

**“Disease, illness, affliction? Don't know”: Ambivalence and ambiguity in the narratives of young people about having acne**

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**Abstract**

The popular characterisation of acne as a mundane and insignificant feature of adolescence sits at odds with academic studies showing the detrimental impacts of the condition on people of various ages. Drawing from in-depth qualitative interviews with 13-25 year olds living in England, this paper will consider some of the tensions between two messages about acne through the ambiguities in young people's narratives. Consistent with existing literature on skin conditions and visual differences more broadly, participants in the study recounted ways in which acne negatively shaped their lives socially and emotionally. However, there were topics around which participants' accounts held nuances and complications, in relation to: understandings held about acne causes; uncertainty as to whether acne was a medical concern/problem; and comparisons to other people's acne or broader health experiences. In attending to these aspects, the paper will explore how different and potentially conflicting meanings are negotiated by young people, producing ambiguous and ambivalent experiential accounts about living with acne.

**Keywords:** acne; narratives; adolescence; appearance; stigma.

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## **Introduction**

Acne is closely associated with adolescence – a link underpinned by physiological frameworks in which changes related to puberty are expected at this age. The notion that 'teenagers have acne' features in the popular social imaginary as a truism and, as such, one which is largely deemed mundane and unworthy of further consideration. Yet a number of studies have evidenced that having a skin condition—including acne as well as eczema and psoriasis—can detrimentally impact confidence and self-esteem (e.g. Jowett and Ryan, 1985; Lowe, 1993; Cotterill and Cunliffe, 1997; Gupta and Gupta, 1998; Mallon *et al*, 1999; Aktan *et al*, 2000; Hawkesworth, 2001; Murray and Rhodes, 2005; Fox *et al*, 2007; Golics *et al*, 2009; Magin, 2013), affecting domains of life such as employment (Cunliffe, 1986) and relationships with family, friends and partners (Murray and Rhodes, 2005; Basra and Finlay, 2007; Griffiths *et al*, 2011). Many studies on the impact of skin conditions have focused predominantly on adults or used parental proxies for children affected. The lived experiences of teenagers and young people with acne have seldom been heard in the academic literature, with some notable exceptions (e.g. Prior and Khadaroo, 2015; Griffiths *et al*, 2011). This is an important omission since asking young people about their experiences with acne may reveal topics and impacts on their lives which have otherwise been overlooked, underestimated or distorted. Subsequently, further qualitative studies on young people's experiences are needed to more fully understand what it is like having acne at this age and ensure that concerns of this heterogeneous group are adequately acknowledged.

A useful framework informing the present paper is the social disability perspective used by Hawkesworth (2001), positing that it is not necessarily acne itself which detrimentally impacts people's lives but rather the effects of lowered self-esteem, body image and confidence. In addition, there is not always a neat correspondence between objective assessments (how many acne spots are visible and the extent of body coverage) and subjective evaluation (how severe a person feels their acne is) or lived experience (how much impact having acne has on the person's life). A person with clinically-assessed 'mild acne' may feel it has a profound negative impact on their sense of identity and confidence, leading potentially to avoidance or heightened anxiety of social activities. The focus here on the emotional and social impacts of acne is not intended to discount the physical pain that can be experienced, such as from cystic spots and broken skin, but instead aims to highlight the powerful effects of fearing and internalising negative judgement from others, both anticipated and actualised. Indeed, there is quantitative evidence to

suggest that these concerns about discrimination are valid, rather than purely self-held, and that people with acne are viewed more negatively by others (Timms, 2013; Ritvo *et al*, 2011). In Timms' (2013) study, participants evaluated photographs of individuals with prosthetic make-up resembling moderate acne, rating them as less mature, less attractive and less likely to be a 'potential friend' than the clear skin counterpart images of the same individuals.

In light of the academic research on the impact of skin conditions, there have been calls for medical professionals to be more aware of possible social and emotional effects for acne patients and, subsequently, to provide appropriate 'psychosocial' support (Smithard *et al*, 2001). In addition, some charities and campaigns are attempting to address discrimination and misconceptions about bodily appearance in the wider context. For example, the charity *Changing Faces* challenges the negative attitudes and treatment towards people with different visible appearance, including those pertaining to skin conditions such as acne (Changing Faces, 2014). Young people have been the focus of 'body positive' organisations such as *Body Gossip* who have a popular online social media presence and have been delivering their own education programme in UK secondary schools since 2008 (Body Gossip, 2017). These initiatives highlight that more understanding and support for people coping with appearance-affecting conditions is pertinent to medical professionals as well as other key actors—such as family members, peers, school teachers and employers—and the general public. Recognition of the socio-emotional impacts of skin conditions may be especially salient for young people, who are often considered to be at a formative stage with developing independence and heightened importance attached to their appearances and identities. Yet this is also somewhat in tension with assumptions that acne is 'just a normal part of being a teenager' and the presence of 'spots' is often seen as a source of trivialisation and/or humour by unaffected others.

Drawing on in-depth qualitative interviews conducted with 25 participants aged 13-25 and living in England, this paper explores how young people narrate about having acne. The paper considers how young people negotiate between these two discourses: that having acne impacts substantially on people's lives *and* that acne for young people is normal, trivial and non-problematic. To address this topic, the paper attends in three sections to the ways young people: navigate connotations and understandings about acne causes; position or refute their acne as a medical concern/problem; and utilise comparisons to others peoples' skins and health experiences. Through these themes, the paper both supports the overall findings from existing academic literature—that there are significant social and emotional impacts of having acne—and explore the nuances and contradictions which complicate the picture

for young people in the study, resulting in more ambiguous and fragmentary narratives than those typically represented. Like the skin itself, the complexity of narratives come into focus as we look closer to reveal features such as 'wrinkles' and 'layers' rather than uniform smoothness.

## **Method**

The empirical material in this paper is from a wider study which aimed to explore the information and support needs of young people with four relatively common skin conditions (acne, eczema, psoriasis, alopecia). A total of 97 qualitative interviews were conducted with 13-25 year olds in England who volunteered to share their experiences of having these skin conditions, with 25 of the interviews primarily about acne. A key output of the study was the production of four condition-specific sections on Healthtalk.org, a multi-media resource for patients, the public, healthcare professionals and policy makers. The study was approved by Berkshire NRES Committee South Central and funded by National Institute for Health Research under its Research for Patient Benefit scheme (PB-PG-0213-30006).

A sampling matrix was used in recruitment to seek a maximum variation sample (Coyne, 1997) including a range of demographic factors and contexts likely to impact on young people's experiences of skin conditions. Of the acne interviews, this included aspects such as: gender (18 women; 7 men), age range (13-25 years; median and mode average age of 20), ethnicities (16 White British; 4 Chinese; 2 White Greek; 1 White Hungarian; 1 White Dutch; 1 White Other); geographical location; and study/employment status. Interviews provided opportunities to consider additional features, such as self-reported severity and length of time since the onset of acne. These latter aspects were not used as criteria for selectively inviting participants to interview and acne severity was not clinically assessed; however, the sample was varied, covering a spectrum of informally observed severities, and a range of durations of living with acne (from a few months to 13 years). Participants were recruited through: health settings, such as general practice clinics and dermatology departments; patient representative groups (including support organisations and online discussion forums); universities, colleges and schools; and social media platforms such as Facebook and Twitter. All potential participants were given detailed information sheets and opportunities to discuss involvement were reiterated throughout the study. Participants gave written consent and parental or guardian consent was also acquired for those under the age of 16.

The interviews were conducted by the author between October 2014 and December 2015. These took place in the homes of the young people or in

alternative meeting spaces, if preferred by the participant, such as local community centres. Participants could choose to be interviewed alone or with other people present, and whether to be video as well as audio recorded for interview extracts to be published on Healthtalk.org in video, audio and/or written formats. Interviews were semi-structured, with an opening question inviting participants to talk about their experiences. Follow-up questions based on a topic guide were then asked to ensure areas likely to be relevant were raised for discussion.

The author/interviewer has acne scarring and some active acne which, as a condition often fluctuating in severity, was sometimes visible to participants. It is thought that the interviewer's visible acne and/or scarring was a source of rapport in many of the acne interviews, with some participants asking direct questions about the interviewer's personal experience (e.g. treatment history) and the interviewer occasionally using this to broach subtopics. In other situations, however, it is likely that the visibility of the interviewer's acne may have limited what participants felt able to say. For example, the age (late 20s) and gender (female) of the interviewer in combination with the visible acne may have impacted on what some participants with different demographic characteristics said when making comparisons between their own experiences and those of others. Aware of this potential impact, the researcher sought to foster interview exchanges whereby participants were encouraged to speak freely without concern as to whether the comments would be taken as a source of personal offense.

All interviews were audio or video recorded with participant consent and professionally transcribed verbatim for analysis. NVivo software was used to organise the data, with interviews grouped on the basis of the dermatological condition. Some interviews featured data on more than one skin condition and relevant extracts were included in the analyses for the data sets of others. A coding framework was developed based on interview content and relevant literature, and refined throughout the coding process. Coding reports were analysed conceptually by the author using a mind-mapping technique (Ziebland and McPherson, 2006) which allowed links and connections to be made across the data as well as the identification of outlier examples. Repeated questions were asked of the preliminary findings to ensure a robust and iterative engagement with the data. Whilst excerpts are not featured here from all 25 participants interviewed about acne, the findings across the full data set inform the discussion and premise of the paper. Participant names have been replaced with pseudonyms.

### **Differences and ambiguities**

Many participants spoke about acne as a common and very visible feature of 'being a teenager'. For some, acne in adolescence had not necessarily or immediately been seen as a concern and instead it could be a welcome sign of 'growing up'. Alice (aged 25, female) was glad when she first developed spots at age 12/13 because she wanted to "get it out the way now" rather than later in her teenage years, though this view changed as her acne endured over time. Gary (aged 15, male) saw having spots as an inevitable part of adolescence: "I didn't like it, like it made me self-conscious, acne, and I'd rather I didn't have them. But I did see it as, you know, the thing that most teenagers get. So I was kind of cool with it." Whilst Gary viewed acne as something "you can't really avoid", his comments also suggested that the prevalence of acne amongst teenagers does not mean it is a fully-accepted, 'stress-free' (non)experience. For example, having acne profoundly affected Poppy's (aged 19, female) feelings about herself and social interactions: "I don't really want to make new friends because I don't want them to see me, the most ugly me [...] So it kind of holds me back to communicate with others and sometimes I feel quite lonely". Even participants who characterised themselves as largely unaffected by having acne could think of some instances when it had made an unwanted difference for them. As Kate (aged 22, female) explained, "every so often there are days where I feel a bit blue about it and regardless of how much I say that it doesn't really bother me that much, I do without fail find myself putting on make-up when I leave the house". Indeed, all of the young people in the study identified at least one aspect of their lives which they felt had been detrimentally impacted by having acne, including their friendships, romantic relationships, family relations, school/university and studies, hobbies, social media use, self-presentation style, finances and employment. Such a finding is consistent with much of the existing literature on having skin conditions and/or visual differences more broadly.

In addition to talking about how acne affected them personally, participants sometimes spoke about the presumed experiences and feelings of other young people with acne. This sometimes served to reinforce the validity of shared concerns (*our* experiences) or it could distance and differentiate the participant from others with acne (*their* experiences but not mine), and both approaches sometimes featured at different points in the same interview. In the following example, Alex (aged 14, male) contrasted his own feelings about acne with those he presumed were held by other people his age: "it doesn't bother me. I wouldn't mind if someone commented on me having spots but I suppose for other people it must be quite harmful and it must bother them quite a lot". At

other points in the interview, it was ambiguous as to whose experience Alex was referring to – that of his own, of others or both:

Hanging out with girls makes it quite awkward sometimes, having spots it changes your image, how people see you in that sort of sense. [...] It kind of does make you a bit more anxious or makes you think how they might be judging you and you kind of lose a lot of confidence talking to people while you have acne because it ruins your image to other people.

As these examples suggest, participant narratives sometimes invoked different and contradictory messages about the importance (or not) of acne in their lives. On the one hand was the notion of acne as an accepted part of adolescence which does not have major impacts for a young person, and on the other that having acne affected them considerably in emotional and social terms.

### **Understandings held about acne causes: negotiating connotations**

In a simplified account of the medical explanation for acne (Dawson and Dellavalle, 2013), skin follicles become blocked, for example when the sebaceous glands produce more skin oils. This allows for infection by *Propionibacterium acnes*, a type of bacteria which lives on most people's skin, causing inflammation and resulting in 'spots' (papules, pustules, nodules, cysts). There can be different underlying reasons for why these acne processes occur and a key one concerns changes in hormones during puberty. For some interviewees, seeing doctors and gaining medical information such as this helped clarify their understandings about acne. Maria (aged 17, female) explained:

I used to think that eating unhealthily made you have acne, or that you were dirty [if] you had acne. So I used to look things up on the computer. And there was loads of things like 'no, it's not that'. It's just puberty and it's all your hormones and things. And all the GPs kept saying that as well. They were like, "You're young. You're going through-, your hormones are all playing up. So it might just sort itself out."

Maria found it reassuring that her acne was not caused by "anything I was doing wrong", an understanding in which multiple sources of information had aligned. Medical explanations about acne—whether acquired online and/or from seeing medical professionals—could offer young people a way to refute assumptions that something they were doing (or not doing) was to blame for them having the condition.

Understandings about acne could evolve from an early age through a collage of information sources, meaning that medical explanations were not necessarily the only or main influence on young people's views about acne. It

was not always possible for participants to remember when or how they first knew about acne, but some recalled being told as children to expect it as part of puberty or seeing older family members (including siblings) with acne. A growing awareness of acne had not necessarily developed alongside an accurate understanding about causes. Pearl *et al* (1998) found that teenagers typically spoke to friends and family about their acne rather than seek a doctor. In relation to the popularity of online discussion forums, Santer *et al* (2017, p756) warned that the advice shared about acne could be “confusing or inappropriate”. For young people in the present study, the diffused process of learning about acne had often meant encountering prevalent social (mis)understandings and stigmatising connotations. Popular beliefs were sometimes re-presented by study participants during the interviews as given facts, regardless of whether these were supported in the medical literature.

There were a number of negative connotations participants thought could be ‘read’ from their visibly affected skins, many of which involved prevalent (mis)understandings about acne causes and triggers. Important gaps in knowledge about acne can be held by both those with and without the condition, and Smithard *et al* (2001, p278) found that many of their study participants had “poor knowledge” about the causes of their own acne. Some connotations recounted by participants in the present study included associating acne with: dirtiness (being unhygienic and not washing enough), ‘unhealthy’ lifestyles (eating ‘unhealthy’ or ‘bad’ foods, drinking too much alcohol, smoking, being stressed and ‘uptight’) or fussing excessively with their skin (the notion that the person spreads germs by unnecessarily touching their skin and, usually in reference to women, by wearing make-up). These connotations around acne can have a particular potency, interlinking with moral judgements about whether a person behaves in a ‘good’ (e.g. ‘clean’, ‘healthy’, ‘responsible’) way. Some participants described anticipating and encountering these connotations, but awareness of problematic misconceptions about acne did not necessarily stop individuals from feeling hurt or frustrated when they faced these views from other people.

Whilst Smithard *et al*'s (2001) study featured participant beliefs about diet and hygiene as causes of acne, it did not elaborate on whether make-up was seen as a cause or trigger. In contrast, a number of young people in this research talked about make-up in these terms. Anna (aged 13, female) believed that “wearing make-up everyday” initiated her developing and continuing to have acne: “I’ll just still have it, even if I put [on medicated] creams and stuff because I put foundation [on] so it won’t stop anything”. Maria had previously believed that wearing make-up led to acne and she distanced herself from this: “there used to be like girls in my year who’d wear like loads of make-up and

wouldn't [be] getting it. And I'd be, 'Oh, why do I get it? I don't wear any make-up'". Some participants, such as Holly (aged 24, female), challenged notions that make-up caused acne and instead asserted the ways that make-up could reduce the visibility of acne and provide emotional benefits:

I've had spots regardless of whether I've worn make-up or not. And I think that's sort of-, it's interesting because make-up has become such a safety net for me, of being able to have more confidence when you have spots. But on the other hand people then assume that, you know, make-up's actually the cause of spots rather than something that's helped to mask it. So, I guess it's that sort of people maybe judging why you have spots or trying to put reasoning as to why you have spots.

Subsequently, using make-up to cover acne could be a dilemma. . Some participants also commented that make-up offered only partial concealment of acne, including of the skin texture such as raised lumps and flaking scabs. Cecile (aged 23, female) found that make-up would often wear off after a few hours and she recalled how using "the wrong shade" of foundation had emphasised her spots – thus make-up did not fully cover her spots but it was a presence visible to others who might attribute it as being the cause of the acne.

### **A medical concern? Preferentially positioning 'acne' or 'spots'**

An important aspect affecting the acquisition and uptake of medical information—including about acne causes—concerns whether 'having spots' is considered a legitimate 'problem' warranting medical attention. As mentioned, young people in the study were often partially aware of acne/'spots' in advance to developing the condition themselves, thus visiting a doctor to be told they had acne sometimes seemed unnecessary and unhelpful. Indeed, not everyone interviewed had seen a doctor or nurse about their acne nor intended to do so in the future. In the process of collecting and analysing the data, it became apparent that an aspect underpinning this circumstance for some participants was their uncertainty regarding whether acne/'spots' was a medical topic. Sometimes participants positioned acne as a predominantly cosmetic concern rather than one which required or permitted medical help. As well as opting for informal advice (rather than medical professionals) and using make-up as a way to manage acne visibility, many of the young people interviewed had at least initially tried shop-bought treatments, such as facewashes and exfoliants for 'oily'/'acne-prone' skin, or paid for beauty clinic procedures. For those who deemed acne a cosmetic issue or a short-lived 'phase' of puberty, visiting medical professionals about it sometimes seemed excessive and especially so

given that commercial products to manage it were easily available in the shops. Jen (aged 20, female) remembers thinking acne was “just something that every teenager goes through”:

I didn't really think it was something you could see the doctor about, because I thought 'yeah, I'm quite spotty but-.' When I went to the see the GP for the first time it was like, “What's wrong with you?” And I was like, “I've got spots.” [laughs] It felt like the most like menial thing to say [...] I didn't really realise that it was something that the doctors could do anything about until a friend of mine at school [went to the doctor and was given a topical treatment].

In contrast to her initial hesitance about the status of acne, Jen reiterated throughout the interview that acne “is a medical condition”. However, other young people retained ambivalence about such a framing and some actively resisted the notion that ‘having spots’ should be seen as a medical occurrence or concern.

One reason why some participants resisted a medical framing of acne may pertain to the potential of diagnostic labels to confer stigma. The struggle in finding a preferential vocabulary for framing acne was demonstrated by Faye (aged 20, female), shifting between words without settling on a suitable fit: “disease, I suppose, illness, disease, affliction? Don't know”. Sometimes participants were aware that adopting alternative descriptions of their skin condition helped them psychologically deflect negative associations, as Sophie (aged 18, female) explained about her response following the first appointment with a GP about having spots:

It's annoying admitting that you've like got an actual condition or a problem. The word 'acne' just sounds a bit harsh [...] I felt a bit like-, I guess disappointed in myself. But, I know it wasn't my fault exactly, I know that everyone has bad skin as a teenager but getting told you've got severe or moderate acne-, yeah, I felt a bit annoyed and a bit insecure about it.

Sophie was unsure about a preferable term or phrase – “[‘acne’] just sounds quite an ugly word. [...] But] it's difficult 'cos I think if you give something a word, that word will eventually then get the connotations”. Sophie recalled telling friends after her appointment: “they would be like, “Oh, so it's actually acne?” and I was like, “Yeah,” whereas they were just- thought that it was just a bit of bad skin”. Implied in this was a distinction between a level of spots deemed normal (‘everyone gets a few spots’) in contrast to a category which doctors produced by attributing the medical name of ‘acne’ (short for *acne vulgaris*), rating severity and prescribing treatments.

In addition to Jen, other young people in the study valued the framing of

their acne as a medical concern. Izzy (aged 22, female) developed acne when she was nine and she could not remember her doctors using the label at the time. Many years later, she found affinity with and validation through related medical language:

I remember actually when I went to the dermatologist the most recent time and he said, you know, 'This is a disease and we're going to treat it,' and I just remember that being such a turning point because [...] it had always just been like 'bad skin, a teenage thing' and then suddenly it was someone who was really taking it seriously as a disease that was treatable. I think the way people talked about it did really have an impact and I didn't really realise that until suddenly this dermatologist was saying-, speaking about it in that way. That made me feel like so much better in some ways because, even though it was like 'oh my God, I've got a disease', it made me feel like I was justified in being as upset as I was and that this was a serious problem – but someone was taking it seriously and was going to fix it for me.

Similarly, Tania (aged 20, female) recalled visiting various GPs about her acne over many years and getting "the impression [... that doctors] think you're wasting their time because it's a natural part of growing up". She added that "to a certain extent, I do agree that having spots or whatever is a normal part of growing up but there has to be a point at which you're like 'that's beyond the normal experience'". Whilst Izzy and Tania recognised the commonplace view that having some spots was 'normal' for teenagers, they differentiated their experiences as more than and distinct to this. For those who seek recognition and access to treatments, gaining 'legitimacy' for health conditions which include symptoms experienced by many in milder forms or very occasionally can present major difficulties. Denny (2009, p994), in the context of endometriosis, observes how the "types of pain that are consistently disbelieved are those pains that many people experience at some time, but that are generally short lived and self-limiting". The popular notion that 'everyone gets a few spots' and 'especially in puberty' can similarly undermine desired framings of acne as a valid medical concern for those who wanted their situation to be seen and treated as such.

### **Other people and health contexts: making comparisons**

As with acne severity and longevity invoked by Izzy and Tania, differences between young people's experiences were sometimes brought explicitly to the fore and produced parameters around notions of 'normal'- 'abnormal' acne. Distinctions within the age range of participants in the research

(13-25 years) were highlighted as important and, although specific ages were not usually given, a demarcation loosely emerged around 14-18 years as the 'normal' time to have acne (i.e. as part of puberty). Those whose acne experiences fell outside of these 'normal' teenage parameters reported feeling extremely self-conscious and often recalled incidents of teasing if not overt bullying by peers. Izzy vividly remembered feeling embarrassed when she once wore concealer at primary school to cover her acne, fielding questions from other children in her class such as, "What's that orange stuff on your face?" Towards the other end of the age range, Holly spoke about developing acne for the first time just before she started university:

I didn't have anything [spots] up until then really, so I guess it frustrated me a little bit because I thought I had passed that; that I'd been lucky to not have any spots really. I guess I was frustrated because I felt like I'm not supposed to have it. I'm not-, it's when-, you have spots when you're a teenager.

Holly's acne cleared up but returned around the age of 23/24. This presented new issues for her as she was then working in a secondary school and "felt like it was almost affecting my being professional 'cos I felt 'I've got spots, I look like the kids now and I'm meant to like be in charge of these kids'". Although no one had said anything directly to Holly, she "didn't feel as legitimate" at her workplace and worried that having acne affected others' perceptions of her "maturity and ability to look after these children". These feelings about acne resonate with the literature on adult acne in the work context (e.g. Hawkesworth, 2001). Whilst the age range used in the present research study could have encompassed both Holly and the "kids" at the school (up to age 18) where she worked, there were important differences for Holly between their experiences in terms of age and roles. The duration of time with acne coupled with age featured as important for some participants and an individual's experience could oscillate with regards to the parameters of 'normality': some participants had developed acne at a young age (deemed 'abnormal'), continued to have it throughout their 'teen years' (seen as 'normal') and beyond into their twenties (reverting to 'abnormal').

Sex/gender was another aspect discussed by some participants as a relevant basis for comparing their experiences of having acne with those of others. Overall, both male and female participants felt that having acne could be particularly distressing for young women because of pressures on appearance and societal expectations to be deemed attractive. Richard (aged 20, male) explained his views on this:

If a guy gets a spot, people think 'oh, it's normal, guys get spots'. But if there's a girl-, usually girls because they wear make-up, their skin always

looks good. So, you get a girl who's got acne or something all of a sudden she doesn't have good skin and she will stand out a lot more. [...] Young women] care about the way they look a little bit more, obviously to a certain extent guys do as well but girls are a lot more image conscious. Self-conscious, I'd say.

Richard also thought that acne scarring was less of a problem for adult men: "being a guy you can kind of get away with it – like you go into sort of late 20s, 30s, you look a bit rugged anyway. So, a few little scars aren't going to really make me feel self-conscious at all". These comments link with Frost (2003, p67) on gendered appearance norms in which young male bodies are often expected to be physically strong, "big, 'hard', sporty and fit", differentiated from the beauty standards for young women. Some male participants spoke about deciding to stop shaving or shaving less often. However, this was not presented as an aesthetic decision but as an attempt to reduce skin irritation. As George (aged 16, male) explained, "it's really, really painful especially with shaving [...] you're chopping them [the spots] all off which is really unpleasant". Although growing facial hair was not described as a deliberate strategy available to men to hide acne, make-up was discussed by nearly all study participants (i.e. male and female) as a potential asset to allow young women to cover their acne. Yet the notion that a young woman could cover her acne with make-up sometimes added to pressures that she should do so. For example, Jen found it painful to apply and remove make-up when she had nodular/cystic acne but felt "guilty [...] for not trying to cover up", especially when seeing male friends. Some participants refuted the assumption that only women 'could' wear make-up but often felt that, in practice, social attitudes prevailed. One exception was Richard who, somewhat contradicting his earlier comments, had semi-regularly used 'blemish balm' (similar to tinted moisturiser) to cover his acne scarring for "a nice matte finish to the skin".

Comparisons between having acne and having another health condition were sometimes made. Different skin conditions were often mentioned, potentially because participants were aware that the overarching research project covered three others (eczema, psoriasis and alopecia). Comparisons to other health conditions sometimes functioned to emphasise and justify the recognition of the negative socio-emotional impacts of acne. Despite some hesitancy about doing so, prefacing with "you don't want to make comparisons but-", Izzy spoke about how "people with other diseases like cancer or diabetes, obviously it has a massive impact on their life, but having something so obvious on your face and particularly in such a formative time of your life has a huge impact". This approach to evidencing the distress of acne has some resonance with research comparing Quality of Life measures for acne with other health

conditions (e.g. Mallon *et al*, 1999). In contrast are social comparisons used by some participants to position acne as relatively 'normal', even 'lucky', compared to other conditions. This approach is implied in the advice Richard gave to other young people with acne:

Don't beat yourself up about it too much, like we've all got problems, we all have health problems. Some people get cancer, obviously that's a severe case scenario, like it's just you've got acne [...] You can kind of look at it from an 'OK I've got acne, but at least I haven't got such and such or like really bad psoriasis all over my body'.

Both Izzy and Richard made comparisons, although they positioned the experience of having acne in different ways: the former elevated the significance of the socio-emotional impacts for those affected, the latter minimised them to render it relatively a mundane condition. Their hesitancy about making these comparisons, however, highlights the tensions in speaking of others experiences and in making an overarching statement about the importance (or not) of acne in young people's lives.

### **Discussion and implications**

Young people are a demographic group widely deemed to be the 'normal' age for acne and with a high prevalence. However, both alongside and beyond this framing of acne as 'unremarkable', many study participants spoke of the condition (and others' responses to it) as profoundly negatively impacting on their self-identity and social interactions. Contradictions in available messages about acne—mundane versus distressing—played out in the narratives of participants in this study. One example concerns the approaches adopted by young people in navigating the connotations oft-associated with acne and its visible characteristics, including (mis)conceptions widely held about causes. If a person understands and narrates their acne causes as being internal (hormonal) processes related to puberty, rather than something they are doing or not doing (e.g. not washing their skin enough, wearing make-up, eating pizza), then this could help relieve feelings of stigma about having acne by constructing it as a normal part of adolescence. Sometimes the same individual oscillated between understandings about acne causes, highlighting different sources of information and residual uncertainty. As such, acne experiences of young people can be both unremarkable ('not a big deal', 'normal', banal) *and* distressing (upsetting, damaging confidence, a struggle), and simultaneously so. These findings link somewhat with the ambiguity found by Oster and Cheek (2009) in their exploration of narratives about having genital herpes, albeit there are important differences between the two (for

example, genital herpes is contagious whilst acne is not). Oster and Cheek (2008) and this present paper both highlight that having health conditions which are relatively common and not in themselves life-threatening can nonetheless be quite complicated for those living with them, involving ambiguity, uncertainty and mixed views.

An important subset of the existing qualitative literature on acne has focused on experiences of adults and sought to counter assumptions that the condition only affects adolescents (Hawkesworth, 2001; Murray and Rhodes, 2005; Tanghetti *et al*, 2014). Some of these studies demonstrate, for example, how difficult it can be for adults with acne to cope with stigmatising attitudes from others about having a 'teenage' condition. The present paper supports attending to the differences as well as similarities between people's experiences and, in doing so, adds that societal assumptions about acne being 'just' part of teenagers lives can be harmful to adolescences and young adults as well as those who fall outside of the age category (including children and older adults). A key message of the paper is that caution should be exercised against assuming that having acne is an unproblematic experience for demographic groups often deemed 'normal' for acne (i.e. teenagers/young people). Having acne is accepted and acceptable for some young people but for others it can nonetheless be profoundly upsetting. Indeed, the same individual may adopt both perspectives over the course of an interview and these ambiguities across a dataset are important to recognise and represent, further nuancing discussions about the impacts of skin conditions.

The findings of the study indicate that there is a need for more accessible, earlier and/or reinforced information about acne to young people specifically but also the general public in the UK context. Information needs include about causes, resonating with Smithard, *et al* (2001) about gaps in knowledge about acne. A better grasp of acne causes could alleviate a degree of unnecessary distress and reduce the likelihood of hurtful encounters in which other people imply that the condition is the fault of the person with acne. This latter inclusion is importance since being aware of popular stigmatising and incorrect assumptions about acne causes does not necessarily protect young people from the distress of encountering other's misconceptions about their acne which blame them for having the skin condition. Having been rooted for some time, misconceptions about acne held by participants could endure or re-emerge even after encountering other understandings such as those offered by medical professionals. Therefore, information about acne needs to be timely and, potentially, reinforced at subsequent intervals. The fact that several participants in this research developed acne in primary school has relevance for school curriculums which include PSHE (Personal, Social, Health and

Economic) education. In addition, given that adolescence is often a time of growing autonomy around medicine use with both family and peer influences (Hansen *et al*, 2009), clearly signposting that medical support for acne is available through GPs and dermatology referrals would be appreciated by some young people – although not suitable or desirable for all.

Whilst some young people found it helpful to view their acne as a 'normal' physiological process (a conceptualisation underpinned by medical understandings of puberty as cause), some did not see it as a medical 'problem' *per se*. A medical framing of acne and associated practices (such as visiting doctors and applying/taking medicines) may be very unwelcome for some in making them feel there is something 'wrong' with them which warrants medical 'fixing'. Smithard *et al* (2001, p279) also found that participants were reluctant to identify with "having acne" due to "the stigma associated with the condition". Yet, in the present study, it is noteworthy that this was not the case for everyone and some people conversely found the medical label/terminology reassuring and legitimising of the distress they experienced. Different interpretations emerged regarding the capacity of clinical labels and related framings of a bodily experience to affect a person: on the one hand, the term 'acne' or a reference to its severity could concretise something as a problem in an unwanted manner but, on the other, it could justify access to treatment and validate the emotional distress surrounding a condition. In relation to Sophie's experience, it had been comforting and preferential to think that there was nothing more to it than 'just some spots'; yet for Izzy and Tania such an approach undermined the medical recognition they wanted accorded to their situations.

The ambivalences explored in this paper also highlight issues for researchers, as there were tensions between the design/premise of the study and the narratives of participants. For example, the uncertainty of participants about the positioning of acne as 'medical concern' jars somewhat with the underpinning research background: the interviewer was a qualitative researcher embedded in a medical department of a university, with a number of clinician co-applicants on the project (GPs, dermatology consultants and nurses), and the research was funded by the National Institute for Health Research. Hence, the project originated in and remained associated with a series of health-orientated, if not explicitly medical, interests. The recruitment of research participants meant that individuals had responded to posters and advertisements which used the language of "skin conditions (acne, alopecia, eczema, psoriasis)" for a website about "health, illness and lifestyles". However, the origins of the research and medical terminologies employed were sometimes challenged by participants in their interviews. This included overt

rejections of medical language but also more subtle re-framings through references to popular and informal descriptions, such as having “zits”, as well as discussing beauty products and services as ‘treatments’. Subsequently, the interviews provided opportunities for participants to explore and reconstruct acne in other ways than those implying it is a medical issue.

### **Concluding comments**

Young people's experiences with acne, and the narratives they (co)produce in research settings about these, can be ambiguous and ambivalent. The experiential accounts of participants in this study exceed reduction to being simply or unanimously evidence that having acne has important social and emotional (as well as physical) impacts for all young people. It is not that the narratives of young people with acne given here have ‘failed’ at coherence; rather, these accounts make sense in the context of different social attitudes and messages in circulation about having acne at this age. As such, the paper argues that the ambivalence and ambiguity expressed by some participants is an outcome of trying to making sense of popular understandings of acne in relation to their own lives, which include conflicting views (those which position acne as a non-issue *and* those which position acne as difficult). The interview narratives are layered with multiple perspectives, potentially including traces of previous (mis)understandings about causes, from a diverse range of sources and influences. Whilst some understandings about acne may be overwritten by other knowledges and encounters, previous or alternative thoughts and feelings about acne are not necessarily nor entirely replaced, and contradictions can emerge.

Given that the skin is an interface between self and world (Benthien, 2002), experiences of having acne cannot be reduced to only the physiological components. Instead, it is vital that the interrelatedness of social and emotional aspects be considered, and the social model of disability offers an important lens for doing so. The approach utilised in this paper also advocates an appreciation that some narratives may seemingly jar with one another and pull in different directions. The experiences of acne across the young people in this study did not fit neatly and entirely into only one category—of ‘important’ or ‘trivial’, of ‘medical’ or ‘cosmetic’—and instead tended to oscillate across the data set and within an individual's narrative. An interpretation is offered through in relation to dominant and pervasive attitudes in society about puberty-related changes and appearances. The approach developed in this paper might be fruitful for researching other experiences which are routinely trivialized and yet for which there can be a substantial impact on people's lives. This may include

other appearance-affecting skin and hair conditions (such as eczema, psoriasis, alopecia, rosacea and vitiligo) as well as experiences associated with particular age groups, and more research is needed to ascertain the applicability of the approach. Finally, the paper encourages readers to reflect on their own attitudes about young people with acne and to consider the domains in which insights about these varied experiences can be translated – including, but not limited to, health care, the family context, amongst peers, and in education settings.

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