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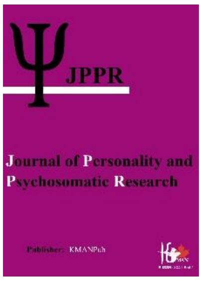

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Components of Body–Self Ambiguity in Dermatology Patients: A Qualitative Study

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ABSTRACT

This study aimed to explore the lived experiences and psychological components of body–self ambiguity among patients with chronic dermatological conditions, focusing on how individuals interpret, negotiate, and reconstruct the meaning of their altered embodiment. This qualitative phenomenological study was conducted with 16 dermatology patients (9 women and 7 men) from clinical centers in Tehran between March and August 2025. Participants were selected through purposive sampling to ensure variation in age, gender, diagnosis, and illness duration. Data were collected using semi-structured, in-depth interviews that invited participants to describe their personal experiences of body–self disconnection and social perception. Interviews were recorded, transcribed verbatim, and analyzed through Braun and Clarke's six-phase thematic analysis using NVivo 14 software. Theoretical saturation was achieved after the sixteenth interview. Trustworthiness was ensured through triangulation, member checking, and maintaining an audit trail of analytical decisions. Analysis revealed four overarching themes representing the components of body–self ambiguity in dermatology patients: (1) Fragmented Body Awareness, describing disconnection from one's bodily image and sensory estrangement; (2) Emotional Turbulence in the Self–Body Relationship, involving shame, anxiety, and emotional fatigue in response to visible changes; (3) Social Mirror and External Reflection, capturing stigma, social withdrawal, and the internalization of others' judgments; and (4) Meaning Reconstruction and Adaptation, denoting acceptance, spirituality, and creative self-expression as pathways toward re-integrating body and self. These findings highlight body–self ambiguity as a fluid and multidimensional experience shaped by emotional, social, and cultural contexts. The study concludes that dermatological illness profoundly alters patients' bodily self-concept, evoking fragmentation yet also fostering potential for meaning reconstruction.

Keywords: *Body–self ambiguity; dermatology patients; qualitative study; body image; phenomenology; self-identity; psychological adaptation.*

1. Introduction

The skin, as the most visible and symbolically charged organ of the human body, plays a central role in shaping one's sense of self and identity. When affected by dermatological disorders, it becomes not only a site of biological dysfunction but also a source of profound psychological and social consequences. The intersection between dermatology and self-perception has gained increasing attention in psychosomatic and qualitative health research, as skin conditions often distort body image, influence interpersonal relationships, and challenge individuals' capacity for self-acceptance (Mohammed et al., 2025). Within this context, body–self ambiguity refers to the blurred boundary between how one perceives their physical appearance and how one internally identifies with their body—a concept especially relevant for individuals experiencing chronic or visible skin conditions. This phenomenon extends beyond aesthetic dissatisfaction to encompass existential uncertainty about bodily ownership, identity, and social worth.

Research over the past two decades has demonstrated that dermatological illnesses can trigger complex emotional responses, including anxiety, shame, disgust, and self-alienation (Rees & Arnold, 2024). Qualitative explorations of women with vulval dermatoses, for instance, have shown that skin conditions can evoke secrecy, social withdrawal, and identity loss as sufferers negotiate the stigma associated with intimate bodily differences (Rees & Arnold, 2024; Rivera et al., 2022). These experiences are not confined to genital or localized diseases; they appear across diverse dermatological populations, revealing that skin-related changes often erode the coherence of the bodily self. Patients frequently describe their skin as "betraying" them or as an external barrier that no longer aligns with their inner self. The existential discomfort stemming from these experiences underscores the need to examine how patients make sense of their altered embodiment rather than merely documenting symptom severity or treatment outcomes (Pascual et al., 2023).

The psychological burden of dermatological disorders is multidimensional, encompassing both intrapsychic and social factors. Studies consistently report high rates of depression, anxiety, and body dysmorphic tendencies among dermatology patients (Muzaffar et al., 2024; Shuhayb et al., 2023; Tros et al., 2023). In acne, psoriasis, and eczema, patients' preoccupation with appearance may lead to persistent dissatisfaction even after successful medical treatment (Costeris et al., 2021a). Such conditions blur the boundary between visible illness and perceived defect, producing what has been termed body–self discordance—a mismatch between one's internal sense of wholeness and external embodiment. Dermatological patients may experience this discordance as fragmentation, where the skin ceases to represent the self but becomes an alien surface to be managed or hidden (Ezzedine et al., 2022). Consequently, dermatology transcends biomedicine to engage with questions of identity, meaning, and social belonging.

From a psychosocial perspective, stigmatization constitutes one of the most persistent consequences of visible skin disease. Patients with chronic plaque psoriasis, for instance, have described feelings of contamination, rejection, and shame as central to their daily interactions (Jankowiak et al., 2020). Stigma is reinforced not only through public attitudes but also through self-internalization, as individuals begin to perceive themselves as "less worthy" or "unattractive." This process has been quantitatively captured through instruments such as the Patient Unique Stigmatization Holistic Tool in Dermatology (PUSH-D), which assesses the multifaceted experience of social discredit (Ezzedine et al., 2022). Yet, while such tools provide valuable measurement, they cannot fully capture the lived meanings of stigma and self-perception. Qualitative inquiry is therefore essential to articulate the subjective narratives that underlie quantitative indicators, particularly in relation to emotional ambivalence and identity reconstruction.

The link between dermatological disorders and mental health is reciprocal. Skin disease can trigger emotional distress, while psychological stress may exacerbate dermatological symptoms through neuroendocrine pathways (Aperi & Koliouli, 2021). For example, research during the COVID-19 pandemic demonstrated that heightened stress levels correlated with worsened skin symptoms and diminished body satisfaction among young adults (Aperi & Koliouli, 2021). Similarly, low self-esteem has been shown to shape preferences for cosmetic dermatology procedures, as individuals seek external interventions to restore internal equilibrium (Almudimeegh et al., 2025). These findings suggest that the body's surface functions as both a biological and symbolic site where personal worth and social identity are negotiated. The intertwining of emotional regulation, body image, and skin health underscores the importance of an integrated biopsychosocial understanding of dermatological experiences.

Despite increasing recognition of psychosocial dimensions in dermatology, patients' subjective meanings of their bodily experiences remain underexplored. Most existing studies have emphasized psychopathology—such as depression, anxiety, or body dysmorphic disorder—rather than the phenomenology of body-self integration or ambiguity (Anaba et al., 2021; Tros et al., 2023). However, dermatology patients often describe ambivalent relationships with their bodies: simultaneously alienated from and hyper-attuned to their skin. This ambivalence resonates with broader concepts in embodiment theory, which posit that the body is not merely an object of perception but the very medium through which one experiences the world. When skin disease disrupts this mediation, individuals may experience the body as both familiar and estranged. Understanding this duality is essential to improving therapeutic communication and fostering empathy in dermatologic care (El-Banna et al., 2024).

Sociocultural and religious factors further complicate body–self dynamics. For example, cultural ideals of beauty, modesty, and purity can intensify shame and secrecy surrounding skin disease, particularly among women in conservative societies (El-Banna et al., 2024). Muslim patients, for instance, have reported ambivalence toward dermatology care that conflicts with spiritual values of modesty and bodily sanctity (El-Banna et al., 2024). Similarly, qualitative reports of patients with inflammatory vulvar dermatoses revealed that cultural taboos surrounding genital discussion amplified feelings of alienation and isolation (Rivera et al., 2022). These findings highlight that body–self ambiguity is not solely intrapsychic but is also embedded in sociocultural discourses about the body, purity, and visibility. The present study therefore situates dermatological embodiment within broader moral and cultural contexts that shape self-perception and identity negotiation.

Body image disturbance remains a pivotal construct in dermatology research. Systematic reviews of patient-reported outcome measures (PROMs) for body image have revealed that many instruments fail to capture the emotional complexity and relational aspects of appearance distress (Jk et al., 2022). While quantitative data offer generalizable patterns, qualitative studies illuminate the nuances of subjective experience—how patients narrate the changing boundaries between self and skin, visibility and concealment, acceptance and rejection. For instance, individuals living with chronic eczema or psoriasis often describe the paradox of wanting to be seen and not seen simultaneously: desiring recognition yet fearing scrutiny (Porter et al., 2024). This paradox epitomizes body–self ambiguity, where the self's relationship with its visible exterior oscillates between connection and disconnection. Such ambiguity can be emotionally exhausting but also transformative, prompting individuals to reconstruct meanings of beauty, normalcy, and authenticity.

Emerging scholarship also emphasizes the therapeutic potential of narrative and expressive interventions. Adkins and colleagues demonstrated that an online writing intervention significantly improved positive body image among dermatology patients, suggesting that reflective meaning-making can restore coherence between the body and the self (Adkins et al., 2022). Similarly, artistic and creative engagements—such as using visual arts to reinterpret scars and lesions—have been shown to reframe aesthetic deficits as sources of personal and cultural expression (Mohammed et al., 2025). These approaches align with broader psychosocial care models that view healing as a process of narrative integration rather than mere symptom management. Through storytelling, patients can re-author their bodily experiences and transform alienation into acceptance.

At the population level, the prevalence and psychosocial burden of dermatological diseases are substantial. Studies among undergraduates and general clinical populations indicate that even non-chronic skin conditions can significantly reduce quality of life, lower self-confidence, and impair social functioning (Abeyrathna et al., 2023). Quality of life assessments conducted among patients and healthcare providers further reveal discrepancies between perceived and actual psychosocial impact (Kowalewska et al., 2020). Such findings affirm that the visibility of the skin amplifies emotional distress by making private suffering publicly legible. As a result, dermatology patients often engage in self-medication or excessive treatment-seeking as attempts to regain control over the uncontrollable surface of the body (Anaba et al., 2021). These compensatory behaviors, however, can intensify dependence on external validation and reinforce feelings of inadequacy (Costeris et al., 2021b). Thus, understanding the subjective mechanisms underlying these patterns—especially the ambiguity between healing and self-erasure—is crucial for designing holistic interventions.

Recent mixed-methods and qualitative investigations have highlighted that dermatology patients' lived experiences are characterized by overlapping themes of fear, uncertainty, and the desire for normalcy (Porter et al., 2024; Soto-Moreno et al., 2023). In acute dermatologic emergencies, patients describe intense concern about disfigurement and loss of control (Soto-Moreno et al., 2023), whereas those with chronic disorders recount long-term adaptation and identity renegotiation. Across these contexts, ambiguity emerges as both a stressor and a coping mechanism—an unresolved tension between rejection of and reconciliation with the body. This dialectical process mirrors what existential health theorists describe as embodied ambivalence, where the body functions simultaneously as subject and object. Exploring this dialectic through qualitative inquiry allows researchers to grasp not only the symptoms but also the symbolic meanings patients attribute to their skin and their sense of self.

Given this background, the present qualitative study aims to explore the components of body–self ambiguity in patients living with dermatological disorders in Tehran.

2. Methods and Materials

2.1. *Study Design and Participants*

This study employed a qualitative research design with a phenomenological approach to explore the lived experiences and subjective perceptions of body–self ambiguity among dermatology patients. The phenomenological method was chosen to gain a deep understanding of how individuals with visible skin conditions experience and interpret their bodily self-concept in daily life.

The study was conducted in Tehran between March and August 2025. Participants were selected through purposive sampling from dermatology clinics and hospital outpatient units, ensuring maximum variation in terms of age, gender, diagnosis type, and illness duration. Inclusion criteria consisted of being diagnosed with a chronic dermatological condition (such as psoriasis, vitiligo, or eczema), being at least 18 years old, having no severe psychiatric disorders or communication impairments, and being willing to share personal experiences.

A total of 16 participants were interviewed. Theoretical saturation was achieved after the 16th interview when no new themes or insights emerged from the data. The sample included 9 women and 7 men, aged between 22 and 54 years.

2.2. *Measures*

Data were collected using in-depth, semi-structured interviews, allowing participants to describe their experiences freely while enabling the researcher to probe relevant dimensions of body–self ambiguity. Each interview began with general open-ended questions such as:

- “Can you describe how your skin condition has affected how you see your body?”
- “In what ways has your relationship with your body changed since your diagnosis?”
- “How do you think your skin condition has influenced your sense of self or identity?”

Based on participants’ responses, follow-up questions were posed to deepen understanding and clarify meanings. Each interview lasted between 45 and 75 minutes and was conducted in a private, quiet room at the dermatology clinic or the participant’s home, depending on preference. All interviews were audio-recorded with participants’ permission and transcribed verbatim immediately afterward. Field notes were also taken to capture nonverbal cues and contextual observations. To ensure trustworthiness, member checking was used by sharing preliminary interpretations with participants for validation and feedback.

2.3. *Data Analysis*

Data analysis was performed concurrently with data collection, following the thematic analysis framework outlined by Braun and Clarke (2006). NVivo 14 software was used to manage, code, and categorize the qualitative data systematically. The analysis proceeded through six steps: (1) familiarization with the data through repeated reading of transcripts, (2) generation of initial codes representing key phrases and meanings, (3) searching for patterns among codes to develop subthemes, (4) reviewing and refining themes, (5) defining and naming the final themes, and (6) producing a coherent narrative linking themes to the broader research questions.

Credibility and trustworthiness were ensured using several strategies: triangulation of researchers’ interpretations, peer debriefing, and maintaining an audit trail of analytic decisions. Dependability was reinforced through continuous comparison of emerging categories, while confirmability was supported by documenting all analytical steps and reflective memos. Transferability was enhanced by providing rich, thick descriptions of the participants’ experiences and the study context.

3. Findings and Results

The study included 16 participants (9 women and 7 men) from dermatology clinics and outpatient centers in Tehran.

Participants' ages ranged from 22 to 54 years, with a mean age of approximately 36 years. In terms of dermatological diagnosis, 5 participants (31%) had psoriasis, 4 (25%) had vitiligo, 3 (19%) had chronic eczema, 2 (12%) had acne-related scarring, and 2 (12%) were diagnosed with rosacea. The duration of illness varied from 2 to 18 years, with an average duration of about 9 years. Regarding marital status, 10 participants (63%) were married, 5 (31%) were single, and 1 (6%) was divorced. Educational levels ranged from high school diploma to postgraduate degree, with 6 participants (38%) holding a bachelor's degree and 4 (25%) holding postgraduate qualifications. Most participants (11 out of 16, or 69%) were employed, while the remainder were students or homemakers.

Table 1

Categories, Subcategories, and Concepts of Body–Self Ambiguity in Dermatology Patients

Category (Main Theme)	Subcategory	Concepts (Open Codes)
1. Fragmented Body Awareness	Altered body image	Feeling detached from one's body; comparing with pre-illness appearance; seeing skin as "foreign"; dissatisfaction with reflection
	Sensory dissonance	Itching and burning disrupting self-perception; hypersensitivity to touch; discomfort with texture changes; body parts feeling "alien"
	Loss of bodily integrity	Seeing the body as incomplete; sense of "holes" or scars disrupting wholeness; emotional rejection of affected areas
	Physical self-monitoring	Repeated checking of skin; obsession with minor changes; fear of spreading lesions; mirror avoidance
	Conflict between inside and outside	Feeling healthy internally but disfigured externally; body not representing true self; internal–external mismatch
	Identity confusion through appearance	Being mistaken for contagious; social labeling; feeling one's identity reduced to the skin condition
	Reconstruction of bodily meaning	Seeking acceptance through therapy; redefining beauty standards; using spiritual or symbolic interpretations of the body
2. Emotional Turbulence in Self–Body Relationship	Shame and embarrassment	Avoidance of eye contact; fear of exposure; internalized stigma; self-blame for condition
	Anxiety and uncertainty	Worry about future flare-ups; unpredictability of symptoms; anxiety before social events; loss of confidence
	Anger and resentment	Frustration toward medical inefficacy; resentment toward social judgment; anger at "unfair" body
	Emotional detachment	Suppression of feelings; numbness toward bodily sensations; emotional distancing to cope
	Search for self-compassion	Practicing self-forgiveness; accepting imperfections; emotional reconciliation with body
	Psychological fatigue	Exhaustion from continuous care; mental depletion from treatments; burnout from hiding appearance
3. Social Mirror and External Reflection	Social withdrawal	Avoiding social gatherings; fear of ridicule; reduced participation in public life
	Interpersonal misunderstanding	People assuming contagion; receiving unsolicited advice; others' discomfort during touch
	Role limitation	Avoiding romantic intimacy; reduced job opportunities; disruption in family and social roles
	Negotiating disclosure	Deciding whom to tell; hiding versus sharing diagnosis; balancing honesty with privacy
	Social comparison	Comparing to people with "perfect skin"; envy toward unaffected peers; feelings of inferiority
	Stigma internalization	Believing others' negative judgments; self-imposed isolation; linking self-worth to appearance
4. Meaning Reconstruction and Adaptation	Coping through spirituality	Viewing illness as divine test; faith-based endurance; finding peace in prayer and patience
	Redefining self-identity	Shifting focus from physical to inner qualities; self-identification with strength and survival
	Acceptance and resilience	Embracing imperfection; adapting daily routines; emotional growth through acceptance
	Seeking professional and peer support	Turning to therapy groups; finding solidarity among patients; valuing empathetic communication
	Creative self-expression	Using art, writing, or fashion to reclaim body image; transforming scars into identity symbols
	Reclaiming control	Developing proactive care routines; gaining knowledge about skin health; asserting agency over treatment choices

The first major theme, *Fragmented Body Awareness*, captured participants' disrupted sense of physical wholeness and the altered ways in which they perceived and interacted with their bodies. Many participants described feeling detached from their bodily appearance, expressing that their reflection no longer represented who they truly were. One participant shared, *"I look in the mirror and don't recognize myself anymore; it feels like my skin belongs to someone else."* Such descriptions reflected the subtheme of altered body image, in which visible lesions and scars symbolized a break between body and identity. Within sensory dissonance, participants noted that sensations such as itching, burning, or tightness heightened their awareness of their bodies as uncomfortable objects. They frequently used metaphors such as *"It's like my body is shouting at me all the time"* or *"My skin feels foreign under my own hands."* The subtheme loss of bodily integrity emerged when individuals perceived the affected body as incomplete or "broken," with one remarking, *"I feel like parts of me have been cut away, not physically but in how I see myself."* Under physical self-monitoring, participants described cycles of obsessive checking, mirror avoidance, and fear of deterioration, reflecting the mental occupation their skin commanded. Meanwhile, conflict between inside and outside illustrated their struggle to reconcile feeling healthy internally while appearing visibly unwell to others. One respondent explained, *"Inside I'm fine, but people look at my face and think I'm sick."* Finally, some participants reported efforts toward reconstruction of bodily meaning, attempting to reframe their experience through self-acceptance and spiritual understanding, often saying that the condition "taught them humility" or helped them "see beauty differently." Collectively, these accounts portray a deeply divided bodily experience in which the skin ceased to be a neutral boundary and became a contested space between identity, visibility, and control.

The second major theme, *Emotional Turbulence in Self–Body Relationship*, encompassed the complex emotions dermatology patients experienced in relation to their physical selves. Participants' narratives revealed a recurrent struggle with shame and embarrassment, particularly when skin symptoms were visible to others. Many avoided public spaces, reporting statements like, *"I stopped going swimming because I couldn't stand the looks."* This emotional distress often intertwined with anxiety and uncertainty, as the unpredictability of flare-ups generated fear of social rejection. One participant said, *"Every morning I wake up scared to see what new patch has appeared."* Feelings of anger and resentment also surfaced, directed both toward the body ("Why is my body betraying me?") and toward external systems such as medical institutions perceived as ineffective. Others expressed emotional detachment, describing attempts to "turn off" feelings to endure daily life, while a few gradually developed self-compassion, engaging in reflective practices such as journaling or meditation to rebuild emotional acceptance. Participants reported psychological fatigue from chronic self-consciousness and relentless care routines. As one explained, *"It's exhausting to always hide, always explain, always pretend you're okay."* Overall, this theme reflected a dynamic oscillation between rejection and reconciliation of the body—a cycle of emotional turbulence where negative affect coexisted with emerging resilience.

The third theme, *Social Mirror and External Reflection*, demonstrated how participants' experiences of body–self ambiguity were shaped through social interactions and perceived judgments from others. The subtheme social withdrawal was pervasive; individuals described reducing their participation in gatherings and avoiding close contact. A 29-year-old woman recounted, *"I used to love parties, but now I find excuses not to go. I can't stand being stared at."* Interpersonal misunderstanding further contributed to alienation, as people often assumed contagion or offered unsolicited remedies, making participants feel objectified. One participant said, *"People ask if it's contagious before asking how I feel."* Role limitation emerged when skin conditions interfered with social and occupational roles; some avoided intimacy or job interviews due to fear of judgment. The subtheme negotiating disclosure showed the careful balance between concealment and honesty, with participants debating whom to inform about their condition. As one noted, *"I tell close friends, but not my boss—I don't want pity."* Social comparison was another recurring thread; many participants reported constant comparisons to those with unblemished skin, describing envy and self-consciousness. Finally, stigma internalization reflected how external judgment was absorbed into self-concept: *"After a while, you start believing you're less than others."* Through these accounts, the body became not just a personal experience but a social mirror—where self-perception was constructed and reconstructed through the eyes of others, often reinforcing feelings of invisibility and devaluation.

The final theme, *Meaning Reconstruction and Adaptation*, captured participants' efforts to reinterpret their experiences, reclaim agency, and restore a coherent sense of self. Within coping through spirituality, individuals reframed illness as a divine test or opportunity for personal growth. One participant reflected, *"Maybe God gave me this so I'd learn patience and empathy."* Others engaged in redefining self-identity, shifting attention from physical imperfections toward inner values and achievements: *"My skin is just a part of me; I'm more than what people see."* The subtheme acceptance and resilience represented a pivotal turning point, as participants described finding peace through acceptance and developing adaptive routines. Seeking professional and peer support provided emotional grounding, with patients emphasizing the importance of empathetic therapists and peer networks who "understood without judging." Some discovered creative self-expression—using art, writing, or fashion—to reclaim aesthetic control, transforming their scars into symbols of survival: *"I started designing clothes that show my skin instead of hiding it."* Finally, reclaiming control involved active health management, such as researching treatments, adopting lifestyle changes, and asserting decision-making in clinical settings. These experiences signified a gradual shift from loss to empowerment, suggesting that meaning reconstruction enabled participants to integrate their altered bodies into a renewed and more compassionate self-concept.

4. Discussion and Conclusion

The present study explored the lived experiences of dermatology patients to identify the components of body–self ambiguity, a concept denoting the uncertainty and conflict individuals feel toward their bodies when living with visible skin conditions. Through thematic analysis of interviews with 16 participants, four interrelated categories emerged: fragmented body awareness, emotional turbulence in the self–body relationship, social mirror and external reflection, and meaning reconstruction and adaptation. These findings illuminate the multidimensional nature of dermatological suffering—encompassing sensory, emotional, social, and existential dimensions—and align with a growing body of evidence demonstrating that dermatological disorders profoundly affect patients' psychological and relational worlds.

The first theme, fragmented body awareness, revealed that participants often experienced their skin as alien or detached from their identity. This fragmentation manifested in sensations of estrangement, dissatisfaction with appearance, and constant vigilance toward bodily changes. These results resonate with previous findings that dermatological illnesses disrupt the coherence of bodily perception, leading to an altered sense of self (Rees & Arnold, 2024). The participants' descriptions of their skin as "foreign" or "betraying" mirror the phenomenological experiences observed in chronic psoriasis and eczema, where patients feel disconnected from their physical image and regard their skin as an untrustworthy mediator of social existence (Jankowiak et al., 2020). Similar to the qualitative accounts of women with vulval dermatoses, this detachment also reflects the internalization of shame and secrecy as protective mechanisms against stigmatization (Rivera et al., 2022). Such embodied fragmentation underscores how dermatological disease extends beyond surface pathology to disturb the fundamental unity of selfhood and embodiment.

Moreover, the participants' preoccupation with physical self-monitoring—checking lesions, avoiding mirrors, or fixating on scars—corresponds with the body dysmorphic tendencies identified among dermatology outpatients (Shuhayb et al., 2023; Tros et al., 2023). These studies demonstrate that hypervigilance toward bodily defects can evolve into obsessive checking behaviors, reinforcing self-alienation and anxiety. Our findings support the notion that the perception of the skin as a site of constant scrutiny transforms it into an externalized object rather than an integrated part of the self. As Costeris and colleagues have shown, even after medical treatment, patients may remain dissatisfied and continue seeking additional procedures, reflecting the persistence of psychological incongruence (Costeris et al., 2021a). This continuity between medical improvement and ongoing emotional dissonance suggests that body–self ambiguity is sustained by internal cognitive-emotional patterns rather than the visible severity of the condition.

The second theme, emotional turbulence in the self–body relationship, demonstrated that living with a chronic skin condition generates persistent emotional instability characterized by shame, anxiety, anger, and fatigue. The participants' oscillation between disgust toward their appearance and compassion for their body reflects what Rees and Arnold describe as "emotional secrecy," where patients conceal distress to preserve dignity while inwardly battling loss of bodily trust (Rees & Arnold, 2024). Feelings of shame and fear of exposure were especially pronounced among women, consistent with prior findings that gendered social expectations exacerbate psychological distress in dermatological contexts (El-Banna et al., 2024). Muslim patients in particular have reported ambivalence toward dermatology care due to modesty norms and spiritual interpretations of bodily suffering (El-Banna et al., 2024), echoing our participants' efforts to ascribe moral or spiritual meaning to their condition.

These emotional reactions are not merely consequences of visible disfigurement but are shaped by broader social scripts about beauty, purity, and normality. In our data, participants expressed resentment toward medical inefficacy and exhaustion from prolonged treatment cycles—a pattern also described in mixed-methods studies on atopic dermatitis, where patients link therapeutic fatigue to feelings of emotional depletion (Porter et al., 2024). Similarly, the overlap between anger, anxiety, and self-blame parallels findings among acne patients, where low self-esteem mediates the relationship between visible lesions and psychological distress (Almudimeegh et al., 2025). Such patterns affirm that dermatological illness functions as both a medical and emotional challenge, necessitating integrated psychosocial approaches rather than narrowly clinical interventions.

The third theme, social mirror and external reflection, highlights how self-perception in dermatology patients is constructed through social feedback. The majority of participants reported avoidance of social settings, fear of ridicule, and misinterpretation by others. These experiences reflect the stigmatization mechanisms described in previous research, where psoriasis and other visible conditions elicit perceived contagion and social rejection (Jankowiak et al., 2020). Quantitative studies measuring quality of life among patients and nurses confirm that social judgment significantly diminishes self-worth and well-being (Kowalewska et al., 2020). However, our qualitative findings extend this understanding by demonstrating how external stigma becomes internalized as a moral evaluation of self. Patients not only anticipate negative judgment but also come to view their body as evidence of personal failure. This internalization aligns with the psychosocial burden documented among undergraduates with dermatological complaints, who report self-isolation and diminished confidence even in mild cases (Abeyrathna et al., 2023).

In addition, the participants' negotiation of disclosure—deciding when and to whom to reveal their condition—reflects the relational dynamics of concealment described in research on inflammatory dermatoses (Rivera et al., 2022). Concealment serves as both protection and prison: while it safeguards against public shame, it also intensifies feelings of loneliness and inauthenticity. Such ambivalence embodies the paradox of body–self ambiguity—a simultaneous desire to be seen and to remain invisible. Similar paradoxes were reported in qualitative studies of dermatologic emergencies, where patients struggled with both the need for care and the fear of exposure (Soto-Moreno et al., 2023). Our findings further support the view that dermatology patients inhabit a social liminality, caught between visibility and invisibility, belonging and exclusion.

The final theme, meaning reconstruction and adaptation, captures patients' efforts to reestablish coherence between body and self through acceptance, spirituality, and creativity. The narratives revealed that recovery is not limited to symptom reduction but involves the redefinition of self-identity and aesthetic values. This echoes prior observations that body image improvement can occur through cognitive reframing and expressive interventions. Adkins and colleagues demonstrated that narrative writing interventions foster self-compassion and positive embodiment among dermatology patients (Adkins et al., 2022). Likewise, our participants described journaling, art, and fashion as mediums for reclaiming control and transforming scars into symbols of resilience. These processes parallel findings in research on the intersection between dermatology and visual arts, where creative expression recontextualizes the skin as a canvas of meaning rather than a site of shame (Mohammed et al., 2025).

Spiritual coping also played a salient role in our participants' adaptation. Viewing illness as a divine test or a path to personal growth reflects the transcendental meaning-making processes identified in psychosocial studies of chronic illness. This aligns with prior research suggesting that spirituality moderates distress by framing the body as an instrument of moral and emotional learning rather than a mere source of aesthetic judgment (Anaba et al., 2021). Similarly, psychological models of resilience emphasize that reconstructing meaning facilitates the restoration of agency and self-acceptance, a process supported by both peer interaction and professional therapy (Costeris et al., 2021b). These findings collectively reinforce that adaptation to dermatological illness requires narrative and existential reconstruction—redefining the relationship between the individual and the skin through symbolic integration, empathy, and creativity.

Overall, the current study contributes to a growing corpus of qualitative dermatology research emphasizing the interdependence of body, self, and society. The themes identified here complement prior reviews that call for integrating subjective, relational, and cultural dimensions into dermatological care (Bazen et al., 2021; Pascual et al., 2023). Whereas quantitative measures such as the PUSH-D scale (Ezzedine et al., 2022) capture stigma in numerical terms, qualitative approaches reveal the nuanced emotional and existential textures of living in a visible body. Furthermore, our findings affirm the clinical observations that patients' desire for treatment often exceeds medical necessity, reflecting internalized social pressures and unresolved self-discrepancy (Costeris et al., 2021a). Taken together, these results underscore the need for dermatologists to adopt a biopsychosocial-experiential framework that addresses not only skin lesions but also the symbolic and emotional narratives inscribed upon the body.

Despite its contributions, this study has several limitations that should be acknowledged. First, as a qualitative study based on 16 participants in Tehran, the findings are not statistically generalizable to broader populations. The sample was diverse in age, gender, and diagnosis, but all participants were recruited from urban clinical settings; therefore, rural or non-clinical populations may have different perceptions of body–self relationships. Second, the study relied on self-reported data obtained through semi-structured interviews, which may be influenced by social desirability bias or retrospective interpretation. Participants' willingness to discuss intimate feelings about their bodies may have varied according to cultural and personal factors. Third, while theoretical saturation was achieved, the phenomenological focus limited the exploration of other relevant psychosocial constructs such as coping styles, health literacy, or family dynamics. Finally, translation of participants' nuanced expressions into coded themes may have resulted in some loss of linguistic and emotional subtlety, despite rigorous use of NVivo 14 and researcher triangulation.

Future studies could expand on these findings by incorporating cross-cultural comparisons to examine how cultural norms and religious beliefs influence body–self ambiguity in dermatology patients. Quantitative validation of the identified themes could be pursued through the development of standardized scales assessing body–self integration or ambiguity in dermatological contexts. Longitudinal qualitative designs might also capture the evolution of self-perception before, during, and after medical interventions, providing insight into adaptive trajectories over time. Additionally, interdisciplinary collaboration between dermatology, psychology, and art therapy could help explore the role of creative expression in healing body–self fragmentation. Investigating how digital and online support communities shape self-perception may also enrich understanding of modern coping mechanisms in dermatological populations.

Clinicians and mental health professionals should approach dermatology patients with an awareness of the emotional and existential dimensions of skin disease. Therapeutic encounters should encourage open dialogue about patients' feelings of shame, alienation, and identity conflict, rather than focusing solely on physical symptoms. Integrating psychoeducation, narrative writing, and creative arts interventions into dermatologic care can foster body acceptance and self-coherence. Collaboration between dermatologists and psychologists is essential to address both the biological and psychosocial needs of patients. Ultimately, adopting an empathetic, holistic, and patient-centered approach may help individuals transform their experiences of bodily ambiguity into opportunities for self-discovery and emotional growth.

Authors' Contributions

Authors contributed equally to this article.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

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Ethics Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

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