their lives to present to readers and how to do so, many women learned to somewhat direct readings of their scars. The following two sections *Managing disclosure* and *Converting scars into tools* show how they did this.

**Managing disclosure**

‘Managing disclosure’ is a term inspired by some chronic illness studies (for example, Charmaz, 1997; Joachim & Acorn, 2000) where disclosure was found to be an important concept in these experiences, as it also was in this thesis. Disclosure is a dynamic process of granting access to secretive personal information about oneself (Charmaz, 1997; Rosenfeld, 2000). This code demonstrates the dilemmas participants faced in trying to minimise the stigmatising, and even disfiguring, aspects of their scars in social situations, and the strategies they used to solve these. Some management included first physically revealing either scars concealed deliberately or those in naturally hidden locations. As emerged from the data analysis, such revelations occurred most often during health or beauty treatments, and with lovers. In these situations women had to make decisions about whether to disclose their scars, then how to best manage this disclosure in
terms of timing, and how to frame it to minimise the negative impact. Other women, whose scars were not hidden, often had to manage interrogations about their scars, as discussed in the preceding chapter.

Photo 12: A scar in a naturally hidden location

**Managing physical disclosure**

While some physical disclosures may be done spontaneously, more frequently participants planned how and when they disclosed their scars. Physical disclosure was often pre-empted by verbal disclosure. For example, participants often felt they had to first ‘warn’ beauty therapists and healthcare professionals in situations where their scars would be seen. Most of the women did so in order to maintain a sense of control over disclosure and prevent ‘confessional’ or ‘fuss’ responses. Shanty described such reasoning:

> If I’m going to expose them [scars], if I’ll be in a situation that I know someone will see them, I’ll mention it first. So I’ll be like ‘Ah, these are my chicken pox scars’. So maybe I’m doing this… so they won’t bring it up, so that I’ve dealt with it.

Women with severely disfiguring scars also felt it was their ‘duty’ to warn, so that people would be prepared for the sight.

The most common circumstances in the data when women revealed hidden scars were with new lovers. As discussed earlier, for women with non-facial scars dating can be particularly stressful. Many participants felt anxious about exposing their scars to new lovers. They feared disappointing them by being damaged goods or by revealing stigmatising information about themselves. Sometimes they delayed intimacy for a long time to ensure they felt more comfortable with dating partners and that these partners were serious about them, so that there was less chance of rejection because of scars. Lora,
for example, waited several months before she undressed with her boyfriend, but her experience was made easier by the fact that her partner knew about her scars from the start of their dating:

We actually knew each other before the accident [where she got her scars] ... And he’s a really nice, understanding person. I had issues about intimacy and it took a while. I think that... it couldn’t have been just with anyone, because it was a very hard time and very hard to feel comfortable being naked around someone else again.

Some women, as discussed, pre-empted the physical revelation of their scars to their lovers with verbal disclosure. Others proceeded with sexual relations, hoping their lovers either would not notice their scars or would not care. Sometimes they said nothing even after the exposure of their scars, hoping their lovers would interpret this as a sign that they accepted themselves and so would also accept them. According to the data, often this latter strategy was successful.

**Managing verbal disclosure**

Participants with potentially stigmatising scars carefully planned not only the timing and circumstances of scar disclosure, but also how to frame their scar acquisition stories in ways that would minimise or avoid altogether a spoiled identity. While respondents were generally creative, most found this task difficult. Lola, for example, struggled to conceal her wrist scars which were easily identifiable as resulting from self-harm. She spent much mental effort planning how to best explain these if someone noticed them. Her preferred explanation was to say that:

‘These are my scars. They were wounds, but they are healed now.’ Like this I’d acknowledge what they are from and that they’re there, but it kind of closes the door. Yes, I acknowledge I was a bit cuckoo for a while, but I’m okay now. You don’t need to worry about it.

Lora was one of several women who said they struggled to re-frame their stories:

I obviously had people asking me about my arms [with self-harm scars]. Just things like, ‘What are they?’ I’ve never really come upon an answer I was happy with. I used to think about it a lot, what I could say. I never really dealt with it very well... I told someone once that I didn’t used to like myself.

Some women, to avoid stigma or being interrogated about experiences they did not want to revisit, fabricated stories about the causes of their scars. Rosa told false stories about her melanoma scar for such reasons: to avoid an identity of a ‘cancer patient’ and being reminded of her melanoma. But, interestingly, she also did this to enhance her identity to one of being interesting and adventurous. She would say her leg scar was a sports injury, or:
‘It’s my shark bite’. I have a bit of fun with this lie... A shark bite is sort of more exotic... It’s a bit of a shock tactic too. I like to shock people... Anything that will make me sound more interesting, because I don’t want to be like everyone else.

Ophelia did not want to reveal that her scars resulted from self-harm, even though she did not attempt to pass unmarked. She often said her scars had resulted from the practice of scarification, and when people ‘misread’ her scars she did not correct them:

I’ll choose who I talk about them [scars] to. Like if someone says, ‘Is that a scar?’ I’ll choose whether to tell them, or I’ll say, ‘I’m into scarification’... ‘How did you get those?’ one client [in her job] asked about the scars on my arms. ‘A cat scratch,’ he answered the question himself. I said: ‘Yes.’

Sarah liked telling the story behind her abdominal scar, which she received after an ovary removal, because she saw it as an interesting occurrence, unusual for someone of her age (24 years). However, she was not prepared to disclose how she got the self-harm scars on her upper thighs. She has never disclosed them to anyone at the time of the interview, but assumed that during intimate situations they might be noticed. When we met, Sarah was in the planning stage of a false story:

There are lots of things I can come up with. Like I walked into a barbed wire fence, or... it was in a car accident and there was glass on me.

Sometimes women found it useful disclosing their scars only verbally, without showing them. Michaela, for example, hid her scars physically and verbally for years from everyone but her immediate family and intimate partners. After undergoing therapy she realised that telling people why she did not undress on the beach could ease her discomfort:

I’m now quite open about the fact that I have burns and [how] I feel very self-conscious on the beach and at a pool... I feel comfortable talking about it. It is who I am.

Consequences

While the act of disclosure is usually emotionally charged and painful, and participants felt vulnerable during the planning stage as well as the disclosure itself, positive experiences of disclosing scars could be liberating and even led some women to feeling their identity was enhanced and loosening their practice of passing unmarked. Nelly, for example, used to pass unmarked but after several tentative disclosures she noticed that ‘people don’t say anything’ or care much about her scars. Consequently, she stopped concealing her scars. However, managing disclosure could also entail some adverse consequences. Negative disclosure experiences, as demonstrated in the preceding chapter through the case of Michaela who was rejected by a suitor, can cause long-term...
distress and negative self-image. Re-framing stigmatising scar stories can be associated with anxiety that the strategies might not work. Telling false stories exacerbated feelings of inauthenticity for some.

**Converting scars into tools**

‘Converting scars into tools’ is my term. This code describes how some participants used scars to achieve various social goals for themselves or to help others, and demonstrates their resourcefulness and creativity. Scar aetiology and disfigurement degree play a role in the choice of this scar-work: women with minor to mild scars acquired through routine medical procedures were most likely to use their scars as tools. However, as shown below, several participants whose scars were more stigmatising and/or disfiguring also did so, even when they practised passing unmarked. The latter women were more likely to use their scars not for their, but for others’ benefit. Figure five ‘Converting Scars into Tools sub-category’ shows the tools into which women converted their scars:

**Bonding tool**

The ‘bonding tool’ term is inspired by Sarah’s words quoted below. This code describes how some participants used their scars to bond with people, directing them to read their scars as marks of shared misfortunes, milestones, adventures, and even seductive devices. Several women told stories of bonding with those who had also been through difficult experiences that left them with physical and/or emotional scars. Sarah, for example, had a pre-cancerous ovary removed at the age of eighteen, a formative experience, which made her feel at once fragile and resilient. She liked befriending other people with scars by talking about her own scar in a language that turned her surgery story into a heroic narrative:

After that [surgery] it was like, ‘Check out my scar!’ and then I was really interested in other people’s scars: ‘What happened to you?’ If I didn’t have my scar on my belly then I wouldn’t have my medical one-upmanship game: ‘You’ve had your appendix out? Well,
I’ve had my ovary out! Ha!’… I became particularly interested in young people’s scars. I’m not embarrassed about asking them, ‘How did you get that? That’s really cool’. Because it’s like, we’re part of a secret clique now [laughs]… I went to uni with a girl; she had a scar just popping out of her top. So I asked her, ‘How did you get your scar?’ And she was like, ‘It’s from a heart surgery when I was really little.’ And I was like, ‘Wow, that’s awesome!’ And then, because I usually don’t want people to think that I’m weird, I’m like, ‘Oh, I have a scar too, but it’s on my stomach’. And if someone has a really long scar, I’m like, ‘How long is your scar?’ [dramatic tone].

Sarah spoke about using her scar also to engage with a manager at her workplace:

We both have really long scars. And he was like, ‘Mine runs down my back’ and I was, ‘Mine is on the belly.’ So that was bonding.

Those women who, as discussed in chapter five, felt that their scars made them more interesting, used these to impress others. Lynne, for example, who received her scar in a childhood accident when a tree stump pierced her thigh, thought the scar made ‘a good topic of conversation’ with any new people she met, not just ‘comrades in misfortune’ as in Sarah’s case. Such a use of scars is reminiscent of the contemporary playfulness in using the body to present the self, as described in chapter two. But while most people express themselves through deliberate choices - projecting versions of themselves through clothing, makeup and bodily modifications, arguably women with non-facial scars are even more creative in making the best of their self-presentation of a culturally devalued body which they did not choose to have.

Moreover, three women (with minor to mild scars) said they used their scars several times for seduction purposes. For example, Helen said that in some instances when she wanted to seduce men, her chest scar was ‘an asset’. She would offer to show these men the scar in the context of telling them about her heart surgery:

Men could pretend this was where their interest was and they’d say, ‘Oh, yes, I’d love to see this’ and so this gave you a reason to take your clothes off… [it was] quite a handy little thing to get a young man to show an interest in my body.
The use of scars as seduction tools can be seen as particularly resourceful, and even as a subversive practice that undermines the conventions described in chapter two, which postulate that beauty is the most valued means for having a satisfying sex life.

**Validation tool**

‘Validation tool’ is my term that describes how some participants used their scars as evidence of their health status and history in order to be understood, get help or even appreciation. Sophia, for example, enjoyed showing her scar because she felt it reflected the gravity of what she had had to endure when her kidney was removed:

> I had a good time showing it [her scar] to them [her friends] and they were gasping and, ‘Oh, my God!’... I enjoyed this feeling of shocking people because I’ve really been through something horrible and here is my scar.

Helen used her chest scar when her sister questioned her history of childhood illness:

> My sister waited till my parents died and then she denied that I had a serious heart condition and had had a serious heart operation… She now minimised this. When she said to me, ‘You need to seek counselling because you think you’ve had a serious heart condition. See a psychologist, you’re sick in the head’, I said, ‘So why do I have the scar down my chest?’

In her work on chronic illness, Charmaz (1997) shows how some chronically ill people who *appear* healthy may be judged by people as lazy or odd if they display symptoms. Some respondents were in a similar situation and used their scars to gain legitimate illness status and practical help. Ellie, a 37-year-old former art teacher, who at the time of interview was living on a disability pension, was one of those women. A striking-looking woman with thick hair and glossy skin, nothing in her appearance indicates the profound physical suffering Ellie experiences on a daily basis because of her chronic back pain. This is why, Ellie said, she needs her back scar:

> Unless I can show somebody my scar, they don’t quite believe what I’m suffering or what I’ve gone through, so it’s a symbol I can show people. Or if somebody is lacking empathy, this [her scar] can change the dynamic... People look at me and think I’m healthy and fit. They don’t know that when I’m looking at them I have so much pain going on down here that I’m just concentrating... So I guess the scar is the only thing that can prove my case. Recently I was in Thailand and they cancelled the plane and they were trying to decide who would go on the next plane, and at that point I’d been sitting there for hours and I was shaking because I was in so much pain. We were all pleading our cases, and I was thinking ‘I’ve got to get on this plane, because I’ve just got to get home’... and I just thought I’m going dramatic here, I’m going to use it [her scar]. I just thought I’m either going to cry and fall to the ground, because I’m so vulnerable, or I’m going to be really assertive and aggressive. So I turned to the ladies and I showed them my scar and said, ‘I can’t miss the plane...’ I was theatrical, and you know, when people see it [the scar], it is dramatic. So... I got on the plane [laughs].

Consequently, unlike other women who framed the hidden locations of scars as ‘lucky’, Ellie said she would have liked her scar to be more visible:

> It would be handy if the scar was more obvious. I’d use it more... I’d prefer not to be verbal about my pain. It would be easier if I could just reveal my back scar.
Helping tool

‘Helping tool’ is a term I coined to describes how some respondents used their scars to help others. They would do so in their professional capacity and also in their private lives. Most of the women who worked in the healthcare and welfare professions said they sometimes used their scars to put their clients at ease. Ophelia, for example, worked with people who often self-harmed. She said some of her clients related to her better because she had visible scars:

It can be handy, if they [clients] see that I have scars. They feel a bit freer to talk about it [their self-harm]... I’ll try and take it off me as much as possible. I’ll validate the experience so they’ll see that I understand but I won’t go into any personal details. It’s more to open the conversation. They’d say, ‘Oh, you’ve got a scar’ and they’d go, ‘I also cut myself’. And I’d go, ‘And how is that for you?’ But if it’s risky for them, I’ll avoid a discussion of cutting... I don’t want to encourage self-harm. And scars also helped when I worked in a women’s refuge. It’s about de-shaming it, and if you see someone who has had a similar experience, you don’t feel so alone maybe.

Michelle, a naturopath, said her scar helped her relate more to her patients:

If they have something going on with their body, or if they have a big scar or something like that, I can show them my scar and say: ‘Look, I haven’t had the same experience, but I have had a similar experience and I can empathise.’ So it’s good [having a scar].

Liz, a researcher, used her scar while studying obesity. She attended a sewing class for overweight people where students created embroidered self-portraits. A slender woman, Liz wanted to empathise with her participants and show she was imperfect too. She portrayed herself wearing a bikini with her scar exposed:

This was like, we all have our stories and here is one of mine. I tried make it [scar] stand out... so this is what I am. And I do wear bikinis.

Photo 14: Liz’s self-portrait

Other participants used their scars to help people in their private lives. Haya, for example, helped a friend by showing her scar:

A friend was going to have a procedure and I said, ‘Don’t worry, now they do key-hole surgery, but it could have been a big scar, like mine.’ So I showed him.
Gemma, who normally kept her breast scars a secret, talked about them with several friends who underwent major surgeries so as to empathise with them. Lola, a member of Alcoholics Anonymous (AA), showed another AA member who also self-harmed her scars to help this woman normalise her experience. Rosa used her scars to encourage others to accept their bodies:

I guess if there was ever a chance for me to make someone feel less self-conscious or less anxious about themselves… I have one girlfriend who is gorgeous and has a beautiful face but she’s overweight and it really bothers her and I remember conversations with her: ‘Look, we all have things we don’t like about ourselves and none of us is perfect. But it doesn’t define you. And look what I’ve got here.’ It’s something that you have, but it doesn’t define you. That’s my line…

*Educational tool*

This code arose out of several participants saying they educated people with their scars. Some women educated their children to be accepting of differences. Michaela was one of them:

Whenever they [her children] were judgemental about someone else’s physical appearance, I might bring it [her scars] up in that context. I’d say: ‘It’s important to accept people for who they are and some are blessed with good looks, some are not or have had accidents. You need to think how it’s for them, when everyone is staring’. And my children have a very strong sense of fairness. So I definitely imbued this into them.

Stacy and Rosa, both with scars from melanomas, use these scars to raise awareness about skin cancer. They began with their children, teaching them to be careful in the sun, then with their children’s friends, and later with more people. Stacy, who usually passed unmarked, showed her scars occasionally as evidence to support her warnings about the dangers of sun:

If I see a mole on somebody I might say: ‘You know, it’s none of my business, but have you had it looked at?’ Sometimes I actually show my leg and say ‘Look at this’. And people go: ‘Oh!’.

Rosa said similarly:

I can say, ‘This [her scars] is what happens, this is the risk’. I can show it and say ‘I learned from this and I want you to learn from this… I had a melanoma, and have you seen my scar? Have a look. That’s what happens if you spend too much time in the sun...’

Finally, scars can also be useful warning signs for women themselves. Lola, who used to abuse alcohol, said her self-harm scars reminded her:

where I’ve been and where I don’t want to go back. I’d cut myself at the peak of my drinking, when I was really depressed… If I ever think about picking up a drink again, it’s [scars] right there in front of my face. It’s like, ‘Don’t you even think about it!’

*Summary*

The managing mark readings sub-category describes how respondents attempted to direct social ‘readings’ of their scars in order to minimise the disfiguring aspects of those scars, and to minimise or avoid a spoiled identity. Beyond self-protection,
participants also directed such readings to avoid interrogations and unpleasant memories, enhance their identity, bond with people, validate their health status, get practical help, assist others, instil compassion and warn people (and sometimes themselves) about health hazards.

Participants utilised several strategies to achieve these outcomes. In order to cope with the problematic aspects of their scars, they pre-empted physical disclosure with verbal disclosure, delayed intimacy with potential lovers, pretended during intimate encounters that they had accepted their scars, positively re-framed stigmatising scar acquisitions or told alternative fictional stories, and disclosed their scars verbally only. While these strategies had some adverse consequences, overall respondents felt they were useful and sometimes even led to lasting positive cognitive and behavioural changes, such as re-framing scar perceptions and anticipated social responses, as well as relaxing the practice of passing unmarked. Participants who used their scars to achieve social goals directed others to read their scars as marks of shared misfortunes, milestones, and seductive devices, as evidence of their health status and history, as educational lessons and as warning signs.

Overall, the coping behaviours described in this section can be classified as proactive coping. As discussed in chapter three, disfigurement researchers find such coping to be useful. Yet the strategies of proactive coping featuring most in these studies differ from those found in the accounts of this study’s participants. In the existing literature the emphasis in proactive coping is on how to manage situations where disfigurements are visible and are at the focus of interaction, whereas in this study the central focus is on disclosure initiated by participants. Dilemmas around disclosure - which emerged as important in this study - are not central in disfigurement research, even though issues of visibility and concealment are a feature in this literature. Most likely this is because, as discussed in chapters one and three, the existing findings are based predominantly on samples comprised of people with facial, or other highly visible, disfigurements. This study shows that for women with non-facial scars managing disclosure entails regulating a delicate balance between intimacy and distance, between truth and fiction, and between the desire or need to be ‘authentic’ about one’s body and identity and the need to protect oneself.
The practical use of scars as tools is a unique finding. Even the educational tool differs from the strategy of educating others about their disfigurements mentioned in chapter three. This study’s participants engaged in education for altruistic reasons rather than to alleviate negative responses to their scars. The finding about using scars as tools shows that women with non-facial scars can be resourceful and creative agents, in that they can challenge the dominant attitudes about the role of Body Surface in people’s lives.

While this, and the preceding, sections described scar-works directed at others, the following section shows how participants performed scar-work directed at themselves in order to promote self-acceptance.

**Doing Acceptance Work**

The term ‘doing acceptance work’ is inspired by wishes expressed by many participants to accept themselves. Findings show that many women have never really accepted their scars. Others have accepted them to some extent. Several women said that after years of distress they had managed to do this. Several more, as discussed in chapter five, even came to like their scars. All participants, though, whether they had accepted their scars or not, attempted to do acceptance work.

Acceptance work can be divided into intra-personal strategies (positive reframing; scar-work as a part of self-work; designating scar hierarchy; reaching out to role models) and inter-personal strategies (getting professional help and reaching out to peers).

**Positive reframing**

‘Positive reframing’ is my umbrella term that subsumes several sub-strategies where women tried to talk themselves into thinking more positively about their scars. Positive reframing was the most recurrent acceptance work strategy in participants’ narratives. Figure six ‘Positive Reframing sub-category’ shows the sub-strategies of positive reframing:

**Figure six: Positive reframing sub-category**

- Positive reframing
- Downward comparison
- Placing scars into a broader perspective
- Framing others
- Not dwelling on what cannot be changed
**Downward comparison**

The term ‘downward comparison’ is borrowed from appearance research as discussed in chapter three. Consistent with the research that cites social comparisons as a common strategy, this study’s respondents often compared themselves to others, most commonly engaging in downward self-comparison associated with positive coping. Women compared themselves to people with more severe disfigurements or other misfortunes. What follows is an assortment of quotes, or rather a chorus of women’s voices, that shows the similarities in how they employed this strategy.

Michelle: Other people lose much more, they lose their arms, their legs... I look at people in Cambodia in minefields and I feel fortunate that I haven’t had those experiences.

Nelly: My scars aren’t anywhere as bad as other people’s, and I’m certainly aware of this.

Sarah: My friends still now might have acne on their face and back. I’d find it more distressing than scars.

Karen: I think about people who are worse off and this really gets me through: what am I complaining about? At least I don’t have sore legs and sore arms. This is what gets me through: thinking of someone a little worse off. What I’ve got is not life threatening, it’s not going to kill me. A lot of people die of cancer...

Madeleine: I had people say to me that they knew somebody who had the same type of operation and they said that their scarring was terrible. They said they’ve done a really good job on me and I took this as a blessing and appreciated that.

Several participants made upward comparisons, which in the literature are associated with negative coping. Upward comparisons reported in this study were all with people participants knew, and were indeed associated with distress. Respondents mostly
engaged in such comparisons when they were in the vicinity of people they considered to be better looking than them, particularly if the latter placed a high value on their appearance and engaged in self-scrutiny and bodywork. Manuela told such a story:

I get really self-conscious when I’m around people obsessed with their bodies, because you feel something is wrong with you. I have this cousin, she’s so gorgeous, so beautiful. She loves walking around naked. She has an amazing body and she was always saying: ‘I put on some weight.’ And I was like, ‘Honey, look at me!’ [cries]… Sometimes I think, the way people judge themselves so badly, maybe I’m too soft on myself? And what would they think of me?

Manuela’s and several other similar participant stories bring to mind the phenomenon of Body Surface panic discussed in chapter two, where it becomes the norm to be concerned about one’s body. As Orbach (2010) wrote, many women can be hypervigilant about their appearance and feel a moral duty to improve it. Other women’s self-policing made some participants feel they should be more concerned about their scars. Manuela indeed became stricter about passing unmarked while she lived with her cousin. I had a similar experience in my mid-twenties when I shared an apartment with a friend who had a great figure but was constantly monitoring herself for the slightest body ‘faults’. I recall feeling uglier then and more concerned about my scars than I previously had been.

**Placing scars into a broader perspective**

‘Placing scars into a broader perspective’ is a term I have developed to describe another common strategy for promoting self-acceptance which emerged from the data, where participants re-framed their scar-related concerns more positively by considering the larger context of their circumstances.

Aetiology was important here. Some respondents reminded themselves of the reasons for their scars. Liz, who acquired her scar from appendicitis removal, said:

Of far more significance to me was the fact that my insides seemed to be repaired and that I have no lingering impact.

Other women reminded themselves that they had been through more serious ordeals than having scars. Anne used her experiences of childbirth to put her scar into perspective:

When far more important things happen in your life, like when you have children and your vagina is so spread and… when your sense of embarrassment is compromised to a such stage that you’re in so much pain, then what’s a scar? You think, it’s all relative and having a scar is nothing compared to giving birth.

Whereas Bronwyn’s comparison was truly sobering:

I’ve had brothers killed in car accident and get divorced, so to me the scars are just another part of all those issues that people go, ‘Oh, it’s terrible that it happened to you.’ One of the girls at work said to me the other day, ‘You’re so positive’ and I said, ‘If I
wasn’t positive, I’d be in a gutter.’ And scars are… like low down compared to other things.

Similarly, Stacy said:

I’ve had worse things [than scars], like, growing up, my father was mentally ill. And we had lots of deaths in the family and this put it all into perspective. I’ve got friends who haven’t lost family members yet. So for them, if they had a scar it’d be a big deal… But for me, and I don’t mean it’s not a big deal, but it’s almost like you get used to things. What doesn’t kill you makes you stronger. And my mum had an operation on her back three years ago and she was left a paraplegic. So it’s like: ‘God, what’s my scar?’

Some women ‘normalised’ their scar experiences by considering that most people have something they are uncomfortable about. Rivka, for example, a handsome woman, said:

And people have hairy legs and you know droopy breasts, and people have all sorts of things.

_Framing others_

‘Framing others’ is my term that describes a strategy for promoting self-acceptance, where respondents framed positively anticipated responses to their scars. Often participants told themselves that people would not care about, or even notice, their scars. Mei, a 33-year-old scientist with scars on her thighs from hip reconstruction surgery, said she kept reminding herself that:

You assume that people are looking at you, but they’re not [laughs]. People are obsessed with themselves, they don’t care. And sometimes you’ve got to remind yourself that nobody actually cares… I’m actually quite self-conscious in many ways. Maybe this is why I always remind myself that ‘people are not looking at you’ [laughs].

Michaela, like Mei, also strategically framed anticipated responses positively. She, though, framed her friends’ responses rather than those of strangers, and as empathic rather than indifferent:

Today when I have anxiety [about exposing her scars around friends], I know the feeling very well, I’ll say: ‘Okay, you have this feeling. Who is here? Who is safe? Are they going to judge you? Are they going to see you as less?’ And the answer is usually ‘no’ because of the people I have in my life.

Similarly, Madeleine framed other people, including potential suitors, as non-judgemental:

You get judged when you have a tattoo, but with a scar you don’t get judged, I think. It’s acceptable, because it’s not something you choose to have… I don’t think anyone thinks worse of you with a scar. And at my age [40], if I’m going to have a relationship with a man, he’s going to be of my age too and he’s going to have a lot of things wrong with him too, so he won’t be that judgemental.

It is important to note that women who used this strategy were those whose scars were less stigmatising. Sarah, for example, framed her hypothetical future lovers as being non-judgemental about her scar from ovary removal surgery:
If they like me enough to take my top off, then they probably won’t be bothered by it [the scar].

However, as discussed earlier, she was highly anxious about men finding out about the self-harm scars on her thighs.

*Not dwelling on what cannot be changed*

‘Not dwelling on what cannot be changed’ is a term I have developed to describe the deliberate decision several participants made to disregard their scars because they cannot be improved. These women, like the majority of respondents, also devoted time and effort to bodywork, but they had decided not to worry about what they could not change, thus framing their scars as being outside of the ‘body project’ discussed in chapter two. Ellie had such an attitude:

I’ve been a bit worried, like ‘my tummy is a little bit chubby…’ I’ve been vain about other things. But I can’t do anything about the scar, it’s not something I can control. So I accept it.

In this spirit, some women even attempted to ignore their scars while exposing them in public. Madeleine, for whom looking good was high priority and who worked out in the gym and ran regularly, had this attitude. Ironically, it was her bodywork that helped her to accept her scar, because she felt she was already fulfilling her ‘duty’ by improving what she could:

I just accepted it [the scar], because what can you do? It’s unfixable… so you have to accept it, because you’ve been inflicted with it and you have no choice. I was quite brave and I just sort of ignored it, and I’d still wear bikinis. I wasn’t self conscious… I just pretended it wasn’t there. I just thought, ‘Yeah, I have a scar, big deal!’

However, it should be noted that none of the women who used this strategy had severely disfiguring, or particularly stigmatising, scars.

**Scar-work as a part of self-work**

‘Scar-work as a part of self-work’ is my term that describes how some participants’ overall engagement in self-development, whether through therapy or spiritual practices, also helped them to accept their scars more. As Rivka said:

I’ve come more to terms with things as they are now rather than fighting them. I think that’s just through working on myself over the years… Being around a place like *Landmark* and having conversations, you can see similarities with people and how everyone is concerned about things like looking good… Just hearing numerous conversations about body image and how people are not happy with what they’ve got… I became happy with what I’ve got.

Michelle, too, accepted her dog-bite scar more after doing spiritual and therapeutic work on accepting the trauma of scar acquisition:

I did a lot of emotional healing and that was what probably made me go ‘Right, it’s [scar] a part of me’. I used lots of homeopathy and did acupuncture, like getting the energy
flowing properly… And writing, I wrote an awful email to the owner of the dog. I never sent it out, but I wrote about how I felt about the whole dog-bite experience and how I have this permanent scar that I see every day and that it’s because of him… That was very cathartic too.

**Designating scar hierarchy**

‘Designating scar hierarchy’ is my term to describe a strategy utilised by participants with multiple scars. These women often said that some scars disturbed them less than others. Making such a distinction seemed to alleviate some of the distress. The hierarchy was designated according to some of the mediating factors discussed in chapter five: disfigurement degree, aetiology and participants’ framings of their scar locations. Mei, for example, was most distressed about one of her three hip scars, which is dented, whereas the other scars ‘are very neat’. Similarly, I am more concerned with the scars on my lower leg, which are most disfiguring and include a dent and a keloid scar, than with my other scars. Bronwyn designates a hierarchy to her scars according to their locations. The scar on her lower leg bothers her less, because:

> it’s so far away from where I’m looking at. Whereas the one on my arm, I can actually see people – they wouldn’t look at my eyes, they would be looking over there. Whereas, they aren’t looking at your legs…

Whereas Sarah’s scar hierarchy, as discussed earlier, was concerned with the causes of her scars.

**Reaching out to role models**

‘Reaching to role models’ is my term to describe a strategy of drawing inspiration for accepting scars from other women with unconventional attitudes to appearance. Six respondents talked about the hope and support such women provided for them.

Michaela saw role models in women who revealed their non-facial scars in public:

> When I see someone with scarring and they wear short skirts or low tops, I just find it so inspiring. I feel, how great! But I don’t see a lot of people like that around [laughs]. That’s why it’s a real thrill when I see it. Good on them for getting over it!

Lora, after being hit by a truck while cycling and acquiring multiple scars in her pelvic area, found inspiration in the artist Frida Kahlo. Kahlo received her scars in a similar location and through road trauma too. What appealed to Lora most about Kahlo’s story was that Kahlo made art about her scars, painting them and the pain they caused her:

> I remember thinking, well, this is someone I really admire... Even though she had a tragic life, the accident fed her artwork. That was what she painted a lot of the time.

Lora, a fiction writer, followed Kahlo’s example, embarking on writing a novel based on her story.
Hannah, a 22-year-old social work student with two abdominal scars from a medical treatment, found her role model in Naomi Wolf, the author of *The Beauty Myth*. Wolf’s critique of the dominant discourses about female appearance inspired Hannah to rethink her attitude towards appearance in general and her scars in particular:

I read *The Beauty Myth* when I was in my first year at uni, and that was an amazing book. The stuff about women having to look perfect being a sort of political thing, a tool to... being subordinate to men. I really took this on.

Hannah rated her scar-related distress as having reduced over the years from 3 to 0 and said that Wolf’s book played a significant role in this process of self-acceptance.

**Getting professional help**

‘Getting professional help’ is a term borrowed from disfigurement research. Three respondents said therapy helped them to accept their scars more. Michaela, for example, said her therapist helped her find strategies to deal with scar-related anxiety and ‘to feel better about myself.’ This finding corresponds with some qualitative studies discussed in chapter three, such as that of Furnace et al. (2006) where respondents with facial disfigurements cited getting professional help as one of their coping strategies.

Seven women said they wanted to go to therapy, but could not afford it. However, some respondents, as chapter eight shows, told stories of disappointment with what they perceived as lack of understanding of scar-related issues by professional helpers. This was identified as an important unmet need. Karen, for example, said:

I don’t think all the counselling in the world can help a burns survivor. You know what can help a burn survivor? Meeting another burn survivor, coming to a retreat and talking to other burns survivors. I’ve done counselling. If they aren’t burnt, what do they know?

Indeed, those participants who had access to peer support found it highly valuable.

**Reaching out to peers**

‘Reaching to peers’ is a term inspired by disfigurement research which mentions peer support as an important coping resource. Respondents reported that contact with other people with scars, particularly if these were acquired in similar circumstances, was
very helpful in their journey of coming to terms with their scars. This is in line with findings from Rumsey et al.’s (2010) study, where participants also reported that talking to others in the same situation was beneficial.

The benefits were numerous. Michelle, for example, found it useful talking to another woman who had been bitten by the same dog that attacked her and had also received scarring. The sharing of experience made Michelle feel she was not alone.

Similarly, Karen had her first breakthrough in coping when the Bali bombings occurred and the stories of the victims, many of them with burn scars, were broadcasted in the media:

Until then I had never ever heard of, or seen anyone, who’d been burnt. So that was a real eye-opener to me, like there are people out there like me.

Shortly after, Karen discovered the Burns Foundation and her life changed dramatically:

When I first met burns survivors, a weight lifted off my shoulders. All my life I’d been thinking ‘I can’t talk to anybody because nobody will understand’. Unless you’ve been in this position, unless you’ve been burnt, you can’t give advice. I met these amazing people... friends I have in the Burns Foundation, they’re... they’re friends I could never have had anywhere else. I have many good friends without burns, but this friendship is different. It’s like my other half. My life has really changed since. I love myself more today…

From her peers Karen learned not only how to accept herself more, but also how to re-frame people’s reactions to her scars and how to respond to them:

[In the past] it was pretty horrible. People would say: ‘What happened to you?’ I’d tell them to go to hell: ‘None of your bloody business!’ If somebody asks me today, I tell them [how she got burnt], because I learnt from other burns survivors, people are curious, they really don’t mean any harm, they just want to know... Like one lady came up to me last year in the deli. I had a short top on and she asked me [what] would I mind telling her. And I told her. She said, ‘You look so comfortable in your skin’. And you know, I felt so honoured that she could see that I was comfortable in my skin and would approach me and ask me. But five years ago I’d have told her where to go and walked off… So my life has really changed since I joined the foundation and met other survivors.

As shown, interaction with peers can be helpful because of the chance to share experiences, get practical advice and obtain a more positive perspective. For Karen, meeting her peers was a life changing experience that led to significant reduction in distress. Additionally, some participants benefited from contact with peers through taking on mentoring roles. Acting as mentors to their peers felt empowering for these women. At the time of the interview with Karen, she had become the CEO of the Burns Foundation (and was happy to be identified as such as described in chapter four) and a popular public educator:

One thing I really love to do is help the burns survivors. A lot of burns survivors I’ve met are not very positive. Like, ‘I can’t do this or that.’ And the message I’m trying to bring across is: ‘Look, I’ve been burnt, I had a complete family breakdown, this is what I’ve been through. If I can do you can do it too’... I just want to give a bit of inspiration to
those negative burns survivors who are still victims rather than survivors. I think I have a lot to give to people and that’s what I want to do.

Karen’s story resembles that of James Partridge, a burns survivor who founded the UK national charity *Changing Faces*, mentioned in chapter three, to support people with disfigurements. Partridge (2006, 2005) argues that becoming an advocate for others advances adjustment to disfigurements. The downside of this strategy, though, according to respondents’ accounts, is the difficulty in finding peers. This unmet need is discussed in chapter eight.

**Summary**

It was shown that participants employed a variety of strategies to promote acceptance of their scars. Some of these correspond with the existing literature discussed in chapter three; others are unique to this study.

Positive reframing was the most common strategy used in acceptance work as identified in the data. It was composed of four sub-strategies: downward comparison, placing scars into a broader perspective, framing others and not dwelling on what cannot be changed. The findings about downward comparison are in line with studies of disfigurements showing this to be a widespread strategy. Not dwelling on what cannot be changed is in line with strategies defined in the literature as a pragmatic approach to coping, or what Rumsey et al. (2010) call ‘getting on with it’. The strategy of placing scars into a broader perspective is compatible with the strategy described in Rumsey et al. as “relegating the appearance concerns to a low level of importance in the overall life experience” (p.82).

Doing scar-work as a part of self-work strategy, which shows that overall self-improvement can also result in being more accepting of one’s scars, is a new finding. Also, the findings on designating a hierarchy to scars and on the negative impact of being around people engaging in self-scrutiny and intensive bodywork are unique to this study. The finding on framing others, a strategy that frames positively anticipated responses to scars, is new too. Whereas the findings that women resorted to role models, professional helpers and peer support for inspiration and practical help are consistent with the literature on disfigurements.

**Doing scar-works**

Many participants utilised strategies from all three approaches to scar-work, at once trying to pass unmarked, manage mark readings and do acceptance work. Analysis
shows that many of these women managed over time to reduce scar-related distress. This is consistent with disfigurement research discussed in chapter three that associates a broad coping repertoire with better adjustment. However, some women, despite employing a variety of strategies, still experienced considerable distress. Stacy’s story is an example. As discussed, to promote self-acceptance she placed her scars in a broader perspective and designated a hierarchy for her scars. Also, sometimes Stacy exposed her scars to educate others about skin cancer. Yet at all other times Stacy meticulously passed unmarked despite the associated discomfort (particularly in hot weather), and despite the resulting loss of activities valuable to her, such as swimming. Such inconsistent choices of scar-works may possibly reflect Stacy’s general ambivalence about her scars, as discussed in chapter five. Such an inconsistent approach was typical of many participants. These choices possibly mirror the overall tensions many women experience around their appearance, feeling pressure at once to strive to appear alluring and accepting of their imperfections. Moreover, this situation shows that despite women’s best efforts to adjust to having scars, in contemporary society this can be a difficult thing to live with.

Conclusion

This chapter described the main strategies participants used to minimise the negative social consequences of their scars and their own negative feelings about them, and also to achieve some social goals. For this purpose, women passed unmarked, planned physical and verbal disclosure of their scars, utilised their scars as tools and tried to accept them.

Insights from body theory help to understand the high prevalence of the practice of passing unmarked among participants. It seems the contemporary attitude towards the body, which is perceived as a project to be improved both for attaining personal goals and fulfilling one’s moral duty, takes a different turn for women with non-facial scars. To ‘improve’ what cannot be improved, women tended to be secretive about their scars, aspiring to pass as non-scarred. However, while passing unmarked carries rewards and can often be seen as an adaptive practice, this can also come at a considerable cost. Therefore, women often needed to make decisions as to what extent they wanted to adhere to this practice. Some respondents oscillated between concealing their scars and revealing them, sometimes for explicitly subversive purposes. Thus, women’s bodies can be seen as potential sites for both conformist and agentic practices.
Even those who meticulously worked to pass unmarked, occasionally had to disclose their scars physically and/or verbally, particularly in intimate situations and during medical or cosmetic treatments. Disclosure entailed its own set of dilemmas about the timing and how to still retain a positive identity. Participants who exposed their scars in public still often needed to plan verbal disclosure if the scars were stigmatising. As was shown, they were often creative about making their disclosures as favourable as possible, so that sometimes this even enhanced their identity. Furthermore, some women even capitalised on their culturally devalued body parts, using them to achieve social goals.

Participants used not only behavioural, but also cognitive strategies of coping when they engaged in acceptance work. Although the women commonly practiced this scar-work, they still found it difficult to accept their scars. This state of things further highlights the contemporary tension, discussed in preceding chapters, where women feel pressured both to perfect their appearance but also to accept themselves. In order to promote acceptance of their scars, some women not only tried to restructure their scar-related cognitions, but also reached to others - caring professionals and peers. As arose from their narratives, professional help can be a ‘hit and miss’ experience, and peer support is often unavailable. These two important themes are addressed in more detail in chapter eight.

As depicted in figure two, the essential category ‘doing scar-work’ relates to the other two essential categories and the core category. The relationship between doing scar-work and being marked is bi-directional. This chapter showed that women varied considerably in their choices of scar-work, but also often sampled strategies from all three scar-works identified in the data. These coping choices were influenced by how participants framed their scars and by social responses to them. For example, as was shown, the motivation to pass unmarked often arose from unpleasant social interactions participants had experienced. This highlights once again the importance of the sociocultural context in the experiences of women with non-facial scars, particularly when they feel a moral duty to conceal their bodily ‘faults’ or wish to avoid stigma. Also disfigurement degree of scars, aetiology, women’s appearance attitudes, anticipated stigma and personality traits can all influence how participants chose their scar-work strategies. For example, as discussed, women with minor-to-mild, routine medical scars usually felt less need to conceal them, some even displaying these scars with pride as signs of their strength. These women were also more likely to use their scars as tools. Participants with more disfiguring and stigmatising scars were more likely to practise
passing unmarked. These latter women also struggled more with planning disclosure. Moreover, women with particularly stigmatising scars (such as those resulting from self-harm) were more prone to tell false stories about them during disclosure.

In turn, the coping strategies participants chose shaped further their experiences of being marked. For example, passing unmarked could trigger its own distress, whereas positive experiences of disclosure could trigger more positive framings of scars and relaxation of the practice of passing unmarked. The relationships between doing scar-work, travelling marked through life and unmet needs are discussed in the next two chapters that describe the latter essential categories.
Chapter Seven – Travelling Marked through Life

‘Time is not necessarily a great healer when it comes to living with the challenge of visible difference.’

Nicola Rumsey & Dianna Harcourt

This chapter describes the essential category ‘travelling marked through life’, which is a term I have coined to capture one of the most recurrent themes in participants’ narratives: that their experiences of being marked and scar-work choices often evolve over years. Firstly, the fluid (subject to change) factors that influence changes in women’s experiences of their non-facial scars are discussed. Then the diversity of women’s life trajectories is demonstrated. These findings are discussed with reference to the existing research. Figure seven, ‘Travelling Marked through Life category’, shows the internal structure of this essential category.

Fluid Mediating Factors

‘Fluid mediating factors’ is a term I have developed to capture the impermanence of the mediating factors included in this sub-category. The most significant fluid factors in women’s experiences of being marked that emerged from the data are scar physical changes, certain concurrent life events and occupations, and growing older. These factors, though, mattered most for women who felt like damaged goods. As will be shown, sometimes these factors also mediated experiences of stigmatising scars, distressing memories and painful rumination triggered by scars, but to a lesser extent.

Scar physical changes

‘Scar physical changes’ is a term I have developed from the data. This code describes several changes that can occur in scars with the passage of time. Pain associated
with certain scars can eventually disappear, as in the cases of melanoma scars that, according to participants, were painful for some of the first years. Red scars may turn paler and rough scars can become smoother, blending better with skin. Sometimes the size of scars can also reduce. Such physical changes may ameliorate distress, or even extinguish it, particularly for those women who feel they are damaged goods, as Candice’s story shows. In the first two years after the surgery that caused Candice’s four abdominal scars, they were red and swollen and, as described in chapter five, Candice experienced back then high appearance-related distress. However, at the time of our interview, four years post-surgery, Candice’s scars had faded and reduced in size and she said she hardly even remembered she had them. When scars reduced significantly, some participants who used to pass unmarked ceased, or at least relaxed, this practice. Candice was of those who stopped concealing their scars.

As illustrated, physical changes in scars can impact significantly on participants’ experiences. However, usually changes in the being marked experiences were multi-factorial. Candice also listed other factors that reduced her scar-related distress. Most notably, she said that during the first two years of being marked she was either single or in unsatisfactorily relationships, whereas when I interviewed her, she reported being in a happy, stable relationship. The next section describes the significance of some concurrent life events, including relationship status and quality, in the adjustment process.

**Concurrent life events**

Concurrent life events is a term derived from qualitative studies (Furness et al., 2006; Rumsey et al., 2010) that identified some events as important in mediating the impact of disfigurements. This code captures life events that were significant in mediating women’s experiences of non-facial scars, as emerged from the data: relationship status and quality, parenting small children, health status and Body Surface changes (unrelated to scars). These are described in the following sub-sections.

*Relationship status and quality*

Relationship status and quality often undergo changes throughout people’s lives. Such changes can influence how women feel about, and cope with, their scars. Data analysis shows that for those participants who experienced themselves as damaged goods, being in a supportive relationship was one of the most powerful ameliorating factors. Women who had acquired their scars while they were already in loving relationships said
their partners helped them feel better about themselves. Similarly, meeting a supportive partner after scar acquisition often altered significantly how women felt about themselves. Shanty told such a story. Her husband was also her first boyfriend. Shanty described the enormous impact that he had had on her experience of being marked from the first time she revealed her scarred chest to him:

I felt very vulnerable and I was really revealing myself, for the first time, to someone other than my mum... And I really felt like that was... that was the moment. Because of how he handled it, he was like, ‘Oh, you’re so beautiful, it just makes you more unique and beautiful’ and said all the right things; it never really became an issue between the two of us. It was a big thing when I realised that he didn’t care about my scars... Everything I needed to hear, my husband said to me. He’d say, ‘It’s your imperfections that make you perfect.’

Sometimes partners successfully encouraged women to relax their practice of passing unmarked. Karen, for example, became less vigilant about passing unmarked after entering a relationship with her de-facto partner:

I feel so relaxed around him and I don’t need to cover up, he loves me, burns and all... With my previous husband, he sort of made me feel that I wasn’t adequate. He never said it was the burns, but I felt that it was. It’s got to the stage where he wouldn’t touch me and I just thought, ‘Oh, it’s my burns’. So that’s what sort of caused our marriage to break up... I suppose I’ve only now started, in the last 18 months since I’ve been with my partner, to not be protective of my body. I just feel so loved and so blessed to have him in my life... For once I feel comfortable in my own body and it’d taken 40-odd years to get to where I am today. I’m not 100% comfortable, but I’m comfortable. He makes me feel... like I can be myself. He knows what I’m about and he loves me for who I am and he tells me I’m an inspiration to him and he admires me and this means a lot... And this is very hard for burn survivors to come to terms with: ‘I’m beautiful’. And I can do it now, to think I’m beautiful. And he tells me every day, ‘You know, Karen, you’re beautiful’ and having this reassurance helps me.

Overall, intimate partners were the only important support people women identified among their relational circles. This finding particularly resonates with my personal experience. Being in a good relationship was always highly important to how I felt about my scars. I was significantly less conscious of being marked and more inclined to relax my practice of passing unmarked in terms of going to pools and the beach when I was in good relationships.

Karen’s story also demonstrates another finding of this study, that being in a non-supportive relationship exacerbates women’s distress. Manuela told such a tale:

He [her ex-boyfriend] didn’t mind [the scars]. But my next relationship was a really bad relationship, so it did bring up a lot of insecurities... I was very self-conscious about scars, no matter what.
As already discussed in preceding chapters, being single and dating are likely to exacerbate scar-related concerns around appearance and stigma. Bronwyn, for example, said she felt more comfortable about her scars when she was engaged than after her engagement was terminated and she resumed dating. A recurrent theme in single participants’ narratives was that if they had a loving partner they would be less concerned with their scars. Meg, for example, said that during her marriage, which she described as supportive if dull, her abdominal scar did not concern her much. At the time of our interview though, she was separated from her husband, dating and feeling like damaged goods. She felt that a new relationship could help:

If I did get into another relationship... and if they weren’t bothered by it [the scar], or even thought it was something special about me, that would help. My energy, on the Jungian scale, is towards the external. So I see myself in terms of relationships. What other people think of me shapes how I see myself.

This finding also strongly resonates with my own experiences of exacerbated scar-related distress during the periods when I was single and dating.

Similarly, some participants speculated that if they separated from their current partners they would become more worried about their scars. Lora was one of the latter. As discussed in chapter four, she felt comfortable about her body around her de-facto partner, but also said:

I’m really hoping that we’re going to be together forever [chuckles]... I don’t know if we did break up what would happen. I mean, it wouldn’t be as hard again with another person, but it’d still be difficult.

Similarly, Michelle said:

I’ve already been with my partner for about six years before this [scar] happened, and we’re still together. But I think if I were single I’d feel like damaged goods, like something is wrong with me.

Parenting young children

Participants with children often said that while their children were still small their attention was less focused on their scars, because of the busyness of their lives. Rosa, for example, said:

I had my daughter and... I had something else to think about rather than my own body. Then in 16 months I had another baby. Life was totally busy and you don’t have time to think about yourself.
Respondents found parenting small children helpful, not only because it created a distraction. Sometimes children helped them to stop avoiding certain physical activities they had withdrawn from in order to pass unmarked, and helped them to accept themselves more by showing their own love and acceptance. Michaela, whose children at the time of our interview were seven and nine years old, tells such a story:

That was great, getting out and playing with the kids. It’s been a very exciting stage of life… Being naked around kids. We have showers together and swim together, which is very beautiful. Recently I said to them, ‘This summer I might occasionally swim without my shorts. Are you okay about that?’ And my daughter said, ‘Of course! That’s a great idea!’ and my son said: ‘Will you feel comfortable, mum?’… I don’t talk to them usually about it [scars], don’t burden them, but they’re so compassionate. They are always: ‘Get in the water, get in the water!’ and that’s really great. I use this as encouragement and this really helped me to get over this hump. It’s really been a great motivator, my kids wanting me to get in the water. And I’ll still get anxious about it, but I’ll show my legs.

Karen talked of similar experiences with her two daughters:

With my first daughter, I felt… I just felt that here was someone who loves me for who I am. You know, a child… they don’t care if you have burns. And I’ve got that from both my children. I was very lucky… My first daughter, she just brought a whole new integration into my life. Children accept their mothers for what they are and they love them unconditionally.

However, sometimes the negative impact of scars was so profound, as in Shanty’s case, that neither mothering a small daughter nor having a loving marriage helped her accept her scars or relax her practice of passing unmarked.

*Health status*

Health status fluctuates throughout people’s lives. In this study, most women who had disfiguring scars and concurrent health problems said the latter concerns overrode their appearance concerns. Ellie, for example, suffered from chronic back pain and also had Crone’s disease. She said that even during such potentially distressing situations as intimacy with new lovers, she was more concerned with managing her physical discomfort than with the appearance of her back scar.

However, health problems seemed to put appearance concerns into perspective only while they lasted. For example, those participants who acquired disfiguring scars in circumstances that involved serious health and/or physical function problems often reported that the scars began to concern them once their physical recovery was complete. Sometimes the recovery process took several years and only then did women begin to feel distressed about their scars. This was Shirley’s experience after she was involved in a road accident:

It [her scars] didn’t really worry me at the beginning, because you’re going through so much… When you come home [from the hospital] you have so many things you have to
deal with. Like, I couldn’t drive. I lost my independence for quite a long time. I had to rely on other people. So these were the things I was thinking about rather than my scars. And plus, at that stage you don’t know how far your scars are going to be reduced. So it was something I didn’t think about at the beginning… Probably at least for two years and probably because I had crutches for a long, long time… My main concern was on the pain and what I needed to do to walk. So the scarring, it took [me to notice it not] until everything else was okay. Then it was like, ‘Okay, I’m over all that. Now I notice my scars more.’

And once Shirley began to notice her scars, as discussed in preceding two chapters, she experienced distress on a daily basis.

Yet once again sometimes the scars’ impact was so profound that not even health problems could distract participants. Lora, for example, at the time of our interview was still undergoing surgeries to repair the damage she had incurred four years ago during a road accident. Still, she was highly distressed by the appearance of her scars. This may have been, at least in part, because her scars were highly disfiguring.

**Body Surface changes**

Body Surface changes throughout the lifecycle: people gain and lose weight, acquire disfigurements, show signs of ageing. Data in this study indicates that certain negative Body Surface changes overrode concerns over scars, unless the scars were particularly disfiguring. Rosa, for example, was more concerned with varicose veins she had developed following her pregnancies than with her scars. The most recurring negative appearance changes, though, that overrode scar-related concerns, were visible signs of ageing and weight gain.

**Occupation**

‘Occupation’ is a term I have developed following several participants’ stories where occupation featured as significant to their experiences of being marked. Occupation can be a fluid factor in people’s lives, with some having several careers or casual jobs throughout their lives. Data in this study indicates that certain occupational roles can mediate appearance concerns around scars, namely those of a performing artist, health professional or military employee.

Three women in this sample were performing artists. Two of them said that since they had begun performing they had become more self-conscious about their appearance and had worried more about their scars, even if these were not visible to the audience. Meg, for example said:

> When I started performing, I looked more in the mirror, thought about what I was
wearing, what makes me attractive.

The third performing artist was engaged in feminist art that critiqued cultural beauty ideals. Thus, her work helped her deal with, rather than exacerbated, scar-related distress.

Respondents who at some stages of their lives worked in the army (n=2) attested to the soothing effect of the uniforms which concealed their scars without drawing attention to concealment, since all soldiers dressed the same. One of these women, Karen, also felt that in the army she was generally more accepted as a fellow comrade. According to her, the military service blurs differences between people. Karen, who entered army employment not long after finishing school where she was bullied, was grateful for this experience of acceptance:

> In the army I was more protected… I was accepted, I think, because I did what other people had to do, running in full gear, climbing.

However, this positive effect lasted for the duration of employment only.

Participants who were health professionals (n=3) talked about more lasting benefits of their occupations. All said that their professional knowledge helped them to accept their scars more, understanding they were there ‘for a good reason’. As Haya, the daughter of a doctor and a general practitioner herself, expressed:

> Having a medical focus and being in a medical family, it makes a difference. Because I just accept it [her scar] more. I accept the fact that something was wrong and this is what had to be done.

**Growing older**

‘Growing older’ is a code that emerged after several participants in their fifties, and even forties, said that growing older affected their experiences of their scars. Women associated growing older most often with a decrease in scar-related distress, explaining this by their changed priorities, with
a lesser emphasis on appearance and becoming generally more self-accepting. Anne (48 years old at the time of our interview) felt like that:

After forty you get over a lot of things, you don’t get swept up by the smaller stuff. You worry about bigger things.

This theme of older age as liberating from appearance concerns was also salient for Gemma (55 years old at the time of our interview), who said that the contrast between her younger and older selves on matters of appearance was stark. She wrote in an email addressed to me:

When I was younger, the pressure to be physically beautiful overrode everything else… Thank God we grow up eventually.

Bronwyn (40 years old at the time of our interview) also felt that her self-acceptance increased with age; however for her the contrast was not that great:

You grow up and you stop expecting yourself to be perfect. Like, when you’re younger it’s always ‘Oh, everyone is watching me’ and you realise that the focus is not on you all the time… I’m still conscious of this [her scars] though...

Indeed, the oldest age group in this study (50 to 58 years old) reported the lowest scar-related distress. However, this does not imply distress always lessens in a direct relationship to ageing. Table four, ‘Distress levels across age groups’, captures the percentages of high distress within each group in order to compare between them:

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of participants</th>
<th>Distress rated as between 2 and 5 at the time of interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29</td>
<td>4</td>
<td>2 (50%)</td>
</tr>
<tr>
<td>30-39</td>
<td>8</td>
<td>5 (60%)</td>
</tr>
<tr>
<td>40-49</td>
<td>9</td>
<td>6 (66%)</td>
</tr>
<tr>
<td>50-58</td>
<td>9</td>
<td>4 (45%)</td>
</tr>
</tbody>
</table>

Table four: Distress levels across age groups

In fact, the next age group with the lowest levels of distress was actually the youngest one, with participants in their twenties. Even more strikingly, women aged 40-49 years showed the highest level of distress, even though some of them, as aforementioned, spoke about ‘growing older’ in the same sense as participants in their fifties did.
In line with the interpretive underpinnings of this study discussed in chapter four, to understand better the connotations women attributed to the notion of ‘growing older’ I looked for latent meanings in participants’ narratives and located those within the cultural discourses of appearance. This perspective helps to highlight the somewhat paradoxical nature of respondents’ references to growing older. The potential of growing older liberating respondents from appearance concerns was often discussed by the women in the context of the less positive phenomenon of feeling invisible in the youth culture of today. Sophia (52 years old at the time of our interview) spoke in this vein:

If a young woman has a scar it’s supposed to be an absolute tragedy, and plastic surgery, and anything out of the ordinary is considered blemished. I don’t like it and I suppose being an older woman I feel quite liberated not having to conform to all this. Age matters for a number of reasons. Firstly, you’re becoming invisible when you reach a certain age. Secondly, you have enough experience, you become much more of an individual. I think it’s a matter of accumulating experiences that teach you not to be so superficial…

Following such stories, it remains questionable whether older women do indeed accept themselves more, or rather internalise cultural discourses on appearance postulating that only the young are entitled to be beautiful and concerned with their looks while rendering older women as being outside of the desirable realm. Indeed, some respondents in their forties and fifties claimed to no longer be interested in sexuality. Also, it is possible that the pressure to be self-accepting discussed in the two preceding chapters operated also in the narratives about growing older.

Moreover, data indicated that scar-related appearance concerns persisted in older women too. As table four shows, the differences in distress between the oldest age group and other age groups are not great. In fact, four out of nine participants who were in their fifties at the time of the interviews expressed many concerns about the appearance of their scars. Some others in this group also mentioned they cared about their appearance. Sophia, for example, said later in the interview:

I’m still the same as when I was 19. I really like looking good.

Whereas some women explained that as they grew older they became less concerned with their scars, because they now did not feel comfortable wearing revealing clothes that could show their scars. Similarly, for other respondents, the experience of being marked became easier as they grew older because they learned to pass unmarked more efficiently. Rivka, for example, with time learned how to find the right clothes to conceal her scars:
I just know what to buy now. I found a bra that I can wear, so I just buy lots of them. So in this respect it doesn’t affect my day to day life anymore.

Growing older may have actually exacerbated distress for participants in their forties, because, for some, this was the age when invisibility set in. But, unlike women in their fifties, respondents in their forties may yet not have been reconciled to the cultural messages that they were losing their attractiveness and so experienced more distress.

Certainly it needs to be noted that several women said that growing older also eased their concerns around spoiled identity and traumatic memories. This was because they felt that older women were less subjected to confessional discourse. As Bronwyn said:

> When you’re older, people are more polite and they won’t ask questions. But in your twenties, people would go, ‘Oh my God, how did you get this scar?’ and they wouldn’t think of this as being rude.

![Photo 19: Scars of a 49-year-old participant](image)

**Multifactorial nature of changes in experiences**

It emerged from the data that most fluctuations in the experiences of being marked and in the choices of scar-works could not be attributed to one specific fluid factor, but rather resulted from a combination of several ones. Manuela, for example, as discussed in preceding chapters, was not concerned with her scars during the first year after the weight-loss surgery that produced them. However, in later years her scars became a daily concern and she began passing unmarked for a number of reasons (one reason, the scar fuss responses she received, was discussed in chapter five):

> After surgery I was thinner and it [scars] didn’t matter so much. But after a few years and after a few relationships things started changing. My body shape wasn’t so new anymore and the scars were so much more… About a year after the surgery I broke up with my boyfriend and I started dating and that was stressful too…
Whereas Michaela noted both permanent and fluid factors that impacted on the levels of her scar-related distress and on her coping:

In our western culture, where over-achieving in beauty and fitness is the norm, I do feel a bit inadequate at times and have sought refuge in over-spending on beautiful clothes over the years. I do, however, have wonderful relationships with my family, my partner and my children, and since meeting my partner my anxiety relating to my scarring has reduced dramatically.

More examples of the multifactorial nature of such changes are given in the next section ‘Marked life trajectories’.

Summary

Several fluid factors emerged from the data as having an influence in changes in the experiences of being marked and the scar-work choices. Physical changes in scars can ameliorate scar-related distress and relax the practice of passing unmarked. This finding contradicts much of the disfigurement research where, as discussed in chapter three, it is often argued that the link between physical disfigurement characteristics and adjustment is weak.

Recent research (Furness et al., 2006; Rumsey et al., 2010) shows that concurrent life events can affect the impact of disfigurements on individuals. However, little is known about what events are most significant and the processes involved, particularly because few qualitative studies have been done in the field. Furness et al. (2006) considered concurrent life events as mediating factors in the lives of people with facial disfigurements, but identified these only as health issues related to disfigurements. Rumsey et al.’s (2010) study also focused on negative life events only, identifying health problems, financial stressors and social difficulties as associated with high disfigurement-related distress.

This study also identified several negative life events as mediating adjustment: negative changes in Body Surface, separation from an intimate partner and health problems. In this study, like in Furness et al., but contrary to Rumsey et al., health problems overrode scar-related concerns. This finding is also compatible with studies discussed in chapters three and five that showed people who received disfigurements from lasting conditions worried more about the health than appearance effects. This study though adds to this literature by showing that the same applies to health issues unrelated to scars. So do negative changes in appearance override scar-related concerns (it should be noted that the finding that weight and visible ageing overrode disfigurement-related
concerns was also present in Rumsey et al., however not conceptualised there as a ‘life event’). Whereas separation, and generally being single, was found to exacerbate scar-related distress. Moreover, this study adds to the discussion of concurrent life events also positive life events that can ameliorate distress: partnering and parenting small children. In fact, data showed that being in a supportive relationship was one of the most powerful ameliorating factors, helping to reduce scar-related distress, promote self-acceptance, and reduce or even cease the practice of passing unmarked. This is consistent with the literature on body image that shows being in a supportive relationship is associated with feeling better about one's looks (Fawkner, 2012). This finding particularly makes sense in light of other findings discussed in the two preceding chapters that intimate relationships and sexuality were central concerns for participants. However, as also discussed, intimate relationships are not an important feature in the literature on disfigurements. Thus, the finding about the relationship status and quality contributes to the emerging research which explores the role of relational factors in mediating disfigurement-related impact, by highlighting intimate relationships as particularly paramount. Similarly, the finding that problematic intimate relationships exacerbated scar-related distress supports the few available studies mentioned in chapter three which show similar results. Whereas the finding about parenting small children as helpful to promote self-acceptance and relax the practice of passing unmarked is new.

It is also possible that some occupations can mediate the experience of being marked. It emerged in this study that working in medicine or in the army can help women accept themselves better. Additionally, soldiers might be able to pass unmarked easier. Whereas being a performing artist may exacerbate feelings of being damaged goods unless these performances challenge cultural norms.

In line with the literature on appearance and disfigurements discussed in chapter three, findings about the relationship between age and appearance concerns are ambiguous. Some respondents said that growing older eased their scar-related distress because they learned to accept themselves more, appearance mattered to them less, they were less subjected to confessional discourse, did not wear revealing clothes and/or had learned to pass unmarked more efficiently. Still, some participants in their fifties did experience themselves as damaged goods. These somewhat contradictory findings highlight the fact that the lived experiences of women with non-facial scars are embedded within the sociocultural context. The role of confessional discourse, ageist discourses about appearance and the pressure for self-acceptance all emerged in the code ‘growing
older’. Overall, in this study objective age did not prove to be a strong predictor of appearance-related distress. Rather, the findings once again indicate the tensions between women’s lived experiences and cultural discourses on appearance. However, it is possible that women in their forties may be at an increased risk of experiencing appearance concerns. Whereas the finding that women in their twenties showed less distress than those in their thirties and forties is incompatible with the literature on disfigurements. As discussed in chapter three, young adults tend to experience more distress about disfigurements. However, considering that women in their twenties were the least represented age group in the study, this finding is insufficient to draw conclusions. Moreover, most older participants whose scars were acquired at a young age spoke about their adolescence and young adulthood as the periods during which their scar-related distress peaked. The following section elaborates more on these issues by offering narratives of linear and fluctuating life trajectories as related to the experiences of being marked.

**Marked life trajectories**

‘Marked life trajectories’ is my term to capture the differences in participants’ experiences of their non-facial scars as they evolved over the years, particularly in relation to the levels of scar-related distress. The focus is on distress, because data shows that when scars generated positive identities for participants or had no significant impact on them from the start (but not because of overriding health concerns), this state remained more or less stable throughout the years. Many participants had lived with non-facial scars for a long time, as shown in table five, ‘The age of scars’.

<table>
<thead>
<tr>
<th>Scar age in years</th>
<th>Number of participants (out of 30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-9</td>
<td>12</td>
</tr>
<tr>
<td>12-19</td>
<td>5</td>
</tr>
<tr>
<td>20-29</td>
<td>7</td>
</tr>
<tr>
<td>30-48</td>
<td>6</td>
</tr>
</tbody>
</table>

Table five: The age of scars
Analysis shows that the marked trajectories of participants are diverse and that it is difficult to generalise about the extent and nature of scar impact in the long-term. However, it was possible to identify two overall trends: linear and fluctuating trajectories where women’s scar-related distress could ebb and flow and they sometimes modified their scar-work.

**Linear trajectories**

‘Linear trajectories’ is a term I have developed from the data to describe the lived experiences of those participants who presented their story of being marked as a linear narrative (n=11), with scars being a hardship that was eventually overcome, particularly as they grew older. Usually, this ‘overcoming of a hardship’ took many years. Rosa, for example, learned to accept her scars more and stopped concealing her leg scar only after twenty-odd years:

> Just recently we [Rosa, her husband and daughters] were overseas and we went to the sea and we rolled our jeans up and we were frolicking in the sea and it was such an amazing thing to do. We were taking photos of each other and there were photos of my scar. I looked at them and I thought, that’s the first time I’ve ever seen a photo of it and been happy, been proud. And I loved those photos... I looked at my facial expression and I was happy, it [the leg scar] didn’t matter. And I thought, ‘Wow, I’ve come a long way’... I remember seeing our photos from the honeymoon in Fiji: we were on the beach and my scar was visible, and I just ripped the photos up... I went shopping with my mum, it would have been about three or four years ago, and I bought a skirt to the knee I liked and this was the shortest skirt I’d bought in 20 years. That was a milestone - that I paid more attention to the skirt than to my leg.

Rosa tied this positive change in accepting her scars more and relaxing her practice of passing unmarked with her overall improved wellbeing in the last four years, since after her chronically ill mother had passed away and her daughters had entered university:

> Now it’s ‘me’ time. Now I feel I’m more together in who I am. I am in a good place.

She also related this process to her supportive marriage, to growing older and therefore more self-accepting, and to the disappearance of pain in the scar area.
Some women who felt their scars were ‘for no good reason’ with time re-framed the scar acquisition more positively. Gemma, for example, as discussed in chapter five, came to see her scars from complications during cosmetic surgery as ‘a useful lesson’, a visible reminder to be more cautious in future decision-making and to be assertive with doctors. She said:

I take my opinion more seriously now. No bloody plastic surgeon will lay his hands on my body again.

Consequently Gemma also somewhat relaxed her practice of passing unmarked in order to use her scars as a tool to show empathy to her friends. Similarly to Rosa, Gemma attributed those changes to growing older and more self-accepting, but also to doing scar-work as a part of self-work and to her concerns with visible ageing and weight that overrode her scar-related distress.

Two of the participants with severe scarring even told of linear life trajectories where eventually they re-framed their scars more positively, their distress was reduced and they relaxed their practice of passing unmarked. Karen was one of these women. For many years she felt that scars ‘ruled’ her life:

In the early years my scars looked ugly to me. I didn’t look at myself in the mirror, didn’t look at photos, because all I could see was burns. But today I’m like, okay these are scars and this is skin. I think since meeting other burns survivors and seeing how they cope, and they’re a lot worse than I am, I think, ‘God, what’s my problem?’… I love myself more today than I did. I think this is due to… meeting other burns survivors. It sort of gave me hope and inspiration to help others as well. And I think having a man who loves you 100% has a big impact on my life. So if I want to go for a swim, I’ll go for a swim, people can look. But there will always be days when it [scars] will affect me and days when it won’t. I’m only human.

As shown, Karen attributed these positive changes mainly to meeting a loving partner, accessing peer support and becoming a leading advocate for burns survivors.

Three respondents, though, told a reverse linear narrative, where at first they did not experience much scar-related distress, but later on being marked became a negative experience. Shanty, for example, received her chest scars during childhood, but was not concerned about them much then, and not even as a teenager:

I went to a girls’ school and we all had to wear the same uniform and I was focused on other things, not boys in particular. And I wasn’t interested for a long time in anything but my friends and school and my work and fun and family. It wasn’t really until I met my husband that I thought ‘Oh, maybe I do like this boy’… So apart from my dressing, the scars didn’t affect me that much as a teenager.

However, as already discussed in the two preceding chapters, after Shanty finished high school, her scars had caused her daily intrusive anxiety.
It is important to note that linear narratives of decreasing scar-related distress do not imply its utter absence. For some participants, the change could be enormous, as it was for Candice who said that from ‘being fixated’ on her scars she moved to ‘forgetting about scars’. However, for others the changes were more subtle. For example, at the time of interviews, Gemma and Karen still rated their distress about their scars as 2 (as opposed to 4 for the earlier years for Gemma and 5 for Karen). In fact, almost half of the linear narratives of decreased distress reported a small decrease only and over a significant number of years, as Michaela’s story demonstrates. Michaela at the time of the interview had had her scars for forty years. As discussed in the preceding chapter, over several recent years she had gradually relaxed her passing unmarked practice from constant practice to occasional, partial, exposure of her scars:

I still get anxious about it [her leg scars], but I’ll show my legs. Not up here [hips, where the scarring is more severe] but down there. So now I wear some skirts that go up to my knee, which sounds pathetic, but it’s a huge thing for me to do. I always feel very self-conscious when I wear them but I feel great. I’m so pleased with myself that I can get over it. And it’s nice to wear these things when it’s hot, have a breeze on your legs... I have a moisturiser which has some tinted colour in it and I put it on to make the scars less noticeable.

This finding is compatible with the findings from Rumsey et al. (2010) stating that “even when adjustment is positive over long periods of time, coping with a visible difference can be an ongoing strain on a person’s psychological resources” (p.200).

**Fluctuating trajectories**

The term ‘fluctuating trajectories’ emerged from my analysis of participants’ narratives. It captures those respondents’ narratives where scar-related distress was described as dynamic and fluctuated rather than progressed linearly. Data shows that fluctuating trajectories are more common than the linear ones.

Lora’s story is an example of a fluctuating trajectory. Lora made self-harm scars on her arms fifteen years prior to the interview. In the first years she was distressed about these scars, but later on stopped worrying about, and concealing, them. However, eleven years later, as discussed in the two preceding chapters, Lora was hit by a truck and acquired multiple scars on her torso and legs. Since then she had felt distressed about the new scars and the older ones on her arms too, and had resumed covering her arms (and newer scars also) meticulously.

Meg’s story encapsulates not only the fluctuating nature of some trajectories but also the multifactorial nature of such changes. Meg acquired her abdominal scar during
the birth of her first child when she had an emergency caesarean operation against her wishes. That surgery had complications and resulted in a raised caesarean scar. During the first months, the scar was also bright-red and itchy and Meg was highly distressed by it. Gradually, with support from her husband, Meg’s anxiety receded. Soon after she had her second child and in the next decade, while she stayed at home looking after two small children, Meg hardly thought about her scar, which by then had also paled, and the itching had disappeared. However, once the children became more independent, Meg left her husband and began practising as a performing artist. Since then, including at the time of the interview, when Meg had had her scar for thirteen years, she was again self-conscious and anxious about her scar, particularly given she was dating again. As evident in this story, a change in relationship status and occupation, parenting small children and the physical changes in the scar all influenced fluctuations in Meg’s experience of being marked.

Summary

In this study a significant minority of the women travelled marked through their lives in a linear fashion, with their scar-related distress usually decreasing over the years, but in some cases increasing. The degree of such increases and decreases varied greatly, and positive changes sometimes required many years to occur. This latter finding is consistent with Brown et al.’s (2008) study, where those respondents who learned to accept their scars said this took them many years. For the majority of participants though (n=15), such travels had many fluctuations and five women said the impact of their scars remained stable, with three of them experiencing no distress.

As discussed in chapter three, the literature too shows diversity in pathways of living with scars. The linear trajectories in this study where distress was decreased are in line with staged models of adjustment (e.g. Partridge, 2005; Thompson & Kent, 2001), whereas increasing distress and fluctuating trajectories correspond with Rumsey et al.’s (2010) longitudinal study described in chapter three in terms of “the dynamic nature of adjustment” (p.83) (although, as discussed in the previous section, factors identified as influencing these fluctuations mostly differed between that study and this thesis). Rumsey et al.’s suggestion for thinking of disfigurements as an ongoing stressor that can be more or less salient throughout a person’s lifespan depending on concurrent stress, corresponds with some participants’ trajectories but not others. For example, as discussed, for some women in this study their scars were a source of an ongoing distress, even if overall their
lives were satisfactory. Taken together, the findings in this study show the sheer diversity in the lived experiences of women with non-facial scars.

**Conclusion**

Recent theorisation on the body emphasises the dynamic, constantly shifting nature of our relationships with our bodies, postulating that “bodies do not remain fixed or static but are mediated by processes and practices” (Blackman, 2008, p.107). In a similar vein, but more particularly to issues of Body Surface, Gleeson and Firth (2006) suggest re-thinking the concept of body image as “body imaging, as a process, an activity rather than a product” (p.79). The conceptualisation of the experience of non-facial scars as being dynamic is compatible with such thinking. As was shown in this chapter, women’s distress levels about their scars and the associated consequences, often changed over the years, either in progressive or fluctuating fashions.

Links between the essential category ‘travelling marked through life’, the core category ‘being marked’ and the essential category ‘doing scar-work’ were demonstrated in this chapter. I described here how women’s experiences and framings of their scars and their scar-work choices can evolve throughout life, particularly in relation to disfiguring scars. I also showed that a combination of various fluid factors and scar-works impacted on such changes. In particular, scar physical changes, changes in relationships, health situations, appearance and occupations, parenting stages and growing older all emerged from the data as influencing how women experienced, and dealt with, being marked. In short, it seems that scars - like our identities – are continuous works-in-progress. However, issues of stigma and unpleasant memories were less amendable by fluid factors. Such a distinction is a new finding and adds to the literature on disfigurements.

The following chapter discusses the unmet needs as these arose from participants’ stories, linking those with the category ‘travelling marked through life’ discussed in this chapter, and with the categories ‘doing scar-works’ and ‘being marked’.
Chapter Eight – Unmet Needs

The term ‘unmet needs’ was borrowed from the literature on disfigurements that identifies the unmet needs of people with disfigurements, as was described in chapter three. This essential category captures the unmet needs described by those participants (the great majority) who have experienced, at least at some stage of their lives, scar-related distress and engaged in scar-work to reduce it. These needs, as emerged from the data, can be broadly divided into three sub-categories as captured in figure eight ‘Unmet Needs category’.

![Figure eight: Unmet Needs category](image)

The following sections describe these sub-categories and their properties, linking the findings with the existing research.

**Sociocultural acceptance**

The term ‘sociocultural acceptance’ was developed by me as emerged through the data. Scars, albeit common, are often viewed as out of the ordinary when they are publicly visible, as discussed in preceding chapters. Responses to scars, whether from family, intimate partners, friends or strangers – as outlined in chapter five - can be often unhelpful, if not outright distressing. People may fuss over scars, staring, pointing fingers or making remarks that can be hurtful. They also may interrogate women about the stories behind their scars. Ironically, people may also minimise concerns participants raise about living with non-facial scars and/or give them unsolicited advice to ‘liberate’ themselves from their practice of passing unmarked.

It is plausible to assume that such responses to scars stem in part from their public invisibility, which in turn means scar exposure becomes an attention-drawing event. This state of things impacts on women’s sense of self and wellbeing, as already discussed, and
on their choices of scar-works. Chiefly, participants often felt compelled to pass unmarked and managed careful disclosure of their scars. Stacy spoke of this impact:

You see all this advertising and the models have all got beautiful, photoshopped, flawless skin... I couldn’t imagine someone being on a cover with a scar. So you think society sees scars as not being very attractive, or not something you’d show off, I suppose. So you don’t [show your scars].

Karen, too, felt this social pressure and spoke about the need to normalise scars and people’s responses to them:

We’re still human under the skin. It’s just burnt skin, we’re not freaks or whatever. We’re people and we have feelings. I think we need to get this message to the public… We just have skin that is not as smooth as yours.

Many participants expressed this need to normalise scars, with some wanting to see publicly visible role models: women wearing their scars in a normalised fashion. Lora, for example, said she was always checking to see whether anyone else in her vicinity had self-harm scars:

I always look at people’s forearms. I sort of want to see it [scars]… to feel that I wasn’t so extreme.

Some participants also wished to see more media and art representations of women with scars in a normalised context. They said they were hoping that such public visibility would help them to feel more normal and comfortable in their own skin - metaphorically and literally.

Participants also wished for more sensitive responses to scars. Some women said they realised curiosity about scars was natural and they did not mind occasionally discussing them. However, the frequency and intrusiveness of responses their scars often evoked if visible could become overwhelming. Participants wanted more public awareness of the impact of such curiosity on them. Bronwyn, for example, said she never asked an acquaintance how she acquired her facial scar, because she knew from her own experience how exhausting it can be when most new people she met asked her about her scars.

Participants expressed the need for more understanding of their situations, particularly consideration of the social consequences of having scars. Although many respondents felt hurt, as discussed in chapter five, when people remarked on how disfiguring their scars were, on the other hand they also often wished that when they chose to raise concerns about their scars, these would be treated more seriously by their
confidants. They wanted to be able to discuss their feelings and receive empathy, but instead often encountered minimisation and liberation responses.

These responses were cited by the majority of participants as the main reasons why they rarely shared their scar-related concerns. As Rivka said, her scar-related distress was just something she felt she ‘had to endure’ in silence. Women avoided discussing their scars out of fear of being perceived as vain and not courageous enough. They also worried that their concerns would be invalidated and trivialised. Many women wanted to talk about their scars with more empathic interlocutors. Shanty, for example, after being repeatedly told by her friends that she should not worry about her scars, stopped sharing her concerns. She said she would have loved it if her friends had responded differently:

If I saw such scars on another person, I’d be inclined to say not that it makes her interesting, but, ‘Poor thing, I know how much this sucks. I know how you feel.’

Older women, who felt that their attractiveness and sexuality were already minimised, were particularly in need of understanding about their scars. As Joanne (55 years old at the time of our interview) poignantly, and in similar words to those of Shanty, expressed this:

I want to talk about it [scars], to have a little whinge... I want somebody to say, ‘You poor thing, how awful. How horrible.’

This similarity in how women described their needs highlights a powerful desire for empathy.

This need to talk about scars and to be understood was palpable throughout the interviews. It was no wonder then that some participants said that our interview was their first proper opportunity to discuss their scar-related concerns without being judged, and expressed their gratitude and relief at being able to do so. Manuela, for example, wept during our conversation, explaining that:

I get emotional talking to you, because I’ve waited for such a long time for this interview, because I wanted to be able to talk about this [her scars].

Similarly, Shanty said:

I’ve never had a conversation about it [scars] that long other than with my husband. I’m saying things that I’ve never said before, which is emotional… It’s a relief really. You must be a good social worker [laughs].

Whereas Michaela emailed me after the interview:

It was a pleasure talking to someone who really understands my situation. I felt completely at ease and natural…
Several participants even spoke about new self-insights they had gained through our conversations. Ophelia, for example, wrote in her elicited text that after the interview:

I was excited, overwhelmed. It’s like I had never had a pure space to just talk about the scarring process without judgement, shock or any sort of questioning. It was therapeutic for me, to just talk it out, discover what it [scars] was for me now.

Additionally, as I kept interviewing, it soon became apparent that my sharing of the fact I also have scars, and the sharing of some of the preliminary findings, held a special appeal. Respondents often said that meeting another woman with non-facial scars, and hearing what other women said about their experiences of non-facial scars, was useful. They kept expressing a hunger to talk about scars with their peers as is discussed in the following section.

**Summary**

Participants expressed their need for the cultural normalisation of scars, particularly through making them more visible. For this purpose they wished scars would be included in art and media in a normalised context and also hoped to see women wearing their non-facial scars in public. This unmet need for public visibility is not a feature of the disfigurement research, possibly because this literature, as discussed in chapter three, has a largely individualised, cognitive-behavioural focus.

Respondents also wished for more public understanding of the social consequences of having scars so that they did not have to explain themselves too often, but at the same time could receive empathy when they wanted to share concerns related to their non-facial scars. These findings too are new.
Peer support

The term ‘peer support’ is derived from the literature on disfigurements that identifies contact among people with disfigurements as being useful for coping and adjustment. It emerged from the data that participants wanted to access peer support. As discussed here and in the preceding chapter, women often expressed a need to discuss their scars in a supportive environment, but particularly they wanted to talk with someone who also had scars and grappled with the same problems they did. Similarly, I personally had always wanted to meet other women with non-facial scars but had never known anyone, and it was this lack that motivated me to undertake this study.

Some participants said that even knowing they are not alone in feeling distressed about their scars would be helpful. This was one of the reasons why, as discussed in chapter four, I sometimes shared preliminary findings and my own experience with participants. Such sharing was always received positively. As Shanty said after I had shared with her some of the preliminary findings:

I feel now like maybe it’s not that silly to be self-conscious about it [scars], if there are other people feeling this way. I never thought there are other people thinking about this… it’s not nice to know other people have scars and find it difficult, but it’s really a relief to know I’m not the only one who reacts like this.

Some respondents were also interested in learning from other women with non-facial scars strategies to deal with distressing feelings and situations. Manuela, for example, said she wanted to learn how to handle dating and intimate situations. Whereas Shirley found it helpful when I told her about the strategy of downward self-comparison, which, as discussed in chapter six, emerged in the data, and wished to hear about more strategies utilised by her peers. This finding is consistent with studies of adolescents with cancer-related disfigurements (Wallace et al., 2007a; Williamson et al., 2010) where participants said they wished to talk to other adolescents with similar experiences about how to deal with changes in appearance.

Unfortunately, few outlets for peer support for people with non-facial scars exist in Australia, while the existing ones tend to be specialised, mostly for people with burns. Sometimes even the existing peer support organisations may encounter obstacles in their efforts to continue operating. Karen, who at the time of the interview was CEO of the Burns Foundation, spoke about such difficulties:

It’s really hard to get funding. People look at us, ‘Oh, you’re adults, you’ll be fine, you can deal with this.’ Because we cater to people from 18 onwards. But people don’t
understand that burnt children will grow into adults and they’ll need the Burns Foundation…

The overall lack of peer support services emerged in the data: participants usually did not know any other women with scars and were unaware of any peer support services. This lack is consistent with the literature discussed in chapter three and is in line with the invisibility of scars in the public sphere.

**Institutional sensitivity**

The term ‘institutional sensitivity’ was developed from the data. This sub-category describes another thread that ran throughout interviews: the needs of participants for sensitivity to their situation often extended to the institutional spheres in their lives. Figure nine, ‘Institutional Sensitivity sub-category’, captures the main areas of concern at this level, where women felt their needs were not being met:

![Figure nine: Institutional Sensitivity sub-category](image)

**Healthcare professionals**

Stories of problematic encounters with healthcare professionals were the most recurring among the stories of unmet needs at the institutional level. The main needs in relation to healthcare professionals, as emerged from the data, were the following: the provision of adequate information prior to and after medical treatments that resulted in scars; inclusion in decision-making around such treatments; and sensitivity among medical and therapeutic professionals to psychosocial issues associated with non-facial scars.

*Information provision and inclusion in decision-making*

Participants with scars resulting from medical treatments often complained that health professionals did not adequately prepare them for these consequences. Some said it was as if such professionals considered scars to be trivial in terms of their impact. Anne, who had acquired a large abdominal scar after her cancerous kidney was removed, was one of those women who spoke about how unprepared they were for their scars:
I just assumed it’d be a smallish cut in my back, not my side, and then I’d be quickly healed with little to see afterwards. So that [her scar] was a big thing. I remember after [the surgery] it was such a big shock. When I visited a specialist, I never thought to ask, ‘How big are you going to cut? Where are you going to cut?’ So really that was a shock, a surprise. Nothing prepared me for my scar, stapled neatly, and long and rough...

Rivka, like some other participants, felt disappointed that she was not given any information about how to look after, and deal with, her chest scar after the surgery that caused it. She said the attention of the medical staff was on her physical recovery only:

I couldn’t even speak to the physio I went to about the scar as such. She was all about getting me to stand up straight and getting me to stretch again.

Several women spoke about being excluded from decision-making on treatments that resulted in scars. Rosa’s story is typical of this. Rosa had a melanoma on her leg that was removed:

When I was going for the surgery, I casually said to the surgeon, ‘Where do you take the skin graft from?’ And he said, ‘We’ll take it from up the thigh.’ I said, ‘No, I don’t want you to, because I swim a lot and I wear bathers.’ I also wore short tennis skirts. I said, ‘Can you take it from here [waist]?’ And he said, ‘We don’t usually, but I can.’ And I’m still so glad that I was proactive. Because if he’d have taken it from the thigh, that would have had a huge effect on me. I’d be so angry and distressed for [him] doing this without discussing it with me. If it was on the hip, that would have been much more visible and this would have been significant...

Here, although the surgeon did not consult Rosa, she was being proactive and achieved a better outcome. Not all participants were that fortunate.

**Sensitivity to scar-related concerns**

Even more frequently than the need for information and inclusion in decision-making, many participants expressed their desire for healthcare practitioners to be aware that scars may trigger a range of psychosocial problems, to be sensitive to their concerns and, when possible, to offer help. As Shirley, who received numerous scars from a road accident, said:

Doctors, they never talk about scarring. And maybe to them it isn’t such a big thing. But they talk about everything else, like they talk about physiotherapy. But they never, ever mention your scars.

**Photo 22: Some of Shirley’s scars**

It is possible that the psychosocial consequences of non-facial scars are particularly overlooked. For example, Nellie, who received significant non-facial scars in a road accident, and also several hardly visible facial scars, said that after she underwent
surgery, medical staff did discuss with her possible appearance-related concerns, but only in relation to her face. About non-facial scars the medical staff said:

‘Oh, that’s quite neat.’ Because, you know, they talk about it in this way [laughs]… You just feel like they’ve just finished sewing a dress and a teacher is looking at it, giving it a 10 out of 10. One plastic surgeon commented on the other [abdominal] scar: ‘Oh, they’ve done a good job.’ That’s what they are, doctors, like...

Older participants particularly felt that medical professionals, like lay people, often minimised their concerns about appearance. Some said they were made to feel by their doctors they were vain if they expressed negative feelings about having scars.

Sophia (53 years old at the time of interview) told such a story:

He [her doctor] is a lovely, lovely man, but so busy with the technical ways of thinking that he didn’t consider the effect of this [scarring] on human beings. There are two ways to go about it [removing her kidney]: do key hole surgery, or open surgery that he liked more because he felt he could really get in there and fix everything and see very well... He said, ‘Of course we can do open surgery with you because you’re not a young woman anymore. The scar will not matter.’ [Laughs]. He meant that I shouldn’t be concerned anymore with the pleasures and vanities of the flesh. And I thought, ‘Well, mate, you really don’t get it. Because women are always concerned about scarring.’

Some health professionals may respond to their patients with non-facial scars in line with confessional discourse, interrogating them merely to satisfy their curiosity.

Ophelia, for example, experienced such an attitude during a routine blood test:

I opened my arm [where she has self-harm scars] and the nurse went ‘Oh, what’s that?’ You know, it was quite... as a health professional you just don’t... I’d never had someone ask me like that before. I was in a trapped position with this person trying to take blood off me and I felt very... uncomfortable and vulnerable. I just made up something like: I fell into a glass pane. And I could say, it’s none of your business, but she was trying to stick a needle into me, so she could have hurt me if I was rude.

These findings about a lack of empathy and trivialising attitudes from medical practitioners correspond with many other studies of people with disfigurements discussed in chapter three, and also with findings from Brown et al.’s (2008) study of scars.

In theory, healthcare professionals providing counselling, such as psychologists and social workers, are well qualified to create a supportive environment for women to discuss their concerns about their non-facial scars. But some participants said they encountered therapists who were insensitive to their concerns. When Manuela, for example, sought help from a psychologist for her long-standing distress about her scars, this psychologist minimised her concerns:

He was, like, “What’s your problem?”

My own experiences of seeking counselling about my scars were similarly unsuccessful. I described one such encounter in an essay I had published:
As soon as I raised the subject [of my scars], the psychologist - highly regarded in his field – interrupted me. With great determination he walked over to the whiteboard he kept at his office, sketched a green woman and gave me a red pen to mark my scars on her body. His next directive was to place my hands over the marks, as though I was embracing my scars. Puzzled, I followed his instructions, yet none of it felt right.

‘So,’ the psychologist asked as I returned to my seat, hoping to resume our conversation, ‘how do you feel now?’

I felt annoyed. ‘Look,’ I said, ‘I’ve touched my scars many times. I don’t need a whiteboard for this. What I want is to understand what makes me feel so guilty about having scars. I always hide them, but then feel like a fraud…’

‘Wait a minute,’ the psychologist stopped me for a second time, seemingly frustrated. ‘Let’s not talk. Your problem is that you’re intellectualising everything. You need to cry.’

‘Believe me, I’ve cried a lot. But I’ve never talked…’

‘Cry!’

‘What?’

‘You must cry!’

I got up, paid him and never went back (Kofman, 2010, pp.187-188).

This finding about a lack of sensitivity from some therapists corresponds with findings from the literature of disfigurements discussed in chapter three that people were reluctant to access generic counselling services, wishing instead for specialist services for disfigurement-related issues. Similarly, several participants in this study expressed their need for counselling with adequately trained practitioners.

**School sensitivity**

The term ‘school sensitivity’ emerged from the data analysis. Several participants who had acquired their scars during childhood spoke about the lack of awareness in their schools about scar-related issues. As mentioned in chapter five, some participants were subjected to bullying at school because of their scars. These women spoke about the need to educate school staff to be more sensitive to, and monitor better, bullying behaviours related to appearance. Four women also spoke about the distress they experienced at their schools during compulsory swimming sessions. The problematic nature of such activities
for students with non-facial scars was not considered. Karen told particularly disturbing stories from her school years on both accounts:

On the days we’d go swimming I would just cringe at the thought of wearing a pair of bathers and having to dive into the pool. But I had to. School said you had to do it. They didn’t really, I suppose, give a shit… I was very conscious - every swimming day I’d try to stay at home, be sick. But it never worked. I just had to do it and it was horrible, getting into the bathers and the whole school seeing me when you have burns all over your body. That was pretty hard to cope with…

Hanna was not subjected to bullying at school. Yet she, too, experienced distress during swimming sessions:

Whenever we had to do school swimming I wasn’t too keen on that [laughs]. I guess I didn’t want to explain it [her abdominal scars], didn’t want people staring at it… When I was 14, 15, it was all about bikinis. We had a swimming pool in our school and we did a lot of swimming and it wasn’t much about doing sport, it was more about parading around… I walked around like this [shows herself covering her stomach with her hands]. And people did ask questions. I was alright with explaining, but I just didn’t want to have to.

Some participants also suggested that sensitivity and flexibility were needed around the issue of female school uniforms which sometimes revealed scars, thus preventing those students who wished to pass unmarked from doing so.

**Trauma-related compensation**

The term trauma-related compensation was developed from the data to reflect the concerns of participants who had acquired their scars through accidents and were eligible for compensation. These women spoke about the lack of legal recognition of their distress and the expenses associated with non-facial scars. Michelle, for example, felt her need for funded counselling was overlooked because the dog-bite scar was on her leg:

I feel like I didn’t get anything at all. And it’s funny, because if it’s facial... you do get more compensation. If I had had better compensation and could have gone further with the counselling, it’d have helped... it would have been good to work through more issues. I did have one session with her [therapist], which was really helpful, but because nothing was paid for, I had to pay for all my treatments myself, it was really hard.

Lora, who had been hit by a truck while cycling and as a result had acquired severe non-facial scarring, similarly said:
I’ve got a very low percentage [of compensation] for my scarring. My lawyer said it’s very rare, unless it’s facial scarring, to get a high percentage. It’s not on your face, you can cover them easily. That’s obviously the idea the medical world and the TAC have.

Photo 23: Some of Lora’s scars

Summary

Several unmet needs of participants were identified in the data at an institutional level. Participants felt that health professionals often trivialised the impact scars can have, and that such an attitude gave rise to several service design and delivery problems: the lack of preparation regarding scar acquisition for people undergoing medical treatments, exclusion from the decision-making around those procedures that cause scars, and inattention to possible psychosocial issues related to scar acquisition, and general insensitivity. The latter issue was noted also in the context of schools where participants felt staff needed to be more educated about issues around scars. These unmet needs are consistent with the unmet needs noted in the literature on disfigurements discussed in chapter three. The need for the legal recognition of problems associated with non-facial scars and subsequent compensation for victims of trauma is a unique finding.

The relationship between ‘unmet needs’ and other essential categories

Relationships between the essential category ‘unmet needs’ and other essential categories (including the core category) are depicted in figure two. The core category ‘being marked’ and the category ‘unmet needs’ have a bidirectional relationship. As was shown in this chapter, participants’ unmet needs often arose from having to deal with responses to their scars. Moreover, how women experienced and framed their scars determined what unmet needs (if any) they had. For instance, those participants who felt like damaged goods and whose scars served as reminders of distressing issues and/or were stigmatising, often desired appropriate counselling. How scars were caused also impacted on what kind of unmet needs participants had: for example, whether they had tried to get compensation for their scars, were marked during their school years or had to
make decisions about medical treatments. In turn, unmet needs affected women’s experiences, exacerbating the negative consequences of having scars described in previous chapters. For example, some participants said that the overall public invisibility of scars enhanced their feelings of being ‘freaks’.

A bidirectional relationship also exists between the ‘unmet needs’ and ‘doing scar-work’ categories. The unmet needs category depicts what resources respondents felt they needed which were unavailable to them in order to cope better with their scars. Thus, resources which were lacking had an impact on what scar-works the women did. For example, the scarcity of peer support described by participants meant that many who wished to reach out to their peers could not do so. In turn, participants’ choices of scar-works determined to some extent what unmet needs they might have. For instance, some of the participants who wanted to pass unmarked during their school years had to wear revealing school uniforms.

Finally, participants’ unmet needs can change over the years. As described in chapter seven, for some women appearance-related distress disappeared over the years and they no longer had to deal with issues related to passing unmarked. Yet some of these women still wished to access peers to discuss how to deal with scars that triggered unpleasant memories. On the other hand, for some women unmet needs in relation to their scars might arise later in their lives, or on particular occasions, depending on how they had travelled through their lives.

**Conclusion**

The existing research on disfigurements does not engage in depth with the sociocultural and institutional contexts within which lived experiences unfold, apart from examining standards of healthcare provision. However, findings from this study suggest that some important needs of women with non-facial scars, and possibly some other people with disfigurements, can be met precisely at these levels. On a sociocultural level, women remain hopeful for more visible role models both in real life and in media and artistic representations. They also wish for more public sensitivity in responses to scars, which can result in the moderation of confessional, fuss and liberation discourses, and in increased empathy for women’s concerns. Participants desired useful conversational spaces around scars, particularly in the form of peer support services. The sociocultural lack of sensitivity to issues around non-facial scars is arguably also reflected in some
unhelpful institutional attitudes identified by participants, particularly in the medical, educational, and legislative and policy domains governing compensation. The needs for more sensitive and inclusive healthcare delivery, attentiveness at schools, and appropriate financial compensation in recognition of distressing aspects of having non-facial scars were all recurrent in participants’ narratives.

The following, and concluding, chapter draws upon these unmet needs, and upon the findings discussed in chapters five, six and seven, to provide some practice recommendations, and discuss theoretical implications of this study for current and future research.
Chapter Nine – Final Notes upon Marked Body Surface

‘The body is the vehicle of being in the world.’
Maurice Merleau-Ponty

The purpose of this study was to explore the lived experiences of women with non-facial scars and to generate a substantive theory, which is a theory that deals with a limited area of inquiry, close to real-world situation (Charmaz, 2006). The study shows that despite some participants’ best efforts to adjust to living with non-facial scars in the contemporary world this can be a difficult experience which involves a considerable amount of work but which can also include positive aspects. These findings add to the existing literature in a number of ways. To date, no research has offered as in-depth an insight into the experiences of women with non-facial scars. This research also adds knowledge to the previous scholarly work on disfigurements, and supports empirically some of the theories of the body, including extending this theorisation into the field of disfigurements.

This concluding chapter first provides a summary of the main findings and notes possible limitations of the study. It then describes how the study adds to the existing scholarship, highlighting its unique offerings and some terminological contributions. Next the chapter shows how insights from body theory help progress the understanding of some of the processes involved in living with non-facial scars in a new light. Implications for practice and research arising from the thesis are then discussed. The chapter concludes with a personal note.

Summary of main findings

The substantive theory of lived experiences of women with non-facial scars conceptualises these scars as marks that can be disfiguring and always hold social and/or personal meanings. Findings from this thesis show that, for some women, scars provide the positive identity of a resilient and interesting person with unusual life experiences. Scars can also trigger meaningful rumination about personal strengths and lessons learnt, which can assist personal growth. However, taken together the findings suggest significant distress exists among this population. This distress has four components: appearance concerns, stigma concerns, reliving painful memories and concerns about
future health. The consequences of having non-facial scars can be profound, with 90% of participants reporting that at least at some stage of their lives, if not continuously, scars had a negative impact on their sense of self, daily wellbeing, social interactions, sexuality and/or the formation of their personality. Most commonly, women felt that their scars marked them at once as unattractive and were painful reminders of suffering and vulnerability, yet also positive metaphors for survival and resilience.

Having non-facial scars can also affect behaviour and choices, resulting in limitations on valued activities involving some degree of bodily exposure, self-presentation, and romantic and sexual choices. Such experiences can generate additional distress, where women feel guilty for being supposedly ‘vain’ and not accepting their scars.

An integral part of having non-facial scars is dealing with social reactions. People often respond to scars strongly, ranging between curiosity, judgement, compassion, pity, fascination and disgust. Particularly common, and problematic, responses to scars identified by participants were confessional discourse (interrogations about the origins of scars), scar fuss (attention to the disfiguring effect of scars), minimisation of scar-related concerns, and liberation discourse (unsolicited urging of women to stop their practices of passing unmarked).

Women employ a range of cognitive and behavioural strategies to deal with the negative impact of non-facial scars on their lives. They hide them, attempt to exercise some control over how others interpret their scars, and try to accept their scars. Many employ all these strategies. Beyond self-protection, some women also use their scars as tools to achieve social goals both for themselves and to help others. These goals include bonding with people, seducing, validating past suffering and present health problems, getting practical help, helping people professionally and privately, promoting compassion in others and warning people about health risks.

The impact of non-facial scars is often dynamic, with women renegotiating meanings around their scars and their choices of coping strategies over time. When scars generate a positive identity from the start, this impact remains more or less stable over time. The negative impact can be stable, increase or diminish over time. Most commonly, distress levels fluctuate over the years.
The impact of scars and its fluctuations in intensity are affected by a complex interplay of physical, psychological, relational, social, demographic and cultural factors. Factors identified as most significant in this study were certain appearance attitudes (subjective interpretations of scar locations, self-described modesty and critical awareness of dominant discourses around appearance), self-described personality traits (sociable, hardy and perfectionist), anticipated reactions to scars, negative changes in appearance, stage of life, relationship status and quality, occupation, disfigurement degree of scars, aetiology and health status. However, the mediating role of appearance attitudes and life stage is equivocal.

Several unmet needs were commonly mentioned by women with non-facial scars. These were public visibility of women with non-facial scars; sensitivity about issues around non-facial scars amongst the public, health professionals and school staff; better access to peer support; better provision of information about the risks of scars embedded in medical treatments and more inclusion in decision-making around these treatments; and compensation in recognition of the negative impact of non-facial scars.

Finally, participation in this study had some unintended therapeutic consequences for many women. It provided them with a safe space to discuss and validate their scar-related concerns, plus gain new insights into their situation through sharing experiences and hearing about the preliminary findings from this study.

In summary, the experiences of non-facial scars can be viewed as layered and ambivalent. Non-facial scars can have a profound positive and/or negative impact on women’s identities, thoughts, emotions, social interactions and private behaviour. They can affect adversely women’s life choices and to some extent life chances. The following section discusses the limitations of this study and offers recommendations for overcoming these limitations in the future research.

**Limitations**

This study presented an early-stage substantive theory. However, this substantive theory has greater face validity and meaning for participants and those directly involved with them or their care than more abstract theories about the processes of living with disfigurements discussed in chapter three. This study also has a number of potential limitations discussed below.
Firstly, caution should be noted regarding the retrospective nature of the data collection. The qualitative cross-sectional design of this study means it is not possible to establish strict causal links. Further confirmatory research is needed.

The small sample size in qualitative research (Bryman, 2004) limits this study’s generalisability. The results here are therefore suggestive rather than definitive. Future research could investigate issues raised in this study quantitatively to establish generalisability. Additionally, women from lower socioeconomic background (n=2) and non-heterosexual women (n=1) were not adequately represented in the study sample. Some ethnic groups that now constitute significant numbers in Australian population, such as Arabic and African ones, did not feature in the sample. Thus, caution should be taken when applying this substantive theory to women from lower socioeconomic background, non-heterosexual women and women from certain ethnic backgrounds. However, as discussed in chapter four, there was a relatively large variation in other participant characteristics. Future research should aim to investigate whether socioeconomic background, sexual orientation and ethnicity mediate adjustment to non-facial scars.

The qualitative method of in-depth semi-structured interviews employed in this study is widely accepted and viewed as rigorous. However, as Taylor and Bogdan (1998) point out, one of the limitations of data gathering through interviews is that researchers can be “deprived of the context necessary to understand many of the perspectives in which they are interested” (p.91). The fact that I interviewed most women in their natural surroundings helped to somewhat overcome this limitation. In order to familiarise myself further with participants, I also spent time with them talking about their lives before, and sometimes after, the interviews.

Qualitative analysis is often criticised for its lack of transparency and for subjective interpretation of the data (Bryman, 2004). However, as discussed in chapter four, I used the following strategies to increase the credibility of emergent theory: a reflexive approach, the incorporation of verbatim data and photos to demonstrate the grounding of findings, comparisons of my disfigurement degree ratings with those of my peers, respondent validation, and an audit trail of theoretical sampling. The methodological section of this study was written in a detailed manner, tracing all research stages and challenges.
Finally, it is important to note the limitation around the use of photography in this study. Photos here were not taken by professionals nor by using professional equipment. Participants and myself created them, using our – often very simple - cameras. As a result, in some photos the images of scars appear blurred.

Despite these limitations, the substantive theory developed in this study provides an in-depth insight into the experiences of a previously unexplored group and constitutes a fertile source of ideas for future research, as well as practice recommendations as described in the remainder of this chapter.

**Opening dialogue with the literature on disfigurements**

As previously asserted, findings from this study add incremental information to the work of other scholars in the field of disfigurements. Some findings support those from previous studies. In some areas, most likely due to its overall qualitative and cross-disciplinary methodological approach, this study provides a more holistic and nuanced picture of the factors and processes pertinent to living with disfigurements (particularly acquired ones). The study also adds unique findings to the existing literature. This section reiterates all these contributions.

**Support for established findings**

The findings from this study support several established premises in the literature on disfigurements: that considerable distress exists amongst people with disfigurements, but also that the impact varies considerably among them, and that the process of adjustment is multifactorial and dynamic.

More specifically, notable negative effects previously reported in the literature by people with disfigurements – poor body image, low confidence and self-esteem, shame, social anxiety, self-consciousness, vigilance, and a sense of loss – were also identified in this research, as was the ability of some people to view their disfigurements also in a positive light and believe the disfigurements can actually foster their personal growth. The concepts of anticipated and enacted stigma, as well as social comparisons, which are important in the literature on disfigurements, were salient in this study too. The ameliorating role of hardy and sociable personality traits in mediating adjustment to disfigurements was also evident in this thesis. Also in line with existing literature, the relationship between age and disfigurement-related distress was equivocal. However, this thesis adds a possible explanation for this ambiguity, described further in this chapter.
The high prevalence of concealment and avoidance among people with disfigurements, and the adverse consequences associated with these coping strategies, as noted in previous literature, were also evident in this study. However, this thesis clarifies some processes involved within these behaviours. Firstly, it identifies the distinction between physical and verbal avoidance. Secondly, the study adds new motivations to established explanations for the widespread use of such strategies due to feelings of shame and social anxiety. Additional reasons for the practice of concealment and avoidance can arise from the desire to avoid unsolicited pity and interrogations, being assigned an unwanted identity, being defined by one’s scars, having to revisit unpleasant memories, and distressing other people. Some also conceal their scars from the self to avoid unpleasant rumination.

Other coping strategies noted in the literature and supported in this study were pragmatism, and reaching out to role models, peers and professional helpers. The study also supports the existing findings about the unmet needs of adequate access to peer support and healthcare professionals trained in understanding disfigurement-related issues, and of sensitivity around disfigurements in schools and medical settings.

Support for emerging findings

This study’s findings support and sometimes clarify some emerging factors and processes in the experiences of disfigurements hitherto mostly noted in small qualitative studies. The following sub-sections summarise these contributions.

Concerns around vanity

The tension where women can be simultaneously concerned with the appearance of their disfigurements and blame themselves for being vain has been noted in several studies. For this study’s participants, this tension proved to be one of their central dilemmas. Body theory insights helped to highlight this issue as salient in women’s experiences of non-facial scars, as is discussed further in the chapter.

Disclosure

Dilemmas around physical and verbal disclosures of scars, such as the timing of disclosure, planning disclosure so as to minimise negative consequences, and issues around secretiveness versus authenticity, were all salient to the experiences of participants in this study. Yet while issues of visibility and concealment are often cited in the literature on disfigurements, issues around disclosure feature less often, and mostly in studies of skin conditions. This lack of attention to disclosure dilemmas can be explained
by the fact that disfigurement research is often focused on facial, or other most visible, disfigurements. This study suggests that issues around disclosure are more central to the experiences of people with disfigurements than is currently recognised.

**Intimate relationships and sexuality**

Some evidence exists to suggest that disfigurements can impact on people’s intimate relationships and sexuality, and that both supportive and hurtful comments from partners can impact on adjustment. However, overall researchers of disfigurements pay little attention to these issues. This study’s findings suggest that issues based around intimate relationships and sexuality occupy a central space in women’s experiences of non-facial scars. The study also provides a more detailed examination of the processes involved, notably of the challenges that scars present when searching for, developing and sustaining intimate relationships, and when engaging in casual sexual encounters. This thesis also adds new findings in this area, showing that women with non-facial scars may limit their choices by partnering with men based on the men’s preference of them rather than through their own interest, or based on the men’s good looks so as to prove their own desirability. On the other hand, being in a supportive relationship was one of the most powerful ameliorating factors cited by participants, while unsupportive relationships and being single could greatly exacerbate scar-related distress. These findings contribute to the emerging findings about sexuality and intimacy problems for people with disfigurements, and to emerging research into the role of relational factors in mediating the impact of disfigurements.

**Life events**

Findings are beginning to emerge that life events may be important in mediating the impact of disfigurements, however little is known presently about the nature of these events and the processes involved. This study shows that separation from an intimate partner can exacerbate scar-related distress, whereas such negative life events as negative appearance changes and health concerns can override such distress. This study also highlights more positive events - parenting small children and entering a supportive relationship - as important in ameliorating disfigurement-related concerns.
Contributions to debates in the literature on disfigurements

This thesis contributes to several debates described in chapters one and three, in particular those about the definitions of disfigurement-related distress, and the mediating role of physical factors and subjective importance of appearance.

Distress definition

The literature on disfigurements focuses predominantly on appearance and stigma concerns, while some small qualitative studies of acquired disfigurements also note issues around traumatic memories and future health concerns. This thesis shows that all of these concerns can coexist in those whose disfigurements are acquired. Ideally, a more comprehensive definition of distress should be utilised in research, to encompass and distinguish between these four types of concerns. The term ‘being marked’ can be useful here to describe such a multifaceted impact and also to allow for the possibility of positive marking. Furthermore, to distinguish the symbolic meanings associated with non-facial scars from the appearance concerns, this thesis offers the term ‘self-revealing body’ that captures such meanings and can also help conceptualise other acquired disfigurements.

Physical factors

This study adds to debates among researchers of disfigurements about the role of aetiology and disfigurement degree in people’s adjustment to living with disfigurements, by showing the impact of both on women’s experiences of non-facial scars and clarifying some processes involved.

Existing research acknowledges that aetiology plays a role in mediating the experiences of disfigurements, yet its salience in adjustment and coping is debated. Results from this thesis indicate aetiology is salient in women’s experiences of non-facial scars. Specific aetiology-related physical effects, including future health concerns, can affect women’s experiences and framings of their scars, as well as their coping choices. Similarly important are the circumstances of scar acquisition both in terms of any attached sociocultural meanings and women’s interpretations of the events involved in the acquisition. With the latter, of particular importance are the issues of whether the acquisition of scars was associated with trauma and/or stigma, was sudden or planned, whether women felt they had a choice in what happened, whether issues of blame and
injustice existed, and whether women perceived their scars as acquired for a good reason. Overall, scars acquired through trauma, cancer removal, self-harm, and complications from medical or cosmetic procedures were associated with more distress, even when they were minor in comparison with scars resulting from routine, medical procedures unrelated to cancer.

A prevalent assumption in the literature on disfigurements is that the link between disfigurement degree and adjustment is weak, yet some evidence also exists to the contrary. In this study, minor and mild scars were not always predictive of levels of distress; their impact was varied and dependent also upon other mediating factors in women’s lives. However, severe scarring was found to be salient in women’s adjustment, affecting how participants thought and felt about them, and what life choices (including choices in coping) they made. Women with severe scarring also consistently reported stigmatising social reactions, less adaptation over time (even when many ameliorating factors were present in their lives) and experiencing higher levels of distress. They were also more likely to meticulously practice passing unmarked. These women also had more difficulties in planning and enacting intimate disclosure. It is possible to explain such a discrepancy between the established research premise and this study’s findings by the fact that the sample in this study was drawn from a non-clinical population. In such a cohort the self-appraisal in terms of disfigurement degree of one’s scars is likely to be more in line with their objective severity.

Finally, aetiology and disfigurement degree combined also played a role in women’s choices of whether to use their scars as tools. Women with minor to mild scars acquired through routine medical procedures were most likely to employ this strategy.

Importance of appearance

The importance of appearance to people with disfigurements is considered in the literature to be a powerful mediating factor, with high importance of appearance correlating with high distress. However, in this study the importance of appearance was not predictive of scar-related distress. Participants who described themselves as caring significantly about their appearance were not necessarily concerned with their scars more than other participants. Sometimes they were more concerned with other appearance aspects. Again, this was possibly so because this study sample was drawn from the general, rather than a clinical, population. In the latter, concerns with one’s disfigurements are likely to be higher.
What did appear to mediate scar-related concerns were appearance attitudes less commonly mentioned in the literature: whether women described themselves as modest, were critically aware of the politics of appearance, and how they valued and framed scar locations. Inconclusive findings about the importance of disfigurement locations in mediating adjustment in the existing literature can be somewhat explained by the findings in this study showing that locations matter more in a psychological than physical sense. This latter finding is not new but an emerging one, with Rumsey et al. (2010) suggesting the importance of the subjective value women may attach to the appearance of their torso as opposed to men. However, this study provides more detailed findings about such subjective evaluations, adding a distinction between ‘lucky’, ‘invested’ and ‘compromising’ locations. The mediating effect of self-described modesty is a new finding, whereas the finding about critical awareness supports similar emerging findings.

**Unique findings**

This section summarises findings that add new information to the literature on disfigurements. Possibly the most unique finding in this study is that some participants showed resourcefulness and creativity by using their scars as tools to benefit themselves or others, thus capitalising on these usually socially devalued body features. In the same spirit of creativity, some participants framed their scars as enhancing their identity by rendering them as unique, heroic and/or interesting.

Existing scholarship, as discussed, acknowledges the existence of appearance, stigma, traumatic memories and future health concerns in the experiences of people with disfigurements. Findings from this study add the distinction that concerns related to stigma, traumatic memories and health are less likely to diminish over time than appearance concerns. Furthermore, the suggestion that the onset of appearance concerns can occur as late as several years after the acquisition of scars is new to this literature. This thesis also adds the stigma-related concern of being identified as a victim that has not been mentioned in previous studies.

This study adds several new negative consequences arising from having disfigurements. It suggests that the acquisition of non-facial scars can heighten women’s self-consciousness about other aspects of their appearance, that women may become conservative and/or less adventurous because of their practice of trying to pass unmarked.

This study also uncovers new more subtle yet problematic discourses operating around disfigurements: minimisation and liberation. These responses usually come from
friends, family and partners, and are often grounded in good intentions to support women with non-facial scars. Yet these women experience them as unhelpful. These findings complicate existing research about the importance of social support from family and friends for people with disfigurements by showing that some types of support may do more harm than good. Moreover, the importance of supportive family and friends in ameliorating disfigurement-related distress – which is generally accepted in literature - was not a salient feature in this study, apart from in relation to intimate partners.

This thesis adds new mediating factors to the literature on disfigurements. Being away from home may provide at least temporary relief from scar-related distress for those women who practice passing unmarked, particularly if they sojourn in foreign countries that are conservative with regard to female attire or have cold climates. Parenting small children can help promote acceptance of scars and sometimes reduce the desire to practice passing unmarked. Two new factors that exacerbate distress were also found: self-stated perfectionism and being single. It is also possible that the medical, military and performing occupations can mediate the experience of having disfigurements, with the employment in the first two fields ameliorating distress. Being a performing artist may exacerbate distress unless the artist subverts cultural norms around appearance. However, these findings about occupations are based only on interviews with two former military employees, three performing artists and three medical professionals. Based on the discussion of these mediating factors, and others found in the study, this study shows sociocultural factors and life events to be as important in the adjustment process. Therefore, I build upon the earlier findings by Rumsey et al. (2010) by suggesting to add such factors to their model of adjustment in the intervening stage.

Findings from this study also offer three new strategies for promoting acceptance of disfigurements. The strategy ‘designating scar hierarchy’ is utilised by women with multiple scars to minimise the importance of some of them. Engaging in general ‘self-work’ can be useful in promoting the acceptance of scars too. Finally, while it has been established in the literature that how people imagine social reactions to their disfigurements affects their adjustment, the strategy of actively framing others’ responses in a positive manner identified here has not been previously described.

New unmet needs have been identified in this thesis: for public education about the social consequences of having scars, for more public visibility of non-facial scars, and for legal recognition of problems associated with such scars. These needs may apply to
other people with acquired non-facial disfigurements. These needs may not have featured in the literature on disfigurements because this research pays most attention to facial disfigurements and has a largely individualised, cognitive-behavioural focus, thus overlooking the broader context within which the lived experiences of disfigurements unfold.

Significantly, this research views disfigurements, and non-facial scars in particular, from a multidisciplinary perspective that extends beyond psychological constructs to add a much needed social dimension that focuses on ‘lived experiences’. The following section presents bridges made in this thesis between research on disfigurements and the scholarship of the body.

**Linking disfigured and theoretical bodies**

Scholars of disfigurements, as discussed in chapters one and three, predominantly utilise psychological theories and concepts to explain factors and processes integral to the lived experiences of disfigurements. However, as argued in chapter three, this focus is insufficient for capturing the richness and complexity of people’s lives, including their meaning making processes and the role sociocultural context plays in their experiences. This study adds to the research on disfigurements by examining some of the findings through the lens of body theory. This section sums up these contributions. In turn, this thesis also extends theorisations of the body by supporting some of its premises with empirical findings about the experiences of women with non-facial scars. These contributions are highlighted throughout this section. Additionally, as described in chapters one and two, this thesis adds the term ‘Body Surface’ to the literature theorising the body and investigating appearance, including disfigurements.

Although body scholars do not specifically theorise on non-facial scars, they direct us to think of them as being invested with personal and social meanings. Through this lens, the experience of being marked appears particularly complex. Scars can at once mark women as damaged goods and with a stigmatised identity, reveal personal or fictional information about them, serve as painful reminders of suffering and future concerns, and be positive metaphors of survival, resilience and uniqueness. The finding that some women frame their scars as reminders of their vulnerability and mortality lends support to theoretical arguments, discussed in chapter two, that scars can disrupt modern claims of physical invincibility. Furthermore, the commonality of confessional discourse
and scar fuss identified in the data arguably reflects fear and fascination to be underlying responses to disfigured and disabled Body Surfaces, as some theorists suggest.

Insights from theorisations of the body allow us also to consider the sociocultural, and sometimes institutional, invisibility within which women’s experiences of scars unfold. This invisibility can amplify women’s feelings of abnormality and may also mean that the exposure of their scars in public is likely to draw excessive and unwarranted attention. Older participants arguably experience an additional layer of social invisibility because of ageist discourses on female appearance that locate them outside beauty and sexuality domains. Some of these participants seem to have internalised these attitudes to some extent, expressing ambivalent acceptance of their scars on the grounds of no longer caring about their appearance. The internalisation of sociocultural messages about female bodies, though, ranged widely among participants, with some exhibiting a high awareness of, and a critical stance on these. These latter women reported making intentional efforts to remind themselves that cultural ideals of female appearance are not realistic, with some occasionally exposing their scars for subversive purposes.

Insights from this research findings extend arguments made by some body theorists (discussed in chapter two) about the inherent playfulness in how some women use their bodies by showing how creative women can be in managing their non-facial scars. Most women make deliberate choices to project more appealing versions of themselves through fashioning their bodies, clothing and makeup. However, arguably some women with non-facial scars are even more resourceful, because they are making the best out of socially devalued aspects of their bodies. They interpret their scars positively and show creativity with verbal disclosures, sometimes even enhancing their identities in the process. Occasionally the women even capitalise on their scars, using them as tools to gain advantages for themselves and others. The use of scars for seduction, in particular, can also be viewed as a subversive practice which challenges social conventions postulating beauty as the best pathway to a good sex life. These findings about creative and subversive uses of scars add to debates about agency amongst body theorists. Taken together with the findings about the negative impact of scars, they suggest the relationships women often have with their bodies are complex and ambivalent, and that it is on the body territory that the tension between conformism and agency plays out.
Insights from scholars of the body highlight the role of social pressures in women's experiences of their bodies, and the existence of tangible negative social consequences for those whose bodies are deemed ‘abnormal’. Indeed, the pressures to conform to dominant discourses about female appearance were integral to the narratives of participants. In this light, the high prevalence of the practice of passing unmarked amongst this study’s participants can be conceptualised as more than mere individual choices rooted in unhelpful cognitions. It seems the contemporary attitude towards the body as a project, which is both our moral duty and in our interest to improve, takes a different turn for women with non-facial scars. In order to improve what cannot be improved, women may aspire to pass as non-scarred, both to attain rewards associated with beauty and to fulfil their duty to appear ‘normal’. Through such a lens participants’ self-consciousness and vigilance associated with the practice of passing unmarked can be viewed not as psychological ‘flaws’, but as elements of a self-disciplinary practice and a natural outcome in a society where Body Surface panic is prevalent even among conventionally attractive women.

Furthermore, as already discussed, a significant portion of women’s scar-related distress resulted from feeling torn between the contradictory social imperatives to perfect and accept their bodies, and the subsequent shame about their appearance and their supposed vanity. They also blamed themselves for being ‘a fraud’ if they practised passing unmarked. The somewhat contradictory choices of many participants both to do acceptance work and pass unmarked also reflect this tension. The coexistence of the social attitudes of scar fuss along with the minimisation and liberation discourses identified in this study is seemingly another manifestation of these paradoxical expectations, which in turn reinforce the dichotomy in women’s lived experiences of non-facial scars. In this light, women’s feelings of shame about their scars can be seen as rooted in the broader context of their lives. Such a perspective serves as a useful counterpoint to psychological framings of anticipated stigma and the preoccupation with others’ responses as cognitive ‘faults’.

Yet the choice to pass unmarked can be viewed not only as a self-disciplinary practice, but also as a creative, agentic endeavour to maximise bodily capital. Thus, behaviours usually viewed in the literature on disfigurements as unhealthy can be also seen as practical and adaptive. Indeed, many participants felt that having the choice to pass unmarked, despite the negative effects it entails, made them feel empowered.
It appears that some factors that can ameliorate the impact of scars are also rooted in the broader context of women’s lives. Firstly, some participants’ positive feelings about their scars can be understood in light of the contemporary quest for uniqueness to be forged through the body, and the differing opportunities available for men and women to lay such claims for uniqueness. While women are stigmatised more than men for modifying their bodies, their scars (if they are not overly disfiguring or appear to be from self-harm) can signify uniqueness, resilient character and/or unusual life experiences without the accompanied stigma. Moreover, some women who were already fulfilling their duty by engaging in bodywork to improve the more ‘fixable’ parts of their bodies, framed their scars as being outside of the body project and thus accepted them more. Finally, it is worthy noting that older participants felt they were less subjected to confessional discourse responses.

In summary, this study’s findings reinforce the contemporary view of interconnectedness between the body and self, showing the importance of body in self-identity formation and in social interactions and that appearance can have profound consequences on people’s lives. Thus, non-facial scars appear to be complex territories on the map of the body, loaded with meanings, memories and concerns, and sometimes functioning as useful tools. Many participants’ oscillations between contradictory positions towards their scars reflect the body-related tensions in women’s lives outlined in chapter two: their wishes at once to be unique and normal, to conform and to subvert through their bodies, and to perfect their appearance while accepting themselves as they are. Moreover, relationships of women with their scars demonstrate the overall complex multi-factorial relationship women have with their bodies. Scars, like female bodies generally, seem to be a source of discomfort, interest and/or usefulness. In these ways they epitomise the contemporary view of the human body as a socially loaded phenomenon linked symbiotically with our self-identities.

**Practice implications**

Denzin and Lincoln (2003) suggest social scientists should aim for their research to be “improving the human lot” (p.6). This thesis follows this imperative and offers implications for the care and support of women with non-facial scars.

Firstly, this research drew on the general, rather than a clinical, population, and participants had had their scars for at least four years, though usually for much longer. Still, scar-related distress was found to be a feature of most participants’ lives at least for
some years, and in cases where distress did diminish, the process usually took many years. Such findings indicate that women with non-facial scars who show no signs of psychopathology and who are not seeking help may still be experiencing distress that can be amendable through intervention. Also, similarly to Rumsey et al. (2010), this study shows that access to appropriate interventions may be needed at any time after acquiring scars.

However, existing service provision, as discussed in chapter three, is scarce and is often targeted at people with facial disfigurements. Such services are predominantly focused on helping people to accept themselves, distract others from their visible disfigurements and generally improve their social skills. This study’s findings demonstrate that while important, these interventions are not sufficient to assist women with non-facial scars, and possibly other people with acquired disfigurements, particularly when these are concealable. Insights gained here can be utilised to design alternative or complementary interventions for addressing specific needs of women with non-facial scars and consider more the context of lived experiences. The following sections discuss the implications for interventions with groups, individuals, the public and institutions arising from this thesis.

**Interventions with groups and individuals**

The study findings have implications for individual and group therapy for women with non-facial scars. This section introduces recommendations for the identification of women at risk, assessment guidelines and intervention design. Some of these recommendations may be utilised in practice with people having any type of acquired disfigurements.

Healthcare professionals may wish to target particularly vulnerable women with non-facial scars in order to offer them assistance. Several groups at risk have been identified based on the findings from this study: women with severe scarring; women with scars acquired from self-harm, in traumatic circumstances, through surgical complications or cancer; and single women. Where possible, it may also be helpful to offer interventions tailored to address the particular concerns of these sub-groups (for example, workshops on dating). Peer-based services for these sub-groups may also be useful.
Findings indicate that clinical assessment of women with non-facial scars should consider their self-perceptions, appearance attitudes, personality, life stage, relationship status and quality, health, social experiences and anticipation of social reactions to scars, disfigurement degree of scars, overall changes in appearance and circumstances of scar acquisition, and occupations. Additionally, practitioners need to be aware of the multi-faceted nature of scar-related distress.

Interventions can build on mediating factors and coping strategies identified in this study. Currently, as discussed in chapter three, interventions based on cognitive-behavioral therapy (CBT) are the most common among those available for people with disfigurements. The findings here suggest that CBT techniques can be applied with some women with non-facial scars to challenge unhelpful beliefs about the causes and locations of their scars and anticipated stigma. Practitioners can also encourage women to develop alternative, more positive meanings around these issues, such as those that emerged in this study. For example, the belief among some participants that their scars exist ‘for a good reason’ or mark them as unique. Other cognitive strategies already used by the women, such as those to promote self-acceptance (designating scar hierarchy, positive reframing, doing scar-work as a part of self-work and reaching out to role models) can be employed in the design and delivery of interventions. Practitioners can also discuss with women the potential uses of scars as tools, thus also promoting subversion of the dominant discourses on appearance.

The study findings suggest that future attention in intervention design and therapy be directed to include issues around sexuality, intimacy and the partnering processes. Rumsey et al. (2010) took a step in this direction by constructing a scale to measure intimate behaviours. The fact that scars often serve as reminders of difficult experiences highlights another need for addressing such issues as trauma, injustice, blame, loss and grief in therapeutic interventions. Similarly, women’s concerns about possible future health problems need to be addressed. Such work can help lessen the impact of scars as painful reminders of past, and possibly future, suffering.

Consciousness-raising can be a useful complementary component in therapy, as demonstrated by the finding on the protective qualities of critical awareness. Practitioners can assist women to frame their experiences with a critical assessment of cultural norms in mind. This approach may be useful for addressing concerns not meeting the cultural ideals of female appearance, and also around vanity. On the latter point, practitioners can
offer women an alternative view of their practice of passing unmarked as being agentic and practical, rather than ‘cowardly’. Practitioners can also facilitate discussion on the objectification of women’s bodies and on the invisibility of non-facial scars, and may suggest that a multiplicity of beauty ideals can exist.

Beyond interventions focused on changing cognitions and addressing emotional issues, this study shows it is also important to discuss practical strategies, for example how to act in situations involving intimacy, how to plan disclosure of scars that reveal stigmatising information or how to pass unmarked effectively during job interviews. Such issues can also be addressed in peer-support groups, but based on the results of this thesis it appears such services in Australia do not meet the potential demand for them. Professionals are encouraged to assist with the formation of such groups. Social workers, whose training emphasises community organising and development, are particularly well placed to assume a leading role in this area.

Furthermore, it is important to target contextual factors in women’s experiences. The findings about the impact of scars on intimate relationships and the paramount influence of intimate relationships on women’s adjustment suggest a couple can also be an appropriate unit for intervention. For example, providing support for partners dealing with women’s scar-related concerns can be useful. In some cases it is also worthwhile offering support and training for other family members to explore alternative responses to scar fuss, and minimisation and liberation discourses. Additionally, interventions may be directed at helping women to elicit more positive feedback about their appearance and, if needed, to change their social locations by finding, or focusing on, those milieus where there is less concern with one’s Body Surface and more acceptance for diversity in appearance. It can also be useful for practitioners to discuss, where appropriate, how women can capitalise on benefits gained while parenting small children, and how to preserve such benefits in the long-term.

The following section presents suggestions arising from this study for meeting some of the needs of women with non-facial scars at the sociocultural and institutional levels.

**Interventions targeting the public and institutions**

This thesis shows that the experience of having non-facial scars is substantially influenced by the broader context within which women’s lives unfold. The public and
institutional lack of awareness and sensitivity to issues around non-facial scars in particular, and disfigurements in general, can be targeted for intervention too. Social workers can be especially instrumental in this area, since our professional commitment is to work towards social change.

Although it is much more difficult to influence society than to assist changes at an individual level, steps can be taken in this direction, as some body theorists suggest. Atkinson (2005), for example, argues that “the body meanings... can be contested and reconfigured... by activating and putting into circulation alternative understandings of embodiment” (p.4). Berry (2007) is also optimistic about the potential for such reforms through such strategies as media engagement, interpersonal interaction and social movements, writing: “if appearance inequality is an individual as well as a social problem for whole cultures, discourse about it will expose its existence and will generate awareness” (p.112). Berry emphasises the role of education in generating such awareness, noting that several universities in the US offer courses on “looks acceptance” (p.120). This strategy can prove useful in Australia too. Social work educators in particular are well positioned to recognise and highlight that appearance is an important factor in perpetuating inequality, and offer ways to mediate this.

To promote social acceptance of non-facial scars, including reducing bullying and interrogating behaviours, this study suggests that the issue of public invisibility should also be addressed. Public education initiatives should be developed to counter messages from the media and society about appearance ideals, promote acceptance of body diversity and reduce the stigma associated with non-facial scars. Media can be utilised for these purposes, as per Orbach’s (2010) suggestion that “the very tools which have given rise to a narrowing sense of aesthetic could be redeployed to include the wide variety of bodies people actually have” (p.12). Wardle and Boyce’s (2009) study in the UK gives hope that such an intervention can be effective by showing that lay people are already critical of stereotypical representations of disfigurements on television. So as to capitalise on this finding, women with non-facial scars can be exposed to the general population as TV presenters and reporters, and media advertisements with positive images of women with non-facial scars can also help with this purpose. In this way, the body can be used, as Shilling (2005) argues, as a site of agency and social change.

Institutional changes are needed too. Drawing from this substantive theory, healthcare practitioners are encouraged to expand their understanding about the struggles
involved for women with non-facial scars, even when these may seem minor in comparison to other disfigurements and/or health conditions which caused the scars. Medical professionals also need to be more sensitive to women’s needs regarding information and inclusion in decision-making related to treatments that cause scars. School staff too need to be trained in sensitivity to issues around non-facial scars, including managing bullying related to scars. Furthermore, lobbying relevant policy makers to consider the distress associated with non-facial scars in legislation around trauma compensation can be useful, and also to put in place proper anti-discrimination legislation. I also believe social work can play a role in this training of healthcare and education professionals and in lobbying. Finally, I encourage my social work peers to include appearance issues on their agenda systematically, whether this be through professional training, individual practice, practice with communities or policy work. The following section continues discussion of the implications of this study, moving to the research area.

**Implications for research**

As is usually the case in research, the findings of this study offer some pointers for future studies, both thematically and methodologically. Primarily, the results highlight the importance of understanding the subjective worlds of people with disfigurements. Further investigation of emerging and unique findings in this thesis should take place. For example, the role of various life events in the aftermath of scar acquisition should be clarified, and the mediating impact of personality traits on adjustment needs to be investigated using standardised tools rather than through self-reporting alone. Future research may also uncover additional factors mediating women’s experiences of non-facial scars. A longitudinal study of women with non-facial scars would be particularly useful for providing further clarification in all these areas.

This study focused on adult women. Similar exploratory research on men with non-facial scars could be useful, particularly given, as discussed in chapter two, evidence exists to show that men too are increasingly becoming concerned about their appearance. It would be interesting to compare men’s experiences with those of women. Examination of issues pertinent to children, adolescents and older people with non-facial scars is also important.

The findings about the experiences of women with non-facial scars can inform research in other areas of disfigurements. For example, the finding that some women can
be creative and use their scars as tools means such ‘body creativity’ is worth investigating with other disfigurements. Most significantly, this study highlights the importance of considering the broader context in which people’s lives are embedded within any analysis of disfigurement-related issues.

This study also offers some methodological contributions for future studies on disfigurements. In order to interview ethically and effectively I recommend adopting the stance of a ‘passionate listener’ and using techniques I borrowed from my practice as a therapist to wrap up interviews. These approaches to interviewing are discussed in chapter four. Additionally, the use of free-flow writing in elicted texts proved fruitful. Participants who utilised this technique said they enjoyed the exercise and gained new insights into their situation through doing so. I found material generated in this way to be rich and valuable. Furthermore, I encourage researchers to incorporate photographic representations in their works to break the invisibility barriers surrounding disfigurements. Finally, I join Inckle (2007) and Rice (2009) who advocate for embodied reflexivity in research with women. I, too, found such an approach to be useful for generating insights and also ethical.

**Final personal note**

The power of verbalising the unsaid and showing the invisible is a cliché. However, clichés are often rooted in truths. For almost thirty years I lived with my scars secretly. Even most of my friends did not know about my scars. Although, paradoxically, at the same time I made art of them by incorporating my experiences of having extensive non-facial scarring in my works of fiction. In fact, my first novel is titled *Scars* and the title reflects its subject matter. Yet in my ‘real’ life I took care of meticulously passing unmarked.

Conducting this research had unintended consequences for me, more powerful than I ever anticipated. During the five years of researching, writing and presenting findings from this thesis I got used to talking about my own ‘body secrets’, to borrow the term from Rice (2009), while explaining my rationale for this study. Furthermore, I finally got the courage to describe my own lived experiences in the essay *Revisiting the Geography of My Body* that also includes some of the literature I had reviewed for my thesis (Kofman, 2010) (see Appendix eight). The lovely responses I received from readers
further reinforced my sense of some ‘liberation’ from the tight shroud of my usual secrecy.

Gradually, as the verbal and written disclosures began featuring more frequently in my life, and as my conversations with participants unfolded, it was only inevitable that words made actions possible too. For the first time in my life I stopped covering at least my chest scar if not my leg, where the scarring is much more disfiguring. Still, this step is already a big relief. In this way, I understand deeper the unintended therapeutic consequences this study’s participants told me about, and I thank them for all the candour and wisdom they imparted to me so generously in the course of these intense years of research.
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Appendix One

EXPLORATION OF LIVED EXPERIENCES OF WOMEN WITH NON-FACIAL SCARS

It is estimated that each year about 100 million people in the developed world acquire scars. Yet, while prevalent amongst the population, scars remain largely a hidden and unspoken of phenomenon in the public domain.

I am currently undertaking the first Australian study, as a PhD candidate at RMIT, to explore lived experiences of women, who have non-facial scars. The findings might have implications for providing better healthcare for women with non-facial scarring.

Are you aged between 20 and 60?

Have your non-facial scars been acquired at least five years ago?

If this is the case, and if your scarring is not related to any ongoing health issues, I will love to hear from you. If you are interested in participating, and/or would like more information, please contact Lee Kofman on 04-19008292, 99259953 (BH) or via email lee.kofman@rmit.edu.au

All communications will be strictly confidential.
Appendix Two

EXPLORATION OF LIVED EXPERIENCES OF WOMEN WITH NON-FACIAL SCARS

It is estimated that each year about 100 million people in the developed world acquire scars. Yet, while prevalent amongst the population, scars remain largely a hidden and unspoken of phenomenon in the public domain.

I am currently undertaking the first Australian study, as a PhD candidate at RMIT, to explore lived experiences of women who have non-facial scars. The findings might have implications for providing better healthcare for women with non-facial scarring.

- Are you aged between 20 and 60?
- Have your non-facial scars been acquired at least four years ago?
- Do you feel that having scars has had some impact (positive, negative or mixed) on your life?

If this is the case, and if your scarring is not related to any ongoing health issues, I will love to hear from you. If you are interested in participating, and/or would like more information, please contact Lee Kofman on 99259953 (BH) or via email lee.kofman@rmit.edu.au

All communications will be strictly confidential.
Appendix Three

Demographics

Age; Ethnicity; Education; Occupation; SES; Relationship status; Children

Interview questions

Scar details

✓ What kind of scarring do you have?
✓ Ordinal scale regarding degree of disfigurement
✓ How long ago did you acquire it?

Impact on well being

✓ What impact has your scarring had on your life?
✓ Do your scars bother you? Why? Why not?
✓ How often do you think about your scars? And/or notice them?
✓ Has your perception of your body changed after acquiring the scarring?
✓ How do you feel about your overall appearance?
✓ Has your appearance always been (un)important to you?
✓ Amongst other appearance concerns, where would you place your scars?
✓ Has your perception of your scarring changed over the time?
✓ Do you think having scars has made you more unique?
✓ What do your scars mean to you?
✓ Do you define yourself, in terms of identity, in relation to your scars?
✓ When do you feel most uncomfortable about your scars (if at all)?
✓ Does scarring affect how you use public spaces?
✓ Does scarring influence your body language? Other body movement?
Do you think if you didn’t have scars, your life would be different in some ways? Or would you be a different person?

Can you tell me a story from your life that has something to do with your scarring?

Social context

How do you think scarring is perceived in our society?

Have you ever discussed your scars with others?

How do you feel about other people seeing your scars?

Is it more difficult to show your scars to people you know or to strangers?

Do people who know about your scarring refer to it in their interactions with you?

Do women react to your scars differently than men?

Coping with scars

What has been the most difficult thing to cope with in relation to your scars?

What helped you to cope?

If relevant – why do/did you feel you have/had to cover your scar? Do you think the habit of covering has shaped your personality somewhat?

Have you had sufficient support in relation to scarring?

Have you attempted any cosmetic interventions? Why/why not?

Needs

What could help but is missing?

Existing data + summary

Can you provide me with any existing data related to your scars?

Ordinal scale about the severity of scar’s impact on your life

Questions following creative activities

- Were the creative activities difficult to do?
- What issues/thoughts came up?
- Where you surprised by what came up?
- Did the activity trigger any additional memories and/or thoughts?
Appendix Four

WRITING EXERCISE FOR THE STUDY OF LIVED EXPERIENCES OF WOMEN WITH NON-FACIAL SCARS

This exercise is based on both creative writing and writing therapy techniques.

Please make 3 writing entries (or more, if you wish) over the course of one week.

Using a free-flow writing technique (a description of which is on the following page), please write each time for at least seven minutes, without stopping, about what your scars, and/or your body, mean to you.

You can use any, some or none of the following prompts to start writing:

1. Since I first got my scar(s)…
2. If I didn’t have my scar(s)…
3. What matters to me about my body is…

The results of this exercise may provide an additional insight into your individual experience of having non-facial scarring.
FREE-FLOW WRITING

*It releases the voice of the subconscious by removing or putting aside the control of the conscious mind.*

Tristine Rainer

*It is the combination of the writing itself, slowing down and tuning in to the body and senses, as well as deepening of the breathing, that serves to increase the awareness.*

Susan Borkin

**What is free-flow writing?**

- A common technique amongst writers
- In psychological terms, it is known as ‘free association’ (Freud)
- Writing with no stylistic editing or inner censorship
- Helps to gain a greater, often unexpected, insight about our lives
- Can be a cathartic experience

**How is it done?**

- Write without stopping; don’t worry about grammar and punctuation
- Follow your thoughts and emotions, even if they seem too ‘mundane’ or not related to your topic
Appendix Five

Dear participant,

My name is Lee Kofman and I am undertaking a PhD at RMIT University under the supervision of Associate Professor Jenny Martin and Professor Pavla Miller. The title of my research is *Lived experiences of women with permanent, non-facial scarring*. The aim of this project is to investigate the various effects permanent, non-facial scarring may have on women’s lives.

I’m inviting you to participate in an interview which might last between one and two hours, depending on your preferences and availability. You may stop the interview at any point, withdraw from participation in the research at any stage and/or to withdraw any unprocessed data previously supplied.

During the interview I will be asking you questions about your lived experience of having scars and whether this has affected you in some ways. As a social worker with substantial counselling experience I am committed to being sensitive in my line of questioning. I also believe there are benefits in participating in this study. Talking about scarring may provide new insights into this experience.

As an optional addition to interview, you might be interested in doing a creative writing exercise before or after our interview. Also, during the interview – if you agree – I’ll be taking a photo of your scarring. Unless you explicitly agree in writing, the text and/or photo will only be used as topics for our discussion and will not be presented as a part of the research data.

Your name and contact details will be required for me to make contact with you to arrange the interview. This information will not be used for any other purpose. All the interviews will be recorded and transcribed, and be held securely according to the RMIT University ethics’ guidelines. If I use any material from your interview, I will put in a pseudonym. Even if you give me a written permission to use your photos and/or texts, your name will not appear next to these materials unless you wish so.

For further information or any other questions you may have regarding this project please contact me or my principal supervisor at the contact details provided below.

Thank you for considering taking a part in this project. I look forward to hearing from you.

Yours sincerely

Lee Kofman BSW, MA
PhD Candidate
RMIT University

CONTACT DETAILS:
Lee Kofman: (W) 99259953; (Mb) 0419 008 292; (Email) lee.kofman@rmit.edu.au
Jenny Martin (Principal Supervisor): (W) 99253131; (Email) jenny.martin@rmit.edu.au

Any complaints about your participation in this project may be directed to the Executive Officer, RMIT Human Research Ethics Committee, Research & Innovation, RMIT, GPO Box 2476V, Melbourne, 3001. Details of the complaints procedure are available at: http://www.rmit.edu.au/rd/hrec_complaints
Appendix Six

Consent Form For Persons Participating In A Research Project *Lived experiences of women with permanent, non-facial scarring*

PORTFOLIO OF

SCHOOL/CENTRE OF: School of Global Studies, Social Science and Planning, RMIT University

Name of participant: [Redacted]

Project Title: *Lived experiences of women with permanent, non-facial scarring*

Name of investigator: Lee Kofman

(W) 99259953
(Mb) 0419 008 292

1. I have received a statement explaining the interview.

2. I consent to participate in the above project, the particulars of which have been explained to me.

3. I authorise the investigator to interview me.

4. I give my permission to be audio taped □ Yes □ No

5. As an additional activity to the interview, I consent to do a creative writing exercise □ Yes □ No

6. As an additional activity to the interview, I consent to create a photo □ Yes □ No

7. I acknowledge that:

   a) Having read the Plain Language Statement, I agree to the general purpose, methods and demands of the study.

   b) I have been informed that I am free to withdraw from the project at any time and to withhold any unprocessed data previously supplied.

   c) The project is for the purpose of research and/or teaching. It may not be of direct benefit to me. The privacy of the information I provide will be safeguarded. The privacy of the personal information I provide will be safeguarded.

   d) The security of the research data is assured during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to two PhD thesis examiners. Any information which may be used to identify me will not be used.

Participant’s Consent

Name: _______________________________ Date ____________________
   (Participant)

Name: _______________________________ Date ____________________
   (Witness to signature)

Any complaints about your participation in this project may be directed to the Executive Officer,
RMIT Human Research Ethics Committee, Research & Innovation, RMIT, GPO Box 2476V, Melbourne, 3001. Details of the complaints procedure are available at: http://www.rmit.edu.au/rd/hrec_complaints
Appendix Seven

1. I have received a statement explaining the purposes for which the photo created might be used.

2. I authorise the investigator to use my photo.

   a) Having read the Plain Language Statement, I agree to the general purpose, methods and demands of the study.

   b) I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied.

   c) The project is for the purpose of research and/or teaching. It may not be of direct benefit to me. The privacy of the information I provide will be safeguarded. The privacy of the personal information I provide will be safeguarded.

   d) The security of the research data is assured during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to two PhD thesis examiners. Any information that may be used to identify me will not be used unless I have given my permission (see point 2).

Participant’s Consent

Name: ___________________________________________ Date: __________________________

(Participant)

Name: ___________________________________________ Date: __________________________

(Witness to signature)

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Appendix Eight
Re-visiting the geography of my body

‘For far too long the attention has been on denouncing ‘perfect bodies’. It’s time we turned to investigating the feelings, the experiences and the sheer diversity of imperfect ones.’ Elspeth Probyn

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I’ll begin at the end. Recently I responded to an advertisement from a skin clinic claiming to possess a magic wand (or did they call it laser?) for removing any bodily faults. So I took my scarred body to an appointment, and my husband accompanied us.

The clinic’s design was a melange of New Age and Docklands’ display apartments. The reception area smelt of eucalyptus. Metallic, fat Buddhas smiled at us as we listened to recorded sounds of rainforest while sipping on herbal tea. Even the phone rang with an organic melody. We sat there with all our five senses entirely engaged. As my husband browsed through magazines left on a glass coffee table that presented images of tight bodyparts, occasionally appearing to connect to people, I self-consciously adjusted my necklace to conceal the long, pale chest scar which stretched from my midriff to collar bone.

The scar-line, surrounded by numerous stitch marks, ended oddly in two small, round dents; I could never understand their surgical purpose. But then, this scar was the medical equivalent of dinosaur - a historical reminder of the wilderness the Soviet medical system was in the early eighties. Devoid of modern technology and sober staff, and firmly stuck somewhere in the 1950s, Soviet hospitals barely coped with providing basic needs, let alone wasting their precious time on such bohemian pursuits as fine skin suturing. Russians took pride in their chess, weaponry and science; the government needed clever, not vain, citizens. I was the result of those priorities, and considered on the lucky side for surviving open heart surgery, for not ending up dead under a knife of an alcoholic surgeon with connections in the Kremlin as some kids from my ward did.

Yet, this awkward scar running between my breasts was not the crown of my concerns. That was my left leg – utterly mangled due to another childhood misfortune. This had taken another drunken comrade – this time a bus driver, who ignored me as I
crossed the road with the green signal, and another surgeon who had lacked any interest in aesthetics. And here I was twenty something years later: a walking-talking deception, an eternal freak underneath my fashionable dresses, underneath my misleading appearance, which often appealed to men (and some women). Here I was, waiting for the western magic of the new millennium to transform me into the princess I had always pretended to be.

The clinical consultant, a buxom woman with a mop of red curls, gestures towards my left leg: ‘Can I have a look, darling?’

An adult woman in my thirties, I am thrown out of balance: ‘Sorry?’
‘You don’t have to take off your jeans, darling. Just lift them a bit.’
‘Right now?’

I’ve always tried to minimise, or rather avoid, exposing my flesh. I never fully undress during massages. In the gym I change my clothes in a toilet cubicle. I conceal my scars as though they are some sin I’ve committed. I worry about how they may compromise the entire idea of me, reduce me to some Frankenstein variety to be disgusted by, or pitied. I fear pity the most.

I lift the jeans, exposing the calf. Between a thick keloid scar that runs into my knee and a large dent in place of the muscle torn by the bus wheel just above the ankle, the rest is an uneven tapestry of regrown pink and brown patches of skin interwoven with fine blue veins. Even my thigh is a lax artwork, decorated with pale skin patches from a skin graft.

This leg can lay no claims to normality.

I look at the consultant’s face, anticipating the initial disgust. But the woman is a real professional: she kneads my scarred leg with her gold-ringed fingers, as though making dough. She straightens my pants: ‘Right, this is what we can do…’
‘So… you can do something?’ Just like that…

After all those plastic surgeons I visited only to hear that nothing could be done. Several years ago I had finally come to believe what the doctors had repeated so many times - my scars were too old, too numerous, too complex to fix. I had also had enough of pretending I didn’t care about that hopeless prognosis (it was always somehow important to preserve bravado at the clinics).

‘Of course, darling,’ the consultant says matter-of-factly. ‘Look, this leg won’t be as good as the other, but you’ll be able to…’
‘Wear dresses without stockings?’ my husband interreres. ‘Will she be able to? Because she doesn’t, you know. It’s like… even on forty-degree days she’ll wear these thick stockings.’

‘There will be a big improvement,’ the clinician says somewhat vaguely, ‘but it will take about eighteen sessions.’

‘And what about this?’ I point towards my chest scar.

‘Oh, that isn’t really so hard… it’ll improve quicker than your leg, darling. Want to make time for a treatment?’

‘Well?’ my husband looks at me.

‘I’ll get back to you,’ I tell the consultant. As we leave, a pretty receptionist wishes us a peaceful night.

I don’t know about peaceful, but the night is warm and milky. The summer is about to end and everyone seems to be making the most of the season’s wardrobes. We walk towards the car through the pasture of bare legs: hairy, smooth, shapely, thick. Unlike all these people, I have never experienced that sense of freedom, where nothing shields your skin from the world. I wonder how this might feel.

‘Are you worried about the money?’ My husband asks. ‘We’ll manage.’

I look at him with sudden suspicion. In a short story about a love affair gone sour I had written: ‘someone I was with before I met you told me that a man who truly loves you will kiss your scar. But he never did.’ A long-discarded paranoia suddenly re-appears: has my husband ever kissed my scars? I can’t remember.

As we drive home, I keep quiet. I don’t yet know how to express in words the anxiety which has suddenly overtaken me.

Every scar is a redeeming story. Or – is it?

I’m finding this essay difficult to write. Talking about my scars has never been a habit. Some of my close friends have no clue as to what I hide underneath my clothes.

Women generally don’t talk about such things, unless their scars are few and are fine and neat, and even better so, have some well-understood, non-threatening but useful origin such as an appendix removal or baby production. Such scars are respected and at times even exhibited to sympathetic audiences as badges of honor, symbols of endurance and productivity. Anything else – accidental, traumatic, disfiguring - usually resides outside the linguistic and public realm.
Yet the popular premise is that every scar is a story, and that its disclosure will benefit the storyteller. The American author Elizabeth Austin, in her essay about the psychological impact of scarring\(^\text{16}\), suggests that to redeem a scar: ‘the wounded person must create a scenario that tells the story of the scar in an attractive and compelling light’.

Homer, the father of storytellers, set the scene, giving us one of the most famous accounts of scarring. Odysseus’s is a heroic tale. In his youth, he was wounded in the thigh when he killed his first bear as part of the initiation into manhood. This scar is further celebrated in the epic, becoming the visual representation of Odysseus’s ‘true’ essence. After years of adventures, when he returns to his hometown Ithaca under a false identity, it is by his scar that his former milk nurse recognises him.

Centuries later, this tradition of redeeming scars through storytelling still works for men. The language of the many websites dedicated to ‘scar stories’ written mostly by men, about men, is foreign to me: ‘cool guys who live lives of action and adventure always have great stories about the scars they've gotten in their travels’\(^\text{17}\). Yet, because I received all my scars in my first ten years, before the inevitable teenage passage into intricacies of gender, there was a brief period when the idea that every scar was a story worked for me too.

At age eleven I emerged from my last, year-long stay in a hospital carrying my thrice-operated-upon leg as a flag to be waved in celebration of a return from my own Odyssey. After spending about eight years in and out of hospitals, I was greedy for attention, and realised quickly my scarred leg was an efficient social tool. I refused my mother’s pleas to cover up with knee-length socks (a popular Soviet fashion). Instead, as we sat in the local park, I would fling my leg forward in front of strangers, smiling sweetly. The device rarely failed and I often found myself at the centre of attention, re-telling my epic over and over. By then already addicted to the art of storytelling, I had developed a well-constructed narrative with dramatic turning points. There were heroes in my stories: the older man in the gurney next to mine as we both waited for our respective heart surgeries, who, to dry my tears, amused me with stories until they wheeled us in. Or

\(^{16}\) Austin Elizabeth, ‘Marks of Mystery - psychological reaction to scars’, \textit{Psychology Today}, July, 1999

\(^{17}\) \url{http://www.montykins.com/mkins/000375.html}
another anonymous man who stopped the bus with his bare hands to prevent it from cutting off my legs, then disappeared into the crowd. And villains: the surgeons and the bus driver. There was the tragic touch (the gurney man didn’t come out of the theatre alive), but also the happy ending – me at the park. My audiences seemed captivated, laughing and crying at all the right moments.

Perhaps it was not just my age, but also the ravaged state of Russia’s own body which somehow rendered my own flesh more acceptable, even a source of fascination. In the Odessa of the 1980s people and places both appeared marked: ravaged by drink, neglect, the perpetual lack of money, fourteen-hour working days, carelessness or apathy. In our neighborhood in the city’s centre, the gutters ran open, mouths were full of rotten teeth and the wooden staircase leading to our apartment had a habit of collapsing. I blended organically into the landscape.

I was twelve when we moved to Israel. Unfortunately, just as I was entering that awkward phase when looks become your currency for attaining status and self esteem, my new country entered its Westernized phase of aesthetics. High-rise buildings were appearing everywhere, burger restaurants were opening alongside falafel parlors, and George Michael’s video clips and Dynasty took over our television screens, offering my generation alternatives to the usual Israeli lifestyle guidelines: ‘it is good to die for our country’ and ‘work is our life’.

I started my new school by making severe errors with my body presentation. Firstly, I underestimated the threat of my then bud-sized breasts and neglected to hide them underneath a bra. I also hadn’t realised the hairs which had started appearing on my legs were a public insult, and let them grow. Most significantly, I still refused to listen to my mother and wouldn’t hide my scars. That last decision was strategic, as I was looking forward - with the little Hebrew I possessed - to working my storytelling charms on my new classmates.

I’m not sure whether those errors were inspired by my Soviet background, or by my personal ignorance of social etiquette. Probably both. Recently I read Eva Hoffman’s memoir Lost in Translation about her migration at age thirteen from Poland to Canada, and was somewhat relieved to discover she too started her western life with an improper body of unshaved legs and no brassiere. Like Eva, I too tried to compensate for my sins. Whereas she let a local girlfriend train her in the necessary cosmetic rituals, I, in the absence of mentors, enrolled in an expensive teenage beauty course, where I learned to
shave my legs, conceal my scars and make myself look much older with green eye shadow and too much rouge. Still, the damage I’d done to my reputation was too grave and I changed schools.

**Every scar is a memory. Or – is it?**

‘It is neither the brain nor the heart that is the organ of recollection. It is the skin! For to gaze upon the skin is to bring to life the past,’ 18 muses Richard Selzer, a writer and surgeon, about the connection between scarring and memory. Poets and theoreticians like imagining scars as memories imprinted on the flesh, as markings of past dramas and victories.

The tendency to always talk about scars with reference to past is reductive. So are the metaphors describing scars as permanent and finished. Only once my skin had finally sealed, disfigured, did my lifelong narrative of concealing, layering and avoiding begin. For me, and I assume for some other women, scars aren’t just reminders of the past. They keep generating new stories, those of a changed appearance and its consequences. Their looks can change, as can our relationships and interpretations of them with every new fashion, new lover, new insight about ourselves, and as we age. Scars, like minds, are works-in-progress.

As I entered my teens, shyness overtook me. I avoided my nudity. I shunned mirrors. Living in a marked body often felt like being exiled from my own flesh.

To learn how to become a proper Israeli teenager, I watched popular American TV sitcoms. Samantha from _Who’s the boss?_ was my ideal. Alone on Saturday nights in front of the television, I observed intently how she partied, always wooed by the cool boys. Hers was a smiling, longlegged sweetness of short dresses and uncomplicated conversations. My literary ambitions took second place while watching Samantha. I promised myself I would become a glamour girl, despite my scars.

How does one do something like this? I couldn’t find any female role models to show me how to reconcile sexuality with having scars.

Nothing has changed since. Scarred female bodies are still absent from the public imagination. Enough has already been written about the media’s love affair with the

18 Selzer Richard, *Mortal Lessons: notes on the art of surgery*
Perfect Body. Artists are not interested in deformities either. Picasso, despite his passion for operating on female bodies with brushstrokes, never depicted any blemishes on them; his fragmented women are visual feasts of appetising breasts and bellies. Even Frida Kahlo, who had more scars than bones, preferred to paint her bleeding wounds. This could have been a clever marketing decision. After all, blood is a temporary thing, wounds can heal and suffering has always had an erotic dimension. It is the aftermath which is problematic.

Cinema isn’t much better. David Lynch’s beauties are sometimes endowed with sexy flaws like eye patches, but otherwise remain Hollywood’s pretty women. David Cronenberg was the only one to demonstrate in his movie Crash that the heavily scarred Rosanna Arquette could be attractive. Yet somehow it didn’t make me feel any better watching her copulate through the vagina-like scar on the back of her thigh.

Female scars are absent not just from public representations, but also from public spaces. Even at the beach where people flash their bodies with all their imperfections - cellulite, dark veins, hairy backs - there are no scarred women in sight. It’s as though we have all signed some agreement to keep away.

Perhaps the absence of scarring in the public sphere has something to do with our fears. In the West, where medicine appears to be omnipotent with all its successes and innovations, the surgeons take pride in their cosmetic abilities. Disfiguring scars are not as frequent as in the so-called ‘developing world’. Severe scarring here might stand for an unwanted reminder of how fragile our bodies remain, how susceptible we are all to wounding and to dying, despite our spectacular technology.

This isn’t an exhaustive interpretation of scar-induced fear, of course. Separately, the authors Elisabeth Austin and Anne Hollander19 come to the same conclusion that scarring threatens another Western aspiration – that of attaining bodily perfection. This pursuit can be traced back to Pluto’s ideal of human beauty as the ‘natural’, unmarked body. His views were later embraced in the Judeo-Christian tradition, which conveniently distinguished its adherents from the pagans who had long practiced scarification and tattooing. More than an obstacle on the beauty path, scarring also became an attribute of the feared ‘others’, the barbarians.

One can keep speculating about the phonetic similarity between scar and scare.

19 Hollander Anne (1999), Feeding the eye
When I was a brooding teenager, the only two women of glamour I knew who possessed scars were Sharon Stone and Catherine Zeta-Jones. Coincidentally, both bore similarly minor (at least, in my eyes) neck scars, which they concealed meticulously with necklaces, make-up and clothes. This became a public game: the more they concealed, the more their fans strived to ‘uncover the truth’. It was not just the stories behind the scars the public desired, but their physical revelation. Such intensity of inquiry peaked with the appearance of a website, dedicated to photos of Stone’s scar and speculations about its origins.20

If even those Hollywood goddesses couldn’t be forgiven for their scars, I realised, I’d better make a good fist of concealing myself, while still uncovering the maximum possible to present my body on desirable terms. At the Jaffa flea market I found a long silver necklace which covered my chest scar whilst still enabling me to reveal a substantial cleavage.

Since then, I have become an expert in the geography of my body, making the most of the few unmarked territories I can reveal to the public eye: my shoulders, right leg, back. But I am even better at concealing. The bible tells us the seven veils can evoke a stronger desire than the naked body. I have learned the art of Salome, mastering my own version of her veils with glamorous jewellery, halter tops, lacy stockings.

At nineteen, when I moved to Tel Aviv from a province, I was already redesigned, with huge green eyes made even brighter with contact lenses, and dangerously short skirts worn tight over opaque stockings. I plunged myself into the nightlife, dancing till dawn, mixing drinks for a living and eventually opening my own business as a party organiser. In short, I became a glamour girl.

Philosophers like Michel Foucault and Julia Kristeva have argued that our bodies are not purely organic matter. We discipline, shape, decorate and present them according to ever-changing cultural norms. In a way, our bodies are maps depicting our times.

But the relationship between the self and body is never a one-way street. It occurs to me my body has a lot to do with the way I developed as a person. Doubtless I am lucky my scars can be covered and I have more control over my image than, for example,

20 www.sharonstonesscar.com
people with facial scarring. I can perform the role of an attractive woman whenever I wish. Such a position though places me immediately in the seductive realm of illusion, and throughout my life I have ventured there often. After my scars were permanently hidden, I dyed my brunette hair blond. My height was enhanced with the Israeli fashion of platform shoes. And this practice of concealment never stopped where my flesh ended. My Russian accent and Russian past had to go for locals to accept me as one of them. My frequent loneliness and longings were dressed with excessive smiles. The list was long.

Into my twenties, my scars kept acting as catalysts in generating their own realities, most of all affecting my intimate relationships. My romantic choices were too often, at least partially, driven by fear and vanity. I used to joke to myself that the only job I could never have was as a call girl. I never went to bed with a man quickly, and not always through any moral choice. The possibility of rejection preoccupied me more than pleasure. To avoid rejection, I sometimes rushed into relationships with men who loved me, while uncertain about my own feelings. What counted most was not to expose myself to an ‘unsafe’ male gaze.

My judgment about what could be potentially unsafe was erratic, reminding somewhat the rules of War on Terror. One time I became infatuated with a man who courted me gallantly with red champagne and even redder roses. When I finally allowed myself to dream about love, he casually mentioned that his ex-wife had beautiful, long legs. I fled. And during the parties I organised I’d often dance with a new man and with the dawn disappear like Cinderella, since even in the midst of those nocturnal carnivals over which I presided, just as elsewhere, the knowledge of my body underlined everything.

I suspected men were shallow. But now it seems to me it was I who was on the shallow side then. All my boyfriends had to be handsome, trophies to be displayed as evidence of my own sex appeal. Still, as much as I basked in their desire, I don’t remember my lovers ever touching my leg scars.

**Scars are evidence of healing. Or – are they?**

Today more than ever our bodies receive attention, not just on fashion channels, but also from psychologists, writers, sociologists, philosophers and other explorers of the human condition. Bodies are gendered, classed and raced; bodies are decorated and displaced.
Yet despite, or even because, of the spawning body theory and our bodily preoccupation, to this day I have no points of reference to articulate my experiences. No one writes about scars; they are even absent from clinical theory. I agree with Pam Warren, a survivor of the rail crash in UK, when she says: “the treatment of physical injuries is well understood and a great deal of time and effort has been spent on understanding the problems associated with mental trauma. But coping with disfigurement has, I think, largely been overlooked”\textsuperscript{21}. Paradoxically, literature which deals with illnesses or other traumas that disfigure the body, is somehow disembodied. The research focuses on the social, economic and psychological aspects of wounding, but not the impact of scarring.

Perhaps this occurs because many therapists, cultural commentators and artists reduce scars to metaphors for healing. Once again, scarring is linked to an ending of something, often with a positive outcome. The American artist Ted Meyer, who creates images of various bodily deformities and himself is also scarred, says that he sees scars as evidence of resilience\textsuperscript{22}. Surely the differences in Meyer’s and Warren’s responses cannot be attributed solely to gender, yet the few existing studies on the psychology of scars show that women cope significantly worse than men with the aftermath\textsuperscript{23}.

As Austin writes, the damaging impact of scarring is so under-acknowledged that doctors are often reluctant to refer their scarred patients for counselling. Perhaps with good intentions, some doctors do so in order not to pathologise the scarring; others may be acting out of a lack of awareness. None of my doctors ever raised the possibility. Neither had it ever occurred to me that scars need to be tended not just when they are still bleeding.

Some time ago I was going through difficulties in my marriage and went to see a psychologist. At our second appointment I suddenly realised that what I really wanted to talk about was the unspoken – my scars.

As soon as I raised the subject, the psychologist - highly regarded in his field – interrupted me. With great determination he walked over to the whiteboard he kept at his

\textsuperscript{21} Study into psychology of scarring, BBC News \url{http://news.bbc.co.uk}, 27 September 2005  
\textsuperscript{22} Kennedy Randy, ‘Artist celebrates scars’ fierce beauty’, \textit{The New York Times}, 4 October 2006  
\textsuperscript{23} See research by L. Kleve & E. Robinson, & Rumsey N.
office, sketched a green woman and gave me a red pen to mark my scars on her body. His next directive was to place my hands over the marks, as though I was embracing my scars. Puzzled, I followed his instructions, yet none of it felt right.

‘So,’ the psychologist asked as I returned to my seat, hoping to resume our conversation, ‘how do you feel now?’

I felt annoyed. ‘Look,’ I said, ‘I’ve touched my scars many times. I don’t need a whiteboard for this. What I want is to understand what makes me feel so guilty about having scars. I always hide them, but then feel like a fraud…’

‘Wait a minute,’ the psychologist stopped me for a second time, seemingly frustrated. ‘Let’s not talk. Your problem is that you’re intellectualising everything. You need to cry.’

‘Believe me, I’ve cried a lot. But I’ve never talked…’

‘Cry!’

‘What?’

‘You must cry!’

I got up, paid him and never went back.

I moved to Australia at twenty-six. A newcomer once again, I decided to try on yet another body. I minimised my rituals of concealment. I stopped coloring my hair and let it grow untamed by fashion. I didn’t lipstick my smiles anymore, and overall tried smiling less often - only when I really meant it. One day I looked in the mirror and realised I hadn’t designed a new body - I had rediscovered the old one.

The common wisdom is that if not therapy, then time heals all. But I find places too influence our sense of embodiment. In tiny crowded Israel, for bad or for good, bodies tend to merge, to become each other’s property. People embrace you often, stand close to you at markets and bus stops. Distant acquaintances feel free to remark: ‘you’ve put on weight’. Men constantly whistle as you walk the street.

Even though like Israel, Australia is an overheated country of pioneers with an outdoor mentality, a country which imagines itself as a place belonging to tanned youths clad in shorts constantly preoccupied with nature, be it surfing, bushwalking or camping, somehow the vast local distances dilute the intensity of the body-exposed lifestyle. Strangely protected by the sparseness of the landscape, I don’t experience the same urgency to hide myself as I used to. I have learned to be more vulnerable and at the same time less self conscious not just because I have grown older, but also because here I don’t
feel as intensely embodied. Still, I hide my scars meticulously and I’ve never really stopped grieving the body I could have had.

**Scars - stories, memories, healing**

I wrote that I would start at the end, but the end keeps rewriting itself. As I kept thinking about booking my first laser session, the anxiety wouldn’t retreat. Ironically, the clinic’s grotesque spirituality had indeed sent me soul searching. Rather than looking forward towards a glamorous, scarless future, my thoughts had been spinning inevitably backwards to age eleven when I was still attached to the suffering I had endured, when I would flamboyantly fling my leg at strangers. Perhaps there was something of Odysseus in me too - my scars signifying some rite of passage, an identity even. For the first time in my life it was possible to modify my scars in some way. To my great surprise, this knowledge disturbed me almost as much as it made me hopeful. Was I forgetting all the limitations in my life I had always blamed on my body?

No, but I discovered ambivalence. These scars were me. My unusual life trajectory was not possible to conceal. Perhaps my scars marked me not only as an abnormal body, but also as a foreigner, and, if you wish, a ‘communism survivor’. For better or worse, they have made me unique, and uniqueness has always been my preoccupation; not just out of vanity, but also as an attempt to deny mortality. Perhaps this is why I took to writing.

As I looked again and again at the clinic’s phone number, I experienced the familiar longing for a scar-free life, for the body I could have had if not the surgeries I undergone. Yet now this feeling was mixed with an additional - anticipated - loss, that of my current body. What if I didn’t have scars, I kept wondering obsessively, would I become then preoccupied with every other little flaw on my body? Would I be able to know for sure that men had loved me for who I was? If I lost my scars – would I become a shadow of myself?

Coincidentally, but not surprisingly for the Body-Perfect-obsessed suburb of Port Melbourne where I lived, soon after another skin clinic with similar technology opened nearby. I decided to get a second opinion. I cannot say I was entirely surprised when the local consultant confirmed what the doctors had told me years ago. There was nothing much he could do. Some clinics, he told me, will promise you anything, protected by the notion they cannot guarantee results.

I left feeling sad. And somewhat relieved.
The author Dennis Slattery, himself scarred, writes that ‘to be wounded is to be opened to the world; it is to be pushed off the straight, fixed, and predictable path of certainty... from a superficial life of distance to a more intimate and penetrating awareness of being in a far richer place’²⁴.

As I re-visit my past, I cannot ignore the ever-changing way I experience my body. Now that I have poured out all these words, my scars feel to me different again and I can sympathise to a certain extent with Slattery. I too feel that my wounds and scarring have deepened my insight and heightened my empathy for other people; it is probably not accidental that I became a writer. If writing means one has to give up grand truths and be willing to explore the ambiguities of our existence, then perhaps I might get to see my scars as an attribute. For now though, as the sunshine of early summer pours into my window and I watch beach-going girls passing by in their short sarongs, I forget Slattery.