EMBODYING ACNE: SKIN, SUBJECTIVITY AND DERMATOLOGICAL 
SCIENCE

by

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Abstract

An extensive body of literature is dedicated towards understanding acne as either a dermatological or psychological problem. Surprisingly, scholars have yet to write critically or sociologically about a skin disease which affects an estimated 600 million people worldwide. As such, I bring together continental philosophies of the skin/body, science and technology studies, and sociological literature on health and illness to produce an embodied sociology of acne. I argue that pimpled skin becomes meaningful through dynamic interactions between science and culture, forming new epidermal identities and solidarities I term “dermosocialities.” I examine the ways dermosocialities are organized through acne, and begin to analyze some of the political, cultural and scientific consequences of dermosocial collectivization. Altogether, a sociology of acne highlights the need to think about the contemporary relationship between skin and self as medicalized, managed and experienced through an emerging class of skin experts, discourses, practices and objects.
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Chapter 1
Introduction

I can still remember my first ever pimple. I was eleven years old and about to exit the swimming pool change room when I noticed a tiny red bump in the mirror. It was protruding from my forehead, just slightly above my left eyebrow. Igniting a frenzy of excitement, I burst outside the doors of the change room to show my swim team coaches and teammates. “I have my first pimple!” I announced to the world with pride. Everyone laughed. The pimple symbolized maturation, adolescence, and the passage of time as I eagerly waited for my body to develop into that of a “man.” It turns out that those feelings were short lived. By the age of sixteen, I had grown accustomed to pimples, and was no longer surprised or excited to discover new ones on the surface of my body. As the years went by, they seemed to be getting worse – colonizing more areas of my skin with a greater density and discomfort than before. No longer did pimples seem like a rite of passage on my journey to become normatively gendered. Instead, I came to know my skin as diseased through a condition referred to as acne. I saw a dermatologist well into my twenties for acne; I aggressively medicated and touched acne; I concealed acne; I obsessively thought about acne. In short, I loathed acne. I wanted nothing more than to escape its omnipresent grip on my life and return to the skin I once knew as an eleven-year-old boy. That skin was and remains a distant memory, however. For better or worse, the skin that I live in now is one that is irreversibly entangled with the lasting scars of acne.

I am not alone in any of this. It is through acne that millions of people are brought to think about and experience the surface of the body in ways that are often said to be
“scarring.” Wanting to know more about the kind of learning that takes place through acne, I ventured over to acne.org’s online message board. Expecting to find all sorts of similarities between the acne I remember and the acne being talked about in cyberspace, I was immediately humbled. Rather quickly, I realized that acne becomes many different things to many different people.

This thing we call “acne” is neither singular nor neutral. It is loaded with values, attitudes, judgments, multiplicities and meanings that many of us learn without having to write a dissertation on the topic. We know very little, however, about how this learning takes place and its subsequent role in the understanding, treatment and experience of acne. The vast majority of research on the subject is aimed towards studying the pathophysiology of the disease at a microscopic level. And although a growing number of scholars have begun to show interest in the psychology of acne, they rarely look to situate the human psyche in its embodied, cultural, political, technological, historical, economic and scientific contexts. This comes as a surprising oversight in the literature for a disease that ranks eighth most common in the world and affects an estimated 9.4% of the global population (Tan & Bhate, 2015).

The purpose of this research is to offer a sociology of acne, but without relinquishing either the biological or the psychological dimensions of this condition. Like Marcel Mauss (1992), I understand biological and psychological questions to be thoroughly enmeshed in the sociological fabric of life. These disciplinary fields are not incommensurable, and yet a quick and cursory look at the existing acne research would certainly make it seem that way. Biological research on acne occurs in different journals, is written by different experts, and makes use of different theories and methods than
psychological research on acne. In short, there exists a chasm separating what we know about the meanings and experience of acne from the dermatological realities of acne. I thus find great promise in sociology’s ability to bring these disciplines together and create what Mauss (1992) might term a “socio-psycho-biological study” of acne (p. 475).

The kind of sociology I am proposing travels under a number of different names ranging from “embodied” (Williams & Bendelow, 1998), to “carnal” (Crossley, 1995) to “corporeal” (Burkitt, 1999). At the heart of these concepts is a shared concern for the place of the body in sociological analysis (Crossley, 2001; Howson & Inglis, 2001; Turner, 2001). The problem, as Bryan Turner (2001) argues, is that the lived body and the discursive body appear at odds with one another:

Foucauldian poststructuralism has examined the enormous variety of discourses by which “bodies” have been produced, categorized, and regulated. At the same time, it denies the sensuous materiality of the body in favor of an “antihumanist” analysis of the discursive ordering of bodily regimes […] [Foucault’s] legacy has produced a range of historical inquiries into the government of the body resulting from institutionalization. By contrast, the phenomenology of the body examines the ways in which the everyday world is organized from the perspective of the embodiment of human beings. Merleau-Ponty’s approach to perception and understanding argued against any separation of mind and body; our perceptions of the world are always grounded in the relationship between our embodiment and the world. (p. 255)

Turner (2001) does not deny that there are differences between these theories of the body, but his thesis is that they are not mutually exclusive. It is not a question of whether bodies are either the objects or subjects of power. Instead, the goal of an embodied, carnal or corporeal sociology is to ask how they are both. Such a perspective, I would argue, requires sociologists to be open to still more theories of the body than the discursive and phenomenological approaches identified by Turner. For example, Freudian strands of psychoanalysis provide valuable insights into the ways the unconscious is structured
through the body. Moreover, materialist theories underline the need to think beyond the human-subject and towards nonhuman actors (e.g., bacteria, drugs, technologies, etc.) that also routinely shape what it is like to experience and know through the body.

In practice, what might these insights be able to add to our understanding of acne? I believe there are three important ways in which a focus on embodiment – defined here as the somatic, perceptual and carnal registers through which consciousness and knowledge are experienced – opens up space to reimagine acne as both an object and subject of power. Firstly, my interest in the sociology of acne does not mean I wish to ignore the materiality of the disease. That is to say, I do not intend to reduce acne to a social construction or cultural “text.” I do want to think further about what acne means and the discourses that help produce it, but I desperately want to avoid treating it as the passive object of culture. Its capacity to move, change form, and produce lively sensations on and through the skin suggests that it also plays an active role in the structuration of cultural and scientific discourses. Quite simply, acne needs to be understood as both a product and producer of social relations.

Secondly, I take seriously the disease status of acne and frequently use the word “disease” to describe acne throughout this dissertation. Although I sympathize with those who argue that our society has become too medicalized (i.e. too many normal, human experiences are being labeled diseases and treated as medical problems), I do not

1 Like most others who write about disease from a critical or sociological perspective, I recognize that acne’s status as a disease is contested and socially constructed. These are points that are implied in my use of the term and become clearer over the course of my analysis. Nevertheless, I opt to use the term “disease” precisely because it appears to be so intricately coiled with biology. Indeed, the biology of acne is something I do not want to leave behind in my analysis, finding in the word “disease” an imperfect, yet effective, rhetorical device.
wish to make the corollary argument that acne is just a “normal” part of life and should thus be left untouched by the forces of biomedicine. Suffering is a real part of the disease for millions of individuals, and biomedical interventions might be able to assist in minimizing or alleviating that suffering. Furthermore, there is historical evidence to suggest that variations of the word acne appear in the texts of ancient Egypt, Greece and Rome (Bastian, 2013; Connor, 2004; Grant, 1951), and that it was “probably employed for the first time in the 6th century by Aetius Amidenus, physician in Constantinople who named “ionthos” or “acnae” the lesions occurring on the face at the “acme” of life, i.e. puberty” (Tilles, 2014). My point is that a variety of mostly Western cultures and historical epochs have attempted to name and treat acne as a medical problem.\(^2\) Doing so is thus neither new nor unique to medicalized societies.

What are new, however, are the cultural and political discourses, economic systems, sciences, technologies, drugs and methods through which acne is understood and experienced as a disease today. Indeed, one needs to pay close attention to the context in which acne materializes, because as the context changes so too does the disease. A quick glance back in time helps make this point clear. In her book *The Body Project: An Intimate History of American Girls*, Joan Brumberg (1997) argues that the field of dermatology developed out of the field of syphilology (i.e., the study of venereal diseases). In turn, “adolescent acne was thought to be the result of ‘sexual derangement’ such as masturbation or promiscuity; in others, pimples were attributed simply to impure

\(^2\) There exists a real lack of historical and anthropological research on the biology of skin. Thankfully, Steven Connor’s (2004) *Book of Skin* and Jonathan Reinarz and Kevin Siena’s (2013) edited collection *A Medical History of Skin: Scratching the Surface* have begun some of this important work. There is, however, a wide range of “skin diseases” (e.g., acne) and non-Western contexts that scholars of dermatology and skin have yet to seriously consider.
or lascivious thoughts” (p. 64). Many middle class Victorian parents thus expressed horror and anxiety over teenage pimples believing that marriage – the only acceptable outlet for sexual desire – could cure the disease (Brumberg, 1997). Although acne and sexuality continue to be interconnected in a variety of ways today (see Chapter 6), associations with moral perversion have in most cases subsided and given way to a different set of sexualized understandings and experiences of pimples than what Brumberg documents in nineteenth and early twentieth century America. In order to make sense of these differences, I make it a point to think about the broader context in which acne contemporaneously takes shape and include acne in an entire web of power relations that, following Brumberg, extends far beyond whatever scientific or medical authorities say about the disease. Skin diseases are, after all, plainly visible. In addition to being seen in a doctor’s office or underneath a high-powered microscope, acne is seen in public where it can take on meanings beyond the medical.

One final way that acne might be reimagined through an embodied lens involves thinking through the complexities of skin. Skin poses a unique set of challenges to both disembodied and embodied theories of power that, in many instances, talk about “‘the body’ as its privileged figure” without fully considering the “fleshy interface between bodies and worlds” (Ahmed & Stacey, 2001, p. 1). As Cavanagh, Failler & Hurst (2013) write, skin has many lives: “Skin, in short, has a biological life, a social life, a fantasy life, a somatic life, a political life, an esthetic life, a life in the “lived body” and a cultural life – all of which inform one another to shape what it means and how it feels to inhabit skin” (p. 3). As much as the biological life of skin interests me, it is impossible for me to partition acne from the many other lives of skin. To borrow an oft-used metaphor in skin-
related literature: acne *folds*. It folds inwards bringing external stimuli into contact with the psychic and social registers of the subject, as it simultaneously unfolds those registers outwards into the world and into contact with other bodies or inanimate objects. If one of the unique features of skin is this capacity to fold (Braidotti, 2000; Connor, 2002), then we might better understand acne as that which routinely folds into the social, phantasmatic, somatic, political, esthetic, phenomenological and cultural lives of skin. As such, I want to be clear in saying that the *relations* of power that interest me are precisely these folds where the multiplicities of subjectivity meet and touch one another through skin. These are relations that routinely (un)fold on and through the lived experience of skin and thus help inform my theoretical and methodological approach to acne.

That approach, I have suggested, is sociological – but not in any strict or disciplinary way. Some critics argue that embodied, carnal or corporeal sociology is less “sociological” than it is “philosophical” in nature (Howson & Inglis, 2001). They contend that phenomenological theories of the body are either incompatible with or detract from the more important and sociological question of structure. Indeed, because I attempt to make some interdisciplinary maneuvers between philosophy, sociology, history and anthropology, there are some who would thus situate my project in the field of “cultural studies” rather than sociology (Howson & Inglis, 2001). Although I agree with the need to think carefully before making interdisciplinary connections, I reject the notion that continental philosophies of the body are incompatible with the broader objectives of sociology. In recent years, there has evolved too wide and too rich a body of literature suggesting otherwise, generating new and important insights into old sociological topics such as racism (Ahmed, 2007), capitalism (Charlesworth, 2000) and sexism (Grosz,
By refusing to see such work as sociology, the implicit assumption is made that the discipline of sociology exists as a fixed entity rather than a fluid, ever-changing, and contested set of ideas (i.e. epistemological, ontological, political, cultural, etc.). For reasons that will be explored more fully in Chapter 2, I want to open up the “disciplinary borders” of sociology to include alternative theories of power so that acne might lead us to consider skin disease and dermatology as important yet understudied sociological phenomena.

My project also intersects with the interdisciplinary field of science and technology studies (STS). Sociology is one of many disciplines incorporated into the field of STS, which aims to write about science and technology as social activities (Sismondo, 2010). STS scholars argue that both science and technology are social because each of them takes shape in social contexts, has social consequences, and involves socialized actors (human and nonhuman). Equally important to STS scholars is the fact that science and technology are activities: “…scientific knowledge and technological artifacts are constructed” (Sismondo, 2010, p. 11; emphasis in original). It is not the case that humans alone are the constructors of knowledge. Rather, STS reminds us of the ways that knowledge is already embedded in and constructed by the same material world that science aims to know.

I admit to being unaware of these foundational STS insights prior to beginning my research on acne. More important than what the dermatological sciences had to say about acne, I figured, was what my participants (who were experiencing acne) were saying. After delving into the research, however, it quickly became apparent to me that one could not easily separate what participants were saying about acne from scientific
knowledge, medical practice or biotechnological intervention. References to doctors, dermatologists, therapists, pharmacists, pharmaceuticals, over-the-counter treatments, diets, and medical diagnoses littered people’s firsthand accounts of what it is like to experience acne. Unable to ignore these important details, I turned to STS in the hopes that it could help me better understand the processes through which people come to know acne – without leaving behind my sociological commitment to the lived and experiential body. Comforted by the noted overlaps between STS and sociology (Law, 2008; Timmermans & Haas, 2008) as well as the embodied feminist research in STS (McCaughey, 2010; Takeshita, 2010), I realized that I was not the first person to navigate these interdisciplinary borders. In Chapter 2, I outline in greater detail the work of those whose earlier paths helped me navigate and negotiate the sorts of interdisciplinary borders described here.

In writing a sociology of acne, I do intend to highlight new ways to think about the cultural workings of power as they operate on and through skin; but I want to be clear in saying that I do not mean for these insights to uproot or dismiss decades of important writing and activism on the politics of racism. In fact, our contemporary moment suggests the need to engage with critical race theorists, postcolonial scholars, feminists of colour and Indigenous knowledges with a sense of urgency. Drawing inspiration from these theoretical oeuvres, I show that the critical study of acne is also a critical study of race in Chapter 4. Dermatology and racism are not – and must not – be understood as mutually exclusive actors, but rather complimentary forces capable of producing new insights into the politics of skin.
Indeed, there are people for whom acne – often intertwined with race – is a central and organizing feature of everyday life. I am unable to simply turn my back on these people’s experiences, regardless of how trivial our culture makes them out to seem. “It’s just acne,” I remember my parents telling me after I broke down in tears one night after experiencing yet another particularly bad breakout. Their message was clear: if I was looking for sympathy or emotional support then I had better find a more convincing cause than some measly pimples. I can also remember an old episode from the nineties sitcom *Seinfeld* making use of a similar narrative. After learning that his romantic partner is a dermatologist, Jerry decides to take her to task on her claim that she saves lives: “You call yourself a lifesaver. I call you pimple popper MD!” (David & Seinfeld, 1997).

Indeed, our culture teaches us that acne is not a “serious” disease because it is not life threatening. It is easy, therefore, to altogether dismiss the experiences of those affected by acne or simply reduce them to being the oversensitive, vain or superficial effects of consumer cultures and beauty norms. I am thus drawn towards the power and politics of acne in precisely this push to “think away” its complexities or legitimacy as a disease.

Having said all of this, I would be remiss if I did not also mention the many contemporary examples of people actively resisting the “it’s just acne” discourse. These people argue that acne is, in fact, both a serious and life-threatening disease because of its emotional and psychological effects.³ In the last two decades, there has been an explosion of published, peer-reviewed research on the psychological and psychosocial dimensions of acne.

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³ Brumberg (1997) notes that this discourse begins to emerge in the twentieth century and was largely fueled by a combination of profit motives and changing conceptions of disease: “As concerns about beauty and disease merged, the pursuit of perfect skin – one of the most common adolescent body projects – was transformed into a legitimate health strategy deserving of adult support, and generating enormous profits for both the cosmetic and drug industries” (p. 62).
of acne; health promoters, doctors and not-for-profit campaigns are trying to raise awareness about the emotional toll of acne\(^4\); the media, journalists and documentary filmmakers frequently tell tragic stories of “acne-related” suicide\(^5\); pharmaceutical companies market their acne medications as those which help produce a healthy skin and healthy mind\(^6\); and many acne patients are beginning to use psychological labels to describe and understand their disease\(^7\). Alongside those politics that discourage us from thinking about the complexities and legitimacy of acne are another set of politics that pull us into thinking about such complexities and legitimacy.

We can and should think critically about whose interests are being served as part of this simultaneous push/pull to think, or not, about the acne subject in our culture. But, I want to do this in a way that does not trivialize the experiences of those who write and talk about what acne feels like. Acne is not a trivial disease for the vast majority of people who experience it and, in fact, comes to play a fundamental role in people’s day-to-day lives as skin, with skin, and through skin. It is my opinion, then, that a sociology of acne must begin at the embodied level, and seek to develop a more critical and complex understanding of the disease than those commonsense beliefs that make research of this kind feel apolitical compared to more “serious” sociologies of skin.

\(^4\) In Canada and the United States, a collection of national not-for-profit organizations and pharmaceutical companies team up to designate specific times of the year as “acne awareness” months or weeks.

\(^5\) In 2012, the BBC aired a documentary titled *Dying for Clear Skin*; the subject of which was acne-related depression and suicide.

\(^6\) Proactiv, the leading over-the-counter acne medication, writes the following on their website: “If you suffer from acne, you know it’s more than just a few pimples. It’s emotional impact is beyond skin deep. Even as the most common skin condition in the world, acne can make you feel isolated, unattractive, and depressed” (Proactiv, 2016).

\(^7\) Patients routinely use words such as anxiety or depression to understand the experience of acne.
I have two major research questions that stem from these concerns and help frame my arguments. First, how do people embody acne? Specifically, I want to know how people live with and through the disease in their everyday lives. The lived experience of acne, I believe, sheds new and critical insights into the relationship between skin and self. Scholars have written extensively on this relationship but have yet to fully consider the ways skin and self are negotiated through experts, practices and objects in the fields of science, medicine, technology and health. In response to this first question, I argue that the biological life of skin animates, and is animated by, the social, emotional and psychosomatic lives of skin. There is no singular acne “experience” nor is there a singular acne; and, recognizing as much requires us to be able to see beyond the pimples of pimpled subjects. These people are, in other words, more than their pimples – leading rich, full, and complex lives that shape but are not determined by acne. My second question follows the first and asks: what are the consequences of these pimpled embodiments? Returning to a point I made earlier about the many “lives” of skin, I want to know how acne reassembles the meanings, histories and differences already marked on and through the body’s surface. What social relations result from that process of reassemblage? My second and corollary argument is that new epidermal solidarities – better termed dermosocialities – emerge out of these dynamic and medi(c)ated exchanges between the nature and culture of the skin. Identity politics have thus become, in some ways, dermatological politics.

The organization of this project closely mirrors my first argument; that is to say, each analysis chapter is designed to highlight the ways acne becomes social, emotional and psychosomatic matter. Before I begin my analysis, Chapter 2: A Theoretical
*Literature Review*, introduces the reader to a number of relevant literatures that help situate this project. One body of literature is comprised of critical and philosophical perspectives on skin – particularly those favouring an embodied approach to skin and subjectivity. My goal is to put these “skin studies” into conversation with another body of literature: critical perspectives on health, medicine and science. Here, I draw from research in the fields of science and technology studies and the sociology of health and illness to alert the reader to a number of key concepts and arguments scholars use to understand disease. Lastly, I provide the reader with a brief overview of the literature on acne. This includes the few published works from within the social sciences and humanities, as well as those written from biomedical and psychological orientations. The biomedical and psychological research on acne overwhelmingly makes up most of what we know about the skin disease today, but often calls upon psychological theories of identity, quantitative methods, and medicalized assumptions in order to make an argument. This amounts to an erasure of the social and political relations of power to which acne belongs; a task that I aim to restore through my proposed theoretical framework. Prior to beginning my analysis, I also provide a brief methodological summary of the project in *Chapter 3: Methods*. There, I explain in greater detail some of the epistemological, practical and ethical considerations I confronted throughout the course of this research. Furthermore, I outline the different texts I used to analyze acne as well as the tools or techniques through which that process of analysis occurred.

*Chapter 4: Pimpled Differences* marks the first of three analysis chapters. In this chapter, I examine the dynamic interactions between the biological and social lives of acne. In particular, I trace the sets of practices, logics and objects through which acne
becomes racialized and gendered matter. Following the work of Anne Pollock (2012), I begin to piece together the various ways dermatological science and medicine intervenes on the material-semiotic boundaries of race through the treatment of acne. My research in this section highlights the ways dermatological decisions about the skin are also racialized decisions about the skin, for doctors and patients alike. In the second section of this chapter, I use the work of material feminists to understand acne as a biology that routinely interrupts “normal” gendered embodiment. I not only chart how gendered discourses shape the diagnosis, treatment and experience of acne; I also outline the ways acne resists those ideas, leading some to embrace, explore and experiment with non-normative gendered embodiments.

In Chapter 5: Dermatological Suffering, I examine the dynamic interactions between the biological and emotional lives of acne. Here, I concern myself with the making of a particular kind of “psychodermatological” person. Using Ian Hacking’s (1986) concept of dynamic nominalism, I examine the back-and-forth relationship between acne as it comes to be labeled, diagnosed and treated as a psychodermatological disease, and acne as it is psychodermatologically expressed and experienced by patients. So-called “acne sufferers” learn about themselves as such through any number of different institutionalized practices, authoritative discourses, emotional vocabularies, visual images and social scripts. I explain what some of these are in detail, highlighting important divisions, fractures and multiplicities within the category of the “acne sufferer.” Quite simply, my aim in this chapter is to show that there is nothing natural about acne-related suffering.
In Chapter 6: Psychosomatic Adventures With Acne, I examine the dynamic interactions between the biological and psychosomatic lives of acne. Using psychoanalytic and phenomenological theories of skin, I highlight how acne enacts a type of power through its ability to overwhelm the subject with sensory information. Individuals experiencing acne feel multiplied, fractured, and undone by a skin that is often perceived as crawling with living and alien “others.” Attempts to control acne are thus shown to be, in part, attempts to reestablish the psychic boundaries of a ruptured (skin) ego. There is also, however, a libidinal significance to these varied attempts to control acne. The second half of this chapter follows the libidinal energies of acne as they circulate through the social body to produce cathected skins, psychosexual desires and intimate relations of touch. Citing specific examples, I use this chapter as a means to show that the libidinization of acne functions as the social glue or adhesive through which some dermosocialities are assembled.

In Chapter 7: Dermosocial Futures: Conclusion, I offer some final remarks and reflect on the potential contributions and limitations of this research for people inside the academy and beyond. I also return to the arguments I made in each chapter and begin to imagine what they might tell us about the future of dermatological practice, acne, and dermosocialities. Although scholars of biopolitics have for good reason paid close attention to the molecularization and geneticization of life, my research ultimately suggests the need to consider something akin to the dermatologization of life.
Chapter 2
A Theoretical Literature Review

Theorizing acne

In this chapter, I introduce three bodies of literature through which I develop a sociology of acne: 1) critical perspectives on skin; 2) critical perspectives on science, health and illness; and 3) critical, biomedical and psychological research on acne. I abstain from locating my project in any one of these literatures, and instead use this chapter as a way to put them into conversation with one another. Contemporary experiences of acne, I argue, do not fit neatly into any one of these bodies of literature and instead highlight the need for an interdisciplinary approach. Critical perspectives on skin, for example, provide significant insight into the historical, philosophical and cultural life of skin, but could stand to benefit from more – especially empirical – research on the scientific, biological and dermatological life of skin. Similarly, those who have written extensively about the politics of scientific and medical knowledge have, with few exceptions, studied dermatology or skin diseases as empirical objects of analysis. Lastly, the vast majority of acne research is written from biomedical perspectives that tend not to think about the social context in which acne is understood, treated and experienced as a disease. We know very little, in other words, about how or why acne becomes the meaningful biology that it is, except to say that it is meaningful in ways that command the attention of scientific and medical experts.

My project aims to make both theoretical and empirical contributions to these bodies of literature. Theoretically, I wonder if acne can “add some skin” to social scientific and philosophical understandings of the body? For example, acne introduces a
number of complex questions related to power, subjectivity and biomedicine that interest many contemporary scholars of the body (Blackman, 2008; Csordas, 1994; Shilling, 2012). What is the relationship between dermatology and identity? How is health managed and experienced on and through skin? Does acne render some bodies more or less visible in society than others? If so, how and with what effects? Acne thus necessitates a careful consideration for the body’s surface. Skin is unlike any other part of the body. It is neither on the “inside” nor the “outside” of the body but always caught somewhere in between, simultaneously perceived from both sides as it were. We also come to learn about our worlds, our bodies and ourselves as skin. Once that part of our body becomes diseased, what happens to our worlds? Our bodies? Our selves? What are the relations of power that unfold through a skin that is labeled, treated and experienced as diseased? Social theories of the body, in other words, need to better account for what makes skin a particularly unique feature of our corporeal existence.

Some scholars have already begun to assume the task of skin-specific research on the body, calling themselves (sk)interlocutors:

(Sk)interlocutors is an international, interdisciplinary research group devoted to the study of the skin […] Responding to the growing scholarly literature on the human skin, (sk)interlocutors actively seeks to investigate the ways in which the epidermis influences and/or participates in experiences of embodiment, identity, the senses, relations with others (cultures, societies and individuals), gender and sexuality, race and ethnicity, class, technology, spaces (geography) and places. (skinterlocutors.com, 2017)

At this point, however, (sk)interlocutors have yet to fully consider the ways diseased skin opens up space to think about some of these experiences differently. One exception is Jay Prosser’s (2001) essay Skin Memories, where he momentarily turns to vitiligo – a skin condition affecting the pigmentation of the skin – to think through some of the
complexities of racialized embodiment, stigma, and racism. References to skin diseases are also made implicitly, or in passing, in select works (Benthien, 2002; Hurst, 2013; 2015). Most often, however, skin appears in humanities and social science literature as that which bears the marks or scars of non-dermatological diseases (e.g., cancer, HIV, MRSA, etc.) or medical procedures, but rarely that which is itself diseased and treated. Despite their ubiquity, diseases such as acne, eczema, psoriasis and herpes are rarely examined through an interdisciplinary or critical lens and, instead, subject to biomedical, social-psychological and psychoanalytic frameworks that often tend to overlook the broader sociocultural context in which those diseases are treated as such.8

If a sociology of acne can contribute to theoretical understandings of embodiment and skin, then it can also offer an empirical contribution to what Timmermans and Haas (2008) call a sociology of disease. Sociologists of health and illness, they argue, often tend to overlook the significance of biology in their analyses. Diseases, after all, have very specific pathologies with very specific effects on the human body. The goal of a sociology of disease, therefore, is to think about the materiality of diseases in addition to their immaterial or linguistic construction. Timmermans and Haas (2008) describe the problem as such:

Sociology’s “biophobia” (Freese et al., 2003, p. 234) includes the deeply held concern that a strong recognition of biological and genetic factors in health implies the automatic devaluation of social factors, and leads to politically suspect forms of determinism. Thus, social scientists are more likely to point out the genetic and biological ‘fabrication’ of conditions. They tend to focus more on how diagnostic categories emerge, evolve, and are phenomenologically experienced in particular health contexts rather than in taking the diagnosis as a starting point and seeing how various people address health problems. (pp. 662-663)

8 One could also include common dermatological occurrences such as moles, corns, calluses and warts to this list.
Importantly, a sociology of disease is not meant to replace the valuable work of sociologists of health and illness but rather supplement it with a series of questions that emphasize the “dialectic interaction between social life and specific diseases” (Timmermans & Haas, 2008, p. 661). With the exception of Fair’s (2010) research on Morgellons disease, skin diseases have been largely absent from the sociological literature on health and illness. Acne, therefore, offers an empirical point of entry into the largely un(der)explored workings of dermatological power. Affecting an estimated 660 million people worldwide (Global Burden of Disease Study 2013 Collaborators, 2015), acne is by no means an insignificant matter but rather a ubiquitous and organizing feature of social life that has, surprisingly, managed to elude sociological critique.

I now direct my attention to the three aforementioned bodies of literature. To help navigate these terrains, I have taken the liberty of creating sub-categories. I want to be clear in acknowledging that these sub-categories are of my own making and designed to help make clear those perceived oversights in the critical and interdisciplinary scholarship on skin, acne, science, technology, health and illness. I acknowledge, in other words, that these sub-categories necessarily obscure at the same time they help organize boundaries and demarcate gaps in the literature. Many of the following bodies of work could also span across a number of different sub-categories, only some of which are mentioned here.

*Critical perspectives on skin*

Scholars from a wide array of disciplines including literary studies, anthropology, history, gender studies, philosophy and sociology have become increasingly curious about skin. The focus on skin is hardly new to the humanities or the social sciences. Most
obviously, projects pertaining to race, medicine or beauty have in some way or another been projects about skin, even if skin is not the explicit focus of attention. Recently, however, scholars in the humanities and social sciences have begun to name and identify skin as part of a much larger “corporeal turn” in the academy. They share in common a belief that skin is more complicated than what our existing theories of the body can account for, and might actually be able to enrich those theories with new considerations for the historical, philosophical and cultural significance of the body’s surface.

Historical perspectives are one sub-category of a much larger genre of academic writing devoted to critically understanding the skin. Perhaps the most common histories of skin are those that focus on processes of racialization in capitalist, imperialist and white supremacist contexts. I cannot even begin to do justice to such a rich and eclectic body of scholarship here; nevertheless, it is important that I at least acknowledge the broad theoretical contributions that historians of race and racisms have made to contemporary understanding of skin. Most notably, their work demonstrates the political significance of skin, as that which has historically been used to mark certain groups of people as different from one another. Historians are interested in racial differences as they come to be inscribed and understood through skin because they consistently play a central and organizing role in the making of capitalist societies and the distribution of resources, land, quality of life, marriage, health outcomes, legal structures, employment, education, and so on. W.E.B. Dubois (1998) and C.L.R. James (1963) draw from Marxist theories to highlight points of intersection between economic and racial systems of oppression. And while there is significant value to exploring these intersections, the stories these historians tell are not so much about skin per se as they are about the ruling
ideologies, social hierarchies and material conditions underneath which skin acquires racialized meaning (Chakrabarty, 2007; Cheyfitz, 2011; Benson, 2011; Roediger, 1991; Roediger & Esch, 2012). In addition to playing a central role in the history of capitalism, the racialized significance of skin has also figured prominently in histories of Western thought: “Race is one of the central conceptual inventions of modernity” (Goldberg, 1993, p. 3). In both science (Hoberman, 1997) and philosophy (Anderson, 2007; Goldberg, 1993), the enlightenment principles of reason, humanism and rationality have been shown to fuel the colonial project. Embedded in those logics are racial grammars that have historically worked to naturalize a social order built upon generations of European violence, genocide and enslavement directed at racialized peoples.

Some historians have also taken an interest in the biology of skin, exemplified in Nina Jablonski’s (2006) Skin: A Natural History: “Despite the importance of skin in human biology and in interactions between people through the ages, most of its rich and interesting history has not been told” (p. 5). The history that Jablonski is referring to is an evolutionary one, with approximately six million years of organic changes and environmental adaptations. Using a combination of evolutionary and anthropological research, Jablonski provides her readers with some historical context through which to understand biological features of skin (e.g., sweat, melanin, touch, and disease). Our skins, she reminds her readers, become the fleshy and experiential “stuff” we know them to be through their intimate interactions with both the social and natural worlds. Medicine plays an important and mediating role in those interactions, as other historians are quick to point out (Reinarz & Siena, 2013). But as Allen Hornblum’s (1999) research documents, context is everything to understanding the science and practice of
dermatological medicine. His book titled *Acres of Skin*\(^9\) tells the story of Dr. Albert Kligman, a dermatologist who amassed a fortune literally on the backs\(^10\) of a predominantly black population of prisoners at Holmesburg Prison between the years of the mid-1940s and 1974. Kligman’s research (funded mostly by pharmaceutical companies and sometimes without government consent) often involved painful procedures that left an already vulnerable and marginalized population of participants with lasting mental and physical scars. Hornblum’s (1999) book is therefore a valuable albeit harrowing reminder that racism features prominently in the history of dermatological medicine.

Historians have also been interested in the skin because of its symbolic value. It is perhaps unfair to reduce Claudia Benthien’s *Skin: On the Cultural Border Between Skin and the World* (2002) to its historical relevance, given that our contemporary moment is included as part of the historical period that interests her. Nonetheless, she begins her analysis in the eighteenth century examining “the relationship among self-consciousness, subjectivity, and skin in literature, art, and science” (Benthien, 2002, p. 1). With such a wide array of cultural texts at her disposal, Benthien paints a complex picture of an organ that has been subject to many different meanings in Western societies. Instead of trying to “clean up” some of the messiness that belongs as part of the skin’s history, Benthien acknowledges that the symbolic significance of skin is often rife with contradictions and ambiguities. That is to say, skin – understood through the texts of literature, art and

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9 The inspiration for the title of Hornblum’s book comes from a 1966 quote from Dr. Kligman himself, telling a newspaper: “All I saw before me were acres of skin. It was like a farmer seeing a field for the first time.”

10 Writing about Retin-A – a common ingredient in many contemporary acne creams and wrinkle-removers – Kligman wrote: “The early human trials were performed on the backs and faces of the Holmesburg inmates.”
science – can occupy a multitude of different meanings at the same time: porous and impermeable, self and other, whole and partial.

This is a theme that also reverberates in Steven Connor’s (2004) *The Book of Skin*. Using a similar methodology to Benthien, Connor looks to the works of philosophers, artists, authors, scientists and doctors to understand the “ubiquitous ostension of the skin” in contemporary Western cultures (p. 9). Reaching as far back as biblical, ancient and medieval texts, Connor shows that our relationship to our twenty-first century skins are perhaps not as new as we think they are. He explains:

…the history of the skin has turned over on itself. The new skin is the old skin, as the skin restores and renews itself through exposure to primitive kinds of suffering and jeopardy. The aim of this book is to show that the time of the skin is always in fact folded-over or complex. For one thing, the multiplicitousness of the skin is not in fact without historical precedent, for the skin has been lived and figured and imagined in a rich variety of ways that cannot be reduced to or neatly synchronized with the history of the medical understanding of the skin I have sketched out. (Connor, 2004, p. 91)

Tracing the historical developments of all sorts of relations with/in skin ranging from itch to unction, Connor’s research makes an important contribution to the critical study of the body’s surface. Like Benthien, he shares a commitment to working through the skin’s multiplicity (even when it leads to ambiguous or paradoxical places), and makes multiplicity an important part of what he terms a “cultural history of skin.” But, as Marc Lafrance (2009) notes, neither Benthien nor Connor provide a cultural *theory* of skin, defined as a “systematic framework for thinking about how the skin and the self interact in and through [the] practices” they devote their attention to (p 4).11 Indeed, it is a cultural

11 Acne is almost entirely absent from each author’s research, and so too are the sorts of skin practices that unfold with and through acne.
theory of skin that motivates scholars to write critically about the philosophical significance of our body’s largest organ.

Although not a systematic framework, Arthur Bentley’s (1941) *The Human Skin: Philosophy’s Last Line of Defense* does represent an early philosophical attempt to make sense of the relationship between skin and self. In skin, Bentley finds a line of “defense” to protect philosophy from scientific takeover. Epistemology, he argues, is the exclusive realm of the philosopher and can be marked as such if philosophers take seriously the complexities of skin:

> Human skin is one authentic criterion of the universe which philosophers recognize when they appraise knowledge under their professional rubric, epistemology […] Yet if philosophers cease thus crudely to employ [skin], all their issues of epistemology will vanish, and the very type of attack they make on cognition will be discredited; whereupon the task of determining the status of knowledge itself will pass from their hands to those of the scientists who have taken over so many regions of philosophical arrogation in the past. (Bentley, 1941, pp. 1-2)

But what exactly is it about skin that allows Bentley to entrust it with the future of philosophy? Why does he look to skin in order to ward off the encroaching and unwanted presence of science? The answer, it would seem, has something to do with its capacity to play with the Western dualisms embedded within scientific and empirical modes of thought. One such dualism involves the distinction between subject and object: “If there is a “knower” and if there is a “known,” if one of these lies apart from the other and if there is a process of “knowing” which involves both, then skin lies somewhere along the line of march, and must be taken into account” (Bentley, 1941, p. 2). Later, he mentions the distinction between the subject’s inside and outside as being untenable positions once skin is brought into the fold: “‘Inner’ and ‘outer’ are ever present distinctions, however camouflaged, in philosophical procedure as well as in conventional speech-forms and in
the traditional terminology of psychology. What holds ‘inner’ and ‘outer’ apart? […]

Bluntly the separator is skin; no other appears.” (Bentley, 1941, p. 3).

Since 1941, others have followed Bentley in thinking through the skin’s philosophical possibilities; but rather than pit those possibilities against science some scholars have actually used science as a starting point to think philosophically about the skin and subjectivity. One example comes from the Norwegian philosopher and microbiologist, Elling Ulvestad (2007), whose research on the human microbiome leads him to consider the skin and the gut as two philosophically rich features of the human body, with complexities and nuances that have yet to be fully considered by those who work in the sciences and humanities alike. Composed of trillions of tiny microorganisms, the skin and gut are not entirely “us.” In fact, scientists estimate that our bodies are overwhelmingly made up of these infinitesimal non-human “others,” outnumbering human cells by a ratio of approximately 10:1. The skin microbiome, therefore, raises a number of interesting philosophical questions for Ulvestad about what it means to be human: “We are, in other words, not isolated individuals but walking ecologies” (Launer, 2013, p. 367). And, if Ulvestad allows room for microbiological science to inform philosophy, the reverse is also true. That is to say, social theories might also help us understand the microscopic lifeworlds of the skin: “Bacteria can be regarded as equally adept [to humans] at social learning […] Ulvestad likens their uptake of ready-made genes from a mobile gene pool to the rapid uptake of new ideas by humans of information from the internet” (Launer, 2013, p. 367).

Philosophically speaking, the skin interests Bentley and Ulvestad because of its capacity to multiply the assumed unity and coherence of the Western subject. This is also
true in the work of French philosopher, Michel Serres, whose writing reserves a special place for skin. With multiplicity being a theme that underscores many poststructural readings of the body, Serres belongs to a much larger tradition that aims to challenge the modernist assumption of a single, rational actor in complete control of their thoughts, body, intentions, etc. He argues that the skin of the body, in particular, is a milieu. It is not only a milieu of parasitic and social relations with (non)human others (Brown, 2002; Serres, 1980), but it also a milieu of the senses (Connor, 1999, 2004; Serres, 2008). As Steven Connor (2004) summarizes:

> Unlike the other organs, [skin] is not concentrated in one portion of the body. Indeed, the skin is the ground against which the other senses figure: it is their milieu. If all the senses are milieu, or midplaces where inside and outside meet and meld, then the skin is the global integral of these local area networks, the milieu of these milieu. (p. 27)

Thus, to understand skin as a milieu is to understand skin as thoroughly entangled – or to use Serres’s terminology “mingling” – with other places, people, lifeforms, meanings, memories and sensations at any given point in time. Complicating Bentley’s call for philosophers to think through the unique epistemology of skin, Serres goes a step further in suggesting that it has become impossible to locate the knower’s skin at all in contemporary societies. That is to say, the skinned boundaries marking the inside and outside of the subject have become less clear and less human in what some have called an “age of interface” (Connor, 2004). Skin and the sense of touch can no longer be said to be that which sets humans apart from the non-human world, or that which offers humans a unique epistemological position or phenomenological experience of the world. Rather, skin is that which humans share with the rest of the world. As Serres (2008) writes, “it can be said that fabrics, textiles and material provide excellent models of knowledge […] the world is a heap of clothes” (p. 83); or, in Connor’s (1999) words, “the skin, and touch
signify, finally, for Serres, a way of being amidst rather than standing before the world, that is necessary for knowledge” (p. 5). Skin, in other words, is not the exclusive domain of the philosopher or human, as Bentley (1941) would have it. Rather, for Serres, skin is dispersed widely across a variety of different human and non-human minglings. It is precisely in that process of dispersion that he aims to destabilize, multiply and fracture the very humanist foundations upon which Western notions of epistemology and subjectivity are based.

With its capacity to challenge some of the core assumptions of Western thought, it is no surprise that skin has piqued the curiosities of philosophers including those who share a psychoanalytic perspective (Anzieu, 1989, 1990; Bick, 1987, 2002; Bion, 1962, 1967; Freud, 1923, 1955; Grosz, 1994; Lafrance, 2009, 2013; Ulnik, 2007). Casting suspicion upon Western notions of a conscious and rational actor, psychoanalytic philosophies of subjectivity are being carefully and critically re-examined by many contemporary scholars whose research interests are in some shape or form related to the body. The skin, these scholars note, has an important place in some psychoanalytic circles because of its presumed role in the process of ego-formation. It is through our skinned encounters and relationships with the world that we begin to develop a concept of self. In the work of Didier Anzieu (1989), the skin becomes a mental representation of the self (i.e. Skin Ego), marking clear boundaries between the subject’s interior and exterior, self and other. It is also the case, as Anzieu (1989) and other psychoanalytic thinkers note (Grosz, 1994; Ulnik, 2007) that the skin continues to harbor unconscious phantasies, desires, and libidinal energies that are learned by the infant prior to establishing an ego. Psychoanalytic theories of skin thus argue for an embodied notion of
subjectivity that is neither wholly mind nor consciousness, but rather includes the whole body and a consideration for the unconscious. Many feminist philosophers have found opportunities in such theories, using them to shed new light into gendered relations of power (Cavanagh, Failler & Hurst, 2013; Grosz, 1994; Segal, 2009). Of course, given the sexist, essentialist and biologically deterministic language that permeates so much of the early writing in psychoanalysis, feminist philosophers proceed with caution; but, in doing so they also manage to contribute to a psychoanalytic theory of skin that is not devoid of politics.

Politics, in fact, are often the focus of one final sub-category of scholars who write critically about the skin – specifically, the skin’s cultural significance. For many of these writers, the meanings of skin cannot be understood apart from the deeply racist cultures in which they are reproduced, learned and lived. Those who write about the relationship between race and identity are quick to show readers that skin labeled “black” or “white” carries with it no fixed meanings, but is instead fluid and contingent upon the context in which it is being read (Ahmed, 2007; Gilroy, 1993; Hall, 2000; Tate, 2005). Furthermore, feminists remind us of the ways racialized skins are layered with intersectional meanings emerging from the simultaneous occupation of several subject positions (e.g., gender, class, sexuality, ability, etc.) (Allison, 1988; Collins, 1990; hooks, 1981; Lorde, 1980; Scales-Trent, 1995). And, more recently, a number of critical scholars (Gilroy, 2000, 2005; Pollock, 2012; Roberts, 2012) identify science, technology and medicine as key arbiters in the contemporary experience of racialized embodiment. Indeed, appeals to the biological reality of race continue to permeate everyday life, raising questions about the depths to which skin is seen in technoscientific cultures. In
addition to being seen on the surface of the body, skin also appears increasingly visible on a molecular, genetic and cellular scale. Quite simply, scholars need to be cognizant of the new technologies, languages and methods through which racialized lenses are being designed in contemporary societies.

In addition to using race as a means to think about the cultural workings of power, many scholars have turned their attention to particular representations of, or practices with/in skin. Beginning their analysis with a particular question about skin, they then come to consider much larger questions about culture, politics, intersectionality, sexuality, subjectivity, social relationships, etc. In their edited collection titled Thinking Through the Skin, Sara Ahmed and Jackie Stacey (2001) write:

‘Thinking through the skin’ is a thinking that reflects, not on the body as the lost object of thought, but on inter-embodiment, on the mode of being-with and being-for, where one touches and is touched by others. Thinking Through the Skin poses the question of how skin becomes, rather than simply is, meaningful […] As a way of ‘thinking through the skin’, we ask: How does the skin come to be written and narrated? How is the skin managed by subjects, others and nations? We examine the different technologies of the skin and how particular discourses – medical, scientific, aesthetic – intersect to produce the intelligible skin, even when the skin cannot be held in place by such knowledges. (pp. 1-2)

If skin becomes meaningful, then how and where do we see this process unfold? What are some of the skinned practices, representations and experiences that cultural theorists have begun to explore? Occasionally, scholars have looked towards the representation of skin in art, literature and popular culture in order to learn more about ourselves and the skins we are drawn to look at, think about, laugh at, desire and dislike (Benthien, 2002; Cavanagh, 2013; Connor, 2002, 2004; Kunkle, 2013; Thomson, 2013). Other scholars have taken a specific interest in skins that are cut in the act of self-harm (Failler, 2013; Galioto, 2013; Kilby, 2001). Contrastingly, Rachel Alpha Johnston Hurst (2013; 2015)
has given considerable thought to skins that are cut and affected by cosmetic surgeons. Bodily transformations such as pregnancy (Tyler, 2001) or the onset and experience of cancer (Takemoto, 2001) also leave their marks on the skin, providing an entry point for scholars to think about everything from celebrity to ethics. Technological advancements have left some to wonder if we are entering a new digital interface, upon which skin is being made electronic and virtual (Castañeda, 2001; Howes, 2005). And, not surprisingly, a concern for the aesthetics of skin has produced a number of interesting writing on the topics of tattooing, piercing, clothing and body modification (Davis, 2013; North, 2013; Pitts, 2003; Salecl, 2001).

Despite the many important insights to take away from the critical literature on skin, scholars who write about our body’s surface have yet to “think through” skin disease. This is a gap that I hope my work on acne can begin to address, and one that I believe harbors interesting and underexplored insights into the contemporary relationship between skin, self, and the dermatological sciences. Critical perspectives on skin are helpful in making sense of acne, but are also limited in terms of what they might be able to tell us about the ways skin is researched, conceptualized, managed, and experienced as diseased. To help address these limitations, I also include as part of this project critical perspectives on science, health and illness. What might they be able to offer to “skin studies” (Lafrance, 2013)? Likewise, what might critical research on science, health and illness gain from the aforementioned insights of (sk)interlocutors?

Critical perspectives on science, health and illness

Although I consider this to be a sociological project, I want to make clear that I am not adhering to a strict, disciplinary understanding of sociology. My own path to
thinking critically about science, health and illness was certainly informed by sociological literature, but also includes the work of anthropologists as well as those who write in the field of science and technology studies (STS). In other words, I approach the topics of science, health and illness interdisciplinarily.

Interdisciplinarity, in fact, is a word that many STS scholars use to describe their own field of study (Fuller & Collier, 2004; Hackett, Amsterdamska, Lynch & Wajcman, 2008; Jasanoff, Markle, Petersen & Pinch, 1995; Sismondo, 2010). As Sergio Sismondo (2010) writes: “The field is a result of the intersection of work by sociologists, historians, philosophers, anthropologists, and others studying the processes and outcomes of science, including medical science, and technology” (p. vii). Indeed, scholars working underneath the banner of STS are not united in their shared interest in science per se. Rather, it is their concern for the processes through which science “makes” or “stages” reality – and the effects of those stagings – that attracts scholars from a diverse set of theoretical and methodological backgrounds to the intellectual project of STS.

For Sismondo (2010), that project involves fundamentally investigating “how scientific knowledge and technological artifacts are constructed” (p. 11; emphasis in original). In part, that means problematizing the commonsense belief that scientists, lab technicians, biotechnological engineers, doctors and other experts are value-neutral or objective onlookers who simply interpret and describe reality as it is. A pure or unfettered form of “nature” does not sit in front of them waiting to be discovered, STS reminds us. Instead, that “nature” is constructed through language, values, norms, emotions and meanings that experts, too, learn as part of their own cultural and professional training. STS scholars, however, go one step further in their analysis. Rather than solely
concentrate knowledge in the minds of human individuals, they also attempt to locate knowledge in bacteria, artifacts, institutions, methods, microscopes, drugs and other non-human actors (Latour, 1987; Mol, 2002; Sismondo, 2008, 2010). What this means, then, is that science and society are “co-produced” (Jasanoff, 2004). It is not simply the case that society constructs or produces nature through scientific practices, as one might be led to believe from a strict and orthodox reading of social constructionism. Additionally, STS directs our attention to the ways society is constructed by that same nature; one that is always already imagined, worked, and structured by some kind of human intervention. An STS perspective, therefore, can be understood to afford acne with a kind of power that is most often reserved for human actors in classical sociology (Jasanoff, 2004).^{12}

None of this is to say STS and sociology are incommensurable paradigms. As stated, STS scholars find many ways to include sociology into their interdisciplinary framework. John Law (2008) has already written about the “differences as well as the overlaps between STS and sociology” (p. 624), which I will abstain from repeating here. It is important to note, however, that Law’s conception of “sociology” is largely based on the works of classical theorists such as Marx, Weber and Durkheim. When he writes about the “preoccupations of sociology” (p. 624), he does not have in mind the kind of “embodied” sociology I am advocating for. I make this point in order to draw attention to the fact that my research is located in the interstices of multiple places at once. Not only does it sit uncomfortably between sociology and STS, but it is also located somewhere in between sociology and what some critics argue is cultural studies (Howson & Inglis,

^{12} Jasanoff (2004) notes that “sociology and political theory, for their part, have tended on the whole to leave science, and only slightly less so technology, out of their analytic programs – again with some notable exceptions (Bourdieu, 1980; Habermas, 1975; Merton, 1973)” (p. 18).
Following Michel Serres, I see great potential in these interstitial spaces between disciplines: “I believe that these spaces between are more complicated than one thinks [...] more fractal than simple. Less a juncture under control than an adventure to be had” (Serres with Latour, 1995, p. 70). Skin, according to the philosophy of Michel Serres, forces us to confront “inbetweenness” (Connor, 2002) as that which opens up new spaces for conceptual and disciplinary adventures.

One question worth asking is: Just how sociological is my sociology of acne? Scholars who use the words “embodied,” “carnal,” or “corporeal” to describe their brand of sociology deliberately call attention to the body (Burkitt, 1999; Crossley, 1995; 2006; Turner, 2001; Wacquant, 2004; Williams & Bendelow, 1998). The philosophies and methods of classical sociology, they argue, overlook the body’s significance in social relations:

The ‘corporealising’ of sociology requires conceptual tools which both enable practitioners to account for the experience of the body-subject and the social location of the body-object; and allow practitioners to be reflexive about their sociological practice. In pursuit of such a toolkit, many sociologists of the body have moved away from theoretical frameworks which privilege social-structural accounts of the body towards those which privilege the body as the ‘ground of experience.’ (Howson & Inglis, 2001, p. 298)

Most often, these sociologists use feminist and continental philosophies of the body to help them “move away” from the kind of disembodied sociology they eschew. Whether or not such “moves” position embodied research within or beyond the accepted disciplinary boundaries of sociology remains, of course, a matter of debate (Crossley, 2001; Howson & Inglis, 2001). It is clear, however, that contemporary attempts to theorize the lived body emerge in response to, and are a deliberate attempt to remedy perceived oversights in our existing sociological theories of power, structure, agency, etc.
The sociology of health and illness, Deborah Lupton (1997) argues, is familiar with some of these oversights. One example comes from what she terms the orthodox medicalization critique. Scholars sharing this perspective leave little room for patient autonomy, reducing patients to passive objects of medicalized power. The bodies and identities of patients are understood to be carefully crafted by doctors, surgeons, pharmacists and marketers whose interests have more to do with their own financial and professional lives than the lives of their sick (or potentially healthy) patients. In another example, Lupton (1997) highlights Foucauldian readings of medical power as having also contributed to a passive, medicalized patient whose body becomes a poststructural object of discourse. In their rush to untangle the disciplinary, surveillant and institutional powers of medicine, these sociologists have little to say about “the phenomenological body, or how people respond to the external discourses and strategies that attempt to discipline them” (Lupton, 1997, p. 103). On this basis, Lupton argues for a sociology of health and illness that not only looks to make sense of the disciplinary force of expert knowledge, but also the resisting force of the embodied subject. How and what does the emotional, unconscious and lived body know, and how do those knowledges interact with the truths, practices and authorities of biomedical science?

I would argue that sociologists of health and illness have been mostly receptive to Lupton’s concerns. For instance, in the last two decades a number of researchers have sought to understand what are variously referred to as “biosocialities,” “patient groups,”

\[\text{13} \] It is important to note that Lupton does not believe Michel Foucault’s theory of power, or discourse more generally, always ends up reducing the body to a “docile” one. Although Foucault’s philosophy has occasionally been interpreted to do as much, she acknowledges that the body is produced or “enabled” (Hekman, 2010) through discourses, but not ultimately determined by them.
“health advocacy organizations” or “embodied health movements” (Epstein, 2008; Friedner, 2010; Landzelius, 2006; Rabinow, 1996; Rose, 2001, 2007). These are, indeed, movements where patients collectivize and self-identify through a shared biology, research that biology, and construct meanings about that biology in order to gain resources and funding for their (un)diagnosed conditions. One of the reasons sociologists are fascinated by this shift is because it affects, quite profoundly, how we understand and experience identity politics in the twenty-first century. But more importantly for the purposes of this chapter, sociologists are drawn to think about biosocialities for the simple fact that they bring to light this precise tension between embodied knowledge and expert knowledge. How do members of embodied health movements negotiate this tension? The answer to this question, like many questions that get asked in sociological research, is that it depends – namely on the specific set of biological and social circumstances facing each specific patient group, be it fibromyalgia (Barker, 2008), Morgellon’s disease (Fair, 2010), breast cancer (Klawiter, 2008) or “rare disease patients” (Wehling, 2011). In all cases, however, members of patient groups draw on the embodied knowledge of their condition to both contest and reproduce the truth claims of medical authorities.

\[14\] In some contexts, a medical diagnosis affords those who are living in poverty with resources and funding for everyday life, more generally. Anthropologists remind us of the central role that culture plays in organizing “diseased” patients, as seen in the ethnographies of João Biehl (2007) and Adriana Petryna (2002). Rather than use some of the aforementioned terms, Biehl and Petryna use “biological citizenship” to describe the biological forms of collectivization that emerge in the contexts of Brazil and Ukraine, respectively. This shift in terminology is meant to highlight the degree to which the benefits of citizenship are precariously tethered to a medical diagnosis thanks largely to neoliberal reforms and a changing global economy.
There is no question that the research being discussed, here, has helped us better understand the politics of scientific and medical knowledge – particularly how those knowledges come to be learned or contested through illness experiences and encounters with medical authorities. But, I wonder if it might be enriched by some of the aforementioned epistemological and ontological questions being raised by STS? Rather than locate knowledge in the minds of embodied subjects and medical authorities, why not spread the act of knowing across an entire network of actors that neither begins nor ends with humans? STS accepts that epistemic regimes change over time and place to affect how we experience and know the world around us, but so too do the scientific practices and technologies through which reality is “enacted” (Mol, 2002). As John Law (2008) summarizes: “The basic proposition that comes from STS and its cognate disciplines is this. Since the real is relationally enacted in practices, if those practices were to change the real would also be done differently” (p. 635; emphasis in original). From an STS perspective, therefore, it would make sense to ask about the practices through which acne becomes a real, tangible object that scientists see, doctors medicate, and patients experience. Embedded in these practices are ways of knowing about acne that must be juxtaposed with the knowledge human actors convey through texts and language.

But how, exactly, does one move beyond the embodied subject to locate knowledge in practices, objects, places, biology, etc., without also leaving behind the bodies through which knowing-subjects ultimately experience the material world? Timmermans and Haas (2008) appear to struggle with this precise question in their call for sociologists to study disease. One of the problems with the sociological literature on
health and illness, they argue, is that it overlooks the important role of biology in terms of
what one experiences or feels. Concepts such as “chronic illness” too often obfuscate the
material realities of specific diseases; diseases which are used as methods to access and
think about sociological concepts as opposed to sociological objects in their own right. In
turn, sociologists know very little about the “dynamic interplay between biological health
response, therefore, is to include biology in those same social, political and historical
relations of power through which health and illness are traditionally understood:

The price paid for conceptual amalgamation is an important loss of
specificity. Most clinicians and patients remain unconvinced that patients
with Alzheimer’s disease, diabetes, HIV, depression, and hypertension can
be lumped together in the melting pot of chronic illness. Investigating
hypertension not as a generic illness but as a specified disease forces the
social scientist to take specific changes in physiology into consideration.
(p. 664)

Their goal, in other words, is not to abandon experience as a topic of inquiry as much as
it is to ground experience in specific biologies that are enacted in and through practice. A
sociology of disease, then, would remain grounded in the “stuff” of which acne is
(re)made. How does acne in particular materialize on and through the body, and what
sorts of experiential possibilities are created and restricted in those pimpled
corporealities?

Sociologists of health and illness are not the only ones considering these
questions. Some feminist STS scholars have already begun to “corporealize” STS by
taking seriously embodied knowledge as that which both informs and is informed by
scientific practices, technologies, knowledges, etc. In one example, McCaughey (2010) reflects on the experience of being both a feminist STS scholar who has learned a particular way to critique breastfeeding discourses, and a mother contemplating breastfeeding: “In considering my commitment to and experience of breastfeeding as a mother/intellectual, I want to examine ways of theorizing both embodiment and complex bio-social practices while also showing just how complicated living/embodying feminist STS theory can be” (p. 80). In another example, Takeshita (2010) embodies the object of her research – the intrauterine device (IUD). She asks: “what did embodying the IUD do for me personally and for my scholarship?” and concludes that “dissecting [her] experience through an STS perspective illuminated how an individual’s contraceptive ‘choice’ is anchored in social and medical systems carefully designed to sustain the viability of contraceptive technologies” (Takeshita, 2010, pp. 53-54). It is not the case, then, that embodied knowledge is incidental to the broader project of STS. If part of that project is “to spread the activity of knowing widely […] out over tables, knives, records, microscopes, buildings, and other things or habits” (Mol, 2002, p. 50), scholars like McCaughey and Takeshita remind us not to forget spreading the activity of knowing over bodies, as well. In doing so, STS scholars might be said to practice what Davis (2007), following Moya (1997), calls a ‘theory in the flesh’ wherein “the physical realities of women’s lives […] profoundly inform the contours and contexts of knowledge” (p. 58).

I want to call attention to the fact that feminists are pushing at the theoretical and methodological boundaries of STS by putting theories of embodiment to work. This is not entirely surprising, given that “feminist theorists and researchers have been among the most prolific contributors to debates about science, technology, and knowledge in the social sciences and humanities” (Whelan, 2001, p. 538). The feminist contours of embodied scholarship, however, might also explain why research of this kind has been relegated to the boundaries by what Whelan (2001) terms “mainstream STS.”
Critical, biomedical and psychological acne research

To this point I have focused my attention on two bodies of literature that I put in conversation with one another throughout this project: critical perspectives on skin and critical perspectives on science, health and illness. Out of this fusion emerges a theoretical framework through which to construct a sociology of acne—one that is fundamentally concerned with the relationship between acne, knowledge and power. Strangely absent from each of these bodies of literature, however, is empirical research on the topic of acne. That is not to say it does not exist, but it is indeed limited. In what follows, I begin to describe the few attempts to research acne from within the humanities and social sciences, and also provide a brief description of the psychological research on acne. This latter body of literature, I argue, has largely erased the broader sociocultural and political context in which acne is being treated and experienced as a disease, thus highlighting the need for a sociology of acne.

Joan Brumberg’s (1997) *The Body Project: An Intimate History of American Girls* features a chapter titled “Perfect Skin” where she pays close attention to the various meanings, experiences, identities, material cultures, racisms, institutions and practices through which acne was understood and treated as a disease in twentieth century America. From Brumberg, we learn that the history of acne is a history that must be told through the intersections of race, class and gender. Using personal diary entries and media representations to tell this history, Brumberg begins to carefully situate the words and the images that she interprets in their appropriate historical context: “Pimples are a natural part of biological maturation but the meaning we give to them is derived from the culture in which we live” (p. 60). As the mirror became a permanent fixture of American,
middle-class homes towards the end of the nineteenth century, Brumberg argues that adolescent women in particular were beginning to pay more attention to their acne which had until then been a mostly tactile rather than visual problem in one’s life. Rendered visible to the self, the newfound place of the mirror in society meant that acne could – to borrow from Foucault – be “incited to discourse” in newly intimate and private ways.

Some of these ways are captured in the diaries of American, adolescent girls. Those who were born to Victorian, middle-class families found great shame in their pimples, not only because they represented an undesirable femininity but because acne signified uncleanliness, dirt and germs. As such, pimples threatened to undermine an emerging set of Victorian, middle-class sensibilities towards the first half of the twentieth century and were thus policed accordingly by the adolescent girls who were writing about them in their diaries, as well as their worried mothers. For racialized girls, pimples took on additional meanings. Brumberg cites the example of Jewish girls during the 1920s whose pimples were interpreted similarly to their Victorian, middle-class counterparts (e.g., dirty, unhygienic, etc.), but often through an anti-Semitic lens to say something unique about Jewish identity. And beginning around the 1930s, adolescent boys were also beginning to ascribe meanings to their pimples. Many of them were beginning to write about feeling discriminated against by potential employers because of their acne, and were therefore unable to find work, embarrassed and self-conscious. It was not until this point in history, Brumberg argues, that the male-dominated field of dermatology could relate to the suffering of their patients and began to take seriously the sociocultural registers of acne, labeling it a “life-threatening disease.” In turn developed an entire industry of new technologies and drugs designed for the explicit purpose of treating acne,
once again changing the way the disease was experienced by those who could afford to medically intervene on the skin.

Today, Brumberg is the only scholar to have written a cultural history of acne, which is surprising given that acne predates her analysis and shows up in cultural artifacts besides those found in the United States. Others have used medical texts to write medical histories of acne, looking as early as the ancient Greeks for evidence of the word’s first usage (Grant, 1951; Tilles, 2014). In most cases, however, these medical histories do not begin to provide much detailed analysis until about the eighteenth century when dermatology emerges as its own discipline. Led by such men as Joseph Plenck, Robert Willan and Thomas Bateman, the field of dermatology introduces a number of different taxonomic structures through which to systematically make sense of and organize the skin’s markings. Acne is of course classified and labeled within those structures, but encompasses a variety of different “types” of marks depending on the taxonomy being used. For example, “acne – the elementary lesion of which is a tubercle – [was] made of 4 varieties: punctate, simplex, indurate and rosacea” within Thomas Bateman’s taxonomy of skin diseases (Tilles, 2014, p. 2). One of the central takeaways from medical histories of acne, therefore, is that the category not only changes to reflect a number of different meanings over time, but is also constantly expanding and contracting to include a variety of different materialities as well.

The historical scholarship on acne is sparse, but from it emerges some important considerations – about intersectionality and the social construction of dermatology – from which to develop a sociology of acne. Unfortunately, intersectionality is largely absent in the work of Ben McMahon (2012), whose research interest is in theorizing acne-related
shame. The shame experienced by acne sufferers, he argues, can be explained by a culture that both normalizes and idealizes clear skin, whilst pathologizing pimpled skin. In other words, whatever differences exist within a given population of acne sufferers are understood to have little or no role in the experience of acne-related shame. Instead, what makes the disease a shameful one is that it represents a deviation from cultural representations of “normal” and “ideal” skin. Important as these insights are, a consideration for the intersectional identities of research participants might have produced unseen layers and modes of resistance to the cultural meanings of “normal” and “ideal.”

Despite its limitations, McMahen’s research is at the very least one example of a critical attempt to make sense of contemporary experiences of acne. Indeed, this is a feature that is often missing from the vast majority of acne research appearing in biomedical journals. These journals might include experts writing in the fields of microbiology, dermatology, family medicine, psychology or social psychology and whose research tends to focus on the pathophysiology, treatment, or emotional suffering of acne. It is beyond the scope of this project to provide an extensive review of each of these bodies of literature; however, given my interest in the relationship between skin and subjectivity, I should briefly mention what I see as being three central problems with the (social) psychological research exploring the relationship between identity and acne. Firstly, researchers doing social psychological research on acne are often quick to observe differences in age and gender (Lasek & Chren, 1998; Loney, Standage & Lewis, 2008; Magin et al., 2006; Mulder et al., 2001; Murray & Rhodes, 2005; Pawin et al., 2007; Thomas, 2005), but often neglect to account for racial differences. This absence is
a problem on its own, in that it fails to take into account the specific issues that non-white persons experience through acne (a topic that I begin to explore in Chapter 4). But the problem is compounded by the fact that (social) psychological acne research lacks the critical and sociological tools to help us make sense of social differences. Politicized identities are made into depoliticized and psychological labels rather than historical and sociological ones. Moreover, the subject of biomedical acne research appears to be a rational, conscious, and thinking actor as opposed to a fractured, unconscious and embodied one. Secondly and relatedly, the methods being used in the majority of (social) psychological acne studies are quantitative, meaning that they tend not to generate the kind of rich and thick description (Geertz, 1973) that would be necessary for understanding the lives of acne patients in any great detail. Lastly, an underlying assumption behind much of the (social) psychological acne research is that acne is a medical problem that can be resolved through some form of medical intervention (i.e. psychological, dermatological, pharmaceutical, etc.). Taken for granted, then, are the logics and practices that go into making acne a medical problem in the first place. Furthermore, as these researchers rush to medicalize the condition, one begins to wonder who and what they are missing in their analysis. Can acne become something other than a medical problem in someone’s life? And if so, how?

With the exception of two notable examples (Brumberg, 1997; McMahen, 2012), acne has been overwhelmingly researched as a biomedical problem. My main contention with this research, however, is that it naturalizes acne in such a way that its material and emotional encrustations appear the inevitable result of a fixed – rather than socially constructed and scientifically enacted – disease. In other words, the realities of acne
appear locatable in both the molecular and psychic lives of the subject, but are rarely considered to exist in the scientific methods, dermatological practices, pharmaceutical objects, visual medias and cultural discourses that make acne the meaningful and perceivable biology that it is today. My project is one that hopes to address this oversight in acne research through the use of two separate bodies of critical literature examining skin and science, health and illness respectively. By putting these eclectic and interdisciplinary fields of study into conversation with one another, I have two goals: I want to make an empirical contribution to our understanding of acne, disease, health and illness, as well as make a theoretical contribution to an embodied sociology that has yet to fully consider the ways dermatology or diseased skin intervene on and organize social life.
Chapter 3

Methods

In the months leading up to my research, I managed to convince myself that it would not be difficult to recruit participants for a study examining peoples’ experiences of acne. Only through a number of specific encounters with friends and colleagues was I able to reach such a conclusion. These were encounters that left me with the optimistic impression that people were excited to share the personal and intimate details of their acne experience. Indeed, I was amazed that my friends and colleagues were willing to speak about their acne experiences so candidly, without being asked the sorts of probing questions that I anticipated having to ask in interviews. Unfortunately, it was not until after I experienced difficulties recruiting participants that I began to reflect critically on these encounters. In most cases, the people opening up to me were people with whom I either shared relationships built on trust and/or a shared critical interest in body politics. There was also no audio recorder to interfere in the exchange, adding yet another layer of trust to the conversation. And lastly, the people with whom I spoke prior to beginning my research were all recalling an experience. For each of them, acne was accessible through memory as opposed to being a present and lived reality. Shame did not enter into their voicings of acne in the same way that it might for a person whose skin is visibly marked by the disease.

My original proposal was to recruit approximately ten to fifteen participants who were currently experiencing acne, and interview each of them on two separate occasions. Using the first interview to “scratch the surface” of acne and establish some trust, my plan was to then ask participants to use visual methods and create a video or
photographic diary of their daily skin routines (Pink, 2006). During our second interview, we would talk about the everyday, taken-for-granted and unconscious habits being represented in their diaries, and use them as a means to access the experiential elements of acne that often “go without saying.” In short, the goal of the diaries was to have subjects reflect on the practices and objects through which acne becomes meaningful in our culture. I designed recruitment posters for the study and displayed them in select locations across Kingston, Ontario, including high schools, community centres, spas, family doctor’s offices, hospitals, salons, esthetics centres, walk-in clinics, and a variety of other local businesses. I also expanded these recruitment efforts into a number of different virtual Kingston communities. Alas, weeks went by without receiving a single email or phone call from an interested participant.

This was not a problem of exposure, I thought. Though I had no way to prove it, I was convinced that potential interviewees were aware of my study because several friends managed to recruit participants for their own research using the same strategies in the same places. The problem, rather, was the topic itself. Who wanted to talk to a complete stranger about the intricacies and intimacies of their acne? Thinking back to the earlier conversations I had with friends, I considered recruiting those people with whom I already shared a relationship built on trust; however, none of those people were currently experiencing acne. Moreover, I did not think it appropriate to approach my friends who are currently experiencing acne given that none of them had ever opened up to me about the subject before. I was not about to suddenly call attention to their acne because of my

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16 I was denied in my request to display a recruitment poster at the local dermatologist’s office.
research. If they had wanted to talk about it, I figured they would have mentioned something on their own.

Humbled by the early results of my recruitment efforts, I began to rethink my methodological approach. In particular, I searched for other ways to access the lived experience of acne that did not require so much voluntary emotional work from a group of participants who are already encumbered by the physical, social and emotional work of acne. By that time, I was already becoming familiar with some of the ways acne was being talked about on the Internet. Internet resources comprised part of my original methodological proposal, because they contained information and discourses about the disease that could potentially help me make sense of my interviewee’s words. As other scholars have noted (Barker, 2008; Conrad & Stults, 2010), the Internet is an important tool through which people learn how to think about themselves as diseased. At this point in my research, however, I began to take a very specific interest in virtual communities of acne patients. Underneath my original methodological proposal, there was little need to engage seriously with these communities of people who shared their stories, experiences and knowledge of acne in virtual space. But, after it became clear that interviews and video/photographic diaries were no longer a viable option, I found that some of these communities might actually contain rich and descriptive insights into the embodied experience of acne.

I was originally drawn to acne.org because of its large membership base consisting of over 500,000 unique users from around the world and millions of posts
dating back to as early as 2006. The community remains active today and provides publicly accessible information to thousands of members and millions of presumed “lurkers.” I was also impressed by the honesty and depth to which users publicly share intimate details about their experiences with acne. Some users even go so far as to record daily “logs” of their skin, where they observe, record and reflect daily on any changes to their skin and skin practices. Could this qualitative data provide me with access to a similar set of embodied practices and struggles that I originally hoped to access through interviews and visual methods? I recalled Annemarie Mol’s (2002) words:

It is possible to listen to people’s stories as if they tell about events. Through such listening an illness takes shape that is both material and active. It is an illness that consists of lying on a sloping table. Of arguing with your anesthesiologist about the cloth in front of your eyes. It is an illness made up of scars on your legs that do not stop you from becoming a new person. This illness is something being done to you, the patient. And something that, as a patient, you do. (p. 20)

I kept these words in the back of my head as I continued to read users’ posts on acne.org, realizing quickly that I had stumbled upon a rich dataset through which to explore the embodiment of acne. Not unlike the personal diaries that Brumberg (1997) used to

17 I grappled with the ethics of researching people who were unaware that they were being researched. According to my institution’s online ethics guidelines, the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2), and methodological experts (see: Ritchie et al., 2014), my research was non-obtrusive and involved texts that belonged to the “public” realm. That is to say, those who post on acne.org do so with the understanding that posts are visible to the public at large. There is no expectation that viewers register with a username and password in order to access acne.org’s material. Nevertheless, the value I place on informed consent continued to make this a difficult decision. Rather than seek consent from a large group of internet users whose only contact information was either insufficient, outdated, or inaccessible, I sought to protect some of their privacy by removing their usernames/handles as well any direct links to their comments or threads. I did not, however, remove or alter any personal identifiers (e.g., race, gender) given the sociological relevance of this information.
18 Lurker is a slang term used to describe those people who simply read users’ posts without ever inserting their own voices into the conversation through a registered member account.
explore the history of acne in twentieth century America, I had available to me a set of virtual diaries. There are, of course, important differences between these “diaries” – most notably the authors, the medium, and the expectations of privacy – but they are, nonetheless, connected by an experiential voice. That is to say, the body as well as the objects, practices and discourses through which bodies become known figure centrally in both sets of diaries.\textsuperscript{19}

I hope that in learning about the methodological history of this project, the reader is better able to understand what draws me to acne.org. Unlike many other sociologists of health and illness, electronic support groups (ESGs) are not the main focus of my project (Barker, 2008; Conrad & Stults, 2010; Conrad, Bandini & Vasquez, 2016; Zaslow, 2012). I am not interested in what acne.org does to “empower” patients whose truths are different from those being constructed by medical experts; nor do I care to determine whether or not members of acne.org end up contesting or reproducing biomedical understandings of their illness. Moreover, this is not a study that takes as its primary focus the Internet’s role in shaping the experience of health and illness. Of course, I remain somewhat invested in these concerns and look to weave them into my analysis where appropriate; but the point of what I am trying to say is that acne.org interests me for reasons that go beyond the contemporary role of ESGs in medicalized societies. In keeping with the broader objectives of this study and following the work of Mol (2002) and Timmermans & Haas (2008), it is acne – more than acne.org – which I intend to critically understand. It is thus worth reminding ourselves, here, that the Internet can be

\textsuperscript{19} I left these diary entries untouched and did not attempt to “clean them up” or participate in the practice of identifying misspelled words with [sic]. What scholars identify as mistakes or errors in online writing are, oftentimes, purposeful re-workings of the English language.
used as the object of research as well as a tool through which one collects data for their qualitative research (Lewis & Nicholls, 2014; Markham, 2011).

This project is more likely to fall underneath the latter of these two options because the Internet is understood to be one of many places where acne comes to be known. To embark on Mol’s project is to also locate knowledge in the events, objects, practices, places and people that are being described on the Internet. This involved moving beyond acne.org and incorporating a wide array of acne-related Internet blogs, articles and videos into my analysis. I also conducted interviews with dermatologists, pharmacists and family doctors, and sought to familiarize myself with some of the scientific and medical literature on acne so that I might “spread the activity of knowing widely” (Mol, 2002, p. 50). This is a process that John Law (2002) calls “decentering the object,” and Mol (2002) describes as such: “It does not simply grant objects a contested and accidental history (that they acquired a while ago, with the notion of, and the stories about their construction) but gives them a complex present, too, a present in which their identities are fragile and may differ between sites” (p. 43; emphasis in original). Indeed, acne becomes something very different depending on whether you are at the dermatologist’s office, visiting your family physician, in front of a mirror at home or in the company of a loved one. The person experiencing acne is also, by no insignificant matter, an important subject in the making of acne. As such, I made decisions about which texts to include in my analysis that would reflect acne’s “complex present.”

Given the overwhelming amount of acne-related information available on the Internet, it was important that I find a way to organize all of my sources into a rich yet manageable dataset. For a span of three years (2013-2016), I used “Google Alerts” to
notify me of any newly published online material that referenced the word acne. These references were compiled into a personalized email that I read each morning as part of my daily routine. When I came across an article, image or video that was relevant to my research questions, I saved a copy of the file to my hard drive so that I could later analyze and code it in finer detail. I also used these opportunities to search elsewhere on the Internet for sources that touched on a similar set of issues, experiences, meanings, or practices as the original source, but pre-dated 2013. In December of 2015, I also began the process of creating a manageable dataset with which to analyze user posts on acne.org. I started by including only those “threads” (i.e. topics of conversation) that generated ten or more posts from users. This was a decision I made based on the assumption that some of the most relevant similarities and differences in the embodiment of acne were to be found in threads that generate the most dialogue and debate.  

Lastly, I interviewed a total of five medical practitioners including two dermatologists, two family

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20 One could perhaps make the alternative argument that threads generating the least amount of dialogue or debate represent experiences that are truly different or “on the fringe,” so-to-speak. From such a perspective, my methodological choices might be understood to marginalize and erase those whose experiences fall outside what is considered to be “normal.” I do not believe this to be the case, however, as Davis (1995) reminds us that part of the way “normal” regulates and disciplines subjects is by identifying those who are “abnormal” and leaving them to deal with the consequences of being labeled as such.
doctors and one pharmacist.\textsuperscript{21} I used purposive sampling techniques in the sense that I specifically reached out to a variety of different professionals who specialize in different areas of medicine; however, I also utilized convenience sampling techniques, which made use of the fact that (with one exception) the interviewee and I shared a mutual friend. The interviews were semi-structured in nature and ranged anywhere from one to two hours in length. Each participant was provided a copy of the written transcript and given the opportunity to make any edits in order to clarify or omit any of the statements they made.

Interview transcripts, acne.org posts and Internet blogs, articles, videos and images were all organized, analyzed and coded in one large dataset using the qualitative data analysis software, \textit{Atlas.ti}. With over 60,000 pages of text (the vast majority of which came from acne.org), my goal was not to analyze every single page with the necessary attention to detail required of qualitative researchers. Rather, I began to slowly work my way through the various sources using codes to identify an emergent set of themes.\textsuperscript{22} As my code-list became more concrete and I found myself adding fewer new codes, I used the search feature in \textit{Atlas.ti} to identify other instances where that code

\textsuperscript{21} I realize that this sample size is small compared to what methodologists argue in the literature. For example, Adler and Adler (2012) recommend having no fewer than twelve interviews in a single study. Part of the reason it is so small, however, is because of the broader scope of the study. I wanted to know what medical practitioners had to say about acne, but did not make this the explicit focus of my research. With a limited amount of time, I had to be strategic about balancing a series of different perspectives. Another reason I limited myself to five interviews with medical practitioners is because of access. Many of the interviews I did manage to secure came as a result of personal connections and mutual friends. Without those connections, I had considerable difficulty recruiting interviewees both within Kingston, ON and beyond.

\textsuperscript{22} I spent approximately five months doing nothing but analyzing my dataset and reading theoretical and empirical literature on skin, health and illness. Those themes that emerged, therefore, emerged out of a dynamic exchange between the data and theory.
appeared in my unanalyzed data. In the end, I was left with a code-list that linked me to thousands of rich and descriptive quotations from a variety of different sources. This helped make an otherwise unmanageable dataset manageable, navigable and ultimately writable.

My use of data management software aside, I do not want to pretend that I come to this project as a neutral observer. My own struggles with acne largely pushed me to this project, and they most certainly came to inform the way I interpreted and made sense of the data being shared with the reader. This became most apparent to me as I was analyzing and writing about some of the themes explored in Chapter 6 (Psychosomatic Adventures With Acne): how does one methodologically access the psychosomatics of acne without having at least some embodied sense for the feelings being described? In Chapter 6, I attempt to grapple with this question using psychoanalytic theories of skin. Acknowledging that psychoanalysis has an “abstracting” reputation amongst people from both within and outside the academy, I want to be clear in saying that I did not use psychoanalytic theories of skin to abstract my relationship to the participants whose words I analyze. Rather, I am thankful that my participants spoke about their acne with the kind of candor and honesty that they showed.23 In doing so, I was able to recognize parts of myself that I had once known intimately through my own experiences with acne. I realize that these details were not knowingly shared with me, as they might have been in the context of a psychotherapy session (which I am not qualified to administer!). Nevertheless, psychoanalysis helped me to both theoretically understand what I was reading, as well as methodologically situate me as an “analyst” of sorts, reading and

23 I am not sure if such candor and honesty would have manifested as part of my original methodology. I suspect that the anonymity of the Internet helps in this regard.
interpreting the stories of different “analysands.” I have no doubt that my own experiences with acne became part of the psychosomatic lives of those I was reading about, creating what is referred to in psychoanalysis as countertransference: “The focus on countertransference points to a final, important part of the first psychoanalytic formulations of the self: psychoanalytic knowledge of the self originally concerned the self of the analyst as well as the self of the patient” (Chodorow, 1989, p. 162). In other words, I have an embodied knowledge for what acne feels like and through which I am sure to have interpreted some experiences of the skin as more meaningful than others.
Chapter 4

Pimpled Differences

In this chapter, I explore the politics of identity as they come to be lived and negotiated at the surface of the body. In particular, I focus my attention on the ways race and gender matter in people’s experiences of acne. Building on the work of Paul Gilroy (2000), I consider the ways contemporary experiences of acne are rooted in two different but related types of racial biopolitics that he refers to as “dermopolitics” and “nano-politics.” Afterwards, I draw inspiration from material feminisms in order to conceptualize acne as that which is both produced by, and produces, gendered subjects. I argue that the boundaries of identity are disrupted in and through the experience of acne. Acne sits uncomfortably on those boundaries and threatens to undo or reconfigure the racialized and gendered contours of the body. In what follows, I explore some of the discourses, practices and objects through which pimpled subjects attempt to negotiate dermatological and political differences atop the surface of the body.

Dermopolitics

In his book Against Race, Paul Gilroy (2000) offers an important critique of Michel Foucault’s notion of biopower. Speaking of Foucault, he writes:

For all his great historical insight into the problem of the individual observer as a locus of knowledge, the formation of epistemologies with novel investments in observation, and the shift “signaled by the passage from geometrical optics of the seventeenth and eighteenth centuries to the physiological optics, which dominates both scientific and philosophical discussion of vision in the nineteenth century,” he seems to have been insufficiently attuned to the significance of protracted struggles over the raciological disunity of mankind that attended the emergence of biopolitics […] Although his analysis, which witnesses the birth of biopower, seems ripe for a decisive confrontation with the idea of “race,” this never happens. (p. 44)
It is true, Gilroy acknowledges, that science and technology allowed experts to see the body in new ways. His issue with Foucault’s history of biopolitics, however, is that it largely erases the fact that the (white) experts to whom he refers also learned new ways to see – and therefore to produce – the racialized body. Upon taking into consideration the racialization of perceptual regimes, one can begin to “periodize” the history of biopolitics somewhat differently from Foucault. Suddenly, it becomes possible to speak about a “historically specific system for making bodies meaningful by endowing them with qualities of ‘color,’” through which the “racialized body is bounded and protected by its enclosing skin […] the observer’s gaze does not penetrate that membrane but rests upon it and, in doing so, receives the truths of racial difference from the other body” (Gilroy, 2000, p. 46).

Gilroy introduces the term dermopolitics to describe this historically specific system where biopolitical power functioned on and through the surface of the body. Of course, the racial sciences were at one point largely concerned with the brains and skulls of racialized bodies, materializing through the well-documented sciences of phrenology and physiognomy. But these sciences eventually gave way to what Gilroy, following Fanon, describes as “epidermalized” forms of power that sought to mark racial difference in skin itself: “The skin has no independent life. It is not a piece or component of the body but its fateful wrapping. Dermo-politics succeeded biopolitics” (Gilroy, 2000, p. 46). Dermopolitics, in other words, designates an important (albeit gradual) epistemological shift in the racial sciences that can be traced as far back as Kant’s *Physische Geographie*, which notes “the distinctive attributes of tough Negro skin and the practical problems it presented to slave husbandry when pain had to be inflicted on
stock with a split bamboo cane” (Gilroy, 2000, p. 46; emphasis added). Importantly, Gilroy warns against understanding this dermopolitical shift in a scientific vacuum, reminding us of “vernacular observational codes that have a tangential or ambivalent relationship to racial science proper” (Gilroy, 2000, p. 45). In fact, it is precisely this confluence of scientific and common sense understandings of skin that Fanon (2008) refers to as an “epidermal racial schema,” or that which reaches beyond scientific communities to structure the everyday, intersubjective experience of racialized embodiment: “I am overdetermined from the outside. I am a slave not to the “idea” others have of me, but to my appearance” (p. 95). In the daily intimacies and encounters that Fanon shares with his reader, skin becomes the epistemological fixation of the gaze; that which structures his relations with self and others, and that which ultimately reaches out into the world and reveals the “truth” of his being.

Gilroy’s (2000) thesis, however, is that our contemporary moment is no longer marked by the dermopolitical workings of power. Instead, in what appears to be a cyborgian commitment to theorizing subjectivity, Gilroy argues that innovations in the fields of biotechnology, biomedicine and molecular biology (specifically their ability to see beyond the body’s surface) produce new ways to racially differentiate one’s self and others besides those which are offered through an epidermal racial schema. Writing about the postmodern shift from dermopolitics to what he terms nano-politics, Gilroy remarks:

When the body becomes absolutely penetrable, and is refigured as the transient, epiphenomenon of coded invisible information, that aesthetic, that gaze, and that regime of power are irrecoverably over. The idea of epidermalization points toward one intermediate stage in a critical theory of body scales in the making of “race.” Today skin is no longer privileged as the threshold of either identity or particularity. (p. 47)
He continues by noting that “the boundaries of “race” have moved across the threshold of the skin [and] are cellular and molecular, not dermal” (Gilroy, 2000, p. 47; emphasis added).

While Gilroy’s argument notes an important and recent shift in the technoscientific production of race, I am unconvinced that our contemporary racial landscape has completely moved on from something other than dermopolitics. I do not altogether reject the argument that race is being molecularized, geneticized and neurologized in new and interesting ways, but positioning dermopolitics as though they are incommensurable with nano-politics seems to overlook some fairly important context. I agree with Edmond Chang (2012) that Gilroy seems to imply that the “body itself, all of its cellular and atomic works, is rendered as more important than its shell, its covering” in our contemporary moment (p. 146). But what if Gilroy were to conceptualize twenty-first-century skins as more than a bodily “accessory” or “wrapping” (Chang, 2012)? Indeed, “how might the skin serve as one way to reconfigure [biopolitical] understandings of the body and of embodiment” (Chang, 2012, p. 146)?

In this section, I am concerned with the mutually constitutive processes by which pimples are both racialized and racializing. Interestingly, acne reveals some of the aforementioned context that I find missing from Gilroy’s (2000) scholarship, highlighting the ways dermopolitics and nano-politics are intertwined. While acne brings to the surface biological differences in the molecular composition of skin “such as pigment; follicular response; curved, flat hair; and fibroblast reactivity” (Johnson, Jr., 1998, p. 3), it also brings about noticeable changes to the colour of skin that are managed, negotiated and experienced in plain sight for the world to see. Thus, acne materializes as both a
dermopolitical and nano-political affair in the lives of racialized individuals for whom those sets of politics remain deeply entrenched in the legacies of biomedical racism and whiteness.

Racializing complexion

It is safe to assume that Kendrick Lamar (2015) did not have acne in mind when he wrote the song “Complexion.” The chorus is sung in soft harmonies with a message that partly acts as an anti-shadeist mantra: “Complexion (two-step), complexion don’t mean a thing (it’s a Zulu love); complexion (two-step), it all feels the same (It’s a Zulu love).” In the verses, Lamar raps about finding beauty in all shades of black skin, reminding their listener that “we all on the same team.” Dating back to the Black Power movement of the 60s, Lamar finds himself reciting an old yet still timely message that “black is beautiful.” Nevertheless, there seems to be an odd disconnect between the complexion that is vocalized in Lamar’s song and the complexion being written about by scientists, treated by dermatologists, and experienced by racialized individuals with acne. Here, the problem of complexion materializes as both a cultural and biological problem; it is that which is threatened, lost and damaged by acne and desired by doctors and patients in practice. In short, complexion comes to mean many things.

On the microscopic level, issues pertaining to complexion and race often begin with a discussion of melanocytes – tiny cells that produce the pigment melanin. As one dermatological textbook suggests, these racialized bits of matter often present a series of complications for dermatologic practice: “Because black skin has more melanin, the effect on melanin pigment by dermatologic disease or environmental factors is heightened. This increased effect becomes the basis for the dermatologic changes of
hyperpigmentation and hypopigmentation” (Johnson, Jr., 1998, p. 3). Melanin interests Gilroy (2000) because it is through this nanoparticulate material that he identifies new forms of racial solidarity taking place. Indeed, he includes several passages from authors (whom he calls “melanists”) that speak about the pigment as if it were biologically capable of “call[ing] out to them and to each other the siren song of collective (never individual) racial memory” (p. 258). But, where melanists find a source of racial pride and cultural history, doctors and patients find risk and racial uncertainty. Melanin does, of course, produce intraracial alliances through dermatological practice as doctors and racialized patients are tasked with the responsibility of preserving its nano-political significance. But, melanin also opens individuals with acne up to unruly pigmentations in and through dermatological practice. The colour of their skin multiplies, hybridizes and acts as a source of dermopolitical tension as it undergoes a process referred to by doctors as hyperpigmentation.

Users of acne.org very rarely make explicit reference to melanin but often allude to pigment in more subtle ways. As one user writes, these differences in pigment make for very different biological and cultural experiences of acne: “…It helps when you see someone of similar color as you. We have different skin types and because we can get brown and black dark spots from acne. It is different for us.” Without using the words melanin, hyperpigmentation or hypopigmentation to describe biological differences in skin, patients come to know about those biological differences in and through their dermatological experiences with acne. There are, as this user suggests, different “types” of skin. Similarly, one of the dermatologists I interviewed used the following nomenclature to describe racial differences in acne:
So, taking care of acne in patients with skin of colour, you have to be a little bit more careful. In people who have darker skin, it’s not just the acne that you’re treating, but also people with darker skin – anywhere from Asian, Latino, African American, sometimes even Mediterranean skin types – when people get pimples, they leave brown spots. So the pimple might last a week or two but then the brown spot will last six months. So it’s really annoying and frustrating. (Jennifer, personal communication, August 24, 2015)

Although melanin goes unsaid in each of these accounts, it is clearly the nano-particulate matter through which acne organizes and is organized by “skin-types.” It is through the experience of lasting, dark and brown “spots” that melanin animates acne into a particularly racialized disease with racialized symptoms and effects.

There is also no mention of the word “race” in either account. Members of acne.org and dermatologists alike are attuned to the colours of skin in ways that re-assemble racial boundaries through references to “skin type.” In a perfect example of the dermopolitics Gilroy rejects, the aforementioned acne.org user writes: “It helps when you see someone of similar colour as you.” Here, the gaze is unmistakably pointed in the direction of skin. Some acne.org users share pictures of themselves while others attempt, as best they can, to describe the colours of their skin (e.g., “dark-skinned Indian;” “light-skinned Black;” “olive Asian”). Either way, racialized identities are negotiated in the intersubjective exchanges between user/user and patient/doctor. Playing with Fanon’s original concept, we might refer to this way of seeing as a “racial dermatological schema” through which the colours of skin are both racialized and medicalized into types. As one user from acne.org illustrates, this is a schema by which skins are perceived as multi-coloured: “Ur redmarks look exactly like mine! I am an Asian too!” In this example, the redness of the marks left behind by acne sits in productive tension with the colour of Asian skins. Whether it is blackheads, whiteheads, dark, red or brown spots –
the colour of one’s acne always accompanies the colour of one’s skin to produce a medical-racial “skin type.” Users practice and develop this schema through hours of looking at high resolution, close-up photographs of skin and reading detailed dermatological descriptions available through acne.org.

Doctors also develop a similar schema through their education and practice with acne. The dermatologist quoted earlier spoke at length about the various nuances involved with diagnosing and treating acne in racialized groups. Although some of this knowledge came from lectures and texts on the subject, she revealed that the majority of her knowledge came from practice: “I was lucky enough to work with a woman who was a skin of colour expert at Glennorth who was very good…so much of our teaching takes place through one on one instruction” (Jennifer, personal communication, August 24, 2015). Moreover, she continues to practice dermatology in a highly populated urban centre, making for a racially diverse clientele: “I have lots of everybody! Lots of Asian patients, lots of white patients…not as many Latino patients. I did at Glennorth but not so much now. Lots of African American patients, lots of African patients…” (Jennifer, personal communication, August 24, 2015). Her experience working with and seeing acne in racialized groups makes clear that she embodies a practical knowledge for different “skin types.” That is to say, she is able to see them whereas many other dermatologists are not.

This point became clear in an interview with another dermatologist who practiced in a small, mostly white town. When asked to explain how one learns about racial differences in the diagnosis and treatment of acne, he explained: “It depends on your training…where you are; because it all depends on what you’re exposed to […] I would
say that we do learn some of it [racial differences in skin], but a lot of medicine is based on experience. You can read about as many things as you want but until you actually do it in practice, you don’t have a lot of experience” (Stephen, personal communication, September 7, 2015). In other words, one cannot learn a racial dermatological schema through textbooks or pictures alone, but must actually have some practice working with, seeing and treating racialized patients. When learning how to see, there is no substitute for real skin. Neither the photographs appearing in scientific and medical journals nor the models attempting to chart various skin types can prepare doctors for the liveliness of skin, its tricks, and its capacity to change form. Indeed, the skins that doctors will encounter in their practice are far less fixed than what photographs or texts are able to capture: “Making a dermatologic diagnosis is often more difficult with a dark-skinned patient because subtle changes in skin color may be hidden. Pink and light red hues may be totally missed. Dark reds and browns may appear as purple, grey, or black” (White, 1998, p. 43). Although textbooks can attempt to visualize or explain a variety of skin types, dermatologists agree that one needs practice seeing them and identifying them in action.

Are dermatologists without that practical knowledge therefore operating outside of a racial dermatological schema? I would respond to this question with an emphatic

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24 One such model is the Fitzpatrick Scale, originally developed in 1975 by Dr. Thomas Fitzpatrick. Importantly, those who did not have “white” skin were excluded from Fitzpatrick’s original research studying the dermatological effects of sun exposure. It was not until later that “darker” skin tones were added to the scale. In practice, the Fitzpatrick Scale used to require clinicians who would assign patients numerical values or “scores” on the basis of three factors influencing skin type (e.g., a patient’s genetic disposition; reaction to skin exposure; tanning habits). Today, however, those skin types are visualized, represented, and widely accessible to patients online who want to determine their own Fitzpatrick skin type (see Appendix A for an example).
“no,” citing the important work of critical race theorists (Delgado & Stefancic, 2001; Roediger, 1991; Yancy, 2005). For these scholars, whiteness acts as the invisible norm upon which otherness is constructed. In this case, despite having very little experience treating acne in patients with nonwhite skin, the aforementioned dermatologist has years of experiential knowledge from his dealings with acne in white patients. He, too, has learned a particular way of seeing skin types – which is to see beyond them: “I mean, if I saw somebody who was of an ethnic background here, I would treat them probably very similarly because our treatment paradigm or treatment ladder of acne is fairly well established and does cover a broad range of types and so I usually treat the patient as opposed to the ethnic group” (Stephen, personal communication, September 7, 2015). In this example, ethnicity is clearly marked as other in relation to a white “treatment paradigm.” This formulaic approach to treatment functions as a paradigm – that is, a way of seeing – whereby racial (or ethnic) differences collapse into a universal subject. This viewpoint was shared by a practicing pharmacist from the same small town: “I never, ever, ever say these things: a teenager is a teenager is a teenager is a teenager [laughter]. And I don’t believe that in much of anything else!” (Deborah, personal communication, April 1, 2016).

These differences in the racial dermatological schemas of physicians and patients are often talked about on acne.org. As members share stories about their experiences with various doctors and treatment paradigms, they write about acne as a distinctly “racialized disease” – a label that is actively being contested in and through their relations with medical authorities, pharmaceuticals and scientific research. Many of them argue that acne brings to life racial differences in the skin (i.e. melanin and the risk of
that the biomedical establishment either cannot, or refuses to see. As one user writes about her dermatologist: “He’s Caucasian (not anything wrong with that) but he obviously doesn’t know much about black skin and hyperpigmentation. Sorry that’s just my opinion.”

*Medicating racialized pimples*

Members also make implicit reference to the racial dermatological schema of pharmaceutical research. When it comes to available, safe and effective acne medications or treatments, the multi-billion-dollar market appears to have a particular (white) consumer in mind: “I hope I don’t sound ignorant when I say that I don’t think that some of those medications were geared for skin like ours,” one user writes. In a different thread about laser treatments, another user writes: “There are plenty of laser treatments available, unfortunately I have been told by numerous Docs that they are not a viable solution on African American skin. It would lead to even worse scarring.” Acne – or more specifically, the experience of medicating acne – thus calls attention to a number of inequalities in the way skin disease is known, treated and lived depending on the colour of one’s skin.

Anne Pollock’s (2012) *Medicating Race: Heart Disease and Durable Preoccupations With Difference* helps us understand these racial differences (and the forms of collectivization they spawn) in context. She notes that race is particularly challenging to talk about in a medical context because many antiracist scholars and activists steadfastly reject any and all biological appeals to race; yet, racial differences in disease appear biological because they materialize on and through fleshy bodies. We can see those differences take shape underneath microscopes, through imaging technologies,
detailed records of mortality rates, or in the case of acne: the skin. Indeed, it is through the diagnosis and treatment of acne that many individuals are brought to an awareness of the politics of melanin, and the biological “stuff” through which acne is experienced as a particularly racialized disease. Whereas many scholars and activists are quick to lament the reification of race and remind people that race is, in fact, a social and political category – not a biological one – Pollock takes a different approach. Instead, she asks what is the historical and political context for these lasting and “durable preoccupations” with race in medicine? In other words, faced with mounting scientific evidence of the biological insignificance of race, how does race continue to be medi(c)ated as though it were, in fact, biologically significant?

Pollock looks to the history of coronary heart disease in America for some answers to these difficult but relevant questions, and highlights the ways race and citizenship are intimately bound to the biomedical project. Her first task is to document the long history of African Americans who struggled to be recognized as both research subjects and experts (e.g., scientists, doctors, etc.) conducting or making use of heart disease research in practice. Problematic biological-racial narratives such as the slavery hypothesis\(^\text{25}\) and race-based pharmaceuticals such as BiDil\(^\text{26}\) have emerged out of these struggles, but rather than “prove them wrong” for their biological determinism Pollock instead wonders how the struggle to racialize disease exists as part of a much larger black struggle for citizenship, recognition and rights in America. She draws parallels to the

\[\text{\textsuperscript{25} The slavery hypothesis is the evolutionary idea that the transatlantic slave trade produced conditions encouraging salt-retention and thus genetically predisposes African Americans to a greater risk of hypertension.}\]

\[\text{\textsuperscript{26} BiDil was introduced to the market in 2005 as the first pharmaceutical designed and marketed to treat disease in a specific racial group.}\]
work of medical anthropologists who write extensively about “biological citizenship” (see: Biehl, 2007; Petryna, 2002), and argues that the articulation of racialized disease is one way for racialized individuals to participate in a biomedical project that has historically and systematically excluded them. She writes:

Pharmaceutical research is a central project of American medicine, and pharmaceutical consumption an important site of American biological citizenship. This renders problematic critics’ complaints that BiDil “not only…biologizes race but also…create[s] the impression that the best way to address health disparities is through drug development. (Pollock, 2012, p. 177)

Pollock thus situates the racialization of heart disease alongside three important pieces of context: 1) consumer capitalism; 2) ongoing struggles for equality and civil rights; and 3) health disparities that continue to follow racialized contours. In doing so, she provides us with a lens to understand the sorts of experiences and requests being articulated by racialized acne.org members, who struggle to find effective treatments for their acne (i.e. those that take hyperpigmentation into account).

This is a struggle that takes place within the context of a rapidly expanding acne market and skincare industry. When asked what has been the biggest change in the medical management of acne, the clinicians I interviewed consistently referred to the number of prescription and over-the-counter acne medications available to their patients. For many, the newfound abundance of acne medications offers a sense of hope and optimism that a “cure” exists out there on the market, only to be found by fully embracing pharmaceuticalized modes of consumption and experimenting with them. But this is a cautious or even skeptical embrace for racialized members of acne.org, who attempt to navigate the acne market together, collectively and carefully. For the majority who are unable to access a dermatologist or doctor with experience treating acne in
people of colour, acne.org provides a virtual setting to share embodied knowledge about treating and experiencing racialized pimples. In effect, these users become what others have termed “citizen scientists” or “patient experts” in the medical understanding and management of their acne (Brown, 1992; Collins & Pinch, 2005; Kroll-Smith and Floyd, 1997); that is to say, they draw upon personal experience to contest the knowledge that is often relayed by medical practitioners. Moreover, they attempt to negotiate a place as “consumer citizens” whose racialized skin also deserves access to a market of pharmaceuticalized interventions promising a healthier and happier subjectivity.

The case of acne.org might also suggest the need to understand racial identities as those that are also being negotiated or, indeed, medi(c)ated through acne. It is important to remember that race is both a material and semiotic category, making pharmaceuticalized encounters ripe for critical analysis: “Pharmaceutical-centred medicine is an excellent site for critique of race because it intervenes on the boundaries between the social and the biological, the material and the semiotic. Race operates on precisely these boundaries” (Pollock, 2012, p. 174). As racialized individuals experiment with and share their experiences using different acne medications, they do more than racialize acne as a disease affecting different melanocytes, pigments and complexions. They also, quite crucially, articulate the ways acne medications racialize. Bleaching agents are one example where acne medications racialize. Bleaching agents are one example where acne medications intervene on the material boundaries of race. And, as Jascmeen Bush (2016) notes in an editorial for the beauty and wellness

27 Although, as Barker (2008) demonstrates in her study of a fibromyalgia electronic support group: the “experiential” or “personal” knowledge being shared in virtual communities is often articulated through medicalizing discourses.
website racked.com, acne medications and other skincare products open up the semiotic boundaries of race, as well:

“Black don’t crack” is the ideal that black people just don’t have bad skin. We’re supposed to age gracefully, with minimal effort […] This hopeful attitude was my skin’s gift and curse, a safe place and an excuse. Acne scars? Eh, they’ll pass. Undereye darkness? No big deal, I was bound to age well. I had no doubt that I’d turn a corner and have smooth, even skin like the other members of my family. They’d coddled me into thinking that obsessing over every little imperfection was unnecessary, even frivolous.

We learn from Bush’s story that racial identity is not only marked in the pigmentation of skin but also the care of that skin. In her interactions with friends and family members, Bush becomes aware of the ways racialized meanings are woven into what she does with skin, to skin, and as skin. It is not without struggle that she eventually learns to accept medicating her acne and other skin conditions. Treatment does not make her any less black: “I was relieved to hear that even though all my issues were common among African Americans, they can also be treated. They didn’t have to be accepted. They didn’t have to be part of being black” (Bush, 2016).

Like BiDil, acne medications are steeped in ambivalence. Their ability to intervene on, and rupture the material and semiotic boundaries of race are ascribed with both negative and positive associations; the difference being, however, that acne medications make these interventions public and visible in a way that many other pharmaceuticals do not. Bush’s (2016) skin, for example, shows “cracks” in the racial thinking that some of her friends and family share. Likewise, in a 2016 Washington Post story, Rosenberg writes about pop star Michael Jackson’s skin as an object of racial spectacle, generating intense media attention and public fascination. When medicine intervenes on the skin, it intervenes on the material-semiotic boundaries of race in such an overt and knowable way that it often conceals those other markers (e.g., blemishes,
pimples, scars) that reside on the skin or pushes them to the background. In turn, the dermatological decisions of racialized individuals are often reduced to their racial significance. But, as Rosenberg (2016) suggests, Michael Jackson’s relationship to his skin was complex. His skin was more than its racialized meanings and also a living organ. She notes that he began to see a dermatologist at a young age in order to control his acne and, later in life, began experimenting with a variety of procedures including collagen injections (sometimes anaesthetized; sometimes not) to cover acne scars. He was also diagnosed with vitiligo and discoid lupus erythematosus and received skin grafts for a severe burn that took place filming a commercial shoot. But, “none of this is to say that Jackson’s relationship to his own skin wasn’t also about race,” Rosenberg (2016) is careful to note. Rather, her point is to carve out space for racialized subjects to also exist as dermatological subjects who make decisions about their skin that are not always and only reduced to race but also include medicine: “If Jackson’s skin raises questions about the mutability of racial appearance and the persistence of racial identity – ‘I’m a black American, I’m proud to be a black American, I am proud of my race, I am proud of who I am,’ Jackson told Winfrey in that 1993 interview – it’s a subject that’s also deeply intertwined with issues of pain and the practice of medicine.” (Rosenberg, 2016). From this perspective, the pains of dermatological medicine become irreparably entangled with the pains of racialized embodiment. Acne medications might, indeed, help alleviate some of those pains but which ones, exactly? How, and with what political and health-related consequences? What does it mean to pharmaceutically achieve a clear and “healthy” complexion if that complexion is noticeably whiter? Acne medications are thus riddled
with a perplexing and visible ambivalence that is momentarily quelled by treating the user as either a dermatological or racial subject, but rarely both.

These ambivalent interactions between dermatological practice and colonialism became the subject of Canadian debate and media attention in March of 2016 when several images of Indigenous children living on the Kashechewan Reserve surfaced on social media; their skins bloodied, scratched and scabbed with undiagnosed lesions (see Appendix B). Kashechewan residents did not wait for medical experts to diagnose the issue and instead attempted to take control over the meanings ascribed to those lesions by hinting at systemic racism. Derek Stephen, a former Kashechewan chief and the first person to post the photographs to social media told one news outlet: “I can’t rule out water yet until I know what’s causing these issues […] A full review needs to be done of our facilities, our infrastructure, and also our environmental impacts” (Paling, 2016).

Moreover, these discursive attempts to frame the dermatological conditions of Kashechewan youth as a social and political issue were accompanied by the attached feelings of horror, shock and guilt that the images evoked in the Canadian public. These are feelings that are deeply embedded in Canada’s colonial past and routinely awakened in the collective unconscious of a settler nation through photographic and statistical reminders of ongoing inequalities (e.g., health outcomes, graduation rates, employment, suicide, addiction, incarceration, etc.). Indeed, there was no need for a medical diagnosis when images of the lesions first began circulating through social media. Canadians with any shred of historical conscience knew the problem was not with the skin’s dermatology but rather the skin’s meanings in a colonial-settler landscape; treatment would have to come in the form of infrastructural change rather than biomedical intervention.
That narrative shifted, however, after three doctors visited Kashechewan and diagnosed the lesions as knowable and pharmaceutically treatable skin diseases. The most common of the diagnoses was eczema, but acne was also one of the diagnostic labels used to describe what were, up to that point, ambiguously referred to as “lesions.” Canadians could, therefore, breathe a sigh of relief knowing that the skin conditions were not a social injustice but rather a common and normal occurrence in human beings at large, as Dr. Gordon Green (one of the doctors sent to Kashechewan) noted: “We were so pleased that it was very mild skin conditions.” In his media communications, Green also cited the percentage of the population suffering from various skin diseases saying: “I’m not sure if the numbers we’re seeing [at Kashechewan] are higher than that percentage. So this may just be a normal variation.” (Rutherford, 2016). Kashechewan children were “treated with creams” while doctors, journalists and politicians gave obligatory and empty statements about the need for better living conditions and access to medical services in Indigenous communities (Rutherford, 2016).

There is much to bemoan about the ways dermatological knowledge functioned in this example. Perhaps most importantly, by assigning dermatological diagnoses and treatments to Kashechewan children, medical experts and the media seemed to quell the initial set of concerns and anxieties pertaining to safe drinking water. Sociologists refer to this process as medicalization and point to the ways it turns social and political problems into medical ones. But, the dermatological treatments that were prescribed and administered to Kashechewan children highlight, yet again, the ambivalence of medicating skin in a colonial context. That is to say, the treatment of those lesions as

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28 Some of the other diagnoses included psoriasis, impetigo, scabies, contact dermatitis, molluscum contagiosum, bacterial folliculitis and venous stasis dermatitis (Hale, 2016).
medical problems opens up new space for Indigenous Canadians to exist as dermatological subjects whose pain is not only bound to the sociohistorical meanings of skin but also the biology of skin. There is, on one hand, a risk that colonial politics get left behind in the move to treat the dermatology of Indigenous skin. On the other hand, there is an equal risk of reducing all forms of Indigenous pain that manifest on and through skin to ongoing forms of colonial violence. Although each position merits serious, careful and critical consideration, dermatology and society need to be understood as co-constitutive rather than independent actors. Indigenous people’s skins can begin to look, behave and feel differently once they are medicated. Those changes can be experienced as relieving, exciting and empowering (e.g., enacting a type of biological citizenship) in the same way they can be experienced as disempowering, medicalizing and confusing (e.g., detracting from broader political critiques; producing side effects in skin pigmentation). Thus, one cannot be sure when making the claim that dermatological drugs serve little to no purpose in the lives of Indigenous and racialized individuals without first attempting to understand the ways those same individuals struggle to embody race, Indigeneity, and suffering dermatologically by intervening on the dermopolitical and nano-particulate matter of colonialism.

Feminism, materiality and acne

Before I begin this section, I want to make clear that I understand racialized pimples to be gendered pimples and vice versa. For example, the aforementioned narrative of “black don’t crack” is about gender as much as it is about race. As I demonstrate in this section, women in consumer cultures are generally familiar with the expectation that skin does not “crack,” show any “imperfections,” or signs of wear.
Likewise, the public’s fascination with Michael Jackson’s skin is not only entangled in a web of racial and dermatological meanings, but gendered ones about masculinity and the transgressed boundaries of a hardened exterior or “tough” skin. My point – which is one that comes out of the work of intersectional feminists – is that it is impossible to partition the social meanings of skin into neat and tidy categories like race and gender when those identities are lived, in reality, intersectionally.

If I recognize that acne is always experienced through multiple and interlocking identities, then why have I chosen to write about racialized and gendered pimples separately? Part of my decision is rooted in the fact that racism has been rendered absent from almost all of the critical, biomedical and psychological literature on acne. As such, I wanted to make those insights and contributions as explicit as possible for a body of literature that has yet to treat racism (let alone intersectionality) as a central or organizing feature of acne. I do not deny the urgent need for more complex arguments about intersectional experiences of acne, but it was necessary that I first try to carve out a space to think about the relationship between race and dermatology critically. Doing so was, in part, a theoretical task that I sought to develop through a re-working of Paul Gilroy’s (2000) concepts: dermopolitics and nano-politics. There, the problem was not so much making dermopolitics intersectional as much as it was rescuing dermopolitics from being consigned to a “bygone era,” found only in the annals of history textbooks and hallways of museums.

Also affecting my decision to write separately about racialized and gendered pimples was this project’s emphasis on theorizing the intersections between nature and culture, mind and body. Granted, intersectional feminism does not necessitate an outright
rejection of nature, biology or matter, and in fact many intersectional scholars include corporeality into their analyses when they examine matters related to disability or illness. But I agree with Elizabeth Grosz (2011) that questions about the subject or identity can dominate feminist theory, and risks obscuring two sorts of issues: “The first relates to what constitutes the subject that the subject cannot know about itself […] The second relates to what is beyond the subject, bigger than the subject, outside the subject’s control or possibly even comprehension” (p. 84). A more experienced and skilled scholar of intersectional feminism might have better been able to negotiate acne’s materiality alongside different yet hyphenated subject positions including (but not limited to) gender and race. It was important from my perspective, however, to keep things under control by only attempting to theorize the hyphen between acne and either gender or race. That is not to say those hyphens existing between gender and race and age and class and sexuality, etc. are irrelevant to the critical understanding of acne, but I kept myself from exploring them with any great depth so as to keep “questions of the nature and forces of the real” (Grosz, 2011, p. 85) – in this case acne – central to my understanding of the subject.

My focus in this section, therefore, is on the dynamic interactions between gendered subjects and acne. Importantly, I use the word “dynamic” to describe these interactions because, as contemporary feminist thinkers remind us, the mind is not separate from the body nor the master of it, as enlightenment thought suggested. Nonetheless, there are good reasons why feminist philosophies have maintained a safe distance from the materiality of the body; most notably, the body is that to which women’s behavior has been historically reduced and the vehicle through which their
subjugation justified. In their struggle to contest scientific and medical discourses that routinely construct female subjectivity as biologically determined, feminists have understandably spent the better part of the last century arguing that the female body is culturally produced. That is to say, feminists have largely rejected biological arguments about the nature of sexual difference, opting instead to think about how those differences are policed based on the assumption that they are, indeed, both naturally-occurring and normal features of human biology (Butler, 1993). This includes focusing on the ways sexual difference is thought – historically, culturally, linguistically, and scientifically – to produce and maintain gendered hierarchies of power.

My intent is not to dismiss these important revelations. Indeed, epistemological insights into the nature of gender make “unnatural” what seem to be “natural” differences between sexes (e.g., gendered divisions of labour, health outcomes, physical and intellectual variance, etc.) by highlighting those differences as the fluid and malleable effects of a particular cultural and historical context rather than some fixed and hard-wired genetic destiny. As such, “poststructural” feminism (a term I use to describe those feminisms through which the body materializes as an effect of discourse, knowledge and power) has been instrumental in opening up new possibilities for individuals to define, perform and experience gender on and through the body differently, and in ways that both transgress the discursive and material boundaries of a “normal” or “healthy” gendered embodiment (Butler, 1990; 1993; Scott, 1991).

But for all of its political and intellectual achievements, many contemporary feminists express concerns about poststructural readings of the body as a text, inscribed with meaning by dominant discourses, expert knowledges and powerful truth claims.
Most notably, critics fear that ontological questions related to the body appear beyond the scope of a feminist project that takes the rational, thinking and conscious subject as its beginning and end point. What, if anything, can feminism say about the world “out there” (i.e. matter, force, energy) if that world is only ever interpreted or represented through language, history, rational actors, etc.? In this sense, do poststructural feminisms draw similar (albeit, reversed) lines of causation between biology and culture, or mind and body as the scientific knowledges they aim to contest (Frost, 2011)? Contemporary feminisms have begun to take such questions seriously, resulting in new theoretical attempts to place biology and culture as interdependent, rather than independent, actors. From such a perspective, the mind ceases to exert power and authority over the “natural” world (Barad, 2003; Fausto-Sterling, 2005). That does not mean truth and knowledge altogether disappear from feminist analyses, but instead that biological events be included as part of the subject’s learning. Expanding on this point, Grosz (2011) writes: “We have devoted much effort to the social, cultural, representational, historical, and national variations in human relations. We now need to develop a more complex and sophisticated understanding of the ways in which natural forces, both living and nonliving, frame, enrich, and complicate our understanding of the subject, its interior, and what the subject can know” (p. 86). I follow Grosz in this section, taking acne as one such natural force.

Grosz and many other feminist writers have, in fact, already begun to think about the materiality of skin as that which complicates and extends beyond its status as the body’s enclosure. In their edited volume titled Thinking Through Skin, Sara Ahmed and Jackie Stacey embark on an intersectional project to understand skin as shared, connected, and that which gives rise to experiences of “inter-embodiment.” Citing select
works in feminist theory (see: Braidotti, 2000; Butler, 1993; Grosz, 1994), Ahmed and Stacey note the ways feminists have long found promise in the skin’s capacity to dissolve the boundaries between subject and object, self and other:

These writers all refuse to take the contours or boundaries of the body for granted: they refuse to simply inhabit the skin or to assume that the skin cloaks the body. Hence we can read their work as contributing to a feminist philosophy of skin. This is not to suggest that skin is their object, but rather that we can understand their work on embodiment as a rethinking of how skin comes to materialize in the forms that it does, at the same time as they show how skins, as well as other bodily surfaces and folds, expose bodies to other bodies, rather than simply containing ‘the body’ as such. (Ahmed & Stacey, 2001, p. 4)

A focus on acne provides an opportunity to further contribute to a “feminist philosophy of skin” by directing our attention to the ways science and medicine assist in inter-embodiment. Here, bodies are not only exposed to other observers (e.g., dermatologists), but also other objects (e.g., pharmaceuticals, makeup, etc.) and other skins (e.g., painful, irritable, unrecognizable, etc.). In other words, acne brings with it an opportunity to further reflect on inter-embodiment as that which is partially encouraged, produced and regulated by a combination of scientific and medical authorities.

Inter-embodiment is also about gender, however. One of the ways individuals practice, perform and read gender in our culture is on and through the surface of the body. For example, gender differences are often articulated through the skin’s softness, wrinkles, stretch marks and scars – or, relatedly, those attempts to conceal and hide the passage of time, the marks of an external world, and the signs of labour (Ahmed & Stacey, 2001; McClintock, 1995; Takemoto, 2001; Tyler, 2001). As Ahmed and Stacey (2001) succinctly note, consumer cultures make skin into something that is constantly worked and workable. Feminine skin, in particular, is marketed and sold in the form of any number of different creams, concealers, lotions, and moisturizers that women are
encouraged to buy. By working the skin, subjects are invited to have some measure of control over skin and the gendered meanings that are communicated on and through it. If skin threatens to mark us as something other than the gender we think we are, then pharmaceutical and cosmeceutical markets offer ways for gendered subjects to purchase a skin that better aligns with the person they think they are or want to become.

In this section, however, I am not only interested in how acne is worked by gendered subjects. Getting back to an earlier point that I made: I am also interested in uncovering the ways gendered subjects are worked by acne. Grosz (2011) clarifies the importance of such a task:

> To the extent that feminist theory focuses on questions of the subject or identity, it leaves questions about the rest of existence – outside and beyond or bigger than the subject, or what is beyond the subject’s control – untouched. Feminism abdicates the right to speak about the real, about the world, about matter, about nature, and in exchange, cages itself in the reign of the ‘I’: who am I, who recognizes me, what can I become? Ironically, this is a realm that is increasingly globally defined through the right to consumption, what the subject can have and own.” (p. 84)

I begin this section by outlining some of the ways acne interrupts gendered subjectivities, and highlight those attempts to medicate acne as part of a much larger attempt to control female bodies and restore “normal” gendered embodiment through skin. However, I argue that acne also directs our attention to a specific moment where skin – as a living, biological agent – routinely resists the gendered meanings we assign to it at the doctor’s office or pharmacy. In those moments of resistance, skin assumes an active role in the production of gendered subjectivities. As such, I later describe some of the ways individuals with acne embrace, explore and experiment with non-normative gendered embodiment on and through their skin, suggesting that our cultural ideas about gender not
only take skin as its object of control but are also quite crucially subject to the skin’s unwieldy agency.

Diagnosing “hormonal acne”

First, it is worthwhile revisiting some of the scientific ideas that family doctors and dermatologists learn about acne and inevitably put into practice. Today, the accepted pathogenic model of acne is one that treats it as a multifactorial disease. In other words, acne can be caused by any number of potential factors including hormones, genetics, inflammation, immunology, bacteria, stress and diet. Confronted with these multifactorial possibilities, how do doctors know the unique pathophysiology of a particular patient’s acne? What are the signs, symptoms and bits of information they look for when making a diagnosis and deciding on a course of treatment? As one dermatologist explained:

It’s based fundamentally on the history and physical. We might do in certain patients who I have an idea or inkling that there might be a hormonally driven component, I might do blood tests and investigations to see if there is anything there. So that’s a possibility in some cases. But by and large, the vast majority of diagnoses are based on history and physical. Does your acne flare with your periods? Where do you work? What do you do for your job? What are you putting on your face right now? What medications? What creams? All of these things. (Stephen, personal communication, September 7, 2015)

In his response, Stephen makes immediate mention of hormonal types of acne and begins by asking who he assumes are female patients about their menstrual cycle. In addition to this question, he might also perform blood tests on the patient in order to find evidence that hormones are the cause of their acne. Essentially, what we learn from Stephen’s practice is that the truth of hormonal acne can be found in multiple places. Whereas

29 Although, it is worth mentioning that the science examining the relationship between acne and food remains contested.
sometimes that truth appears in the words of the patient, other times it might not. In fact it need not, given that Stephen has available to him a method (i.e., blood testing) through which he is able to eclipse the subjectivity of the patient and observe the reality of hormonal acne in blood. This is a method he chooses to pursue only when his own subjectivity (described as a personal “inkling”) rubs up against, or seemingly contradicts, the subjectivity of his patient.

I am reminded, here, of Annemarie Mol’s (2002) research on atherosclerosis, where she makes a convincing argument that knowledge about disease is always diffused across a number of different experts, patients, microscopes, buildings, records, etc. What acne is or becomes (e.g., hormonal, genetic, bacterial, inflammatory, psychological, etc.) is a reality that is “enacted” in a particular place, with particular people, particular practices and particular objects. Mol’s task is to “spread the activity of knowing widely” (p. 50) so that it appears decentered across subjects and objects as opposed to locatable in the mind’s of subjects, alone. Dermatologists and patients might enact hormonal acne in their conversations about menstruation, but another way hormonal acne is enacted is through blood tests. It is possible, then, for hormonal acne to appear in one place (i.e. history & physical) and not the other (i.e. blood tests); a phenomenon that Mol (2002) describes as it relates to atherosclerosis: “Doctors don’t like it if the atherosclerosis of the interview does not coincide with that of the physical examination. But sometimes it happens. [The clinic] does not enact a single object. There are two of them. Two objects. One is enacted through talking, the other through a hands-on investigation” (p. 51). It is also possible for bacterial, hereditary, psychological and environmental “types” of acne to be enacted in addition to hormonal ones during the patient’s history and physical.
Mol (2002) cautions her reader against understanding the “manyfoldedness” of disease as fragmented because, somehow, diseases such as atherosclerosis or acne continue to hang together and live a type of singular existence: “A single patient tends to be supplied, if not with a single disease, then at least with a single treatment decision” (p. 84). In other words, the multiplicity of disease does not imply an absolute plurality beyond repair, but rather a diversity of objects that are brought together under one name, and through “various modes of coordination” (Mol, 2002, p. 84). In the case of acne, gender is one such mode of coordination, helping doctors treat the disease as either “hormonal” or not. As the same dermatologist explains:

A lot of women have hormonally induced acne, or hormonally exacerbated acne. So they’ll flare during their periods or before their periods, or sometime with the hormonal cycle. So if you can regulate the hormonal cycle using birth control pills, or, sometimes you can use a hormonal blocker called spironolactone which is also blood pressure medication as another example. So we do have abilities to manipulate the hormone somewhat to lessen or even treat the acne in women, a lot more than we do in men. (Stephen, personal communication, September 7, 2015)

In this sense, gender helps doctors coordinate the multiplicity of acne into two types (i.e. hormonally-induced or non-hormonally induced acne) from which they are then able to make treatment decisions. Whereas female patients are commonly prescribed birth control or spironolactone in an attempt to regulate their hormones, men’s acne is very rarely – if ever – treated as a hormonal issue.

The relationship between hormones and acne is well established in the scientific literature. Sebum is an oily substance that is produced in the sebaceous glands and is commonly thought to be one of the main contributors to acne (SanMiguel & Grice, 2015; Schommer & Gallo, 2013; Suh & Kwon, 2015). A common feature of all sexed bodies, so-called “male” hormones (i.e. androgens) are understood by scientists to play an
important role in the making of sebum. Quite simply, the more androgens a body has, the more sebum it will produce. And, with an increased level of sebum comes an increased risk of blocked skin pores, as both the sebum and thousands of dead skin cells try to escape the pore to the surface of the body. When excess sebum is trapped in the hair follicle, it creates an ideal environment for certain harmful bacteria to thrive, feed and infect the pore – resulting in a series of biological interactions that manifest on the surface of the body in the form of a pimple.

But, despite the scientific evidence linking androgens to acne, increased levels of testosterone (particularly during adolescence) is understood as a problem for women’s skin in a way that it is not for men’s. When asked why hormones are not treated as part of the etiology of acne in men, one dermatologist responded: “You don’t want to block or alter testosterone levels. Most men quite enjoy their testosterone levels because it has good effects: you grow muscle mass and sex drive…all of these things that are important for being male […] so I don’t think we would ever consider hormonal blocking in men, but that is a potential possibility” (Stephen, personal communication, September 7, 2015). The dermatologist does not outright reject the notion that men’s acne is in any way related to hormones, but rather acknowledges the cultural and political hurdles involved with treating it as such. Should there come a day when men’s complexions are valued over their masculinity and secondary sex characteristics, we might then begin to see doctors such as Stephen treat acne as a hormonal disease in male patients. There is evidence to suggest, however, that these priorities are already shared by some men who demand access to hormonal acne therapies. The self-identifying men of acne.org routinely ask questions about how to “decrease” their testosterone and some users even
entertain the idea of castration as an option for clear skin. Furthermore, the acne market has recently grown to include male-targeted hormonal acne therapies such as “AcnEase;” a drug designed to “meet the demands and preferences of the male market” by helping “the body to regulate the impact of androgen hormones on sebaceous gland secretions; in particular the analogs of testosterone” (“Herborium Group Engages,” 2013). Some men, at least, seem open to the possibility that their acne is hormonal, and have thus begun to seek treatment options outside of a medical establishment that routinely naturalizes sexual differences to fit within a two-sex paradigm (Fausto-Sterling, 2000).

Women, on the other hand, are the frequent beneficiaries of hormonal acne therapies thanks to that same medical establishment and two-sex paradigm. Oral contraceptives and antiandrogens are not labeled as “acne medications” per se, but are often prescribed off-label and recommended to women in their struggle for clear skin. As noted, one of the more common prescriptions for women (particularly adults) is an androgen-receptor blocker and inhibitor known as spironolactone (Zaenglein, Graber & Thiboutot, 2012). Some of the users of this drug are diagnosed with an endocrine disorder known as polycystic ovary syndrome (PCOS), rendering their acne a symptom among many (e.g., hair growth, weight gain, irregular periods, infertility, etc.) as opposed to a disease. In other cases, acne remains a disease for a class of off-label spironolactone users who use the drug without a PCOS diagnosis: “Since women with the disorder [PCOS] have high levels of the same hormones responsible for adult acne, learning how the condition responds to treatment [spironolactone] can offer some insight into helping adults with acne who don’t have PCOS” (Fessenden, 2015). Being a woman, in other words, is the most important factor determining whether a person uses spironolactone to
treat their acne. With the understanding that women, unlike men, have nothing to lose and everything to gain from a reduction in testosterone, spironolactone emerges as a technology through which physicians and patients exercise a “populational biopolitics […] by helping the normal take precedence over the natural” (Fausto-Sterling, 2000, p. 8). In other words, acne brings natural variations in the body’s endocrinological makeup to the surface of the body where they can be observed, policed and controlled through dermatological forms of expertise. It does not follow that acne renders “unruly” or sexually ambiguous those whose bodies are read as female, but it does suggest that conventional practice in the field of dermatology is far more comfortable manipulating endocrinologies that fall somewhere in between a two-sex model than those appearing towards the ends of that spectrum.

*Accutane, risk and gender*

But there is another important reason why women are overwhelmingly treated for a hormonal type of acne besides a normative, two-sex model of sexual difference that shapes how they (and their doctors) make decisions about skin. That reason, I would argue, has to do with teratogenic fears (i.e., anxieties about birth defects or abnormalities) surrounding one of the most common acne medications: isotretinoin. Women have found it difficult to access the drug better known by its brandname Accutane, stemming partially from an unwillingness on the part of individuals to either prescribe or use the drug because of its well-documented teratogenic side effects. Despite its many other, highly-publicized and in some instances contested side effects (e.g., depression, suicidal ideation, colitis, Chron’s disease, etc.), Accutane’s risk to the unborn fetus tends to be given priority over other types of damage that may result from women’s use of the
In other words, the drug materializes as risky in very different ways depending on whether or not the patient is labeled as female, and brings to light a conservative politics through which the bodies of female Accutane users are valued less than the imaginary bodies inside of them. In turn, some physicians outright refuse to prescribe Accutane to their female patients (Jennifer, personal communication, August 25, 2015), whilst some female members of acne.org govern themselves by refusing Accutane prescriptions and its associated risks. In addition to these cultural obstacles are governmental regulations that make Accutane a particularly cumbersome drug for doctors to prescribe, administer and monitor. Women who are attempting to access the drug are also confronted with paperwork, lectures, rules, wait times and tests before they are able to use it. Though many women do, in fact, gain access to Accutane – they do so within a context that is purposely designed to make that access difficult and frightening.

Consider the following passage from a dermatology textbook, teaching medical students about the risks associated with prescribing Accutane to women:

The greatest concern during isotretinoin therapy is the risk of the drug being administered during pregnancy and thereby inducing teratogenic effects in the fetus […] A significant number of fetal abnormalities have been reported after the use of isotretinoin. For this reason, it should be emphasized that isotretinoin should be given only to patients who have not responded to other therapy. Furthermore, women who are of childbearing age must be fully informed of the risk of pregnancy. The patient must employ two highly effective contraception techniques such as the use of an oral contraceptive and condoms with a spermicidal jelly. Contraception must be started at least 1 month before isotretinoin therapy. Female patients must be thoroughly counseled and demonstrate an understanding of contraception techniques before starting isotretinoin […] No more than 1 month’s supply of isotretinoin should be given to a female patient so that she can be counseled on a monthly basis on the hazards of pregnancy

Evidence of this prioritization can be found in some of the biomedical texts, institutional procedures and health promotion efforts that are detailed in the pages that follow.
during isotretinoin therapy. A pregnancy test must be repeated monthly. (Zaenglein, Graber & Thiboutot, 2012, p. 911)

In this example, it is clear that Accutane is thought to pose a threat to the health of the fetus and thereby the population at large. Doctors are thus tasked with the responsibility of making sure that the drug’s contact with female bodies is carefully administered and monitored. It is not so much the health of the patient that is at risk from Accutane as much as it is the health of the body politic, imagined through the female body (Franklin, 1991; Newman, 1996; Stabile, 1992). Furthermore, doctors learn that treating female acne patients with Accutane is a laborious and time-consuming process. Canada, in particular, faces a shortage of dermatologists who are struggling to meet an increasing demand for their services. One of the dermatologists I spoke to explained that the lack of available dermatological services, combined with an increasing demand for those services, has limited the amount of time he can spend with each patient:

**Stephen:** We’ve only had one dermatologist in our town for the past ten, fifteen years. And so the demands on a newly developed dermatology division, which is what we are here, is tremendous. We get about 150 new requests for patients per week.

**Scott:** Oh my god…new requests?

**Stephen:** New requests, yeah. I see about a thousand patients a month, now – which makes it unfortunate because it limits your time with each individual patient because you’re trying to satisfy this huge need so it’s this constant struggle to balance the individual’s need with the global demand. (Stephen, personal communication, September 7, 2015)
In a context where Accutane materializes as both a risky and time-consuming drug, hormonal therapies can appear to be a safer and more convenient option for doctors and female acne patients. ¹³¹

Yet, the latest available data suggests that men and women alike are being prescribed Accutane and using the drug at record levels. Despite having a reputation for being a “last resort” drug in the treatment of acne (i.e. reserved only for those “severe” cases), one Canadian study found that 64% of isotretinoin users were prescribed the drug after their first doctor’s appointment, and 50% of all isotretinoin prescriptions were for women (Azoulay, Oraichi & Berard, 2006). Similar trends can be observed in the United States: “During the first 11 years of prescribing isotretinoin in the United States, there were relatively small increases in the annual number of dispensed prescriptions; however, in the last 8 years there has been a 2.5-fold (250%) increase in prescribing” with almost an even split in terms of the drug’s sex distribution (Wysowski, Swann & Vega, 2002, p. 508). Women, in other words, are continuing to access and use Accutane despite a cultural context that views such drug use as risky, frightening, and dangerous to the social body. Moreover, national pregnancy prevention programs designed to help mitigate those risks and fears have failed to do so, as the number of reported pregnancies in Accutane users continues to alarm public health experts. One such program, iPledge, was introduced by the Food and Drug Administration (FDA) in 2006 after officials learned

³¹ The relative safety of oral contraceptives was recently disputed, however, amidst claims that Diane 35 (an acne medication that is also commonly prescribed off-label as birth control) could lead to potentially fatal cases of blood clotting. Hundreds of such cases were reported in many parts of Europe and North America, prompting an EU Commission and Health Canada Drug Review into the safety of Diane 35. Both advisory boards quelled any fears by noting that the benefits of the drug outweighed the risks so long as appropriate steps were taken to educate users and doctors about how to safely administer Diane 35.
that the number of isotretinoin-exposed pregnancies was not decreasing under its predecessor-program: System to Manage Accutane Related Teratogenicity (SMART) (Isotretinoin Update, 2006). To address the issue, the FDA created iPledge as a means to implement stricter requirements around the prescription and use of Accutane. Even though patients must now “pledge” to use two methods of birth control (with abstinence being one of the options), take regular pregnancy tests with doctors, and pass a “comprehension test,” studies report that “there were still 150 women annually who became pregnant while on oral isotretinoin in the United States” and that “adherence to contraception use continues to be an issue” (Tan et al., 2016, p. 180). In Canada where the national prevention program is more lenient (compared to iPledge), approximately 100 pregnancies were reported annually between the years 1996-2011 with about 30-50\% of Accutane users reporting non-compliance with contraceptive requirements (Henry et al., 2016).

As Kane Race (2009) reminds us, “drug choices take place within a whole world of meaning and cultural value” (p. 152). As much as Accutane is understood as a “risky” or “dangerous” acne medication for women, it is also considered a “miracle drug” in many professional and pedestrian circles. In other words, Accutane can be used as both a technology of patriarchal control and an object through which women feel in control of their bodies and health. It is true that on one hand women’s bodies, reproductive rights, and sexualities are closely policed in and through the use of Accutane, as evidenced by national pregnancy prevention programs such as iPledge. Beginning from the heteronormative assumption that the iPledge patient identifies as straight, Queer-identifying subjects whose biology scripts them as “female” are subject to the same
regulatory impositions as their straight counterparts; an experience that one acne.org user recalls with great frustration:

I go in for my first consultation, set up the whole ipledge junk [...] and take my first blood tests and pregnancy tests. Please allow me to go on a short rant about these pregnancy tests. I'M A LESBIAN!!!! ALWAYS HAVE BEEN, ALWAYS WILL BE! I AM 26 YEARS OLD, AND IF I HAVE NOT SLEPT WITH A MAN YET, I’LL BE DAMNED IF I DO WHILE I’M ON THIS HORRENDOUS MEDICATION THAT CAUSES YOU TO GIVE BIRTH TO BABY CONEHADS! On top of the obvious unfairness of being required to pee in a cup for no apparent reason, I DON’T HAVE $50 A MONTH TO SPEND ON FREAKING UNNECESSARY PREGNANCY TESTS!!! Cause these just can’t be regular pregnancy tests...no...these have to be LABORATORY URINALYSIS PREGNANCY TESTS!

Moreover, prescription rates in the United States show that white women are about twice as likely to receive an Accutane prescription from their doctor than black women (Fleischer Jr., Simpson, McMichael & Feldman, 2003). Many black women are thus stripped of the chance to even make a “pledge” in the first place. Subject to advanced pre-natal surveillance, black women confront both the fears of a patriarchal society and a white supremacist one that constructs the fetus as especially at-risk from a criminalized, black mother.

On the other hand, there is far more complexity and multiplicity to female Accutane use than a type of wholly exploitative or controlling biopolitics that reduces women to cultural dopes. Michelle Murphy (2012) writes that “thinking feminism as biopolitics is also about yearning to continue experimenting with technoscientific practices that could foster better means of enabling life with eyes open to the constitutive contradictions of an entangled world” (p. 24). That is to say, feminist movements have not only staged historical opposition to the controlling features of technoscience but have also attempted to stake control over the ethical management of life in/through
technoscience. Thus, for Murphy (2012), “feminism was a biopolitical project, that is, a project that took life, its kinds and qualities, as the object of its politics” (p. 10; emphasis in original). This is not to suggest that all female isotretinoin users are staging some grand act of feminist resistance to ongoing policies that continue to shape how they experience their body or make decisions about that body, but rather to simply acknowledge the ways Accutane is caught up in all sorts of different “attachments of material, technical, and social relations across divergent and even antagonistic terrains of politics” (Murphy, 2012, p. 12).

As a drug that is both carefully policed and widely celebrated for its efficacy, Accutane makes clear two such antagonistic, but mutually constitutive sets of politics that are the subject of Kane Race’s (2009) book, Pleasure Consuming Medicine: “I want to ask how, why, and with what effects contemporary strictures around the “improper” use of drugs are so ruthlessly maintained, while in the medical sphere the liberal application of drugs for varied purposes is increasingly promoted as a simple matter of consumer choice” (p. viii). In other words, how do pharmaceuticalized consumer societies simultaneously encourage and prohibit drug consumption? Race suggests this contradiction emerges out of a historical context that sees the convergence of two discourses – that is, medical discourses of patient compliance and legal discourses of drug abuse – which place responsibility in the hands of individuals to make informed and lawful drug-choices based on the expert advice of clinical and legal professionals. Each of these discourses takes “self-administration as their problem and object of concern, and both propose medicine as the proper authority against which to reference this conduct” (Race, 2009, p. 15; emphasis in original). At the same time these discourses were
converging, however, *self-administration* was also being celebrated as ushering in a newly empowered, free and autonomous patient-consumer who could make decisions about her own health thanks to the rapidly expanding free market of pharmaceuticals. As Race (2009) argues, “a medico-moral discourse on drugs is invested with the task of securing the body – as normal, in control, and stable – against the licensed pleasures of the market (p. 18).

If there is something unique about the medico-moral discourse on Accutane, however, it might be that it draws our attention to the body of which Race speaks. The body in need of securement is the social body, imagined to exist in the womb of female Accutane users. As such, the material and symbolic boundaries of this social body (i.e. the nation-state) are understood to be at risk and are thus protected from the agential and mutually constitutive forces of isotretinoin and female sexuality. Biopower is exercised through the self-administering subject for whom medical discourses of patient compliance materialize in the form of a “pledge” – one that pledges allegiance to the state, or more specifically the medical expertise and normative codes of behavior outlined by that state. These relations of power, however, do not determine the lives and experiences of women who also exercise their own biopolitics through the use Accutane. This is an important point emphasized by Maren Klawiter (2008) in her reminder to Foucauldian scholars: “Foucault’s focus on biopower and historically specific regimes of practices did not mean, as he insisted on dozens of occasions, that the state is unimportant. But ‘one of the first things that has to be understood,’ he argued, ‘is that power isn’t localized in the State apparatus,’ and, further, that the ‘relations of power, and
hence the analysis that must be made of them, necessarily extend beyond the limits of the State’ (p. 22).

For starters, a person’s decision to use Accutane needs to be understood as part of a broader neoliberal context in which freedom and autonomy are exercised through one’s purchasing power. If “pharmaceutical consumption is central to biological citizenship, and access to pharmaceuticals and especially to brand-name ones becomes part of articulating inclusion in American ways of life” (Pollock, 2012, p. 146), then female struggles to access Accutane – one of the most effective and recognizable medications on the acne market – can be understood as, in part, a much larger struggle for patient autonomy and choice. Indeed, it is through the multi-billion-dollar acne market that many patient-consumers come to experience unparalleled levels of autonomy and choice in their healthcare. One of the most frequent discourses articulated on acne.org is the need to experiment widely with (i.e. purchase) as many acne medications as possible until a unique “cure” is found for each unique skin. Without an endless possibility of options to choose from, acne sufferers are severely throttled in their pursuit of a healthy embodiment.32

What is interesting about Accutane, though, is that it rarely appears as “just another choice” amongst others on the acne market. Rather, many users are driven to try Accutane in the hopes that they are relieved from what feels like an overwhelming amount of choice. Confronted with so many options on the acne market, the pursuit for clear skin often feels like a hopeless, futile, and never-ending cost to one’s financial and

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32 For reasons that have already been examined in this chapter, non-white individuals with acne have to regularly confront a number of limitations on their choice. So too do poor and working class individuals who are unable to afford the costs associated with choosing new, expensive and oftentimes uninsured acne medications.
emotional wellbeing.\textsuperscript{33} Although members of acne.org generally agree that there is no universal treatment therapy or “cure” for acne, they admit that Accutane might be the closest thing to one. In this way, Accutane materializes a bit differently from other drug choices available to consumers on the acne market in that it represents a sort of escape from that market; its overwhelming variety, the experimentation it demands, and its tantalizing promise that a “cure exists around the corner.” As one acne.org member describes: “Everybody has different deficiencies and causes of their acne, you must find yours and then through your own path find the solution. That or try Accutane.” Similarly, another user posts: “If you don’t [want] to put in the effort – just go straight for the Accutane. It’s not a cure all but it basically eliminated mine.” Accutane, in other words, provides users with an alternative treatment modality besides one that relies on tireless acts of consumption and experimentation. This kind of “discovery work” is draining, or as one user describes it: effortful. It is also quite expensive, especially for those who are either uninsured or whose health insurance plans cover a limited number of acne medications. The financial costs of doing this kind of “discovery work” is a central concern for some poor and working class women who write about their experiences on acne.org, and who seek the advice of others whose journeys include a consideration for cheap and insured acne therapies. In their struggle to access Accutane, women thus find themselves embroiled in a much larger struggle to enact autonomy in ways other than with their wallet (i.e. purchasing power). If scientific, dermatological and lay circles agree about the relative efficacy of Accutane (and they do; particularly with regards to its

\textsuperscript{33} Some members of acne.org even go so far as to suspect that the market is purposely designed that way, with scientists and corporations withholding a “cure” in order to extract as much profit from the insecurities and vulnerabilities of acne sufferers.
anti-inflammatory properties), female Accutane users highlight the value of that evidence to their own decision-making. They opt for immediate relief instead of the mere “chance” at relief, perennially “waiting around the corner” in that next acne drug.

In addition to accessing a type of health care that emphasizes certainty over chance and patienthood over consumption, some female Accutane users also participate in sexual activity that is deemed “risky” or “irresponsible” by the state. Although the vast majority of them comply with regulations and risk discourses intended to look out for the health of the imagined “social body,” hundreds of Canadian and American isotretinoin users have reported pregnancies in the last several years. In response, journalists, health promoters and doctors generally propose a number of different solutions to what they understand as a problem of non-compliance. These include everything from imposing stricter guidelines on the sale and distribution of Accutane to better educating doctors and patients about the teratogenic risks of the drug.

One of the issues with these types of recommendations, however, is that they overlook some of the crucial power dynamics through which (un)protected sex is always negotiated. For example, public health attempts to eradicate “risky” sex practices in sub-Saharan Africa have failed to deliver significant reductions in HIV infection rates for women living in the region. The problem is not always that women are being non-compliant, scholars argue. Rather, they point to the ways gender-based violence and patriarchy informs decision-making in sexual partnerships (Dunkle et al., 2004; Ramjee & Daniels, 2013). In other words, men can be powerful agents in deciding whether or not a woman participates in “risky” or unprotected sex, as well. But, these concerns are absent from the sorts of proposals being made by public health officials whose only target
audience is the female Accutane user. The onus of responsibility to practice “safe,”
protected sex becomes the sole responsibility of women despite a patriarchal context that
makes it challenging for some to enact that kind of agency in reality.

Another issue with discourses of non-compliance is that they tend to ignore what
Race (2009) refers to as the “subintentional zone” with which things like sex and drug
use occurs. He writes:

   I want to consider the shortcomings of the doctrine of strict intentionality
   as a way of framing everyday practice, including sex and drugs.
   Recognizing how gradients of intention run through all manner of activity
   might even help to counter some of the ways in which drugs have come to
   participate in a moral drama of extremes, in which pure intention and total
   disinhibition materialize as the only available alternatives. (p. 167)

In other words, things like drugs and sex illustrate an important point for Race, which is
that subjectivity is in large part determined by forces, energies and drives that are only
ever partially intended by our conscious selves.

From such a perspective, medico-moral discourses on drugs appear misguided as
a public health strategy, because they begin from the assumption that subjects act
intentionally. That is to say, they deny “the agency of drug users: the capacity of our
bodies to be active producers of pleasure – and incidentally, care” (Race, 2009, p. 166). It
is probably not the case, then, that female Accutane users purposely engage in “risky”
unprotected sex so as to actively resist state techniques of governmentality; nor does it
seem likely that they simply do not know any better. Rather, it is far more plausible to
follow Race in thinking that some find pleasure in “risky” sexual practices “in order to
lose themselves” (Race, 2009, p. 167). Losing one’s self is an experience that Race
argues is pleasurable precisely because it occupies a “subintentional zone” – meaning that
it is neither wholly intentional nor unintentional. In other words, there is some awareness
on the part of individuals engaging in risky sexual practices, but even that awareness can be pleasurable, according to Race (2009): “The recognition of these moments of unpredictability can be one of their pleasures” (p. 166).

In this sense, we can also understand Accutane as a drug that offers the pleasure of losing oneself through its ability to transform the body. “Accutane logs” are used by many acne.org members as a way to record both the observable changes in their bodies as well as any changes they experience in affect. The logs rarely follow any sort of linear trajectory and instead direct our attention to the unpredictable vicissitudes of the drug. Confronted daily by new, unfamiliar and disorienting embodied realities, Accutane “loggers” write as a means to re-discover themselves in what are unrecognizable becomings:

[DAY 16] Mood seemed ok today. I did get slightly snappy with a co-worker but caught myself right away and made nice […] Lips are still dry but manageable. Face on the other hand especially my cheeks feel slightly inflamed. […] I noticed my joints in my right hands ache when I type. I think I have slight carpal tunnel anyway but I think the accutane is exacerbating the situation. Last night when I tried to sleep my lower back ached a little too […] Hair is less oily too […] My nose is quite dry […] Area around my knuckles are starting to feel dry. Overall though my complexion is looking good! It was not so great when I first started and I feared it would get worst. Probably the calmest it’s been in a few weeks actually.

It is possible, then, to think about Accutane and unprotected sex as each offering women a kind of pleasure rooted in the experience of losing an “old” skin/self. Together, Accutane and unprotected sex converge to produce skins that are exhilarating, exciting and productive compared to those which many of them know as embarrassing, painful and restrictive. Even the writing of these new but strange Accutane-skins can be seen as pleasurable, as Prosser (2001) writes: “Skin autobiographies show writing skin as cathartic. Writing recovers a skin ego damaged in the original skin/sin memory” (p. 66).
Becoming “bad girls”

I have focused thus far on the many ways gendered logics, norms, practices and policies come to shape acne in all sorts of ways ranging from the “type” of acne a person is diagnosed with to the sorts of medications they are prescribed and consume. As important as these insights are, they do not yet capture the full complexity with which gender, skin, and medicine become entangled in relations of power. Acne has, for the most part, appeared subject to human actors whose gendered ideas, medical practices and technologies ultimately work, shape and mold the skin. But skin very rarely responds to the actions of human subjects in ways that are either intended or predictable. In this way, biology enacts a force of its own that is neither wholly determinative nor determined by the forces of culture (i.e. gender, medicine, etc.). In what follows, I describe some of the ways the materiality of acne – as a living and generative force – plays an active role in the making of gendered relations of power.

One such example comes to us in the form of touch; or more specifically, acne’s potential to transgress some of the haptic boundaries through which gender is embodied and practiced in daily life. One of the striking themes to emerge out of my reading of acne.org was that of the “bad girl” – that is, a female acne sufferer who recognizes herself as crossing the “appropriate” haptic boundaries of acceptable female comportment by picking at or popping her pimples. Consider the following quotation from an acne.org member: “I have huge red bumps all over my skin and yes, I’m a bad woman, I keep picking at them like it’s my job. SO depressing.” In a different thread, another user

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34 By “haptic boundaries” I mean those phenomenological limits or thresholds by which gendered subjects learn to reach out and touch the world and be touched by it (see: Young, 1980).
confesses that she, too, embodies “bad” touch on occasion: “I was a bad girl last night though. Don’t know if it was the over-excitement of starting the Accutane…or maybe my (self-diagnosed, mind you) OCD kicking in…but I pretty much destroyed my face to drain a little bugger that quite simply wasn’t ready.” In another separate thread, one woman simply writes: “I was a bad girl yesterday and picked a few pimples last night so today they look a little red.” Clearly, in these examples, women understand themselves as non-compliant on more than one front. Not only are they breaking from the expert advice of medical authorities but they also seem to understand themselves as breaking certain codes of an acceptable or “good” femininity.

Importantly, there are some girls for whom a “bad” femininity is already read on and through the skin. At school, young black girls are far more likely to be disciplined and sent to juvenile detention centres for being “bad” than any other group of racialized woman. Furthermore, research on the school-to-prison pipeline shows that the perceived “badness” of black girls results in “more severe sentences when they enter the juvenile justice system than do members of any other group of girls” (Crenshaw, 2015, p. 6). In other words, not every girl needs pimpled skin in order to learn about and embody a “bad” femininity. In a white supremacist context, having black skin is often enough.

Nonetheless, Erin Manning’s (2007) work helps make sense of the “bad girls” of acne.org, whose badness appears written into and transgressed through the act of touch in particular. She uses the word “tact” to describe those forms of touch that are learned, disciplined and carefully policed in a given context. For example, we might say that health discourses make picking and popping pimples an “unhealthy” behavior. This kind of touch might lead to scarring, or make acne worse because of added bacterial risk or
inflammation. Acne sufferers thus learn to discipline the drive to pick or pop their pimples and exercise a type of “healthy” tact. In fact, acne offers insight into the ways a “prohibition to touch” (Anzieu, 1989) can be informed by health discourses and medical expertise. To exercise control and restraint in this medicalized way is to eschew unconscious forms of control that might emerge from the act of touch: “Touching is the first step towards obtaining any sort of control over, or attempting to make use of, a person or object” (Freud, 1912-1913, p. 33).35 Touch, in other words, manifests itself in extremely conflicted and contradictory ways for acne sufferers, as that which both necessitates control and affords subjects with a certain degree of control. For Manning (2007), this embodied tension boils down to a struggle between tact and touch, described as such:

Tact is anathema to a politics of touch, but never wholly disjointed from it. Touch is always at risk of being tactically re-secured. Tact abides within the conditions of possibility of touch. To circumvent tact, touch resolves to reach beyond tact, beyond the unspoken judgment that urges me to refrain from touching. To touch entails acknowledging the risks associated with the unknown toward whom I reach when I touch. Touch must always lead beyond where I anticipated it would. Tact, on the other hand, keeps me in the realm of the almost-known, the anticipated-in-advance.” (p. 135)

Using Manning’s terminology, picking and popping can be understood as “taboo” forms of touch. Indeed, upon reflecting on these haptic (mis)adventures female acne.org members recognize such activity as “bad;” a discursive technique that might be argued to reassert a “healthy” and “responsible” patient subjectivity in the face of an “unhealthy” behaviour.

But, it is clear that picking and popping represent more than a breach in the unwritten codes of a good or healthy patient. Terms such as “bad woman” or “bad girl”

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35 Anzieu (1989) refers to this as the mastery drive.
draw our attention to the ways tact is bound to feminine embodiment. Women, especially, write about their failure to exercise tact as a moral failure to uphold and practice an appropriate femininity. In other words, individuals who understand themselves as “bad girls” for picking at and popping their own skin suggest that movements of this sort transgress the stable boundaries of (gendered) identity. It is precisely the body’s movement that interests Manning (2007), because “without a commitment to the ways in which bodies move, bodies become stabilized within national imaginaries in preordained categories, such as […] man, woman” (p. xv). Manning’s theoretical commitment to movement is thus in line with broader shifts in contemporary body theory that aim to think about the body in its multiplicity (Blackman, 2008). It is through movement, Manning argues, that bodies relate, multiply and exceed them-selves and the “concept of ‘me’ that is at the heart of a politics of identity” (Manning, 2007, p. 137).

Using Gilles Deleuze and Felix Guatarri’s (1987) concept of the “body without organs,” (BwO) Manning evokes the language of exfoliation (a suitable metaphor to understand picking and popping) in order to theorize the body in all of its excess:

A body that is always in the potentiality evoked by a reaching-toward is a body that must also always already be beyond its-self. This body is abstract in the sense that it is always virtually becoming its potential. Because there is no end-limit to becoming, this body-in-potential cannot be conceived of as a permanent space-time, but must instead be thought of as an exfoliating movement toward another exfoliating movement. The body as exfoliation cannot be grasped. But it can be thought – abstractly. As an abstract potentiality, this body is not solely contained within an enclosure – skin – which can be organized (tactfully) within a system of governance (a body-politic). The BwO is more than its discrete outside and inside. This body-as-multitude is a strata onto which intensities congregate. (p. 136)

If we follow Manning in this line of thought, then we might understand acne as a type of exfoliation. Acne sufferers consistently make reference to the various intensities (i.e.
itches, pains, discomforts, tickles, etc.) congregating atop and underneath their skins, by which they feel compelled to move and pick or squeeze at the surface of the body.

Moreover, women tend to write positively about the pleasures they experience as a result of such movement, as self-identifying women write: “The thing is, I LIKE popping my zits;” “As disgusting as this sounds, I love it when I have a really deep spot, and it is ready for exploding, and then I squeeze it and it cracks!;” “Yes it is gross but OH SO SATISFYING. My favorite[s] are the big ones that make a noise when squeezed.” In these examples, the distinctions between subject and object collapse so that women experience the simultaneous pleasures of being both the exfoliator and the exfoliated. Driven to exfoliate the intensities lying on and beneath the surface of the body, female acne sufferers thus momentarily reject the tact expected of them. Rather than tactfully work towards a smooth and soft (read: feminine)36 future-skin, they find themselves pleasurably and playfully worked by a present-skin that (using Manning’s terms) calls attention to the body’s “potentiality” to exist as something other than a symbolic “container” or “enclosure.” In this sense, they shed the bounded skin expected of them and become the radically unbounded, holey and permeable body without organs of which Manning speaks: “Bodies without Organs are disagreements with/in space and time, challenging at every juncture the constitution of the subject that operates at the basis of politics” (Manning, 2007, p. 141). Engaging in intimate relations with pimples, self-described “bad girls” or “bad women” thus feel themselves being touched by pimples and touch back, creating a “multiplicity that challenges the dichotomy between the one and

the multiple” (Manning, 2007, p. 138). In effect, they become-with pimples to engender “a different kind of politics” (Manning, 2007, p. 141) than the ones structuring a disciplined feminine “tact.” If tact attempts to secure the surface of the female body, “bad girls” routinely penetrate that surface using a touch that not only transgresses the symbolic-haptic boundaries of “health” but also femininity.

These are findings that are largely inconsistent with the existing critical research on acne. The concept of “normal” appears frequently throughout McMahen’s (2012) reading of acne, arguing “the shame associated with acne is rooted either in the failure to achieve a physical ideal or what is deemed physically normal” (p. 16). Building on the work of Lennard Davis (1995), McMahen uses acne as a means to explore the relationship between “ideals” and “norms.” He thus challenges Davis’s argument that Western societies have moved from an “ideals-based society” to a “norms-based society,” and suggests that these are not mutually exclusive realms. As such, he comes to the conclusion that “those suffering with acne and acne scars might, consistently, be desiring merely normal skin in one sense while also desiring perfect skin in another sense […] if perfect skin has been normalized through the advent of magazines, television programs, and the Internet, in which everyone shown has perfect skin, then perfect skin becomes normalized” (McMahen, 2012, p. 70). McMahen’s thesis makes an important contribution to the theorization of ideals and norms in contemporary Western society, but the subjects of his analysis appear relatively determined by their cultural context. In other words, acne sufferers appear united in their common pursuit to embody the status quo. My analysis of the acne.org forums, however, paints a different picture.\textsuperscript{37} As the figure of

\textsuperscript{37} McMahen also analyzes forum posts on acne.org.
the “bad girl” suggests, acne is not only that which drives individuals to conform to norms or ideals, but is also that which opens up new space to resist them. Said differently, many acne sufferers are in fact driven to think about and do skin in ways that do not so much conform to, as much as they contest, the politics of “normal” and “ideal” skin.

The politics I am referring to are specifically gendered politics. Words such as “normal” or “ideal” come to mean very different things for the skin depending on the gender of the subject. Moreover, the politics I discuss here have less to do with the skin one wants or imagines, and more to do with the skin one lives and experiences. This is a skin that is active, lively and in a constant state of flux; a skin that constantly becomes something different with the passing of time.38 As such, I contend that we must not only understand acne as the object of normalizing regimes of power but also afford it with the agency it properly deserves. Acne deserves to be understood as a material force that regularly resists those normative regimes to produce other, non-normative ways of living as skin, with skin and through skin. I am thus indebted to the works of material feminists who, as Frost (2011) describes, “explore how the forces of matter and the processes of organic life contribute to the play of power or provide elements or modes of resistance to it” (p. 70).

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38 Here, I follow Grosz (2011) in understanding difference as a generative force. The capacity for biological matter to differentiate itself and become something else helps us think beyond constructivist understandings of difference: “…difference is the undoing of all stabilities, the inherent and immanent condition for the failure of identity, or the pressure to develop a new understanding of identity that is concerned not with coinciding the subject with its past so much as opening the subject up to its becoming-more and becoming-other. Difference means that the constraints of coherence and consistency in subjects, and in the identity of things or events, is less significant than the capacity or potential for change for being other” (p. 97).
Perhaps the most poignant example of acne’s force can be found in makeup; or more specifically, acne sufferer’s use of makeup. Like most products in the cosmetics industry, makeup is primarily marketed to female consumers who want to conceal their body’s “imperfections” – ranging from anything to blemishes, scars, pimples, freckles, etc. Indeed, an entire acne.org sub-forum is dedicated to makeup, where many women come together to share advice on what products to use and how to use them on specific types of acne. There is also no shortage of videos available on websites such as YouTube (referred to as “makeup tutorials”) with detailed instructions on how to use makeup to hide particular types of acne. The overwhelming popularity of these kinds of Internet tutorials and online makeup communities suggests that acne plays an important role in determining why many female acne sufferers use makeup and how they use it. McMahen (2012) writes that women feel compelled to purchase and use makeup precisely because they have failed to meet a particular ideal of feminine beauty: “The shame that results in the failure to meet certain ideals, including ideals of femininity, often provides the motivation to diet, exercise, or purchase cosmetic products” (p. 114-115). If we follow this train of thought, then it would seem as though makeup belongs to a normalizing culture that makes acne abnormal, unattractive and shameful – particularly for a woman’s skin. As such, acne needs to be hidden from plain sight; a discourse that female subjects overwhelmingly embrace and conform to in McMahen’s thesis.

My research, however, suggests that many women actually resist this discourse after having lived with acne for some (usually extended) period of time. Already familiarized with acne’s resiliency – that is, its capacity to survive, adapt and evolve even
under the most extreme pharmaceuticalized climates – some female acne sufferers are led to experiment with and embrace alternative ways of living with acne that do not begin from the premise that acne is disgusting or something to be ashamed of. Writing for the online women’s magazine Bustle, Meg Zulch (2015) explains how her acne’s persistence and refusal to simply “go away” left her feeling powerless. Unable to change acne on the molecular level, Zulch instead opts to change acne on a cultural level by choosing to think about it as something other than a disease. In other words, she begins to reject the hatred and disgust she has learned to direct towards her skin and instead begins accepting and loving her acne:

I began taking photos of myself constantly without any makeup on, sometimes using filters to accentuate the dark or irritated parts of my face. I began to love my flawed skin as much as I love my eyes or my breasts or any other part of my body I find particularly beautiful […] These days, I try to document my flareups with numerous selfies and Instagram photos. I do this so I never stop loving the person in the mirror, even if her face and skin are highly sensitive […] I refuse to shy away from my sensitive skin, and rather force it to the forefront – as I tend to do with my queerness. By forcing people to look at it, I start a conversation about beauty norms.

Zulch acts in stark contrast to the majority of female acne sufferers represented in McMahon’s research. She reminds us that some women resist the biomedical understanding of acne and, therefore, do not attempt to hide their acne from public view. In fact, their resistance involves making acne more public, which often results in an outright rejection of makeup. As such, Zulch and many others attempt to bring political conversations about femininity, normality, body issues, and shame to public discourse through their acne.

In another related example, Kate – a blogger for the online feminist community Autostraddle – writes about her “big queer pimples” (2013). She recounts the time she began to actively seek out and use makeup, which happened to coincide with her then-
worsening acne: “My mom didn’t understand why I wanted to use makeup when I’d never shown any interest in the past, but I was determined that these big angry sores on my face were about to make a swift exit […] I didn’t leave the house unless it was in a layer of caked-on Cover Girl liquid foundation in shade 02. I figured I was hideous without it.” Later in the piece, makeup makes another appearance in Kate’s life…only in a much different way than before:

I still think about what it means to be a masculine queer person, how my standards of beauty are very different from the experience I had growing up as a feminine girl who was expected to be feminine. And if I have a bad day and need to wear a little cover-up, I’ve learned that it’s not even a remote threat to who I am or how people perceive me […] One of the most freeing elements in my struggle with acne was learning how queerness works to subvert mainstream beauty standards and expectations for appearance, and accepting and fueling that subversion in myself. Being queer makes me confident in myself, and that self includes a lifetime of acne […] I’m out in public, right this very second, and there’s not a lick of make-up on these cheeks.

In both scenarios, Zulch and Kate end up rejecting makeup because they have learned to love their acne. Instead of being some alien or foreign “invader” that threatened their status as women, acne became part of who they were as queer subjects.

This relationship between acne and queerness is worth exploring in greater detail, because it helps illustrate the dynamic interactions between biology and identity as interdependent processes that “have reciprocal agentive effects upon one another” (Frost, 2011, p. 71). In other words, I want to eschew causative explanations for Zulch’s or Kate’s experiences. A queer identity is not that which determines how they understand their acne, nor is acne that which determines how they understand themselves as queer. Instead, their stories point to the ways that acne and queer identities co-emerge, helping to inform one another. Neither Zulch nor Kate think of themselves as queer apart from their acne, but rather come into that understanding of self with acne and through acne. To
better elucidate this point, I want to draw specific attention to a particular sentence in Kate’s aforementioned quotation: “One of the most freeing elements in my struggle with acne was learning how queerness works to subvert mainstream beauty standards and expectations for appearance, and accepting and fueling that subversion in myself.” In particular, I am interested in Kate’s use of the words “accepting and fueling,” because I think they highlight different types of agency. To fuel is to act intentionally on a path to becoming queer, where queerness emerges through conscious practices and thought processes (e.g., ideas and practices surrounding makeup). But fueling, as well as accepting, also suggests that queerness is already there, waiting to be nourished and welcomed as part of one’s identity. In this sense, Kate and Zulch already have an embodied understanding of themselves as queer thanks to their longtime struggles with acne. Not only do they turn towards acne in order to perform their queerness, but they also look to acne in order to understand their queerness. Oftentimes, those who have experienced acne for extended periods of time know their skin as a queer biology, precisely because it routinely manages to escape biomedical control. Having usually experimented with countless cosmetic and pharmaceutical products, many acne sufferers will admit that their skin is that which cannot be normalized. Time and again, they experience the agency of the skin as that which becomes something other than a “clear,” “healthy” or “feminine” complexion. Accustomed to the ambiguous materializations of skin, Zulch and Kate already have an embodied sense for themselves as queer subjects. Acne is that which they can look towards and depend on to fuel a queer becoming, because they know the materiality of acne to refuse normative labels, categories and biotechnologies. As such, they each exhibit a commitment to being acne and performing
acne so that they are able to recognize themselves as, and practice, a queer subjectivity. Nowhere is this commitment clearer than when Kate remarks that her-self is a self that “includes a lifetime of acne.”

Of course, none of this is to say that queer identities are not also forged in and through makeup. Men, for example, threaten to disrupt the boundaries of a (hetero)normative masculinity when they attempt to conceal their acne with makeup. One of the more common questions asked by self-identifying men of acne.org is whether or not it is “okay” for them to wear makeup in an attempt to hide their acne. In a thread titled “How can a guy not get “caught” wearing makeup?” a user writes: “I was thinking of wearing makeup on certain occasions to cover up redmarks. I’m a male, so…I don’t want anyone to know I’m wearing makeup since that would be mega awkward. In fact, I’m actually incredibly afraid of that happening.” Unlike the aforementioned examples of Kate and Zulch, this male acne.org user wants to reject and hide acne as part of his identity. A queer identity is not that which he actively seeks to “fuel” or “accept” but rather hide. As such, he is left with the task of hiding both his acne and the act of concealment itself. He attempts to negotiate both a normal skin, and a normal masculine embodiment despite the queer biological force that is acne.

Both male and female acne.org members chime in with advice on threads such as these. Many express strong opinions that men should never wear makeup, and attempt to discourage those who are entertaining the idea: “I don’t recommend makeup on a guy, it may be harsh to hear, but instead, try to man-up.” Another user writes: “yeah for sure, nothings manlier than some blush and eyeliner *rollseyes*.” A woman offers her words, as well: “If I find out a guy used makeup I’d be like […] he must be really insecure about
himself if he feels he needs to wear makeup […] I’d still question his masculinity.” With responses such as these, it becomes clear that masculinity must be policed through male forms of acne. Whereas women are almost expected to lack the necessary confidence needed to unashamedly show their pimples in public, men are expected to embody a “thicker skin” through which the disease materializes as trivial, aesthetic and banal. Acne, in fact, is one way through which men can develop a “thick skin” by learning how to shoulder public acts of humiliation, shaming and teasing. Men and women, therefore, learn very different sets of rules about how to normatively do gender as skin through their experiences with acne.

Nonetheless, many men do experiment with makeup as a technique to hide their acne. These are men who are ashamed of their acne and for whom the metaphor of “thick skin” rings hollow. Instead of affecting acne by practicing a hard and emotionless masculinity, they admit to being affected by acne. Unable to simply “brave” their way through the disease “like men,” they turn to alternative options such as makeup in order to hide their shame. In short, they begin doing skin in ways that are marked as fragile, vulnerable, feminine and queer. For straight men, it is precisely this doing of skin – that is, those queer habits and activities that occur in private – that they feel obligated to hide just as much as their acne. One “slip-up” might call their masculinity and sexuality into public question, as one user writes in quite simple terms: “If your caught with it [makeup] on at school your a deadman.” Another acne.org user shares a story: “I was getting ready to help a customer, and all of a sudden I heard [my co-worker say] “I wouldn’t want to

39 “Thick skin” is an apt metaphor to understand the production of a particular type of “hardened,” “impenetrable” or emotionless masculinity that is practiced and cultivated through acne.
see (my name) without makeup” and then I heard the worst… giggles! She said it so loud […] I wanted to disappear forever.” A similar story is shared by a different user about being “outed” as a makeup user: “A girl I like in school was playing with me and put me in a headlock, in a playful way. I tried to resist but before I knew it, my make-up was all over her light blue shirt […] The word was out by Friday […] Man I’m fucked.”

There is nothing particularly new or surprising about the fact that masculinity and sexuality is policed on and through the skin. Makeup, in particular, directs our attention to the ways gender is “made up” on skin. There is a kind of reiteration of norms that takes place through the use of makeup such that men’s skin very rarely materializes as hidden or concealed. When it does, it calls that subject into question or renders them ambiguous within an entire system of gendered and sexed differentiation:

Suffice it to say that the boundaries of the body are the lived experience of differentiation, where that differentiation is never neutral to the question of gender difference or the heterosexual matrix. What is excluded from the body for the body’s boundary to form? And how does that exclusion haunt that boundary as an internal ghost of sorts, the incorporation of loss as melancholia? To what extent is the body surface the dissimulated effect of that loss? (Butler, 1993, p. 65)

What is particularly interesting about the ways masculinity and sexuality are policed through skin, however, is that it calls our attention to the productive potential or agency of skin to disrupt normative gendered embodiment. If we follow Butler’s questions, then we might be led to consider shame as that which is being excluded in order for the boundaries of the masculine body to form. If acne is, as I have heretofore argued a queer biology, then part of that queerness manifests in the very surfacing of shame. With impressive force, the shame of acne has brought together virtual communities of men who collectively experiment with queer skins. Most of the men who enter into these communities for the first time have never learned what makeup is or how to apply it (i.e.
when to apply makeup, where to apply makeup, techniques for applying makeup, specific brands to purchase, etc.), but various YouTube makeup tutorials, acne.org discussions and blogs exist to help impart this knowledge. Of course, we can read these communities and the knowledge being shared as normalizing in their own right, given what appears to be a common emphasis on achieving an “untouched” or “natural” look with makeup (i.e. one where it is not recognizable to others that makeup is being used). But, we should not overlook the political and cultural significance of the act itself, as that which is opening up new possibilities for masculinities to be embodied, expressed and experimented with beyond the cultivation of a “tough skin.”

Applying makeup on the skin is just one of many embodied acts through which pimpled subjects play with the boundaries of identity. Throughout this chapter, I have argued that acne sits uncomfortably on those boundaries and threatens to undo or reconfigure the racialized and gendered contours of the body. Besides makeup, individuals use a number of other objects, participate in a variety of individual and collective practices, and produce an amalgamation of biomedical and cultural discourses through acne, either as a way to regulate the racialized and gendered contours of the body or experiment with new ones. By parsing this chapter into two parts that analyze racialized and gendered pimples separately, I have left underexplored some of the intersections through which pimpled-boundary work ultimately takes shape. Makeup, for example, is as much about race as it is gender. The “tough skin” that some men are shedding through their experience with acne comes layered with historical and racial meanings that were outlined at the start of this chapter in Kant’s *Physische Geographie*. In other words, tough skin is not as easily shed for black men as it might be for other men.
who use makeup to conceal their acne. The boundary work that occurs with and through acne thus stands to be made more intersectional than what I have outlined here, but must also afford acne an active role in the making of intersectional subjectivities. It is precisely this dermatological *activity* that I have attempted to chart throughout this chapter with the hopes that it might continue to generate new insights into the ways contemporary identity politics are lived, managed, and transgressed on and through the materiality of skin.
Chapter 5

Dermatological Suffering

In this chapter, I focus on the making of a “psychodermatological” person. I discuss how psychology and dermatology converge in the contemporary moment, and the effects of those convergences. Using Ian Hacking’s (1986) concept of dynamic nominalism and Maren Klawiter’s (2008) notion of “disease regimes,” I analyze acne as it comes to be labeled, diagnosed and treated as a psychodermatological disease, as well as psychodermatologically expressed by patients. In other words, I consider the context in which contemporary associations between skin and self appear “natural” and “common sense.” Following Klawiter (2008), I pay specific attention to the “regime” of institutionalized practices, authoritative discourses, emotional vocabularies, visual images and social scripts that make acne into the “sufferable” disease that it is today. I argue that acne-related suffering is neither the natural nor inevitable consequence of acne, and is instead culturally produced through a disease regime that makes acne a disease that one is, rather than a disease that one has.

In The Book of Skin, Steven Connor (2004) proposes that there are three stages in the medico-cultural history of skin. The first stage can best be illustrated through the metaphor of a screen. Citing the works of classical and medieval writers as well as biblical scripture, Connor argues that the skin in its earliest stage was “that which made the wholeness of the physical being present, and that which made disease visible, [but] was itself invisible, like a screen” (p. 26). As dermatology began to develop around the eighteenth century, however, the skin began to be understood in more mechanistic terms. Using the word “membrane” to describe this second stage in the skin’s cultural history,
Connor argues that its primary function was to eliminate waste from the body. In other words, skin was beginning to be “seen” in a way that it hadn’t before, reflected in the early works of Joseph Plenck and Robert Willan whose emerging nosology of skin diseases laid the eventual groundwork for the science of dermatology. But as skin and its functions began to be singled out by a biomedical gaze, Connor notes that its functions also began to “multiply beyond the merely medical understanding” (p. 26). With this multiplication is the third and present stage in the skin’s cultural history: a milieu. In our contemporary moment, skin is irreducible to any one function, any one place, or any one sense but instead represents a “place of minglings, [and] a mingling of places” (Connor, 2004, p. 26).

I follow Connor in thinking about the skin as a milieu because it captures, quite nicely, the ways acne can and does become much more than a mere “skin disease” in people’s lives. That is to say, Connor’s historical present speaks to an important shift in the understanding and experience of skin disease, as that which not only affects the skin but also the psyche. Indeed, we rarely speak of acne today without also making an attempt to acknowledge the ways its exterior form mingles with formless interior registers, moods, emotions, affects, and so on. My aim is to understand these minglings in context. Specifically, I want to know how, and with what effects, dermatology intervenes on the emotional lives of subjects.

One way to approach this question is to ask how the medical and scientific label of “acne” includes details of the patient in addition to the lesion. What sorts of things are being said about the dermatological patient, their behaviors and their affect? Where are they being said, and by whom? What other labels are being used to describe their
condition in addition to acne? These are sub-questions to which I intend to develop responses; however, I also want to acknowledge the fact that biomedical labels do not make the person. Speaking about labels, Ian Hacking (1986) reminds us:

…Let me state at once that for all his famous fascination with discourse, naming is only one element in what Foucault calls the “constitution of subjects” (in context a pun, but in one sense the making up of the subject): “We should try to discover how it is that subjects are gradually, progressively, really and materially constituted through a multiplicity of organisms, forces, energies, materials, desires, thoughts, etc. (p. 226)

Important as they might be, the words we use to describe acne do not ultimately define or determine its expression in nature. Rather, some of the language we use to describe individuals with acne (e.g., suffering, depressed, anxious, ashamed, stressed, etc.) might actually emerge from acne itself. To acknowledge that our categories are not entirely of our own (i.e. human) making and also spawn from the forces of nature (e.g., acne) is to practice what Hacking (1986) terms dynamic nominalism:

The claim of dynamic nominalism is not that there was a kind of person who came increasingly to be recognized by bureaucrats or by students of human nature but rather that a kind of person came into being at the same time as the kind itself was being invented. In some cases, that is, our classifications and our classes conspire to emerge hand in hand, each egging the other on. (p. 228)

What follows is an attempt to put Hacking’s concept of dynamic nominalism to work. It is not only the case that biomedical authorities label, diagnose and treat a “psychodermatological” kind of person whereas, before, they did not. Following Hacking, it is also important to acknowledge the ways a psychodermatological kind of person has come into being through nature – or in this case, the vibrant, lively and fluid matter that is acne. It is precisely these qualities that make acne a notoriously affective disease through which patients are learning, practicing and inventing a psychodermatological subjectivity for themselves.
One of the reasons dynamic nominalism is such an appealing concept to me is because it theorizes power as dispersed. That is to say, it does not understand power to be centralized in the hands of a few biomedical authorities whose expert knowledge, diagnostic labels and biotechnologies converge to determine the shape and form of a particular disease or diseased subject. Instead, Hacking acknowledges the ways disease is also experienced from the ground-up, materializing through a variety of human and nonhuman actors to resist existing biomedical labels and sometimes create new ones. It is precisely through the dynamic interactions or back-and-forth exchanges between patients, experts and nonhuman life that a language of disease unfolds alongside its embodied subjects.

Maren Klawiter (2008) uses a similar approach to theorizing medicalized relations of power. Like Hacking, she is drawn to understand both the language and materiality of disease as simultaneous and co-emergent processes, introducing her reader to the concept of disease regimes:

In my formulation, disease regimes consist of the institutionalized practices, authoritative discourses, emotional vocabularies, visual images, and social scripts through which diseases are socially constructed, medically managed, publicly administered, and subjectively experienced […] The concept of disease regimes is designed to help illuminate the relationship between the practices through which breast cancer is (bio)medicalized, the forms of embodied subjectivity that these practices produce, and the emergence of new forms of biosociality. (p. 32-33)

My reading of disease regimes is that it is commensurable with Hacking’s notion of dynamic nominalism. By identifying five constitutive elements of disease regimes, Klawiter provides us with a useful framework through which to see dynamic nominalism unfold – highlighting places, people, and practices where our classifications and classes are, indeed, “egging the other on” (Hacking, 1986, p. 228). This “egging on” can
manifest in changes to the practices of a disease regime; a process that Klawiter (2008) argues alters the “spatial, temporal, and visual dimensions of disease and leads to the production of new subjects and social relations of disease” (p. 33). As such, I have organized this chapter according to Klawiter’s five elements of disease regimes, using them as starting points to begin thinking through the making of a psychodermatological person.

Institutionalized practices

“How does acne make you feel?” The question is one that is regularly posed by dermatologists and family physicians to those patients struggling with this disease. It hasn’t always been this way, however:

I don’t think I was in tune to [the psychological components of acne] early on. Definitely, as time has gone on there has been more discussion about how [acne] affects people…it’s something more on my mind when I’m dealing with acne […] I think years ago I probably didn’t connect [acne and psychology] as much as I do now. (Claire, personal communication, April 14, 2016)

In the short span of just twenty years – since this particular doctor began practicing family medicine in 1996 – acne went from a disease affecting the skin to a disease affecting the skinned subject. As such, clinicians trained to diagnose and treat acne have learned to change their dermatological practice in a number of different ways.

One such way involves the sorts of questions they ask acne patients. Asking the patient how they feel has become something of a norm for those treating acne in their practice. As one dermatologist said, dealing with the psychology of the patient becomes “part of [the] job” […] “I think that dermatologists are always bumping up against [psychology] a little bit” (Jennifer, personal communication, August 25, 2015). This “bumping” or mingling between the skin and the psyche are thus put on display in the
doctor’s office, as clinicians and patients engage in what this same dermatologist refers to as a dance: “I think that whenever you meet patients there is always a sort of dance...you really have to get to know each other” (Jennifer, personal communication, August 25, 2015). The dance being referred to, here, might best be understood by returning to Hacking’s notion of dynamic nominalism. There are times when the patient might take the lead in that dance, expressing their acne through words, affect, stories, etc. At other times, doctors attempt to lead in that dance, using labels such as body dysmorphic disorder, suicide, or stress to better understand the patient’s experience. With these labels, doctors and patients share a common language through which the dance becomes “choreographed” to look and move a certain way. The “first dance” between the acne patient and their doctor is an important one, because it is where classifications and classes “conspire to emerge hand in hand, each egging the other on” (Hacking, 1986, p. 228). It has become common practice to perform this dance in the doctor’s office; a ritual designed to summon a psychodermatological person out of diseased skin that both speaks and is spoken about.

It is worth thinking about the dermatological turn to voice in greater detail, because it marks a fairly important departure from what has traditionally been one of the most ocularcentric practices in medicine. One cannot overstate the pedagogical value of visual aids to the science of dermatology. Paintings and wax moulages are just some of the ways artists have attempted to represent different classifications of skin disease; many of which now grace the halls of medical museums (Schnalke, 1995; 2004; Sticherling & Euler, 2001). Around the middle part of the twentieth century, photographic technology was becoming more widely accessible and had reached a point where it could capture
skin diseases with great (and coloured) detail (Joshi, 2010). As such, the art and craft of moulaging gave way to the photograph as the primary teaching aid in dermatology. To this day, photographs continue to feature prominently in dermatology textbooks and journals as a way for students and practicing doctors alike to learn about the different dermatological classifications. One family physician described to me that she reads about five medical journals a month, and specifically looks for photographs of unlabeled skin lesions as a way to practice and hone her dermatological eye: “There are a couple journals that have this whole section where they have pictures of different skin things. And then you can kind of decide what you think it is” (Claire, personal communication, April 14, 2016). Visuality, in other words, has been a central organizing feature of dermatological diagnosis. Students need to be trained how to recognize and classify the subtlest differences in lesions that appear on a part of the body that is most visible to the naked eye. Foucault (1973) uses the term “medical gaze” to describe this kind of training, where students of medicine are taught how to see with an “ever-more attentive, more insistent, more penetrating gaze” (p. 15).

But, while the development of a discriminating gaze has been a central feature of the dermatological project, it also appears limited in terms of its ability to diagnose and treat the psychodermatological patient. In addition to a discriminating gaze that now looks at body language as well as lesions, today’s doctor must also practice a discriminating ear that can listen for and recognize the signs of psychodermatological anguish, pain, suffering, etc. Sometimes, those signs make themselves fairly obvious in the aforementioned dance between patient and doctor, as one family physician notes: “Sometimes [the patient] will break down and cry and say “I don’t go out with my friends
anymore; I’m not functioning very well” (Claire, personal communication, April 14, 2016). Other times, however, the signs are less clear and require a different set of questions besides “how does acne make you feel?” as well as a different way of listening to the patient’s response. As one dermatologist describes:

If the patient has a flat affect, they talk in a sullen tone. If they look at the floor and sort of have something called anhedonia, which is a general lack of interest in life and everything. So I tend to engage my patients, and with teenagers in particular, I will ask them how is school? How are your friends doing? Have you been doing any activities? Do you do any sports? If they crack a smile…are they happy? Will they laugh with me if I make a joke? I tend to be a fairly jokey individual. So those kinds of things I use as clues to gauge their current temperament. (Stephen, personal communication, September 7, 2015)

As this dermatologist makes clear, he is attuned to much more than what a patient says. Importantly, he is also listening to how a patient says things. For him, it is clear that acne is a multivocal disease that speaks through a variety of different registers. As such, he performs a series of techniques so that he and the patient can dance to some of the other non-verbal melodies of acne. Asking specific questions and listening for non-verbal cues such as laughter, tone, eye contact and comportment, it is clear that this particular dermatologist has developed – and is still in the process of developing – a discriminating ear. At this level, acne cannot be “seen” by even the most trained dermatological gaze or high-resolution camera.

Authoritative discourses

40 Here, the dermatologist purposely attempted to speak in the “sullen tone” to which he is referring. His voice is low, and his words are enunciated slowly. His expression is monotone, but each word seems to lilt in a downward trajectory reaching an even lower decibel or tone of expression. His bodily comportment changes in this moment too; his shoulders slumped forward, his head positioned slightly downwards with his gaze just barely able to meet mine.

41 We might also say that the dermatologist is in the process of developing an affect through which he “tunes into” the emotional states of his patients through his own feelings.
Important as these institutionalized practices are to the overall understanding and experience of acne, they belong to a much broader discursive landscape that has grown increasingly comfortable making connections between the skin and the psyche. These connections are certainly not new nor the simple result of institutionalized changes to the practice of dermatology. In fact, some of the earliest diagnostic labels in dermatology can be said to have drawn connections between the mind and the skin, with nineteenth century texts making reference to everything from “skin neurosis,” “delusional parasitosis,” and “trichotillomania,” to the more familiar “body dysmorphic disorder” (França, Chacon, Ledon, Savas & Nouri, 2013). Freud and many other practicing psychoanalysts of the twentieth century also counseled and wrote about patients whose psychological and dermatological problems were thoroughly entwined (Ulnik, 2007). What is new, according to the doctors I interviewed, is the regularity with which patients seem to be experiencing psychodermatological problems. The most common of skin conditions – acne vulgaris – is now regularly experienced and understood as a psychodermatological problem before patients even arrive at the dermatologist’s office.42 Once considered to be a rare set of medical problems occurring at the margins of psychology and dermatology, emotional issues now appear to be a normal, if not expected part of skin disease.

What, then, are the discursive conditions that regularly permit and encourage a psychodermatological understanding of acne? Experts alone are not responsible for the ease with which skin conditions slip into psychological conditions and vice versa.

42 The word vulgaris is Latin for “common,” and can be used to refer to either the frequency with which something occurs, or the people (i.e. commoners or masses) it affects.
Dynamic nominalism reminds us that patients, too, are inventing the acne sufferer – a type of person for whom acne is both a dermatological and psychological problem. At this moment in time, an ever-increasing number of acne sufferers seek help for their suffering through dermatological avenues, leading one commentator to ask: “Are dermatologists the new therapists?” (Matlin, 2015). Indeed, if suffering is being spoken about in dermatological settings and through dermatological diseases such as acne, then what is being said? What are the authoritative discourses through which the suffering of acne is made culturally intelligible?

A lot has changed since the time psychodermatological labels were first developed in the nineteenth century, or honed in psychoanalytic practice throughout most of the twentieth century. Most notably, our historical moment is one that has grown increasingly comfortable with the fields of psychology and psychiatry respectively. It is through the language of mental illness that many Western cultures have learned to understand an ever-greater range of human behaviors:

A huge cultural transformation in the construction of mental illness has occurred in a relatively short time. The broad array of mental illnesses at the beginning of the twenty-first century has little resemblance to older stereotypes of madness that persisted throughout most of human history […] The extensive use of disease categories for a wide variety of human behaviors is unique in human history; most of the many mental illnesses that are now taken for granted as objective natural entities are recent creations. (Horwitz, 2002, p. 4-5)

This is important context for our purposes. The sudden rise in understanding, experiencing and describing dermatological diseases (e.g., acne) as psychological problems coincides with a subsequent rise in what Horwitz (2002) calls a “culture of mental health that […] is now the everyday reality of daytime talk shows, television
series, popular magazines for girls and women (and sometimes men), and virtually all advice columnists” (p. 4).

We need not look any further than the acne.org forums to find evidence of acne sufferers using psychological or psychiatric labels to understand themselves and their skin disease. Some of the most common self-diagnoses include depression, anxiety, body dysmorphic disorder and obsessive-compulsive disorder; labels that are meant to magnify the emotional toil of acne. As one user writes: “My insurance denied to cover me because they think I can live w/o accutane so [my parents] are paying $430/month for me…I think it’s stupid because it’s like being depressed and getting Prozac. I think having acne makes me miserable so if it were to be treated with accutane it would cease my depression! Like an anti-depressant, right?” As this example makes clear, psychological and psychiatric labels carry a political force that acne does not. Words such as depression might help in making an increasingly inaccessible category of drugs (i.e. prescription acne medications) more accessible. Perhaps, if Accutane belonged to a different category of drug (i.e. antidepressants) it might be more widely covered under insurance formularies, and reimagined as an essential and life-saving medication as opposed to some sort of frivolous lifestyle drug. The struggle to make acne a psychodermatological disease, therefore, is in part a struggle to access a particular class of drugs; expanding the discursive limits of psychopharmacological drugs so that skin, in addition to the brain, is included as part of the biology of affect.

I would argue that this shift in the way acne medications are being classified by users is an effect of psychological discourses or the “culture of mental health” that Horwitz (2002) speaks of. Indeed, patients and experts alike are being encouraged to
think about what one doctor refers to as “the unseen part of [the] disease,” or said differently “how it makes people feel about themselves” (Bures, 2015). These are considerations that dermatologists and family doctors, in particular, are being asked to medicalize and treat through the skin, as one practicing dermatologist makes clear: “If your acne is becoming so troublesome you are embarrassed, having psychological problems or it is impacting on your work or social life, you should go to see your GP, who will refer you to a dermatologist” (Sturgis, 2016). Similar messages are reproduced outside of medical settings, as well, with national, not-for-profit groups such as the Acne and Rosacea Society of Canada unveiling the first “Acne Awareness Week” in September of 2015. Central to their platform is making people aware of acne’s emotional and psychological effects: “Often dismissed as “just pimples,” acne can result in emotional distress and permanent scars […] The society also addressed that acne is more than just pimples, as the rate of depression among acne patients is 10%, according to the release” (“Acne Awareness Week,” 2015). With pharmaceutical giants Novartis, Bayer and Galderma providing most of the Acne and Rosacea Society of Canada’s funding, it seems likely that psychological discourses offer new opportunities and value for shareholders invested in the multi-billion-dollar acne industry, “a $3 billion dollar (sic) industry in the United States alone” (Park, 2013).

None of this is to say that patients are coerced into speaking about the emotional suffering that accompanies acne. In an article published in Oxford University’s student newspaper titled “We desperately need an open dialogue on acne,” we can observe the ways psychological discourses are welcomed by individuals for the simple fact that they offer a language through which to make sense of suffering; an experience that Arthur
Frank (2001) argues “resists location, identification, and action [and] has no necessary connection to illness” (p. 355). The author writes:

I decided to break the silence after I read multiple articles on how acne frequently leads to depression, and that this is “often independent of severity.” Despite living with acne, I’d never considered that my low mood over a breakout was something natural, I’d just thought it was how I dealt with it. In fact, acne has a significant, negative psychosocial effect, and we don’t talk about it because pointing out our flaws is the very last thing we want to do. (Loannidi, 2014)

In this example and many others like it, the individual makes public what was previously kept hidden as a kind of private suffering. Using psychological labels to “break the silence,” a sort of Foucauldian confession takes place where acne becomes a vessel through which to think about herself and her suffering differently. Whereas before, Loannidi understood her “low mood” to be a private and radically individualized part of her struggle with acne (i.e. “I’d just thought it was how I dealt with it”), she speaks about finding meaning and comfort in knowing that her mood is something “natural” and shared with others who are also struggling with the skin disease.

As much as psychological and psychiatric discourses figure prominently in people’s understanding of dermatological suffering, their power is also uprooted and dispersed across the skin. Acne, in other words, is not only shaped by the authoritative discourses of experts who study the brain, but it is also reshaping them. One of the dermatologists I interviewed described the limits of conventional psychological or psychiatric labels in diagnosing dermatological suffering:

I would say that most of the time people who I have seen in my clinic have a predisposing diagnosis or come in with a diagnosis of a psychological problem. So I often am not making that diagnosis. Now, I would say that what I often see in my clinic is what I call situational psychological disturbances – so people who have acne who are depressed by their acne. And those people I would say are not necessarily depressed individuals who would benefit from psychiatric intervention. Those are people who I
look at and I say “If I can make your acne better, will you be a happier teenager or happier adult?” and often the answer is yes. So their psychological distress is caused by the disease that they have, and I can make those people better. (Stephen, personal communication, September 7, 2015)

As this dermatologist explains, depression is an inadequate label to describe the kind of suffering he encounters in his practice. As such, he develops his own term – situational psychological disturbance – to more accurately characterize the emotional and mental anguish that his acne patients experience. It is not that these patients, themselves, are sick individuals whose brains are in need of medical intervention. Rather, their skin disease (i.e. acne) has momentarily interrupted or “disturbed” an otherwise normal brain and psychologically healthy person. Through acne, medical experts are thus beginning to reconsider some of the existing psychological labels available to them, with some even going so far as to develop new ones. The question that haunts them is an ontological one: is the acne sufferer’s problem dermatological or psychological in nature?

Lawyers and scientists ask if the acne sufferer’s problem is also pharmacological in nature. In particular, they are interested in what – if any – neurological changes take place in the brains of acne sufferers who are being prescribed the drug Accutane. As a result, these interests have led to an extensive body of scientific literature and case law examining the relationship between isotretinoin and the brain. The media has also shown an interest in this relationship, covering high profile civil lawsuits between Accutane users and the drug’s manufacturer (Hoffmann-La Roche) as well as the tragic stories of suicide that often form the basis for those lawsuits. In 2012, the BBC aired a documentary titled Dying For Clear Skin where Accutane featured prominently as a drug that may or may not lead users to take their own lives.
It is precisely this uncertainty surrounding the exact nature of the relationship between Accutane and the brain that has generated intense media scrutiny, new scientific research and a series of lawsuits into the psychological effects of acne medications. In other words, there is speculation that the medications designed to treat acne, rather than the disease itself, might be at the root of acne sufferers’ suffering. With no conclusive scientific evidence to prove otherwise, individuals with acne, their families and lawyers are given a financial incentive to psychologize the skin disease and file lawsuits against multi-billion-dollar pharmaceutical giants. Psychological discourses, in other words, are only one part of a much larger nexus of power/knowledge that understands acne as an emotionally sufferable disease. That nexus also includes legal and scientific discourses through which one of the most popular and lucrative prescription acne medications is thought to have “associations” with depression and suicide. What, exactly, the nature of those “associations” is, or how those interactions take place is uncertain. But it is this uncertainty that invites Accutane users (as well as their doctors, family and friends) to closely monitor any perceivable changes in mood from the time they begin medication, and inscribe those changes with a pharmacological significance. Essentially, Accutane users become a psychodermatological person through and with the drug: “the drug goes in the person, and a new person results” (Martin, 2006, p. 276).43

Psychodermatological subjects are also produced through the authoritative discourse of health. Jonathan Metzl (2010) has written about health discourses and the

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43 Here, Emily Martin is writing specifically about psychotropic pills. What is interesting about Accutane, however, is that it neither works like nor is it marketed as a psychotropic pill. In other words, it is a pharmaceutical that is primarily focused on changing the biology of the skin rather than the brain. Accutane, therefore, seems to disrupt longstanding historical associations between personhood and the brain in Western thought, by enacting personhood through the skin.
relations of power that are exercised in and through this ostensibly benign and value-free term. Health is a word that figures prominently in our cultural lexicon as a desired state, but as Metzl (2010) argues, “it is also a prescribed state and an ideological position” (p. 2). In other words, the meanings we assign to the word health are not self-evident but rather contested and contingent on a number of scientific, historical, technological, economic, cultural and political factors. What interests Metzl about our contemporary moment, then, are the ways that health normalizes, moralizes and medicalizes to discursively say all sorts of things about the type of person someone is. What are the value judgments being made in and through health? Indeed, this is a relevant question for the purposes of this project because of the ways a “clear” complexion has, in recent years, become synonymous with health. In fact, we might do well to take this line of questioning one step further and apply it to the case of acne so as to ask: what are the role of health discourses in making acne an emotionally sufferable disease?

My reading of acne.org suggests that health discourses play a central role in making acne a shameful and embarrassing disease. One example comes in the form of those individuals for whom acne threatens and interrupts their sense of self as a “healthy” subject. For these individuals, health carries with it positive meanings that are woven into the body and practiced through the body via disciplinary techniques (e.g., exercising regularly, eating “right,” etc.). These embodied practices are not commonsense or value-free, but rather loaded with meaning in a neoliberal context that positions health as an individual’s responsibility and moral imperative. As many sociologists have argued, those who discipline and subject the body to expert knowledge in the life sciences also practice a “good” type of citizenship by treating health as an individual’s responsibility
(Biltekoff, 2013; Rail, 2012). It is perhaps not surprising, then, that so many users on acne.org make a point to list all of the disciplinary activities that make them a healthy and good person, as one person writes, “I eat well, drink lots of water, try to be active...” while another capitulates, “I do everything I can to keep myself healthy and in shape, but there is not a darn thing I can do for my face.” Alas, there are many examples of acne.org users who struggle to embody a healthy subjectivity by proving to others (and themselves) that their acne is by no fault of their own.

But, who else is to blame? Inundated daily with messages celebrating hard work, individual responsibility and autonomy, it is difficult for many acne sufferers to even conceive of the disease outside of a neoliberal paradigm. Although science helps offload some of the blame onto “natural” processes (e.g., genetics, hormones, bacteria, etc.), acne sufferers are also routinely exposed to lay discourses and marketing discourses that place responsibility for a healthy and clear complexion squarely in their own hands. For instance, drug developers rely heavily on militaristic language to market over-the-counter medications as useful allies in the “fight,” “battle,” or “war” against acne. Pimples amount to unwelcome and foreign invaders that threaten to colonize the skin unless there is a willing and “armed” consumer prepared to resist. Proactiv, the leading over-the-counter acne medication, makes use of such imagery in their marketing slogan: “Clear skin starts with you.” It is no wonder, then, that so many acne sufferers experience a deep sense of shame when their skins refuse to acquiesce to the power of over-the-counter acne medications. According to the pervasive commercial messaging of the skincare industry, they are “losers” in their ongoing battles against acne.
Furthermore, acne sufferers are subject to the commonsense idea that health reveals itself through one’s facial complexion. As one dermatologist states: “You can tell a lot about someone’s lifestyle from their face, including what their diet is like and how much they smoke or drink” (Lambert, 2013). Rather than function as a milieu, this example seems to highlight a contemporary example of the skin functioning as a “screen” – a metaphor Connor (2004) uses to describe a classical and medieval epoch in the medico-cultural history of skin. On this screen, observers are supposed to be able to gauge the health of internal organs and biological processes such as the heart, digestive system, respiratory system, kidneys, etc. which are projected onto the surface of the body. Today, this practice is better known as “facial mapping,” and it is one that is talked about, referenced and shared frequently by acne sufferers (and occasionally doctors) online.

Facial mapping (see Appendix C) involves dividing the face up into various regions and then identifying the region(s) to which your acne belongs. Each region is then associated with the biological functions of a different internal organ. Acne on the forehead, for instance, signifies problems in the digestive system whereas acne on the cheeks represents respiratory problems. The practice, which has its roots in Eastern medicine, has become a popular way for individuals to understand the cause(s) of their acne. But importantly, each cause on the face-mapping diagram is also accompanied with a list of treatment strategies. Acne representing digestive problems could mean that you are eating the wrong foods or not drinking enough water; and, acne on the cheeks could mean that

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44 A similar narrative unfolds through those scientific and lay discourses claiming the existence of a link between acne and diet. In this case, clear skin becomes contingent on making the “right” (i.e. healthy) food choices, leading some to develop a shame around the foods they eat. As many of the acne.org “acne diets” show, this shame can quickly venture into the realm of disordered eating.
you are smoking. Facial mapping thus ends up reproducing the idea that acne is ultimately the fault of the individual, whose unhealthy decisions are not only negatively affecting the health of the skin but also other vital organs. On acne.org, some users express feelings of guilt and shame for what they believe is a moral failure on their part to live healthily, while others mention feeling stressed and frustrated by acne’s refusal to cooperate with healthy behaviours. Regardless of which way they feel, it is clear that the emotional experiences of acne sufferers need to be understood as thoroughly entangled with authoritative health discourses.

Emotional vocabularies

We have seen, thus far, some of the words that are used as part of the emotional vocabularies of acne: suffering, depressing, embarrassing and stressful. There is no sense in further examining these words here, as I have already begun to map their connections to the institutionalized practices and authoritative discourses of acne. But there is another word that I have yet to examine; one that neither leads us to the institutionalized practices nor the authoritative discourses of acne but rather its everyday and embodied routines. That word is tired. Far from being the only word in the emotional vocabularies of acne sufferers, tired is one that interests me because medical experts so often overlook it. That is to say, it is rarely diagnosed, treated or talked about as having anything to do with the suffering of acne yet it is frequently mentioned as such by those who experience the disease. It is a stark reminder of the ways emotional vocabularies are not only the result of a top-down power that inscribes the body with meaning, but also manifest from the bottom-up, out of people’s embodied interactions with medical logics, objects and practices.
Although fatigue is an experience that we commonly associate with physical exhaustion, scholars began using the term “burnout” around the 1970s to also describe exhaustion as an emotional experience (Schaufeli, Maslach & Marek, 1993). Academic and popular literature on the topic of burnout has exploded over the last half-century, giving rise to what Schaufeli, Leiter and Maslach (2009) argue is now the medicalization of burnout (i.e. treating burnout as a medical problem). But, burnout is not a medical problem, these authors argue, because a medicalized understanding of burnout decontextualizes the phenomenon. The authors write:

Chronic exhaustion – physical or mental – is a legitimate label for problems encountered by many people within or outside the working world. However, there is no scientific reason to use the term, burnout, when referring to exhaustion only […] A retired or unemployed person may feel exhausted, but it is impossible to identify the “something” about which unemployed or retired people should feel cynical or inefficacious. Hence, arguing that burnout is a generic, context-free phenomenon goes necessarily hand in hand with a limited definition of burnout as the equivalent to exhaustion. (Schaufeli, Leiter & Maslach, 2009, p. 211-212)

Quite simply, work and the workplace are central to the idea of burnout. Without that context, many scholars argue that we are talking about exhaustion – a medical problem.

This dichotomy between a non-medicalized burnout and medicalized exhaustion (or, more generally the social and biological) is one that is ruptured by dermatological fatigue. Burnout is a medical problem. This is not some sort of abstract or conceptual argument that burnout should be included as part of our medicalized definition of exhaustion. Rather, what I mean to say is that medicalization can produce a type of burnout in individuals tasked with the overwhelming corporeal labour of what Nikolas Rose (2001) terms somatic individuality:

Selfhood has become intrinsically somatic – ethical practices increasingly take the body as a key site for work on the self. From official discourses of health promotion through narratives of the experience of disease and
suffering in the mass media, to popular discourses on dieting and exercise, we see an increasing stress on personal reconstruction through acting on the body in the name of a fitness that is simultaneously corporeal and psychological. Exercise, diet, vitamins, tattoos, body piercing, drugs, cosmetic surgery, gender reassignment, organ transplantation – for ‘experimental individuals’ the corporeal existence and vitality of the self have become the privileged site of experiments with subjectivity. I have termed this ‘somatic individuality.” (p. 18)

As I believe acne sufferers make clear, somatic individuality can be – and often is – a physically and psychologically exhausting experience. Acne is not tiring because of some “context-free” and biological function(s) that we have yet to fully understand about the disease. Rather, acne is tiring because of the context-specific work that goes into concealing, medicating, cleansing and grooming the skin. Acne sufferers take what Schaufeli, Leiter and Maslach (2009) identify as the “medicalization of burnout” and turn it on its head, so that we are instead left to consider the burnout of medicalization.

Medicalization does not necessitate pharmaceutical modes of intervention. As confidence and self-esteem are increasingly assigned a medicalized significance, cosmetic procedures and products also offer ways to adjust and “improve” one’s body and foster a “healthy” body image (Conrad, 2005; Fraser, 2003; Merianos, Vidourek & King, 2013; Pitts-Taylor, 2007; Sullivan, 2001). In this way, makeup comes to have a medical significance for many (especially female) acne sufferers because it helps them conceal their disease and thus alleviate some of the psychological effects of the disease. In fact, the medical understanding of makeup is one that is often reproduced on acne.org, leaving some members confused or frustrated by what they perceive as non-medical uses of makeup. One user writes, “It honestly doesn’t make sence to me when I see clear skinned people put on makeup,” while another member agrees: “Yes, this girl at my school is constantly dashing to the bathroom to apply concealer over her PERFECT
skin…and fixing her INVISIBLE undereye circles…it drives me insane.” Here, acne appears to give makeup a medical meaning compared to the assumedly aesthetic, cultural or political meanings attached to the makeup practices of “clear-skinned” individuals.

Members of acne.org often remark at how little pleasure they derive from the routine and daily application of makeup. In a thread titled “how long does it take you to apply your makeup?,” members of acne.org estimate the number of minutes or sometimes hours it takes for them to conceal their acne. Makeup is time-consuming and exhausting work, as one user writes:

Right now it takes me like a ridiculous HOUR to just get my skin ready. This is cuz my skin is dry and I have to put on a few layers of moisturizer, I have to mix 2 mineral foundations samples from baggies, use crappy brushes (which I usually have to wash cuz I forget to do it at night), and have lots of redmarks to conceal […] putting on makeup to go out is such a chore.

Interestingly, this member of acne.org uses the word chore to describe the work involved with makeup routines. Unlike those usually clear-skinned individuals who might find enjoyment in the application of makeup, it is experienced as a particularly laborious and unpleasant kind of work for acne sufferers; that is to say, work they have to do rather than want to do. The word chore also directs our attention to the regularity with which acne sufferers feel compelled to apply makeup. Acne rarely, if ever, takes “days off.”

It is not only the physical labour of concealment, however, that makes this type of skin work so tiring. Acne sufferers also speak about concealment as mentally exhausting labour because of the constant attention it demands. One such example is captured in Gard’s story: “Now 44, [she] recalls being ‘totally in love’ with a guy in grad school. ‘But I was so preoccupied,’ she says. Her acne kept her running to the bathroom to see if her makeup had stayed in place any time they kissed” (Fessenden, 2015). Many other
acne sufferers speak about their longing for a clear complexion, where they no longer have to worry about makeup. Makeup, in other words, is a temporary, delicate and unreliable “fix” for acne sufferers. They live with the worrisome knowledge that at any moment their makeup could be un-made and their acne revealed. As such, they subject their made-up skins to an exhausting, 24/7 surveillance or work schedule, from which many of them feel burned out by a compulsive and obsessive relationship with mirrors and other reflective surfaces.

The process of medicating is another way somatic individuals experience a type of dermatological fatigue in their quest for a “clear” complexion. At first glance, there might appear to be very little work involved with the process of medicating. Indeed, biotechnological developments are supposed to be making it easier than ever to medicate. Like many other critical scholars of medicalization, Emily Martin (2006) devotes her analysis of the “pharmaceutical person” to “pills, or more precisely, tablets and capsules” (p. 273). After all, pills represent perhaps the easiest, most convenient and most popular way to medicate in our contemporary moment. But, acne sufferers only ever occasionally ingest medicine for their skin. When they do, it is almost always accompanied by medicine that is administered topically on the skin.

Accutane is one example of an oral medication commonly prescribed for acne. Other topical forms of medication, however, almost always accompany its use. In part, the move to simultaneously medicate skin through topical and oral interventions stems from a much broader effort on the part of practitioners and drug developers to make “combination therapy” the new norm in acne treatment. Dr. Andrea Zaenglein states: “There are a variety of effective treatments available for acne, and dermatologists have
found that combining two or more treatments is the best option for the majority of patients” ("American Academy of Dermatology," 2016). Additionally, many Accutane users topically medicate their dry, itchy and cracking skins (i.e. common effects of the drug) out of necessity. The following is, therefore, a typical acne.org account of the work involved with medicating the skin – even when that skin is being treated through oral means, such as Accutane:

The way someone with weight problems always has to watch what they eat is how I liken my acne to my everyday life. I have to take care of it, use a good cleanser (with povidone-iodine – that’s generic betadine – it’s cheaper!), use facial masks, wash my hands a lot, change my pillowcase every couple of days, rubbing alcohol my phones and YES I still use prescription topicals (Renova) but Accutane REALLY changed my life!

If pills are designed to change the skin from the inside out, then topical agents represent an option that begins from the outside of the skin and works its way inwards. Pills, of course, are designed to do most of the work of medicating on their own. That is to say, they require very little from “us” in terms of physical labour or total energy expended. The application of topicals, on the other hand, demands much more time and energy from its subject.

Like makeup routines, medicating routines involve performing a particular set of dermatological activities each and every day. One must quite literally work different materials into the skin by using massaging, scrubbing and exfoliating techniques. Moreover, as the aforementioned quote makes clear, topical work can reach beyond one’s own skin and onto the surfaces of other objects – phones, pillowcases, etc. Blurring the lines between subject and object, the “skin” that is to be worked also materializes in non-

Accutane users and doctors often use the word “purge” to describe the experience of the drug and its effect on the skin.
human objects and relations with the world, exacting a type of physical and mental
exhaustion on the acne sufferer who is tasked with the constant labour of clean(s)ing.

One final example of the work involved with acne is grooming, by which I mean those embodied habits such as picking or squeezing pimples. Not unlike the work of concealing, medicating or cleansing, many acne sufferers manipulate their skin by
spending countless hours picking, prodding and popping their pimples – usually in front
of the mirror. Some members of acne.org unconsciously perform grooming habits,
whereas others attempt to make grooming into a conscious activity. Regardless of their
approach, grooming amounts to a type of physical labour that acne sufferers perform on
the surface of the body, as a body.

It is important to note, however, that the physical labour of skin grooming is also
a form of mental labour. A considerable amount of attention goes into analyzing each
pore with the kind of detail that only magnification mirrors or particular types of light can
illuminate. Furthermore, grooming often begins with painful or uncomfortable sensations
that are experienced underneath or atop the acne sufferer’s skin. It is in the experience of
these sensations – or more specifically, their intolerability – that many acne sufferers are
confronted with an internal struggle. Many of them know they are not supposed to groom
because of the added risk of bacterial infection or scarring, but the urge to groom proves
to be too much for a lot of individuals on acne.org:

I also had a huge zit in the middle of my forehead, which was throbbing.
Oh gosh it hurt so bad I just couldn’t handle it. I have not messed with a

46 The primary reason for this difference has to do with risk. Those who consciously
groom attempt to make picking and popping into a less “risky” activity by using sterile
objects (rather than bare fingers) and a controlled restraint in their touch (rather than an
undisciplined force).
pimple yet so far, but this was just too much. I had to get rid of the pressure or something because this thing seriously hurt. I’m only human.

The abstract sense of “pressure” or tension being described here is something that acne sufferers are left to work through. Their skins are bustling with the activity of a force or energy that exerts itself outwards, wanting escape. Grooming thus amounts to a type of emotional work, as individuals seek relief from a mounting stress that is bubbling beneath the surface. Likewise, the decision to abstain from grooming also becomes a type of emotional work as acne sufferers learn to live and cope with (rather than relieve themselves from) a unique and often irritating brand of dermatological stress.

**Visual images**

Visual representations of acne also play an important role in the making of a psychodermatological subject. In this section, I concern myself with a particular genre of video that has become an increasingly popular way to represent dermatological suffering. Accessed digitally through websites such as YouTube, many of these videos are shared widely across social media amassing thousands and sometimes millions of views. I term this genre of video the “acne for a day experience,” where well-intentioned “clear-skinned” individuals hire makeup artists to transform their skins into an acne-ridden surface and attempt to live with the skin disease for a day. Visual images appear central to the making of a psychodermatological subject not only because of what they show, but also because of what they do not show. As such, I also dedicate the latter portion of this section to thinking about the normalization of clear skin in popular culture, and those related struggles to introduce acne into our field of visibility. For some, the struggle to visually represent acne is part of a much larger cultural struggle to alleviate some of the stigma attached to the disease and, by association, dermatological suffering.
But let us first begin with the visual images of dermatological suffering that circulate electronically through “acne for a day” videos. There are a number of lessons that viewers learn through these videos, but perhaps the most obvious one is that acne sufferers occupy a unique and shared subject position, identity and experience of the world because of their disease. Individuals without acne attempt to know what this experience is like by transforming their skins through the professional work of makeup artists, and then report back to their viewers with the results, insights and findings of their “experiment.” The entire process is eerily reminiscent of John Howard Griffin’s (1961) infamous attempt to know black people’s experiences in the Jim Crow South by changing the colour of his skin. Rightfully criticized for ignoring the voices of black Americans and over-simplifying the complexities of racialization and white supremacy, YouTube personalities featured in “acne for a day” videos are similarly criticized for having reduced dermatological suffering into a day’s worth of made-up acne.

In the user comments section of a video, one person writes, “They are so lucky that they get to just take it off,” while another expresses their frustration by exclaiming, “He could take [acne] off at the end of the day but someone like me can’t. I don’t know it just bothered me.” For many acne sufferers who watch these videos, the images are a frustrating if not offensive representation of dermatological suffering because they fail to encompass one of the most important features of that suffering: its persistence. Although some YouTube personalities make a point to acknowledge how fortunate they are to be able to wash their acne away at the end of the day, acne sufferers are understandably angered by this reminder: “Idk why but this video makes me mad. 5 years of acne and I

47 Idk is shorthand for “I don’t know.”
have yet to wash it all off at the end of the day.” Acne is a resilient disease that does not
even capitulate to some of the most powerful pharmaceutical concoctions, let alone
water. The suffering being represented on the computer screen therefore seems worlds
apart from the suffering being experienced at home by those for whom acne is an
everyday and seemingly permanent fixture of one’s life.

Acne sufferers also take issue with the fact that dermatological suffering is
represented as a purely aesthetic concern in “acne for a day” videos. It is not only what
acne looks like that makes it a sufferable disease, but also what it feels like. A YouTube
comment summarizes this point best: “The judgment and self consciousness of [acne]
sucks, but what they can’t experience is the PAIN of cystic acne. Like sometimes I don’t
care if I look like a goblin, I just want the pain to stop.” This pain is yet another central
component of dermatological suffering that gets overlooked in “acne for a day” videos.

Why aren’t acne sufferers, then, being cast to showcase the realities of
dermatological suffering? Moreover, why is there no equivalent genre of video
documenting the experience of acne sufferers who get to experience “clear skin for a
day,” with the help of professional makeup artists? I ask these questions in order to call
attention to the fact that people without acne are, strangely, the ones being used to
legitimize the emotional claims of acne sufferers. This small insight might tell us
something about the intended audience of “acne for a day” videos. Whereas many acne
sufferers find it difficult to relate to the on-screen subjects of these videos, those with
clear skin do not. In one instance, a person leaves a comment commending the bravery of
the experimenters: “They’re so brave for coming out like that! If I had acne like that
(even if it was fake) I would definitely go hide under a rock.” Others use the video as an
opportunity to reflect on how “lucky” they are to not have acne: “I am….so…incredibly lucky omg;” “I feel so lucky that I have like the clearest baby soft face ever;” “I FEEL SO BLESSED I HAVE PERFECT SKIN.” And, in other cases the makers of the videos are thanked for helping “raise awareness” for an important cause: “SO much respect for you doing this. This seriously helped me empathise with people who have acne and appreciate what they have to go through;” “I feel bad for saying this but I actually feel like this is something I’ve never even thought about! […] this video has been a real eye opener about how [acne] can really affect people.”

“Acne for a day” videos are a fascinating cultural lens through which to view the making of a psychodermatological subject, because they render visible a set of identity politics through which acne is understood and embodied. Whereas clear-skinned individuals are quick to believe they can “access” dermatological suffering through prosthetic acne, those for whom acne is a real and daily struggle take issue with the representational liberties of their clear-skinned counterparts. Instead, they argue that one needs to actually experience acne as a disease (rather than a symbol) in order to know the emotional and psychological pain that goes along with it. More than anything, then, “acne for a day” videos draw attention to emerging forms of solidarity and collectivization that occur on and through the biology of skin. Part of what makes the videos so captivating is that they play with that biology, thus calling into question the very boundaries upon which solidarities are formed through acne.

In a sense, viewers watch clear-skinned individuals become someone else after being outfitted with prosthetic acne. For example, the person with clear skin begins to look differently into the camera. In one case, a model starts by looking directly into the
camera as the makeup artist begins to apply prosthetic acne to her face. As that process unfolds, however, the model’s gaze moves from meeting the viewer directly in the eye to closing her eyes completely. Another video shows a journalist whose eyes, by the end of the makeup application, are noticeably teary. Frequently, the experimenters comment about how difficult it becomes to establish or maintain eye contact with people in public, and often reference a feeling of being watched, leered and gawked at by others. In fact, they develop a sense of themselves and their body as seen from the perspective of the other: “I was convinced that the lady behind the counter was looking at my face and that she was staring at me, but she probably wasn’t. I just felt like she was.” Ultimately, the experience proves to be a disorienting and disembodied one for clear-skinned individuals: “I just wasn’t myself; I didn’t feel myself.”

Acne sufferers, however, are largely unmoved and unconvinced by these pleas. There are some, of course, who do not feel strongly about the fact that their dermatological suffering is represented on and through clear skin. For these people, both real and fake acne are equally capable of speaking truth to the disease and the emotional pain that comes along with it. Others, however, understand the actors in “acne for a day” videos to be transgressing the acceptable boundaries upon which dermatological identities are formed. “My acne is not your culture,” writes one YouTube user, in what I read as an attempt to police the porous boundaries of dermatological solidarities. If we follow this line of thinking, then acne appears to be a natural identity rooted in the molecular composition of the skin as opposed to a cultural identity rooted in one’s perceptions of that skin. In other words, it is not the dermatological identity one “makes up” that is central to the experience of suffering but rather the dermatology through
which one’s identity becomes made up. Some acne sufferers therefore use a naturalized dermatological identity as a way to “reclaim” their suffering from the misrepresentations of impostors, thereby establishing some level of authority and control over the meaning(s) of that suffering.

Representation is an important issue to an emerging class of psychodermatological subjects. Who gets to represent psychodermatological subjectivities? And how? I have heretofore argued that these types of questions matter in the visual imagery of dermatological suffering thanks in large part to nascent forms of collectivization occurring on and through the materiality of skin. But, there is another way visual images figure centrally in the lives of psychodermatological subjects. Many of them argue that the emotional scars of acne are inflicted during interpersonal encounters with clear-skinned individuals. Sometimes these manifest in a judgmental look, a fascinated stare or a disgusted recoil, while other times they might appear as hurtful comments, stigmatizing discourses or discriminating actions. While these are exactly the sorts of encounters that are documented in “acne for a day” videos, the clear-skinned subjects of those videos often leave their viewers with the same message: to seek medical help. They excuse the gawking, leering and unwelcome comments of clear-skinned individuals, attributing it to human nature as one YouTube experimenter explains: “In society, people can’t help but look. It’s kind of human instinct. People do just look; they can’t help it. They stare. They can’t help but look at me like ‘what is wrong with her face?’” Acne sufferers, on the other hand, question the degree to which these insufferable encounters are “natural” and are not so quick to assume that the resulting emotional damage can be, or should be, medically treated. Instead, they interpret the disgust and
fascination that clear-skinned individuals exhibit towards acne as a cultural problem, arising out of a visual culture that has largely erased acne from our sights. In fact, we see this erasure in “acne for a day” videos, where the viewer is spared from having to look at “real” acne altogether. One of the arguments from acne sufferers, then, is that there needs to be greater cultural exposure to the seemingly “unsightly” or “disgusting” image of acne so that people are no longer surprised when they see it, and therefore less likely to participate in the sorts of unwanted gestures and comments mentioned here. In short, acne – rather than clear skin – needs to be normalized in and through visual culture.

Occasionally, there are moments in popular culture where acne seems to jump from the image and catch us by surprise. Our contemporary gaze is accustomed to seeing airbrushed skins, cosmetic skins and professionally lit skins but rarely inflamed, bumpy and pimpled skins. It is as if pimples become part of the canvased material’s skin; its presence felt atop the otherwise glossy magazine page, the smooth glass of the smartphone or the slick exterior of a plastic toy doll. In 2014, acne was one of a number of “bodily imperfections” used to manufacture what some labeled a “normal Barbie” doll (Vingiano, 2014). And while Internet commenters were happy to embrace some of the bodily changes (e.g., realistic body proportions, cellulite, stretch marks and tattoos), acne seemed to be the one change that many people were unable to look beyond and reconceptualize as normal: “I like the normally proportioned doll, but think the acne and stuff is a bit stupid?;” “Yes many teens and people get acne, but no kid wants an acne doll;” “I understand the scars and the freckles and the other marks – but the acne?”

Celebrity photos are another example of acne disrupting the otherwise smooth topology of popular visual culture. When celebrities are “caught” with acne – usually by
members of the paparazzi – the media and fans almost always understand the event as both a public “outing” (i.e. they carry the identity of acne sufferer) and a humanizing process. In a typical headline for these sorts of clickbait articles, one celebrity news website writes: “Kate Upton face has zits? The Sports Illustrated cover girl shocks fans in Paris fashion week photo that show she is human after all” (“Kate Upton Face Has Zits?,” 2013). Members of acne.org also frequently discuss the names of various actors whose acne makes them relatable, ordinary, and partial to a shared experience of suffering. When acne materializes through celebrity skin, then, it is momentarily visualized and represented as something normal. It becomes, in effect, spectaculously normal – made into a spectacle and object of fixation that we determine (only after meticulously examining each photograph and overcoming our initial shock) unspectacular.

Attempts are also made to represent one’s own acne and publicly circulate those images with the hopes of normalizing the disease and reducing some of its associated shame and stigma. Unlike celebrity acne photos where the subject is unknowingly photographed and represented by the media, a growing number of acne sufferers are assuming control in the representation of their acne by acting as both the photographer and photographed. Posting untouched “selfies” to websites such as Facebook and Instagram with the hashtags #acnejourney and #acnesufferer, acne sufferers invite others to look at their skin, share similar photographs and write about their experience. As one user explains: “Hiding will only lower your self-worth more and encourage others to treat acne as something that should be kept ‘hush-hush’” (Stark, 2015). The selfie, therefore, serves as an example of the therapeutic and supportive, rather than normalizing role that visual images play in the making of a psychodermatological subject: “When I realized
how supportive other acne sufferers are on there, it really became a nice support system for me! [...] Sometimes I would reluctantly post a photo, but always got such supportive feedback because they know what I’m going through” (Stark, 2015). In this example, visual images are understood positively, as that which might alleviate rather than worsen dermatological suffering. This is not to suggest that the emerging “visual economy” of selfies does not also reinforce and police norms on and through the skin. Certainly, we are accustomed to reading headlines such as “Stigma of acne worse in the age of selfies, experts say” (CBC News, 2015). But it is also important to pay attention to what acne sufferers are actually doing through selfies and the meanings they ascribe to that cultural practice.

Social scripts

Klawiter (2008) uses the term social scripts to refer to an overarching set of ideas, norms, and structures through which social relations are habitually “scripted” or organized. As an example of a social script, she uses Talcott Parson’s (1951) concept of the “sick role” to understand regimes of breast cancer from around the beginning to the middle part of the twentieth century. Parsons (1964) argued that sickness amounted to a type of deviance. Sick individuals needed to be classified as such, so that they could be temporarily excused from having to participate in regular, everyday social responsibilities (e.g., work, family, etc.) and begin on a path to recovery or “health.” For Parsons (whose perspective was heavily influenced by structural functionalism), hospitals and doctors comprised an important regulatory “cog” in the overall “machinery” of society. Beginning around 1970, however, Klawiter (2005) identifies a shift in the social scripts of breast cancer, moving from the sick role to what she terms a risk role: “The shift in
social scripts from the sick role to the risk role meant that, instead of being cured, women treated for cancer rejoined the breast cancer continuum and became permanent members – or so they hoped – of what Arthur Frank (1995) has termed the ‘remission society.’” (p. 16). Here, the lines between “sick” and “not sick” are less clear than what Parsons envisioned with the sick role. Klawiter speaks, instead, of a continuum through which those binary distinctions are seen to overlap and fluctuate. There are also no absolute “cures” in Arthur Frank’s understanding of the “remission society,” where patients are understood to live in a perpetual state of risk, “effectively well but could never be considered cured” (Frank, 2005, p. 163). Lastly, patients take steps to define and practice “health” in their own lives as opposed to relying upon the expertise and technologies available to them in the hospital.

This social script, identified by Klawiter (2005; 2008) as a risk role, is one that I think deserves more attention in the making of a psychodermatological subject. Acne sufferers understand themselves as “carriers” of the disease, unable to fully move into the subject position of “clear-skinned.” Whereas many of them imagine a cure for their disease and sometimes even experience momentary relief from acne, very few understand themselves as “cured” in practice. Even in the absence of any visible acne, they continue to treat and manage their “acne prone” skins as if they are diseased and in need of preventative care. Take, for example, the many Accutane users whose acne “clears” but whose suffering remains, as they continue to worry about what their diseased skins might do: “I am over the accutane treatment but now I think I am more obsessed with my skin than I have ever been in my life. I mean 5 small spots are driving me nuts […] I keep thinking about my acne coming back;” “I relapsed a year later; so I took [accutane] again,
and stayed clear longer. But my acne is PERSISTENT. Though it never comes back as
bad as it was…it comes back;” “My fear is when I stop taking the meds will my skin start
breaking out […] I don’t wanna start breaking out again. Was anyone else scared when
coming off accutane?” In other words, acne sufferers live with the worry and fear that the
next breakout is always around the corner, and thus never “cured” of acne. My research
suggests that this dermatological anxiety produces and is produced by a combination of
scientific and risk discourses, and that acne sufferers feel constrained and limited in what
they are able to do because these discourses increasingly render more aspects of their
everyday lives as “risky.”

What is not risky for the acne sufferer? Indeed, this is a question I found myself
returning to as I combed through thousands of user posts on acne.org and other Internet
blogs. Food is risky; exercise is risky; sleep is risky; touch is risky; medicine is risky. Can
acne sufferers enjoy anything in life without feeling guilty that they are putting their
vulnerable or susceptible “acne prone” skins at further risk? This is a question that many
members of acne.org pose to one another jokingly. Sometimes, however, members ask
the question more seriously. Are there limits to the skin’s relationality? What is it not
connected to?

These sorts of questions do not emerge out of thin air. As they are being debated
amongst virtual communities of acne sufferers, scientists also find themselves
contemplating their significance. Today, developments in the field of microbiology are
changing the way we understand the skin and ourselves as dermatological subjects. If
acne sufferers feel uncertain about the seemingly infinite number of possible causes for
their acne, then it is also important to situate those worries and fears within a much larger scientific context that visualizes skin in new, mysterious and uncertain ways.

In the last decade, we have seen scientists and the public gradually shift their attention away from the human genome to the human microbiome. A multi-million dollar US public investment, the Human Microbiome Project began in 2008 with the goal of identifying microorganisms and mapping their subsequent relationships to human health and disease. In turn, a growing body of literature has emerged with regards to the gut microbiome and the skin microbiome. These parts of the body, we are learning, are comprised of thousands of tiny microscopic lives (i.e. viruses, fungi, mites and bacteria). There are philosophical implications to this research, as Norwegian microbiologist and philosopher Elling Ulvestad suggests, because it challenges the fundamental notion that we are “isolated individuals” by highlighting our essential multiplicity and interconnectedness. We are better off understanding ourselves as “walking ecologies,” according to Ulvestad. Or, as John Launer (2013) writes: “Our lumbering, multicellular bodies act as unwitting landlords to a vast community of far more resilient lodgers who could happily move to alternative accommodation in someone else’s gut or skin – and quite often do” (p. 367).

With the microbiological turn in the life sciences, skin (disease) is being rethought. A cloud of ambiguity swirls around decades’ worth of conventional belief in the dermatological sciences, as evidenced by one 2013 study that made international news for its discovery that some strains of propionibacterium acnes (p. acnes) might actually be “good” (Fitz-Gibbon et al., 2013). This, of course, came as a shock to members of the scientific and medical communities, for whom p. acnes were treated as
“bad” actors in the pathophysiology of acne. In fact, many of the existing medications on the acne market, including most antibiotics, are designed to kill p. acnes. Scientific insight into the skin microbiome, in other words, questions long-established beliefs and practices in the dermatological treatment of acne. Not only is there new evidence to suggest that some p. acnes could be an ally in the treatment of acne (Fitz-Gibbon et al., 2013), but there is also evidence to support the idea that p. acnes play a vital role in our overall health by boosting our immune system (Akst, 2014) and protecting us from invasive pathogenic microbes (Findley & Grice, 2014). This re-thinking of the skin microbiome has, in turn, cast a reasonable level of doubt on decades’ worth of mostly in vitro acne-related research as well as traditional medications designed to treat the disease. Today, thanks to newly developed metagenomic instruments and methodologies, scientists are able to perform in vivo research on the skin. As microbiologists Alban Mathieu, Timothy Vogel and Pascal Simonet (2014) argue, these lived interactions between different microorganisms are central to our future understandings of skin disease: “Only relationships between the various bacterial populations involving the activities they carry out in close interactions and with their host could explain specific skin pathologies” (p. 71).

In the meantime, however, acne sufferers are expected to make important decisions about their skin; decisions that according to some microbiological experts, may or may not have long-term health consequences. Not only does this context render certain medications such as antibiotics as riskier than others, but it also introduces further choice to the already overwhelming number of acne treatments available to consumers. Heralded by the American Academy of Dermatology as “the next big thing” in acne treatment
therapy, pharmaceutical companies have begun the process of manufacturing, marketing and selling “good” p. acnes on the multi-billion-dollar acne market. It is not the case that this emerging class of drug – topical probiotics – is replacing older, more established acne medications. Rather, they exist alongside them and in relation to them. In other words, topical probiotics have begun to ascribe new meanings to old acne medications where the lives of p. acnes appear loaded with biological and cultural significance. Acne medications such as tetracycline and isotretinoin will almost certainly continue to be used in the treatment of acne, as they are today (sometimes quite effectively); but they become even more uncertain next to topical probiotics and microbiological discoveries. My interviews with doctors as well as my reading of acne.org revealed that many physicians and patients already understood older classes of acne medications as risky for a variety of reasons, some of which include: the potential for antibiotic resistance (Cooper, 1998), harmful side effects and litigious concerns. Further compounding those risks, however, is another question about the skin microbiome: how do these older medications affect ecologies of the skin?

Scientific research on the gut microbiome has also breathed new life into an old debate about the relationship between diet and acne. Many of the dermatologists I spoke to were adamant about the fact that there is minimal, weak and/or ambiguous scientific evidence around the association between diet and acne. As one dermatologist explained:

If people ask me about diet, I will say again the signal is not great…the data that we see and that we’ve looked at is not great. The major information is that high glycemic index diets seem to be associated with a slightly increased risk of acne and worse acne. But would I say that that’s enough for me to suggest to someone who has scarring acne? No. […] If we had a study that came out and said “If you eat this thing, your acne is going to be a thousand times worse,” then I would say don’t eat that thing to every patient. But the data isn’t that good. […] I saw one study that
shows that there may be an association; there have been several studies that show there is no association...so I would call it controversial data, because you have things that are showing the opposite direction. (Stephen, personal communication, September 7, 2015)

In other words, the science is murky. With no conclusive evidence to prove the existence of an association between certain foods and acne, doctors only seldom make cautious and caveated diet recommendations to their patients if they do at all. One of the reasons for this uncertainty stems from recent scientific interest in the gut microbiome and its connections to the skin. Some researchers are returning to a theory originally conceived in 1930 known as the “gut-brain-skin axis,” which holds that one’s emotional state can affect gut microflora and, in turn, produce inflammatory responses on the skin (Arck et al., 2010; Bowe & Logan, 2011; Bowe, Patel & Logan, 2014). In another recent study, a research team found that small intestinal bacterial outgrowth was far more likely to occur in patients with rosacea than those without the skin disease (Parodi et al., 2008). And, studies examining the effects of probiotics on the skin (Bowe & Logan, 2011; Di Marzio, Cinque, De Simone & Cifone, 1999) have been called “promising” by some observers (Rupani, 2015). Others who locate themselves outside of biomedical communities, such as those writing about and/or practicing “natural” or “alternative” medicine, have also embraced emerging research on the gut microbiome, as one author gives the following advice: “The skin is simply a map of the gut – if you want to know what’s happening in the gut, just look at the skin. And if you want to clear the skin – you have to heal the gut first!” (Cover Media Group, 2015). The gut, in other words, has emerged as an important and understudied component in the science of acne, reigniting old concerns about the relationship between diet and skin disease.
Acne sufferers’ uncertainties about what to eat and how to eat, however, are not only the result of new microbiological discoveries. Certainly, insights into the human microbiome have produced new, yet contested ways to speak about and visualize the relationship between food and skin. But it is also important to understand the relationship between food and skin as one that is embodied; or more specifically, one that is embodied in a context where “eating right” is loaded with cultural, political and moral significance (Biltekoff, 2013). In this way, too, eating materializes as a risky and anxiety-ridden experience for acne sufferers. Is what I am about to eat “good” or “bad” for the skin? Is my current breakout the result of something I ate? These are questions that members of acne.org regularly pose to themselves and one another in their collective attempt to eat “right.”

Interestingly, however, many acne sufferers already believe themselves to be “eating right” in the sense that they refer and adhere to expert forms of knowledge (e.g., nutrition scientists, dieticians, public-health practitioners, etc.). As Charlotte Biltekoff (2013) argues, nutritional expertise carries with it a great deal of cultural and political value: “Nutrition provides guidelines about how to be a good person and a good citizen, a means of self-making, and a quantifiable moral measure that can be used to assess and compare others” (p. 44). We might, then, understand acne sufferers as one group of people for whom “good” or “right” eating becomes an important way to communicate a particular message about one’s self, which is that they are an acne sufferer but through no fault of their own. They are, in other words, good citizens despite what their skin might say.
Nevertheless, “eating right” is not a simple task for acne sufferers. What experts say is “right” is oftentimes shown to be “wrong” on and through the acne sufferer’s skin. How, then, do acne sufferers know when they are eating right or wrong? In some cases, a simple breakout following what was originally thought to be a healthy food leads some acne sufferers to believe they have an allergy to that food. Sometimes all it takes is one particularly bad, memorable or painful breakout for acne sufferers to become afraid of a particular food and label it as an allergen, whereas other times they look for patterns in the ways their skin reacts to foods before labeling those foods as risky. In other cases, acne sufferers engage in what Anzieu (1989) might call an “intersensorial” form of knowledge production whereby the lifeworld of touch is folded into that of taste. For example, one user writes about her experiments with drinking green tea: “I find that it definitely makes my skin feel tighter and I think slightly more oily, no idea why though.” Here, food appears to leave a “dermatological aftertaste” that can be sensed through skin, and as skin. Acne sufferers use words such as “greasy,” “oily,” or “sweaty” to describe the epidermal effects of eating certain foods and pay close attention to these aftertastes when deciding which foods are “right” and which ones are potential risks. It is thus through these forms of embodied knowledge that acne sufferers also develop a lived sense for the aforementioned gut-brain-skin axis, where foods are actually experienced as “good” and “bad” through and as skin.

One last example of psychodermatological subjects being made through the social script of a risk role comes to us in the form of sleep. Acne prone skin remains active even in those moments where the mind is inactive (i.e. at rest), and thus represents a potential health risk for some members of acne.org. In a thread entitled “you know it’s bad
when…” one user finishes the sentence with the following: “…you try to sleep on your back instead of your sides.” Similarly, in a thread entitled “How to sleep on the back?” one user explains that her attempt to manage her sleeping body “was really hard” and that now she feels “very tired” because she “didn’t get a good night’s sleep.” Sleep commands the attention of acne sufferers precisely because of the inevitable inattentiveness to which it gives rise. This dermatologization of sleep (i.e. sleep is a dermatological problem posing dermatological risks) therefore necessitates around-the-clock management, surveillance and care of the skin.

As previously noted, microbiology seems to have, at the very least, helped scientists, marketers and consumers visualize the skin as an active and ecological surface. Microscopic images of bacteria or mites that crawl and interact with one another contribute in no small way to our understanding of the world’s surfaces, including that of the body (Hird, 2009). The facial skin, in particular, is understood as being an especially susceptible part of the body because of its regular exposure to acne-causing bacteria that live on pillowcases. Marketed as a medicating pillowcase containing “bamboo fibres and microcapsules that release a special serum into the skin that helps reduce facial bacteria,” Nufabrx accurately captures a context where “sleeping well” exists as a commodity to be bought and sold in the marketplace (Williams, 2011; Wolf-Meyer, 2012). Indeed, Nufabrx seems to support Crary’s (2013) claim that “…any persisting notions of sleep as somehow ‘natural’ are rendered unacceptable […] sleep is now an experience cut loose from notions of necessity or nature […] it is conceptualized as a

48 Smartphones are another everyday surface that marketers have attempted to paint as risky for the facial skin. One company (NueVue) has even introduced an “antimicrobial protected” screen to protect the skin from acne-causing bacteria.
variable but managed function that can only be defined instrumentally and physiologically” (p. 13).

Crary (2013) describes how sleep has come to be seen as an intelligible practice within the context of late capitalism. Products such as Nufabrx are representative of a greater cultural shift towards what he terms “24/7 routines” which are aimed at making sleep into a more efficient and productive part of daily life. Pillowcases or specially designed “night time cleansers” are just some of the products available to acne sufferers who might be said to participate in these routines. The ongoing attention paid to the “health” of the skin thus becomes an exhausting and anxiety-ridden chore for the acne sufferer, whose skin is worked on and, indeed, worked towards well into the wee hours of the night.

Products designed to treat the surface of the sleeping body give rise to a 24/7 patient consumer whose diseased skin is never quite cured but instead exists in a perpetual state of risk, prone to an acne that exists “out there” in the microorganismic world. More specifically, the dermatologization of sleep involves preventative practices – such as cleansing the body, sleeping on the back and changing pillowcases – that make skin into an object of 24/7 mastery and obsession. As the infinitesimal workings of the life world overwhelm the acne sufferer and threaten to cover his or her face at precisely that moment when he or she is most vulnerable, sleep in the context of late capitalism appears to be a risky dermatological activity. Indeed, to dermatologize sleep is to “sleep with one eye open” through a strenuous 24/7 surveillance of acne prone skin.

Taken together, the observations shared in this chapter make it difficult to locate acne-related suffering in any one place, practice or person. Some of that suffering appears
to emerge in conjunction with a number of historical shifts in the fields of dermatology and psychology respectively, such that their contemporary coalescence materializes rather “naturally” for doctors and patients alike. Indeed, acne sufferers learn about themselves as such through diagnostic rituals, scientific research, pharmaceutical marketing and health promotion / awareness campaigns that regularly take for granted the assumption that skin and mind are connected. However, some of that suffering also appears to emerge out of the overwhelming variety of drugs, prohibitions, and expert-knowledges designed to manage the relationship between skin and self. Experiencing skins that are onerous, exhausting, restrictive, painful and embarrassing, individuals know a kind of dermatological suffering through the exact methods that are intended to foster a “healthy” relationship between skin and mind. I have thus dedicated my time in this chapter to problematizing the commonsense notion that suffering is a natural consequence of acne, arguing instead that acne-related suffering is learned through a cacophony of different institutionalized practices, authoritative discourses, emotional vocabularies, visual images and social scripts. The contemporary “disease regime” (Klawiter, 2008) of acne, in other words, makes acne a disease that one is or becomes rather than simply has, inviting the kinds of psychodermatological embodiments that both perplex experts and collectivize patients today.
Chapter 6

Psychosomatic Adventures With Acne

In the preceding chapters, I have shown some of the ways acne materializes with social and emotional significance for doctors, drug developers, scientists and patients. Skin carries with it meanings outside of medicine that find a way into the understanding, management, and experience of skin disease. In Chapter 4, I argued that pimples – like any other part of the skin – are racialized and gendered in ways that both shape, and are shaped by, dermatological practice. And, in Chapter 5 it became clear that scientific and cultural discourses render acne-prone skin as “risky” in ways that individualize, normalize and moralize the disease to produce a kind of dermatological subjectivity known as the acne sufferer. But I have yet to fully consider the ways acne materializes as a psychosomatic biology for its embodied subjects. How does acne excite both the somatic and psychic lives of the skin? And, how are these excitations related to the broader biomedical context that treats acne as a disease?

In this chapter, I build on psychoanalytic theories of skin (Anzieu, 1989; Connor, 2002, 2004; Freud, 1923; Grosz, 1994; Ulnik, 2007) that begin from the general premise that skin figures centrally in the process of ego-formation. Writing in the first half of the 20th century, Sigmund Freud (1923) began to hint at the psychosomatic significance of skin when he wrote: “the ego is ultimately derived from bodily sensations, chiefly from those springing from the surface of the body” (p. 26). It is as skin and through skin that we first come into contact with the world; an insight that is expounded upon in the later work of Didier Anzieu and his concept of the skin ego. For Anzieu (1990), these infantile skinned encounters with the world are significant in that they constitute the child’s “first
sensory motor experiences, the first communications and the oppositions that relate to the very basis of perception and thought” (p. 43). Anzieu’s contributions were especially notable at a time when the psychosomatics of skin were largely understood in centrifugal terms (i.e. proceeding outwards from the mind to the skin). As Ashley Montagu (1986) notes, there was also a need to include the “opposite approach, namely from the skin to the mind; in other words, the centripetal approach” (p. 19). Answering this call, Anzieu helped open the doors for contemporary thinkers such as Jorge Ulnik (2007) to theorize the relationship between the psyche and soma as utterly dynamic, rather than linear or causal in nature. As Ulnik (2007) writes in the opening of his book Skin in Psychoanalysis, “…the multiple influence of the psyche over the body has always been known, but what is far less known […] is the influence of the body over the psyche, in particular that of the skin over the psyche” (p. xv). This chapter represents one such attempt to know more about skin’s capacity to take hold of the psyche, and vice versa, as those relations of power unfold in and through the very specific and rich example of acne. Chiefly, I want to know more about how these relations of power are configured in a medicalized context, where skin is routinely subject to a number of different somatic (and thus, psychic) transformations.

But first, it is worthwhile to examine the relationship between the ego and skin in greater detail. In her reading of Freud, Elizabeth Grosz (1994) identifies two main functions of the ego. First, she suggests that the ego serves a unifying and cohering force in Freudian thought; as that which is meant to bring some measure of structure and sense to an otherwise overwhelming multiplicity of perceptions that are lived on and through skin. And second, the Freudian conception of the ego understands the emergent relation
between subject and body as a libidinal one, infused with feelings of love, hate, etc.

Grosz (1994) summarizes this point quite succinctly:

> The ego is a consequence of a blockage or rechanneling of libidinal impulses in the subject’s own body in the form of a narcissistic attachment to a part or the whole of its body. In this sense, the ego is the meting point, the point of conjunction, between the body and the social. The narcissistic genesis of the ego entails that the subject cannot remain neutral or indifferent to its own body and body parts. The body is libidinally invested. (p. 32)

Each of these features that Grosz identifies in Freud’s writings can also be found in Anzieu’s notion of the skin ego. He writes: “By Skin Ego, I mean a mental image of which the Ego of the child makes use during the early phases of its development to represent itself as an Ego containing psychical contents, on the basis of its experience of the surface of the body” (Anzieu, 1989, p. 40). Like Freud, Anzieu conceptualizes the ego as a mental apparatus intended to help contain and make sense of an abundant supply of sensory stimulations occurring on and through skin. And, as he acknowledges elsewhere in his work, the skin ego also maintains an important libidinal function in terms of its ability to both (sexually) excite the skin and recharge or manage those excitations of the mind (what he terms “internal energetic tension”) (Anzieu, 1989, p. 105). In sum, skin commands psychoanalytic attention (at least in the writings of Freud and Anzieu) because 1) it helps establish mental boundaries in order for the subject to make sense of, and bring order to their perceptual experiences of the world; and 2) makes that process of boundary-making a libidinal exercise.

I draw the reader’s attention to these two insights because they figure prominently in terms of how people with acne narrativize the somatic and psychic experience of pimples. Firstly, I argue that acne can be understood as a threat to the boundaries of the (skin) ego. I highlight the way acne feels strange, exploding the skin into a multiplicity of
“foreign” or “alien” critters that seem to live atop or underneath one’s skin. The skin no longer feels familiar as it crawls, tickles, itches and pulses with a tantalizing and persistent type of activity that is not one’s own. In addition to rupturing the psychic and corporeal boundaries of the ego, my research also suggests that this cutaneous activity produces an overwhelming amount of sensory information for individuals who find it difficult to direct their attention elsewhere. In other words, the animate matter that is acne 

distracts – producing a type of embodied consciousness through which the life of the skin interferes with the life of the mind. Secondly, I argue that those attempts to repair or reestablish the boundaries of the (skin) ego are not only attempts to restore a lost sense of psychic integument, individuation or containment, but are also corporeal practices that reinvest the skin with libidinal energy. As such, I spend the latter half of this chapter examining some of the somatic pains and pleasures of acne, or more specifically the libidinal significance of dermatological experimentation. If skin, like many other “natural” objects, is rendered scientifically or technologically pliable in our contemporary biopolitical moment, then it is worth considering how this capacity to experiment with, play with, and experience different skins becomes a desirable activity for its psychosexual and unconscious significance.

Rupturing the (skin) ego

One of the nine functions of Anzieu’s skin ego is individuation. Lafrance (2013) summarizes this function as such:

For Anzieu, a strong sense of somatic borders and, by extension, psychic borders allows the individual to distinguish between not only its self and the self of the other, but between what Winnicott calls its “true” and “false” selves. A well-defined psychic skin is, therefore, necessary for individuation and, ultimately, individuality. (p. 28)
Anzieu’s notion of individuation is a useful place to begin our analysis, because it appears to be one of the functions most affected by acne. That is to say, acne disrupts the somatic and psychic borders of the ego such that many users on acne.org find it difficult to recognize themselves in and through their skin. Instead, they recognize “others” that are often named as such. “Alien” and “monster” are just some of the names members of acne.org use to describe individual pimples in a discursive practice designed to mark them as other, nonhuman lifeforms and thus killable. As one acne.org user writes about a particular pimple: “Anyone else experience this kind of monster? Any thoughts as to what I might be able to do to kill it once and for all?” Indeed, the fatal mistake of these nonhuman lifeforms is that they have crossed an important symbolic border – that is, skin – upon which the human subject is established. In some instances, however, members of acne.org show far less certainty with regards to the (non)human status of pimples. They still recognize pimples as individual agents, but it is not clear whether or not their existence on the skin represents a symbolic crossing of borders. Rather than label the pimple a monster or alien, one user opts instead to give them names: “I had a new friend today and I think I’ll be having another one join tomorrow by the looks of it […] I named him Henry, lol hence Lara saying hello to him…” In another example, a pimple is described by a different member of acne.org as an unborn human: “There was this gnarly cyst-bump-ma-bob growing on the back of my right ear, where the ear meets the head, and I thought it was some sort of maligned tumor or some sort of small fetus-child.” Acne, therefore, calls into question the very concept of individuation, creating a slippage between self/other that acne.org members attempt to negotiate through a variety of symbolic and linguistic techniques.
Their skins, however, continue to surge with somatic energy. Irrespective of the names or labels they use to (re)establish psychic borders is a lived sense of becoming undone by the skin. Alien, monster, or human-like pimples are named as such only after they have exerted their force, disrupting the aforementioned “somatic borders” of Anzieu’s skin ego. In some instances, acne.org members describe this force as a generalized type of activity. “Active” pimples are those that are alive and exist in a state of potential. On its way to becoming a whitehead, blackhead, cyst, scar, etc., the activity of a pimple is often first experienced well before it has materialized on the body’s surface as such. One acne.org user writes, “I can feel stuff under the skin forming;” while another shares a similar experience, “My skin has been relatively clear, however, there was activity going on under the skin.” As these examples illustrate, skin can be much more than a passive object that is touched; it can also be an active agent that touches the subject, giving rise to what Grosz (1994) calls a double sensation:

The information provided by the surface of the skin is both endogenous and exogenous, active and passive, receptive and expressive, the only sense able to provide the “double sensation.” Double sensations are those in which the subject utilizes one part of the body to touch another, thus exhibiting the interchangeability of active and passive sensations, of those positions of subject and object, mind and body. (p. 35-36)

As pimpled skin teems with activity, it becomes unclear exactly where skin (and thus, the somatic borders of the ego) begins and ends. Normally associated with the exterior of the body, pimples are in this instance experienced underneath the skin as immaterial forces or energies before they materialize atop the surface of the body. In this way, they manage to cross the aforementioned somatic borders upon which Anzieu’s skin ego individuates itself from others.
Furthermore, the somatic energy of acne also manages to disrupt another function of Anzieu’s skin ego, which is that of protection:

Just as the epidermis protects the body against physical trauma, the skin ego protects the psyche against psychical trauma. This function, according to Anzieu, is brought into being by the infant’s introjection of the caregiver’s bodily surface. That is, when the infant is in its earliest moments of life and its ego is too undeveloped to perform its own protective functions, the caregiver’s bodily surface serves as the infant’s surrogate shield against excessive stimulation. Through the experience of a protective caregiving skin, then, the infant comes to experience its own skin as a source of security. (Lafrance, 2013, p. 28)

Acne, however, points us to an occasion where the skin is no longer understood or experienced as secure. Instead, the activity of pimples results in the kind of excessive stimulation that the skin ego is, ideally, meant to protect against. In some instances, members of acne.org complain about pulsing (“they felt like living, pulsing alien beings”) or throbbing (“a huge zit in the middle of my forehead, which was throbbing”) sensations. In other cases, they complain about the ways certain types of pimples inflict pain, either exerting their force outwards in an attempt to perforate the skin, or exerting that same force inwards as if to establish a complex root system in the innermost depths of the body. As one user writes: “I have this HUGE cyst that’s hibernating in my left cheek. It’s weird bc it really hurts but won’t really come up.” Even when subcutaneous energies materialize in the form of a pimple, they often continue to inflict pain: “So I had a good 7-8 actives come out in the span of a couple days! And man were they painful! The “I can’t move my face or even touch it too hard” kind of painful! Each new spot is just soooo sore!” The skin ego thus fails to perform its protective function for acne sufferers, whose skins regularly awaken, agitate and traumatize the psyche with an excess of sensory information.
Importantly, Anzieu emphasizes that it is an *excess* of sensory information rather than a particular *type* of sensation (e.g., pain) that the skin ego is designed to protect against. That is not to say pain is a welcomed part of acne, but rather that it is one of many possible sensory experiences being perceived by subjects at any given point in time. How, then, does one live with an abundant and incessant supply of haptic information? And, what are the embodied consequences of this breakdown in the protective function of the skin ego?

The work of Maurice Merleau-Ponty (1962) might offer some valuable insights into these questions, giving us a lens to understand the phenomenology of perception. Indeed, here I am less interested in the words acne.org members use to label, describe or interpret the (sub)cutaneous sensations they experience, and more interested in knowing what it is like to perceive with and through those sensations. For Merleau-Ponty perception is an embodied rather than intellectual phenomena, meaning that the (sometimes painful) pulsations, tickles, itches and throbs of acne comprise a phenomenological backdrop through which consciousness is experienced. Said differently, acne is always-already interpreted and perceived by the body as opposed to some abstract and disembodied subject or mind:

> There is, then, a certain consistency in our ‘world,’ relatively independent of stimuli, which refuses to allow us to treat being-in-the-world as a collection of reflexes – a certain energy in the pulsation of existence, relatively independent of our voluntary thoughts, which prevents us from treating it as an *act* of consciousness. (Merleau-Ponty, 1962, p. 92; emphasis in original)

To be-in-the-world with acne, therefore, is to experience a kind of disturbance in the “consistent” or “pulsating” rhythms of which Merleau-Ponty speaks. By permeating the protective borders of the skin ego, acne animates the skin in unpredictable and off-tempo
ways that are instantaneously perceived, regardless of whether or not the subject “voluntarily” chooses to think about them or not.

In fact, one of the recurrent themes to emerge from acne.org is just how difficult it is for people experiencing acne to think about anything other than skin. Of course, as Chapters 4 and 5 demonstrate, some of this difficulty stems from a historical, political, cultural and scientific context in which “skin has become more than ever visible” (Connor, 2004, p. 50). But despite the well-intentioned attempts to normalize acne in mainstream culture, or commonsense advice from some experts, parents, and fellow acne patients to “just not think about it” or “not obsess over it” – many members of acne.org feel helpless in treating this lively and vibrant matter as, what Merleau-Ponty might term, “an act of consciousness.” Instead, what is far more common is for members of acne.org to describe their consciousness as that which has also undergone a transformation, much like their pimpled skins: “Acne has literally made me crazy;” “I can’t stop thinking about it;” “I am more obsessed with my skin than I have ever been in my life. I mean 5 small spots are driving me nuts;” “My acne has completely consumed me […] My skin is all I think about.”

It is interesting to note these individuals’ use of the terms “crazy” or “nuts” to describe a general sense of having lost one’s self, or more specifically one’s ability to think and act with intention. In Western philosophical traditions (beginning with Descartes), intentionality has conventionally been understood as a cognitive process. But, as Merleau-Ponty (1962) correctly points out, intentionality is not a simple act of thinking: “What is meant by saying that this intentionality is not a thought is that it does not come into being through the transparency of any consciousness, but takes for granted
all the latent knowledge of itself that my body possesses” (p. 270). It might thus be argued (based on the experiences of acne sufferers) that one such type of embodied intelligence is the skin ego. Without its protection, the skin can overwhelmingly stimulate intentionality leading to a type of perceptual consciousness that is as distracting as it is disorienting. It is not for lack of effort that many acne.org members experience difficulty thinking about something other than their skin. But for those whose skins are alive with the somatic activity of “other” lifeforms, acne is more than a cultural problem about how one learns to think about their skin. It is also a material problem with skin itself, or more specifically the skin’s powerful capacity to communicate an overwhelming amount of sensory information to the brain.

It is not surprising, then, that so many individuals experiment with the materiality of skin by manipulating and medicating the surface of the body. They are not only after a skin that looks different from the one they know as intelligent subjects, but also a skin that feels different from the one they know as intelligent bodies. Indeed, so long as pimples are “alive,” the body seems able to perceive their movements right up until the point they are dead. One acne.org member writes about developing an embodied knowledge of a pimple’s lifespan: “[a] zit formed right near the crevice near my left nostril. Well, it formed yesterday but today it got bigger. I can tell it’s going to die soon though. Two to the right of my nose (cluster couple) are going to die too. I can tell because they are past the pain throbbing stage.” In some instances, individuals wait for pimples to die of “natural” causes, as one person writes, “Speaking of hurting and inflamed, I got 2 newbies […] I’m hoping they have their fun and get to steppin.”
Others, however, attempt to expedite the process. One such method is to pop pimples, or as one person puts it, “squeeze the life out of them.” Here, pimples are imagined to have their own bodies and their own skins, with clear lines marking the boundaries between inside and outside. Moreover, the bodily fluids that are forcibly pushed out of the pimple take on a phantasmatic significance as the “lifeblood” of acne; that which constitutes the very ontological material through which pimples are able to move, exert force, and become. Another method of “killing” pimples is to medicate them to death. In Chapter 5, I explained that militaristic language features prominently in the marketing of acne drugs, making those drugs into weapons used in the “battle” or “war” against pimples. But as Kane Race (2009) reminds us, our cultural scripts about drugs extend far beyond the textual, visual or representational realms:

Obviously drugs do something – otherwise one wouldn’t spend such vast amounts of money on them! Yet what drugs “do” is an effect, in part, of the cultural narratives we have about drugs – narratives that are reproduced in scientific discourse.\(^{49}\) In this sense, it really does matter how science represents this relation, for these representations substantiate an increasingly determined relation. (p. 175; emphasis in original)

If one of the objectives of acne treatment is to kill active and living pimples, then a drug like Accutane materializes as a particularly powerful weapon in a person’s pharmaceutical arsenal because of what it does. In fact, one member of acne.org describes the drug as a type of atomic bomb that “nukes” pimpled life to death. If one were to ask any Accutane user to describe what the drug feels like, it is almost certain they would respond using the word “burning” to describe the experience. Indeed, this word appeared time and again in my reading of acne.org posts; but rather than perceive

\(^{49}\) It is important to note that Race’s understanding of “scientific discourse” also includes marketing discourse. Race – like Sismondo (2009) – understands the boundaries separating science from marketing as murky, at best, within a pharmaceuticalized and neoliberal context.
burning as a negative side effect, many users expressed relief and a desire for burning sensations and the resulting dried out and peeling skin. One user expresses his excitement to move from benzoyl peroxide (BP) to Accutane: “I would like the feeling of dry skin and dry lips, I love the feeling I get from BP. Suffering through a few side effects would also inform me that the product is working well.” Another user (on his eighth consecutive day taking Accutane) writes the following in his log: “My lips are starting to get chapped yeah!!!! Finally something is happening. Even though it’s a bad side effect, at least it’s something.” Many acne medications, therefore, are desirable objects for the simple fact that they offer consumers a way to enact and experience a “war” against pimpled lifeforms. With the help of acne medications, that war is brought to life, embodied and imagined to unfold in the (sub)cutaneous sensations those drugs help create.

*Libidinal dermatologies*

Thus far, I have outlined some of the ways acne ruptures the somatic and psychic boundaries of the (skin) ego, arguing that this process has important consequences for the skin both in terms of the ways it is imagined and experienced. I do not mean to suggest, however, that this rupturing is always unwanted and disorienting. It is true that acne upsets the protective, individuating and containing functions of the skin ego, but it is also true that acne excites another function of Anzieu’s skin ego: the sexualized function. Once again, I refer to the concise work of Lafrance (2013) to help summarize this function in Anzieu’s work:

> While the infant is handled and held by its caregiver, the pleasures of the skin are awakened and the erogenous zones are enlivened. As Freud points out, the pleasures of the skin enable the emergence of autoeroticism and, by extension, a more mature sexuality. Put differently, these primitive pleasures serve as the first and most fundamental support for the development of the sexual drives. In this way, they lay the foundation for
the infant’s erogenous potential and, ultimately, its ability to have gratifying sexual relations in later life. (p. 28-29)

By incorporating this function of the skin ego into our analysis, I mean for us to think further about what Ulnik (2007) identifies as a “central paradox about the psychic apparatus: the need to protect itself from stimuli and the simultaneous need to incorporate them, or at least perceive them” (p. 31). In other words, there might be good evidence to support the fact that people attempt to protect themselves from the sensory information communicated in and through acne. But there is also evidence to suggest that acne – as well as those techniques and objects used to manage acne – produce stimuli that psychosexual subjects desire to incorporate and perceive. What follows then is an introduction to some of this evidence, which highlights the contemporary logics, practices and objects through which acne materializes with significant libidinal energy.50

First, I want to return to Accutane. In Chapters 4 and 5, I provided some context to help us understand Accutane’s status as a “risky” drug. In addition to the potentially dangerous side effects of Accutane, however, are those expected effects: burning, peeling, and dried out skin. Those who have never experienced acne might, at first glance, be inclined to say that Accutane’s intended effects are negotiated by users as undesirable “trade-offs” for the promise of clear skin; but users, themselves, paint a different picture. For many of them, what makes Accutane a desirable drug is precisely its ability to scorch the surface of the body and produce a burning experience. That is not to say they find pleasure in that burning per se. Rather, the burning sensation produced by

50 One of the issues I take with psychoanalytic theories of skin disease is that the disease is often conceptualized in a vacuum. Much is said about the individual and their skin, but far less is said about the context in which their skin is treated, medicated, diagnosed, etc. As such, they tend to ignore the ways pharmaceuticals, scientific knowledge, (bio)technologies, therapies and other human actors intervene and help shape what skin diseases become, and how they are experienced.
Accutane seems to be one way for users to express their angers and frustrations towards a skin that many of them have learned to hate:

Human subjects never simply *have* a body; rather, the body is always necessarily the object and subject of attitudes and judgments. It is psychically invested, never a matter of indifference. Human beings love their bodies (or, what amounts libidinally to the same thing, they hate them or parts of them). (Grosz, 1994, p. 81)

Hate is, perhaps, one of the most common words acne.org members use to describe their feelings towards acne.

As unsurprising as this finding might be, I do not want to understate its significance. The multi-billion-dollar acne market features no shortage of biotechnologies from which consumers are able to express their hatred towards acne. Besides Accutane, a number of other prescription and over-the-counter topical acne medications produce burning sensations on the skin such as benzoyl peroxide, salicylic acid or clindamycin. Burning is also a prominent feature for those patients who decide to undergo chemical peels to treat their acne. And, many of the new biotechnologies in acne science also make burning an expected and normal part of the treatment experience. This might include laser therapies such as those administered by estheticians (e.g., Fraxel) or an emerging class of acne-gadgets designed for at-home use. One such gadget is the “illuMask,” described by one reviewer as an “at-home LED light therapy mask which comes in the form of an apparatus you wear on your face like a hockey mask” (Mau, 2014). That same reviewer goes on to write, “I could feel the lights burning away my pimples” (Mau, 2014). Another such gadget is “Zeno,” an over-the-counter device that is electrically charged to reach high temperatures and then placed on each individual pimple to essentially burn them to death. It would appear as though developers of acne treatments go out of their way to develop products that burn.
As noted, creating a burning sensation is in part a way for developers to communicate a dermatological drug’s efficacy, activity, and potency to the user; to let them know that the drug (or the technology) is working and doing something to pimpled life. But, as most individuals with acne know, the majority of these products do not in fact work or do anything to pimpled life. Sometimes, a burning sensation is all that they have to offer. Why, then, continue using the product? This is a question that perplexed one dermatologist I spoke to:

One of the things I do see is people using ineffective treatment modalities for far too long […] If you walk into the pharmacy, there is shelves filled with acne washes and there is lots of advertisements with celebrities showing you which products to use. Because it’s a billion-dollar industry, right? So often people are influenced by that and they use all of these medications that are by-and-large ineffective for serious forms of acne. They do these for a while and the process continues, the scarring develops, and only after they’ve exhausted that and spent “x” amount of dollars do they decide to go see their family doctor. (Stephen, personal communication, September 7, 2015)

From this dermatologist’s perspective, the efficacy of an acne treatment depends solely on its ability to eradicate or significantly lessen acne. The burning sensations that accompany so many products on the acne market, therefore, are understood as ineffective should they fail to yield any observable and tangible results. From the perspective of the user, however, efficacy might well be judged in other unconscious ways. Although the vast majority of biotechnologies fail to deliver on their promise of clear skin, they can be understood as effective in their ability to express and channel feelings of hatred, violence, anger and disgust that many individuals harbor towards acne. As Grosz (1994) explains: “External objects, implements, and instruments with which the subject continually interacts become, while they are being used, intimate, vital, even libidinally cathected parts of the body image” (p. 80).
There are, however, a variety of alternative acne treatments that do not inflict pain or burn the surface of the body. Some of these drugs are accessed as over-the-counter cleansers, masks, and exfoliating creams that are massaged or applied directly to the surface of the body. Others are what acne.org users call "natural" or "household" remedies, which include everything from foods (e.g., teas, honey, turmeric) to bodily fluids (e.g., urine, semen, breast milk). Users often understand these alternative therapies as "less powerful" than their aforementioned counterparts, whose power is inextricably linked to the harsh, uncomfortable and painful sensory experiences they are able to produce. But, what they lack in pain they often make up for in pleasure, highlighting a different set of libidinal energies through which to understand the psychosomatic effectiveness of acne medications.\(^1\)

Indeed, individuals might be tempted to use (or continue to use) treatments that fail to deliver on the promise of clear skin, in part, because those treatments do deliver on the unconscious promise of the skin ego, which is that "skin pleasure becomes a background for sexual pleasures" (Anzieu, 1989, p. 104). I was amazed at how frequently members of acne.org confessed to abstaining from sexual contact out of fear that it might worsen their acne. Some of this fear is framed as a hormonal concern, as one user writes:

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\(^1\) I do not mean to set up a false dichotomy between two groups of people: i.e. those who take painful versus pleasurable acne medications. No such dichotomy exists, as people experiment widely with medications from each camp and oftentimes take more than one acne medication at a time. Moreover, I do not want to overlook the possibility that certain acne drugs invoke a kind of pleasure in their very ability to induce pain or discomfort. One such example is benzoyl peroxide, which often produces itchy skin. Writing about itch, Ulinik (2007) notes: "An itch generates a scratching behavior which produces a feeling of pleasure, but also a demand for more scratching due to a sort of increase in tension […] The feeling provided by the itchiness-scratching cycle has a certain "voluptuousness," which is similar to that of sexual stimuli. Freud uses the term "itching" or the term "centrally conditioned itching" several times to refer to sexual excitation" (p. 28).
“Everything that you do affects your hormones in some way […] To dismiss ejaculation (sex, masturbation) as having ZERO impact on your hormones is a pretty ignorant and selfish thing to say to someone who actually experiences this problem.” Attempts to discredit such truth claims with scientific and empirical evidence are often quickly dismissed by those who have already begun abstaining from orgasmic pleasure, and whose experiential knowledge proves otherwise. Others are less fearful of hormonal concerns and more concerned with the intimacy of sexual contact: “I don’t think hormones cause breakouts in sex, but I do think that all the skin-on-skin contact does! Loves’ got to come first, of course, but there have been moments where I avoided contact for fear of the dreaded cysts!!!” Another user writes: “I’ve now got a new boyfriend who wants to touch my face romantically. I’m not ready to tell him about my acne situation but it bothers him that I won’t let him touch my face […] I worked so hard to stop touching my face, I can’t imagine ever letting someone else touch my face.” What these narratives show is a voluntary renunciation of skin pleasures on the part of some individuals with acne. But, as some skin pleasures are prohibited and disciplined in a medicalized context, others are encouraged – namely, those forms of touch that are not explicitly sexual but *iatrical* in nature. It is in such a context that users medi(c)ate the psychosexual significance of skin through objects designed to treat the surface of the body.

What are some of these acne treatments through which subjects report pleasurable experiences with/in their skin? There are too many to list here, but I do hope to provide the reader with a tiny glimpse into some of the ways over-the-counter, “natural” or “household” treatments both touch the subject, and are touched by the subject, in ways
that might be understood to support the sexualized function of the skin ego. Keeping in mind Anzieu’s (1989) argument that “the Skin Ego fulfills the function of providing a surface for supporting sexual excitation […] drawing in libidinal cathexis over its entire surface and becoming a complete envelope of sexual excitation” (p. 104; emphasis in original), I want to direct the reader’s attention to specific examples of that sexual excitation being supported through the use of acne treatments. One such example comes from a user describing an “anti-blackhead cream cleanser” as something that feels “like a facial massage – it really relaxes my face.” In another instance, a woman is shocked at how pleasant her sister’s breast milk feels when used as a topical acne remedy: “The milk was odorless and had a much more pleasant texture than I thought it would, so I strutted around the house confidently” (Jackson, 2015). Indeed, acne treatments are often perceived on the basis of both their olfactory and tactile qualities, as evidenced by the following account of a lemon poppyseed cleanser: “OMG that cleanser smelled so good and made my skin so soft!” Meanwhile, those who experiment with the medicinal and topical capabilities of honey frequently mention its smoothing quality as an attractive feature: “Honey just feels so good when applied to the skin, it doesn’t irritate at all and when you apply it it feels so smooth;” “I use a honey mask at least once a week […] I love it. Makes my face soft and smooth to the touch.” And lastly, a product’s ability to “cool” the skin can also be a desired tactile experience, as one acne.org member explains: “I like the way [Noxzema] cools my face off […] I like to let my face air dry because the Noxzema film cools my face off a lot. It reminds me of summer.”

I do not expect the reader to be surprised to learn that individuals can and often do experience pleasure in the application of various types of fluids, chemicals, soaps, etc. to
their pimpled skin. What might be surprising, however, is my claim that there is a productive power to this pleasure, and an important psychosexual dimension to the process of experimenting with various types of acne treatments. As mentioned, acne often leaves people feeling restricted in terms of their ability to touch themselves and be touched by others sexually. But, as psychoanalytic scholars remind us, one cannot easily separate the act of touching from the sexual drive (Anzieu, 1989; Freud, 1905; Ulnik, 2007). That is to say, touch does not need to be consciously or intentionally recognized as sexual in order for it to be experienced as such. Thus, in policing and disciplining those more explicitly sexual forms of touch, our medicalized context also opens up space for the flow of sexual drives to materialize through those iatrical forms of touch it permits and encourages. This is an insight I come to through the work of Race (2009):

Drugs can be approached as an attempt, on the part of users, to construct new materialities in the context of specific embodied circumstances and normative regimes […] I suggest that the transformations, pleasures, and forms of enablement, disablement, and escape found in drugs should be approached more simply as experimental and material engagements with the circumstances of life. (p. 31)

In other words, people’s experimental ethos towards acne treatments might reveal something important about our “context of specific embodied circumstances” or more specifically the touching drive, as that drive becomes increasingly medi(c)ated through the discourses, practices and technologies of biomedicine. The pleasures of touching and being touched are not stripped from those who experience acne, but they are re-introduced to them with the help of objects. As we have seen, people experiment with a variety of different objects – some of which are fun and enjoyable to touch with, and others that touch back in exciting and exhilarating ways – thus, animating the ways “the skin can either be a source or an object of the drive” (Ulnik, 2007, p. 30). It is true that
experimenting with acne treatments can seem like exhausting, necessary, time-consuming, expensive and futile work for an emerging class of “citizen scientists” or “patient experts,” as Chapters 4 and 5 showed. But it is also desirable work in the sense that it produces psychosomatic excitements that are both fantasized and experienced through the skin. Members of acne.org are rarely satisfied with any one object for very long and instead regularly express excitement about the next object, perennially waiting around the corner. They have yet to experience that object on and through the skin but fantasize about its touch and autoerotic potential. Just as exciting as the actual experience of a new topical acne treatment, therefore, is the anticipation leading up to the next one.

None of this is to say, however, that pimples go untouched without the intervention of some kind of topical agent. In Chapters 4 and 5, we also found examples of people popping their pimples, despite expert advice cautioning against this “bad habit.”\textsuperscript{52} Though it was not the main focus of either chapter, I have alluded to the pleasures of popping. Chapter 4 highlighted specific examples of women confessing to liking the activity, and Chapter 5 described the embodied feeling of pimpled stress that exerts itself outwards and the subsequent feelings of relief that come with popping. Here, I want to think further about the libidinal force of acne, or more specifically its ability to tempt and satisfy several drives (e.g., mastery, attachment, looking) which are regularly experienced through the practice of popping. This is yet another example by which acne appears to animate the surface of the body with sexual excitement, thus fulfilling the sexual function of Anzieu’s skin ego.

\textsuperscript{52} Interestingly, medical authorities only tend to endorse popping as a “safe” activity when it is performed with the help of sterile objects (e.g., gloves, sewing pin, etc.), and not direct contact with the fingers.
The mastery drive is closely linked to the act of touching, as Ulnik (2007) writes: “touching is the bridge to thinking, fantasizing and imagining, or to awakening the mastery drive” (p. 33). Following Freud, Ulnik uses the concept of a “mastery drive” to highlight the ways power and control are first learned through the infant’s tactile experiences of grabbing, latching onto and manipulating people and objects. But, “not everything can be touched, seized or controlled” (Ulnik, 2007, p. 48). One must also learn from a young age how to exercise control over the mastery drive, or what Ulnik (2007) and Anzieu (1989) refer to as the “prohibition to touch.” This tension between wanting to touch and feeling restrained in that touch is one that recurrently manifests as a source of significant psychosomatic conflict in the lives of individuals with acne. Many of them speak about having a desire to directly touch pimples and assert control over them, but also confess to knowing better: “I keep popping whiteheads and I need to stop. Dammit it’s addicting!” They are, indeed, driven to pop for reasons that are unknown, unconscious and against their better judgment.

But as this quotation suggests, this form of “bad touch” feels good…almost like a drug. Another member of acne.org writes: “I finally caved and squeezed a couple tonight…I know I suck, I’ve been so good with self-control and I just gave in, it’s like a crazy little addiction.” Indeed, it is not uncommon for people to use the language of addiction and invoke drug imageries to describe the experience of popping, as Sali Hughes (author of a book about beauty practices) illustrates in an interview with Vice.com, using terms like “junkie,” “high” and “buzz” (Wilkinson, 2014). Similarly, one of the family physicians I spoke to revealed: “I think [patients] are kind of aware of it, but they can’t really stop it. There are a lot of people picking things. We have a
conversation about it like, “Okay, you know, it’s obviously causing scarring and it’s not good,” and they’re like “I just feel like I can’t stop it”” (Claire, personal communication, April 14, 2016). In contrast to what Race (2009) argues is a “cultural script that is pharmacologically enacted” (p. 176) the act of popping pimples thus points us to an occasion where disinhibition (i.e. losing one’s self) is not pharmacologically but dermatologically enacted. To understand this phenomenon we might again refer to the work of Ulnik (2007):

When the skin is the object of the drive, we come closer to auto-eroticism, exhibitionism and masochism, because for example the wish to master one’s own skin as an object leads to the action of pinching it, sucking it or hurting it. These actions are mastery intents, either visual or even tactile, and usually have sadistic characteristics […] This is the reason why diseases which involve pinching and scratching (acne, psychogenic itching, self-inflicted dermatoses) could be considered taking into account this instinct of mastery, not only because of the “grasping” or “mastering” of the spot or the scale of epidermis, the skin or the pimple, but also because of the cruelty and sadism of the procedure. (p. 27)

Pimples seem to make the skin into an object of the mastery drive through which subjects can exercise control and power; but what is particularly fascinating about this process is that members of acne.org regularly describe it as one of relinquishing power and losing control over one’s self. In other words, they become subject and object, popper and popped. As enjoyable as it is for individuals to exert a certain measure of control and mastery over their pimpled skins, they also find autoerotic and sadomasochistic pleasures in being squeezed and picked apart at the surface. It becomes impossible to separate, therefore, the psychic from the somatic as each become entangled in an exchange of libidinal energy, creating the euphoric “highs” that individuals crave with each pop of a pimple.
For further evidence that popping pimples is a pleasurable activity both for the popper and the person whose skin is being “mastered,” we need not look any further than those who report sharing this intimate form of touch with another person or persons. This is the subject of a 2003 Salon.com article written by Anna Holmes, whose interviewees reveal the full extent to which popping is not only an individualized activity but also a shared and intimate encounter. One of her interviewees, Julia, says the following about extracting her partner’s skin: “It’s difficult to explain, but picking at Dave and removing his blackheads or ingrown hairs makes me feel like I’ve done something useful…something good.” Another person shares: “I’ll tell him to turn one way or another, and he’ll comply and even keep on reading while I pick […] I feel kind of proprietary towards him, like ‘this is my person, and I get to pick at him!’” The libidinal significance of the activity is not lost on Holmes (2003) whose interviewees frequently and effortlessly slip into talking about sex when describing popping. Julia admits: “I will say that Dave and I have had to stop having sex before because I’ve become so obsessed with getting a pimple […] We’ll be in the midst of foreplay and I’ll see something on his face and become fixated. I can’t stop looking, and I can’t think about anything else.” Another interviewee reveals that she found popping her boyfriend’s skin more pleasurable than sex: “I jumped on his back with a certain zeal and enthusiasm that I can’t say I had with regards to sex.” And, of course, there are many people who pay professionals to pop their pimples. Professionals, too, can experience gratification from

53 There are also examples of more than two people participating together in this embodied practice together. Reflecting back to their high school years, one of Latimer’s (2012) interviewees tells a story of “group” popping: “There was a room in the back corner of the library, which was an excellent place for studying, gossiping and apparently, group zit-popping sessions. I was truly disgusted on one occasion to observe three friends assisting each other in the act of zit-popping.”
the process, as one esthetician admits to pursuing such work because of the pleasures associated with manipulating dermatological life: “I love picking and I’ve always loved it [...] My grandmother had a lot of blackheads and hairs and I just loved to pick on her skin and back. It was my dream to become an esthetician and work with skin, and I love what I’m doing” (Holmes, 2003).

As these examples illustrate, intimate bonds are forged in and through acne. Acne has the potential to attract, excite and bring together romantic partners, friends, family members and strangers into relations of care. Part of the productive power of acne, therefore, lies in its libidinal energy. This is an energy that has given rise to the very brand of “skincare” being detailed by Holmes (2003), which seems to challenge other more conventional methods and experts in skincare. What specifically interests me about this brand of skincare is that it appears to be almost exclusively administered by women. That is to say, women are regularly the ones who confess to liking (or are represented as liking) the act of popping another person’s pimples. I disagree with those who make the biological argument that a woman’s drive to pop another person’s pimples is part of a “natural” and “caretaking” instinct (Holmes, 2003). Feminists have written at length about the politics of caretaking, and how the physical and emotional labour of care is inequitably tasked to women. Popping, it would seem, is no exception; but it is also a type of learned caretaking that many women admit to desiring and enjoying. When performed on the skin of another individual, the practice can be understood to satiate the attachment drive: “Attachment can be considered as drive, and, as such it is intimately connected with what Moll called “contrectation drive,” which is the impulse to be in epidermic contact with another person” (Ulnik, 2007, p. 134). As such, this unique brand
of skincare highlights a number of other attachments through which it becomes possible to understand the political and libidinal meanings of caretaking beyond the mother-child bond. If skin requires caretakers in our contemporary moment, then it would appear as though our culture not only looks to women to learn and fulfill those responsibilities, but also makes dermatological caretaking exciting and desirable work for some women…taking shape in the home, the spa/salon, or increasingly the hospital.54

Alas, I have still yet to mention what is, for some, perhaps the most exciting part of pimple popping: watching the process unfold. Watching a pimple being popped can be just as pleasurable as the aforementioned forms of touching that accompany it. As Ulnik (2007) notes, the psychic pleasures of looking are thoroughly entwined with the somatic pleasures of touching: “Looking is a surrogate or a substitute for touching. There could be a “visual libido” as well as a “tactile libido”” (p. 23). As such, I want to direct my attention to the libidinal energies associated with watching pimples pop.

Popping is, importantly, a visual experience in addition to being a haptic one. For starters, the practice almost always takes place in front of a mirror. This is in part a practical decision for individuals who want to see parts of the body (usually the face or neck) that cannot otherwise be seen, and manipulate the skin in that area with optical, as well as tactile precision. But, this assumes that the individual is always attracted to the mirror by what is first sensed or perceived as the embodied force of a pimple. This is not

54 In 2016, the Canadian Medical Association compiled and analyzed statistics from the last twenty years (1995-2015) to provide a “dermatology profile” of the country. Whereas the number of male dermatologists in Canada has remained constant for the last twenty years, the number of female dermatologists has essentially doubled (Dermatology Profile, 2016). There are now almost an equal number of male and female dermatologists in Canada, which exceeds the national average of male to female physicians more generally (“Number of Active Physicians,” 2016).
the case, however, as many members of acne.org write that the desire to pop is only experienced after looking into a mirror. Oftentimes, it is only after seeing “clogged” pores, whiteheads or blackheads up close that individuals are moved and energized into action. One user writes about the feelings of anger that overwhelm him after looking at the skin on his face: “Then I came back to my apartment after Thanksgiving break and looked in my mirror. Holy shit. Could have been the worst I have ever seen my skin. Just covered in little tiny whiteheads. Cysts on my jawline. Scabs and redmarks everywhere. I just lost it and started popping shit. Washed my face and passed out from anger exhaustion.” In another example, a member of acne.org describes making a ritual out of looking into a magnifying mirror before falling asleep each night: “I used to keep a [magnifying] mirror on my night stand just so that I could pick my face before bed.” The mirror, in this instance, serves as an important tool through which the libidinal energy of picking is channeled. In addition to the autoeroticism of looking at and handling pimples in front of a mirror are the aforementioned relations of touch by which a partner acts as the “picker” or “popper.” Under these circumstances, popping becomes visible not to the self but to excited others who, as we learned, desire to act as the “eyes and hands” of the person with acne.

The most convincing piece of evidence to suggest that there is pleasure in the act of watching pimples get popped, however, can be found in the thousands of pimple popping videos being uploaded and watched on the Internet. Headlining an article for Vice.com, Sophie Wilkinson (2014) asks, “Are zit-squeezing videos the new porn?” And, in a different article written for the Guardian, Parkinson (2015) asks: “What’s fuelling the growth of the online community?” Each author acknowledges that the dedicated viewers
of pimple popping videos find something immensely pleasurable about watching these dermatological eruptions on their computer screens. Asking the members of one virtual popping community – who often self-identify as “popaholics” – to explain what compels them to watch the videos, Parkinson (2015) is welcomed with a number of different theories. Some, she says, enjoy watching the videos for cathartic reasons, describing the experience as “soothing,” “cleansing,” “relieving,” or “satisfying.” Others, however, find the videos exhilarating and thrilling as one member writes: “It’s something illicit and certainly gross. Just that slight sickening feeling in your stomach is pleasurable to some. Some people just get the same sort of thrill as, say, riding on a roller-coaster” (Parkinson, 2015). It is also important to note, too, the variety of different types of videos available online. On some pimple popping websites, users are given the option to sort and search through thousands of videos based on categories (e.g., back zits; blackheads; cysts; neck zits, etc.). This feature, it seems, is an important one for a community whose common desires to watch pimple popping are also differentiated on the basis of type or location of the pimple: “It’s just so satisfying, especially blackheads for me – they’re my favourite. I like solid when it comes to popping, those giant cysts constituted almost entirely by liquid don’t tickle my fancy” (Parkinson, 2015). There is also a genre of video in which the person doing the popping is a doctor. Dr. Sandra Lee (a.k.a. Dr. Pimple Popper) has created a YouTube channel amassing almost 2 million subscribers and nearly 900 million total views featuring videos of her performing different types of extractions on her patients.55

55 Dr. Lee is just one of several dermatologists to become Internet celebrities for their videos in this genre.
Upon learning about or stumbling upon the virtual communities of “popaholics,” outsiders are often quick to express their disgust or horror. Parkinson (2015), a self-confessed “popholic,” understands it is normal to feel that way. But as she admits: “I want to say euw, gross. I want to wretch in disgust. But I’m afraid that, well…my name is Hannah, and I’m a popaholic.” Somewhat embarrassed by the confession, she takes solace in knowing that there are millions of other “addicts” like her, whose appetite for popping is satiated with each click of the mouse: “The above numbers are testament to the fact that I am not alone” (Parkinson, 2015). Anyone who has ever watched a pimple pop is likely familiar with the squeamish feelings it elicits. In particular, the substance that oozes out of the pimple – whether it is blood, pus, a whitehead or a blackhead – often becomes the specific object of disgust. Although viewers of popping videos frequently admit to being disgusted by the squiggling substances emerging out of the pimple, they also admit to being attracted and excited by them. Helping us understand this paradox of bodily substances, Elizabeth Grosz (1994) writes:

Detachable, separable parts of the body – urine, faeces, saliva, sperm, blood, vomit, hair, nails, skin – retain something of the cathexis and value of a body part even when they are separated from the body. There is still something of the subject bound up with them – which is why they are objects of disgust, loathing, and repulsion as well as envy and desire. They remain (peripheral, removable) parts of the body image, magically linked to the body. They illustrate the narcissistic investment in the body image: these body products can only be negatively coded (with disgust or horror) because there is also the possibility (and the prior actuality) of a love of the body and all its substances.” (p. 81)

In other words, despite being surfaced and therefore “outside” the symbolic boundaries of the (skin) ego, the abject “stuff” of a pimple is also realized as having once existed on the “inside” – that is, as part of the self. In rendering that “stuff” visible atop the surface of the body, the subject experiences a sort of perverse and narcissistic attraction to it. Their
gaze is simultaneously pulled towards a substance they identify with and through at the same time it is pushed away in disgust.

Grosz’s insights help us make sense of what attracts people to watch the ostensibly disgusting or horrific practice, but what is to be said about the visual mediation of pimple popping? If popping produces abject bodily fluids that retain a part of the subject’s body image (i.e. the subject recognizes their self), then how do we account for what is clearly the transference of libidinal energy from skin to screen? Quite simply, how does one not only (mis)recognize themselves in and through another person’s popped pimple but also the image of that person’s popped pimple? Skin, of course, is no stranger to visual culture. The central thesis of Steven Connor’s (2004) book, however, is that skin has never been as visible as it is today, and that its contemporary visibility remains utterly somatic and tactile. Writing about this relationship between visual culture, technology, skin and touch, Connor (2004) notes:

The flesh displayed in posters and magazines, and in the electronic screens that are more and more a feature of public space, looks touchable, caressable, for what is to be impressed upon our eyes is the way that it has been touched by light; but we know that its touchability is of a higher order than the ordinary touchability of skin […] Odourless and textureless, these skins nevertheless acquaint us with a kind of higher touching, an immaculate, intangible, imperishable touch of the eye. (p. 60)

I am in agreement with Connor that popular representations of skin both impel and satiate the looking/touching drives, but disagree that the resulting forms of touch are of a “higher order than the ordinary touchability of skin.” To be certain, the kind of technological and visual mediation of skin referred to here involves a different embodiment of touch, but to suggest that it is somehow “higher” than ordinary touch because it is more cognitive, intelligent and ocularcentric seems to me both unnecessary and Cartesian in its assumptions.
Nevertheless, by identifying a unique brand of touch that manifests in and through the act of looking at images of skin, Connor (2004) helps us better understand digital representations of pimple popping. The pimples featured in popping videos are, indeed, touched by the lights of cameras and unconcealed by makeup making them hypervisible to a culture that has for so long tried to hide them from public sight. Before the invention of the Internet, individuals had to rely on mirrors or medical textbooks for comparable images, which meant the act of looking was a largely individualized and private affair. Today, however, those images have become far more accessible allowing individuals to look at pimples together. And, as they watch them being popped, they experience the psychic and somatic pleasures together through a kind of shared “electronic skin” (Howes, 2005). Following Marshall McLuhan’s philosophy that “in the electric age we wear all mankind as our skin,” Connor (2004) provides us with some further context through which to understand the sensory potential of electronic skin:

In the twentieth century and beyond, it is the nervous system rather than the arm or leg that is enhanced by technology, and therefore in the process transformed. In the epoch of electronic media, the actual skin that bounds us within our individual selves is dissolved away and replaced by a polymorphous, infinitely mobile and extensible skin of secondary simulations and stimulations, which both makes us more versatile by enlarging our psychic surface area, exposing us to more and different kinds of experience, and also numbs us, precisely because of the dazing overload of sensations which this synthetic pseudo-skin conducts.” (p. 65)

If we follow Connor in this train of thought, then we might understand pimple popping videos as offering new, exciting simulations and stimulations to an enlarging electronic skinscape. Firstly, the videos offer the viewer a chance to look at abject skin as opposed

56 It is important to note that those who watch popping videos do not necessarily suffer from acne. The electronic skin being referred to, here, implies that it has become possible to share and enjoy the psychosomatic pleasures of (popping) acne through visual and technological mediums, in addition to those more direct forms of touching.
to the smooth, radiant and glowing skins of consumer culture. The videos thus invite a much different set of libidinal energies for the viewer to imagine compared to those experienced through the everyday mediations of a commercial skinscape. Secondly, the videos do more than tempt the touching drive by also touching back. With each pop of a pimple comes a wave of energy that is sometimes described by viewers as excitement and other times relief. Calling themselves “popaholics,” it is clear that viewers understand the specific images of pimple popping – and not other representations of skin – as those that are capable of providing them with their desired stimulatory experience.

The cultural context in which acne becomes digitally popped has thus made public and collective what used to be a largely private and individual pleasure. As viewers become aware of others who enjoy watching pimples explode, they begin to develop a common language around electronic skin. The word “popaholic,” for instance, directs our attention to the ways electronic pimples – much like real ones – can produce drug-like “highs” for the viewer…even to the point of addiction. As the unconscious pleasures of abject skin continue to be digitized, publicized and normalized, the electronic skin will almost certainly grow to enlarge our psychic surface area by incorporating images of other dermatological conditions and procedures, in addition to creating new psychosexual identities, kinks and fetishes besides those which can be found in popaholic communities.

Popping videos are just one of many examples in this chapter that highlight the need to think critically about the psychosomatics of acne. I have also directed the reader

57 There is already evidence to suggest that this is the case. Some of the video categories on PopThatZit.com include things like “belly button lint,” “ear infections,” “fungus infections” and “veterinarian treatment.”
to some of the words acne.org members use to describe the experience of pimples, as well as an assortment of drugs, technologies and people that come into intimate contact with pimples. My analysis of these topics led me to develop two arguments: 1) that acne threatens the boundaries of the (skin) ego; and, 2) attempts to reestablish the boundaries of the (skin) ego are as much about the libidinization of pimpled skin as they are about repairing a lost sense of psychic integument. In sum, there exists a critical need to think about the cultural context in which touch is prohibited, medicated and cathected. Expert knowledge about skin and skin health becomes embodied and makes taboo, permissible, irritating, painful, pleasurable and desirable an entire set of sensory relations between pimples and people. Emerging out of those sensory relations are dermosocialities for whom the experience of a diseased skin is libidinally charged and pharmaceutically, discursively, and technologically enacted.
Chapter 7

Dermosocial Futures: Conclusion

As I stated in the introduction to this dissertation, I was drawn to research acne because I was unsatisfied with the commonsense notions that acne is either a medical problem or an inconsequential part of life. I followed my gut, which in my case seems to remember and carry with it all of my skin’s history; or perhaps I followed my skin, which might be understood as the somatic exterior of the gut? Either way, my “gut-skin-brain axis” (Stokes & Pillsbury, 1930; Bower & Logan, 2011) – if there is such a thing – told me that acne is complicated. That complexity gets lost, I thought, through the discourse of “it’s just acne.” What would happen if I actually tried to understand people’s lived experiences of acne from a critical yet compassionate lens, instead of telling them to change how they think about and experience the disease? “It’s just acne” is a discourse that is meant to keep in place an understanding of the disease as simple and banal despite an overwhelming amount of evidence suggesting otherwise. I also figured that complexity was being lost in those related attempts to contest the “it’s just acne” discourse using psychological theories of human behavior. I came into this research equally dismayed by the idea that messy, lived experiences of acne could be reduced and simplified to a singular narrative of emotional-psychological suffering. I knew from my own experience with acne that the disease was so much more than that. I thus set out on a project to unsettle commonsense understandings of acne by paying specific attention to one very important but overlooked detail of the disease: context.

There is a risk of naturalizing acne, as well as its relationship to the psyche, when scholars ignore the context in which it exists. Pimples themselves have evolved to
become something quite different from when humans began treating them with antibiotics in the 1950s. Acne drugs, as well as the economic system in which those drugs are produced, distributed and consumed, have also undergone significant changes. At the molecular level, acne appears in mysterious ways for scientists who can now see previously unseen components of the disease through new technological and theoretical lenses. The Internet has meant that acne can be shared, publicized and studied in ways that were once thought unimaginable. And of course, there is no shortage of racist, gendered, psychological and health discourses that change over time and place, but similarly inscribe the skin – including acne – with new meanings. My goal in writing a sociology of acne, therefore, has been to denaturalize pimples by taking seriously the context in which they are experienced. Acne is unequivocally social. So too are the sciences and medicines that intervene on the skin and through which people come to know, touch, and experience new embodied realities. Rather than position dermatology, microbiology, psychology, etc. as medical solutions to the problems of acne, I sought to include them within a much larger social network of power relations that contemporaneously shape what it means to live with skin and as skin.

Thinking dermosocialities

I have sought to develop two major arguments: First, I have shown that the biology of acne animates, and is animated by: the social, emotional and psychosomatic lives of skin. In other words, people have already learned a great deal about skin, as skin and through skin before they ever develop acne. My point is that this “skin knowledge” (Howes, 2005) not only energizes acne and makes it into lively and perceptible matter, but that it is also energized by the liveliness of acne, its capacity to move, multiply, touch
and become something other than what the skin knows. My second argument has revealed how new epidermal solidarities – better termed *dermosocialities* – emerge out of these dynamic and medi(c)ated exchanges between the skin’s nature and culture. In other words, acne comes to reassemble the meanings, histories and differences that are already marked on the surface of the body to create new forms of collectivization and identity.

I have spent the preceding chapters outlining some of the ways dermosocialities are organized through particular configurations of people, knowledges, objects and practices. Here I want to describe and illustrate the consequences of dermosocialities. Paul Rabinow (1996) argues that there are a number of different implications to what he originally termed “biosociality.” Writing at a time when the Human Genome Project promised genetic answers to philosophical and existential questions about life, he hypothesized: “…that the new genetics will prove to be a greater force for reshaping society and life than was the revolution in physics, because it will be embedded throughout the social fabric at the micro-level by a variety of biopolitical practices and discourses” (Rabinow, 1996, p. 98). Although my interest has less to do with genetics and more to do with those sciences that conceptualize life on and through skin, I find it useful to follow Rabinow and think about the consequences of dermosociality at the micro-level. This can involve questions about identity, as Rabinow (1996) describes: “My argument is simply that these older cultural classifications [race, gender, etc.] will be joined by a vast array of new ones, which will cross-cut, partially supersede, and eventually redefine the older categories in ways which are well worth monitoring” (p. 103). Additionally, the micro-level workings of biosociality can be seen in the reorganization of peoples, institutions and objects in society: “These [biosocial] groups
have not only managed to create new kinds of identities for patients, but more importantly, novel forms of bringing together patients, scientists, institutions, funds, and in some instances, biotechnology companies” (Gibbon & Novas, 2007).

In Chapter 4 I explained how racialized and gendered identities are being renegotiated on and through the materiality of pimpled skin. Borrowing from Fanon’s (2008) original concept of an “epidermal racial schema,” I suggested that there is something akin to a “racial dermatological schema” through which doctors and patients perceive medical-racial skin “types.” New dermosocialities are formed through this racial dermatological schema, which sees both the color of acne and the color of skin in dynamic tension. My research also brought me to consider the ways gendered subjects organize and are organized through the queer biology that is acne. In some instances, dermosocialities are forged through scientific diagnostic criteria and medications that create gendered experiences of the disease. In other instances, subjects attempt to embrace, explore and experiment with the queerness of acne, creating dermosocialities that are grounded in non-normative expressions and embodiments of gender. This has led some women to accept their acne as part of who they are and even learn to love it in a culture that teaches them to hate it. Borrowing from body positivity, self-love and fat acceptance movements, these women embark on a project to wear their acne proudly and defiantly as part of their identities as women. In doing so, they participate in a politicized gesture meant to resist the normalizing, medicalizing and stigmatizing rhetoric of health and beauty discourses that all too often leave women feeling ashamed of their bodies.

The dermosocialities examined in Chapter 4 reveal some important insights into the ways racialized and gendered identities are being redrawn, reimagined and
renegotiated through the biology of the skin. In addition to having effects on political and
cultural categories of identity, these dermosocialities have real effects on medical
practice, as well as pharmaceutical and cosmetic markets. As one dermatologist
explained to me: “I love treating patients with skin of colour. I sort of have a reputation
for loving it and being good at it […] I take care of a lot of patients [of colour] with acne
who refer their friends to me” (Jennifer, personal communication, August 25, 2015).
Having been excluded from dermatological research, practice and treatment for so long,
emerging forms of racialized dermosociality are making themselves and their demands
known to the broader biomedical establishment. In turn, doctors such as the one quoted
here are beginning to take notice, providing specialized dermatological services for
patients whose skin is not white. One clinic in New York City advertises itself as “a
comprehensive general and cosmetic dermatology practice that has a special interest in
the treatment of skin care needs for darker skin tones” (“Derma di Colore,” 2016). The
skincare industry is also taking notice. Featuring (among other things) an entire line of
racializing acne gels, toners, cleansers, soaps and creams, one business states that its goal
is to “service the unique skincare needs of skin of color for men and women” (“Black
Opal,” 2016). Many other businesses are beginning to offer cosmetic options to
dermosocialities of men who are embarrassed by their acne and want to conceal it. In
Chapter 4, I also highlighted online communities of men whose collective attempts to
mask acne and experiment with cosmetics brings them together. In turn, industry leaders
are beginning to offer cosmetics that are virtually the same as those being produced for

58 Clinics such as this one, offering dermatological expertise for people of colour, tend
not to be found in places where there is little to no market for such services. It appears
that racialized skincare is a “specialty” in dermatological medicine that practitioners can
learn should they be confronted with market demand, but is certainly not a requirement.
women, except that they are marketed and packaged differently (often in black exteriors such as Clinique’s “for men” skincare line). The “Men Pen” is a concealer that is also dressed in black and is designed to look “just like a chap stick container […] to be discrete” (“Men Pen,” 2016). As we move forward in our understanding of dermosocialities, it seems important to continue tracking the ways they influence existing and established marketplaces. So long as they wield a certain purchasing power, dermosocialities will likely continue to play an important role in the making of the skincare and cosmetics industries – forcing them to continue developing products that offer consumers new ways to embody race and gender on and through the skin.59

In Chapter 5, I introduced the reader to the psychodermatological person. I examined some of the ways individuals learn about themselves as psychodermatological subjects, and connected this learning to one particular form of dermosociality: the acne sufferer. I discovered that there is no singular acne sufferer or common, shared experience of suffering that transcends differences in people, places, practices and skins. Psychodermatological embodiments, in other words, materialize differently from one person to the next and are context-dependent on a variety of cultural, political and scientific discourses or practices that shape what it is like to live with acne. Perhaps the most obvious consequence of this form of dermosociality is the fact that acne has emerged as a subject position unto itself. That is to say, acne is not a disease that one has but rather, a disease that one is or becomes. The acne sufferer, in other words, is someone for whom acne is an entire lived experience of difference and hardship written on and through the skin.

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59 There is good reason to wonder if pharmaceutical research teams and skincare marketers lurk and scour online message boards such as acne.org. Curiosities such as these open up interesting avenues for future research.
through skin. With this shift emerges new ways to medicalize and treat social experiences of suffering as dermatological problems.

Sometimes acne sufferers seek psychological solutions to these dermatological problems, thereby broadening the scope of acne medications and dermatological practice to include psychiatric labels, drugs, and techniques. These changes are already underway, as I noted throughout parts of Chapter 5. In other instances, however, acne sufferers demand cultural solutions to their psychodermatological problems. In these instances, the issue with acne is that it is a stigmatized and marginalized subject position. It is not uncommon to hear the language of identity politics being invoked to describe what it is like to be an acne sufferer, whose skin is marked as “different” and thus at the root of one’s suffering. Consider the following excerpt from Huffington Post article titled *Stop Telling Me I Have Problem Skin*:

> I can turn on my television and see people from all different kinds of ethnic backgrounds. I can find television shows with characters from all the major religions; I can find shows with characters of several different sexual orientations. There are television shows with trans characters. There are television shows with disabled characters. There are never any people on my television or in magazines or even in cute, independent, deliberately not-Hollywood movies who look like me, with angry red skin and patches of whiteheads and that greasy sheen… (Theriault, 2013)

In this example, acne is treated like any other politicized category of identity, as dermosocialities of acne sufferers push for increased visibility and representation in popular culture with the goal of destigmatizing pimpled skin. Some acne sufferers (particularly adults) are also beginning to frame their marginalized status within the context of the workplace. Members of acne.org frequently talk to one another about the stresses of interviewing for jobs with acne: “I’m really nervous about my job interview tomorrow. Since I’m really shy because of my acne I always look down.” In addition to
the shame they carry with them into job interviews are those insecurities brought on by the discriminatory practices of potential employers themselves: “During the interview the operations manager told me that I am qualified and they want me to work for their company. However, I have acne and they require an employee with a PLEASING PERSONALITY as I’m gonna be dealing with customers for ground services. WTF??!!” Stories such as these persist and serve as the catalyst for new research into the perceptions of acne – most often not from those who experience the disease, but those who do not (Dréno et al., 2016; “Research: Misconceptions Lead,” 2016).60 Although such research is encouraging, it is also cause for concern should it continue to unfold in non-intersectional ways. Without acknowledging the multifaceted politics of skin and suffering, psychodermatological subjectivities and the experts who try to understand them risk overlooking the ways acne-based discrimination intersects with other forms of discrimination rooted in the structures of capitalism, racism, ableism, sexism and homophobia.

Experts who write about acne also tend to overlook the psychosomatic significance of labeling and medicating diseased skin. When writing Chapter 6, it quickly became apparent to me that dermosocialities are also formed in and through relations of touch. Human subjects are constantly being bombarded with sensory information that acne communicates through touch; likewise, human subjects know acne by reaching out and touching it. I thus set out to think critically about what was being said in the acts of touch between acne and subject, wondering how this embodied knowledge might also

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60 This turn to study the perceptions of those who do not have acne is reminiscent of the turn in critical race theory to study whiteness. As of yet, acne research of this kind has yet to fully link the perceptions people harbour towards pimpled “others” to a set of material consequences (e.g., salary discrepancies, employment rates, etc.).
give rise to forms of dermosociality. Some dermosocial subjects, I learned, embark on a common journey to regain control of their skin from alien “others” whose presence both threatens and overwhelms the (skin) ego. Self-identified “pickers” or “poppers” are those who attempt to “kill” active pimples through a form of direct touch, whereas other groups attempt to end the lives of pimples using a pharmaceutical touch.\textsuperscript{61} Additionally, my research led me to an organized group of people who identify as “popaholics,” for whom the act of popping (i.e. popping another person’s pimples; having one’s own pimples popped by another person; watching pimples being popped) is a pleasurable and cathected activity. Some forms of dermosociality, I learned, are libidinally assembled.

One of the immediate consequences of “popaholic” organizing is that it seems to have encouraged a kind of public confession from those who might enjoy the act of popping. In \textit{The History of Sexuality}, Foucault (1978) notes the ways this act of confession – indeed, a kind of “confession of the flesh” (p. 19) – is tied to power. The difference in modernity, however, is that confessors do not seek salvation from a priest as much as they aim to be rescued by experts. With communities of popaholics growing bigger and more vocal, it is worth keeping a close eye on the expert knowledges used to discursively construct the act of popping and the resulting effects it has on sexual identities and sexual practices. Another related consequence of libidinal dermosocialities is the effect they seem to have on the electronic skinscape. Digital videos of other skin diseases besides acne are already beginning to surface as part of our electronic skin, enlarging our psychic surface area whilst creating new financial opportunities for doctors.

\textsuperscript{61} Some of these groups have names for themselves, such as “tane buddies.” Tane buddies are those who begin their Accutane journeys together, at roughly the same time, and offer support and advice to one another whilst comparing experiences.
and patients (i.e. as content creators). As these pleasurable forms of touch are increasingly digitized, made visible, and shared as part of a virtual economy of skin disease, it will be interesting to see what effects they have on the future development of skincare therapies, medications and biotechnologies. Will capitalist interests eventually find new ways to commodify and sell what are currently “taboo” forms of touch? Furthermore, might we begin to see those without skin disease desire similar experiences of touch to the ones being represented on screen? I do not have answers to these questions, but leave them here for readers and future researchers to consider.

Contributions and limitations

I believe this critical examination of the practices, knowledges, objects and people that come into contact with acne contributes to an existing body of literature exploring the relationship between skin and self. In their edited collection entitled *Thinking Through the Skin*, Sara Ahmed and Jackie Stacey (2001) write that to think through the skin is to “pose the question of how skin becomes, rather than simply is, meaningful” (p. 1). With this focus in mind, the collection’s contributors are brought to think about a number of different cultural practices through which skin becomes meaningful including tattooing, (Connor, 2001; Salecl, 2001) cutting/self-harming (Kilby, 2001) and pregnancy (Tyler, 2001). My research also suggests that we might want to think about the ways skin becomes meaningful through the scientific and cultural practices of dermatology, psychology, psychodermatology, microbiology and pharmacology. These are practices that not only change the ways people think about skin but also, following Ahmed and Stacey (2001), change the ways people think through skin. Shifting our focus to the ways skin touches and is touched by some of the sciences listed here, might add to a body of
literature that has already begun to untangle the power relations between skin, self and a number of other scientific, medical and (bio)technological actors (Pollock, 2008, 2012; Prosser, 1998; Roberts, 2012; Stacey, 1997; Hurst, 2015).

Similarly, my analysis of acne medications can also be understood to contribute to a growing body of critical research on drug use (Dwyer, 2011; Fraser & Moore, 2011; King et al., 2014; Race, 2009). Scholars writing within this paradigm seek to understand drugs “not as stable substances but rather as complex, fluid, and multiple objects that are continually made and remade as they are “enacted” by drug users, service providers, law enforcement agents, journalists, policymakers, and researchers” (King et al., 2014, p. 251). If anything, there is a great need to understand acne medications and other drugs used in the treatment of skin disease as a complex category of drugs. We tend not to think of these drugs as terribly complicated or powerful agents in comparison to opiates, amphetamines, benzodiazepines, barbiturates or any number of other drugs that affect our central nervous systems, brains, and sense of “self” in far more obvious or perceptible ways. But, as I hope to have demonstrated throughout the course of this research, something as seemingly “benign” as prescription, over-the-counter and household acne drugs have powerful, lasting, painful and pleasurable effects on the psyche. As research on the skin microbiome continues to accelerate along with the multi-billion-dollar skincare industry, there is an urgent need for scholars to carefully consider what it means to both medicate the skin and medicate through the skin.

Lastly, I hope my research highlights the need for further critical, embodied, sociological, historical and anthropological work on skin disease. The last thing I want is for acne to stand in as a substitute for all skin diseases. Acne is unique in that it has its
own biologies, affects, histories, drugs and meanings. I would suggest, then, that critical scholars avoid the temptation to theorize skin diseases abstractly, and instead try to provide rich, descriptive and empirical accounts of specific ones. I say this not to dismiss the work of those offering theories of skin disease, but rather to push those theories in new directions. Much of the theoretical work on skin disease favors psychoanalytic tools of analysis (Anzieu, 1989; Prosser, 2001; Ulnik, 2007). And although these theories offer insight into some diseases, or some aspects of a disease (e.g., acne), the diseases themselves are complicated by the fact that they materialize in particular contexts and through multilayered skins. As skins change, so too must the theories we use to understand them.

Having just argued for the need to contextualize other skin diseases, I also want to be clear in stating that acne warrants further critical attention. I have written a sociology of acne, but only one. It is a partial and situated reading of acne, rooted in my own experiences with the disease as well as some of my theoretical, methodological and political persuasions. I thus want to acknowledge some of the limitations of my research and outline them here in the hopes that they might generate future and critical work on acne.

One of the limitations of this research is that it highlights the need for historical research on acne, but does not adequately begin to address some of those historical concerns. Unfortunately, with the exception of Brumberg’s (1997) research, those attempts to historicize acne tend to focus exclusively on the ways scientists and medical practitioners talk about the disease (Grant, 1951; Tilles, 2014). Missing from these accounts, however, are the voices of those who experience acne and attempt to make
sense of it in their own terms. These are interpretations that need to be included alongside those which can be found in the primary texts of medical and scientific journals, for, as Foucault (1989) reminds us: “medical space can coincide with social space, or, rather, traverse it and wholly penetrate it” (p. 31). To access these firsthand and social accounts of acne, therefore, historians and literary scholars might wish to follow Brumberg (1997) and examine non-expert primary sources (e.g., diaries, magazines, newspapers, oral histories, novels) in order to see how acne was both understood and experienced in other historical and cultural contexts besides 19th and 20th century, middle-class, American homes.

It is also important that histories of acne attempt to think critically about the 18th century rise of dermatology as that which ushered in a new class of skin “experts,” patients and dermatological forms of social control. Joan Brumberg’s (1997) research is, once again, helpful in this regard. Highlighting the ways dermatology emerged out of the field of syphiology, Brumberg effectively argues that pimples acquired a sexualized significance during the Victorian age. If pimples represented sexual derangement, then an emerging dermatological science was involved with the normalization and policing of (un)acceptable sexualities. Racialized violence is also an interwoven part of dermatology’s history. Allen Hornblum’s (1999) research chronicles some of the dermatological experiments that took place in Holmesburg Prison (located in Philadelphia) for over about a thirty-year span beginning in the 1940s and finally ending in 1974. The title of Hornblum’s book, Acres of Skin, was hauntingly inspired by the dermatologist in charge of those experiments, Dr. Albert Kligman: “All I saw before me was acres of skin. It was like a farmer seeing a fertile field for the first time.” Testing
unproven pharmaceuticals on the mostly racialized and vulnerable skins of Holmesburg inmates, Kligman amassed a private fortune somewhat literally on the backs of his test subjects. Moreover, tretinoin (an active ingredient found in most acne medications today) has its roots deeply planted in this violent dermatological history – one that has left physical and mental scars for so many of Holmesburg’s incarcerated. Tracing the historical configurations of dermatological power up to our contemporary moment was outside the scope of my research, but might lead researchers to ask different sorts of questions than those entertained here (e.g., how do pharmaceutical companies produce acne medications, today?). Although I have begun to highlight some of the ways race, class, gender, sexuality, technoscience and capitalism are entangled parts of dermatological science, much more can be said about the historical context in which these relationships are continuously assembled and re-assembled. Moreover, my findings suggest the need to include psychology as part of the history of acne so that we can better understand an important shift in dermatological practice where “the [acne] patient is the rediscovered portrait of the disease; he is the disease itself, with shadow and relief, modulations, nuances, depth; and when describing the disease the doctor must strive to restore this living density” (Foucault, 1973, p. 15). Acne, in other words, might offer interesting insights into the historical conditions underneath which dermatology and psychology co-emerged to produce the contemporary psychodermatological subject.

Another limitation of this research is its methodological reliance on medical experts and the Internet. On one hand, these sources were not limiting at all for the types of research questions I was asking. Many members of acne.org felt comfortable sharing private, rich and intimate details about their disease that might have otherwise been
difficult to access through traditional interviewing techniques. Furthermore, it was important to me that I attempt to locate these members’ experiences – at least partially – in scientific and medical objects, practices and discourses that frequently come into contact with acne. Lost in these methods, however, are the voices of those who neither seek medical interventions or scientific expertise for their acne, nor the advice or emotional support from laypeople. Of course, globalization has made Western biomedical disease categories and pharmaceutical economies accessible to people across the world, but rarely do they simply “erase” a culture’s pre-existing ways of understanding and treating a particular condition. As such, I do not want to assume that acne consigns one to a dermatologically, psychologically, psychodermatologically, microbiologically or pharmacologically medi(c)ated experience of skin, and instead would like to see anthropological research examining the ways “Western” and “non-Western” understandings of acne are negotiated in a globalized context. I would also like to see the ways class shapes, and is shaped by, the experience of acne. The majority of acne.org members were financially secure enough to feel comfortable debating which acne medications to use and what acne experts to listen to. Furthermore, acne’s status as a “dirty” or “unhygienic” disease suggests that class is marked on and through pimpled skin and is that which is being negotiated through biomedical avenues. What, then, does acne mean to those whose class identities might not feel threatened by pimples, or who might be living in poverty and without health insurance? These are people whose experiences might not be best represented through Internet methods.

62 And, as I mention in Chapter 3, I had great difficulty recruiting interviewees to tell me about their experience with acne. Acne.org offers its users a certain level of anonymity, community and support that makes it easier to talk about a disease that some people find too embarrassing to even show in public, let alone talk about in front of a stranger.
Similarly, whiteness was something I was trying to think about as I was analyzing and writing about acne.org, but I do not think Internet methods allowed me to explore whiteness with the kind of depth it deserves.\(^{63}\) Given the nature of the methods, I came to rely on people’s own racial self-identifications. Obviously, this introduces a number of problems for thinking about whiteness because white people tend not to think of themselves as racialized, nor are they coming up against the same sorts of issues that non-white people experience with acne. As such, I had to ask myself the following question: When race goes unsaid, is it fair to assume that person is white? This was a question that weighed heavily on my conscience, particularly in Chapters 5 and 6 where I examine dermatological suffering and the psychosomatic significance of acne. People tended not to racially self-identify when writing about these things in the same way that they did when discussing their interactions with dermatologists or acne medications. Ultimately, I responded to the question by saying “no;” I decided it was not fair to make an assumption about the race of the person talking. Of course, one is always already making those assumptions whether they are reading online texts or meeting a person for an interview, and perhaps I could have brought those assumptions to the reader’s attention and used them as an opportunity to reflect more on the intersections of race and acne. I abstained from doing so, however, because I thought it detracted from what participants were trying

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\(^{63}\) Since finishing this project, a question that I have been asking myself is: Knowing what I know now, how would I approach acne differently as a topic of study? Through my limited reading of dermatological textbooks, interviews with dermatologists, and online methods, I came to realize that the relationship between dermatology and racism requires far greater attention than what I was able to cover in Chapter 4. Focusing on this precise relationship (as it is negotiated in and through the experience of acne) would have led me to ask different research questions, and use different research methods than what I use here.
to say about their embodied experience of acne by focusing, instead, on my interpretations of race (or gender, for that matter) in online space.

One final limitation of this research is that it overlooks the significance that certain bodily regions play in the experience of acne. Critical literature exploring the relationship between the face and subjectivity could have added a number of complex layers to my research, given that the face is so often the bodily “zone” through which acne is perceived. In Ethics and Identity, Emmanuel Levinas (1995) writes:

I wonder if one can speak of a look turned toward the face, for the look is knowledge, perception. I think rather that access to the face is straightforward ethical. You turn yourself toward the Other as toward an object when you see a nose, eyes, a forehead, a chin, and you can describe them. The best way of encountering the Other is not even to notice the color of his eyes! When one observes the color of the eyes one is not in a social relationship with the Other. The relation with the face can surely be dominated by perception, but what is specifically the face is what cannot be reduced to that. (pp. 85-86)

The work of Levinas (1961, 1995) poses a number of ethical questions that were not the focus of my research, but would certainly add to our understanding of acne – or more specifically, the gaze that directs itself towards acne, observes it and fixates upon it. In his reading of Levinas, Burggraeve (1999) succinctly summarizes: “By its “countenance,” its visibility, the face challenges my self-interested effort of existing to imprison the other there, in what I see, or, to invoke a play of words, the other who is seen, “is seen”” (p. 31; emphasis in original). We might ask, then, how acne adds to the vulnerability, nudity and visibility of the face and thus brings about an added risk of
violence? My own research questions led me to embrace theories of skin that include, but do not end with the ways skin is seen and perceived in our field of vision. Future acne research could look to better incorporate critical writing about the face and thus bring to light a series of different but related questions about the intersubjective power relations of pimpled skin.

_Towards the dermatologization of life_

Biopolitics is a word that scholars have used to mark an important shift in the workings of power and governance, beginning around the eighteenth century. As Foucault described, this shift was marked by a move away from a sovereign type of power that exerted its control by coercive force (i.e. by either “allowing life or giving death” (Rose, 2001, p. 1), towards a type of productive power that saw life itself as the object of control. From such a perspective, the well-being and general health of the population became major points of emphasis for the state, making the biological existence of human subjects a central organizing feature of political and social relations. Scholars such as Nikolas Rose (2001) have gone on to argue:

Biopolitics was inextricably bound up with the rise of the life sciences, the human sciences [and] clinical medicine. It has given birth to techniques, technologies, experts and apparatuses for the care and administration of the life of each and all, from town planning to health services. And it has given a kind of ‘vitalist’ character to the existence of individuals as political subjects. (p. 1)

As Rose and others have noted, contemporary biopolitics often proceed through the molecularization and geneticization of life. Awakened or “brought to life” by

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64 This question becomes even more interesting if we consider the cultural context in which the face is being rendered visible by new surveillant technologies (e.g., smart phones, selfies, Facebook, facial recognition software, etc.) and racist-sexist fears (e.g., proposed legislation to prevent Muslim women from wearing a niqab or burqa in public) (Razack, 2016).
unprecedented developments in technoscience, molecules and chromosomes are made into visible, knowable, mutable and valuable bits of matter. For good reason, then, scholars in the social sciences and humanities have been drawn to understand life at a microscopic level, precisely because such life appears plastic and artificial in our contemporary moment. In other words, biomedicine and biotechnology are giving the “natural” body a makeover, such that it has become impossible to speak about the body’s “natural” biology without also acknowledging the ways that same biology is engineered, bought, sold, resourced and exchanged on the market.

Although molecules and chromosomes play integral roles in our biopolitical moment, they are not the only biological matter through which relations of power unfold. For many scholars of biopolitics, life appears increasingly microscopic and out of arm’s reach without some form of biotechnological or medical intervention to permeate the body’s surface and adjust what that body is like from the inside. But if we direct our critical attention to the skin, we are also struck by the perceptibility of life on the outside of the body. Psychodermatological discourses, for example, render the psychic life of the subject visible in the form of pimples, lesions and scars that adorn the skin. It is there, atop the surface of the body, that the life of the mind can be newly seen, managed, treated, touched and cared for by any number of people besides dermatological and psychological experts.

Microbiological discourses also help us visualize, imagine, and experience the skin’s liveliness. I can remember watching an old NOVA/PBS (1996) documentary titled The Odyssey of Life: The Ultimate Journey as a child, and seeing microscopic videos of the tiny living creatures that called my skin home. Speaking over the image of wiggling,
squirming hair-follicle mites, the narrator of the film reassures the viewer that they are “small enough to escape the attention of our nerve cells…otherwise we wouldn’t stop scratching.” Almost immediately, however, he makes a point that I find particularly interesting: “Just knowing they exist is bad enough.” With the recent explosion of research into the skin microbiome, we know more about the existence of such life than ever before. What makes that knowledge “bad enough,” is that it undermines the very symbolic borders upon which self and other are established. We are reminded of the fact that our skin is an entire world unto itself; an ecology where thousands of tiny microorganisms co-habitate, burrow, live and die; and a valuable food source to entire populations of species. One gets the urge to scratch just thinking about it. What, then, will be the role of dermatology as we struggle to come to terms with the uncomfortable knowledge that our skins are crawling and teeming with microbiological life?

Lastly, health discourses also play a central role in bringing life to the surface of the body. The skincare industry is proof of this fact, as it continues to grow into a multi-billion-dollar juggernaut featuring a seemingly endless supply of creams, moisturizers, soaps, ointments, technologies, cosmetics and fabrics designed to create a healthy skin and healthy mind. As clear skin becomes synonymous with “good” health, it also becomes increasingly packaged and sold in the form of products that promise to eliminate “bad” dermatological actors. Indeed, skin figures centrally in our contemporary understanding and experience of health, and many private interests are investing significant sums of money into this marriage. In fact, the conflation of health and skin has led to a demand for dermatological services that exceeds the supply of available dermatologists in many parts of North America. Out of this problem has emerged a new
system of health care referred to as “telemedicine.” Users download apps to their smart phones (e.g., PocketDerm; YoDerm) and send selfies to registered dermatologists, who can then diagnose the skin disease and send electronic prescriptions. Charging users a subscription fee, the apps seem to be about making dermatological services more expedient, efficient and profitable as opposed to accessible. Moreover, it remains to be seen whether telemedicine has any other practical applications to other types of healthcare besides dermatological practice.

Scientific and cultural fascination with the skin is, of course, a longstanding feature of imperialist and white supremacist thought. But I hope my research has shed some light on the ways that preoccupations with the biology of racial subjects has also grown to include the biology of dermatological subjects. This historical shift can be understood as the dermatologization of life, and I believe skin diseases provide sociologists with the necessary empirical grounds to further explore the complexities and contradictions of dermatologized relations. As my research suggests: medical professionals, scientists and patients are not only experimenting with new ways to know and manage life through skin, but they are also experimenting with new ways to experience life as skin.
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Appendix A: Fitzpatrick Scale

Fitzpatrick Skin Type

The most commonly used scheme to classify a person’s skin type by their response to sun exposure in terms of the degree of burning and tanning was developed by Thomas B. Fitzpatrick*, MD, PhD. Examples are given below.


<table>
<thead>
<tr>
<th>Eye colour</th>
<th>Do you turn brown?</th>
<th>Score</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Light colours</td>
<td>0. Never</td>
<td>0–6</td>
<td>Skin Type I</td>
</tr>
<tr>
<td>1. Blue, gray or green</td>
<td>1. Seldom</td>
<td></td>
<td>Always burns, never tans (pale white skin)</td>
</tr>
<tr>
<td>2. Dark</td>
<td>2. Sometimes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Black</td>
<td>4. Always</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Natural hair colour</th>
<th>How brown do you get?</th>
<th>Score</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Sandy red</td>
<td>0. Never</td>
<td>7–13</td>
<td>Skin Type II</td>
</tr>
<tr>
<td>1. Blond</td>
<td>1. Light tan</td>
<td></td>
<td>Always burns easily, tans minimally (white skin)</td>
</tr>
<tr>
<td>2. Chestnut or dark blond</td>
<td>2. Medium tan</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Your skin colour (unexposed areas)</th>
<th>Is your face sensitive to the sun?</th>
<th>Score</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Reddish</td>
<td>0. Very sensitive</td>
<td>21–27</td>
<td>Skin Type IV</td>
</tr>
<tr>
<td>1. Pale</td>
<td>1. Sensitive</td>
<td></td>
<td>Bums minimally, always tans well (moderate brown skin)</td>
</tr>
<tr>
<td>2. Beige or olive</td>
<td>2. Sometimes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Dark brown</td>
<td>4. Never have a problem</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Freckles (unexposed areas)</th>
<th>How often do you tan?</th>
<th>Score</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Many</td>
<td>0. Never</td>
<td>28–34</td>
<td>Skin Type V</td>
</tr>
<tr>
<td>1. Several</td>
<td>1. Seldom</td>
<td></td>
<td>Rarely burns, tans profusely (dark brown skin)</td>
</tr>
<tr>
<td>2. Few</td>
<td>2. Sometimes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Rare</td>
<td>3. Often</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. None</td>
<td>4. Always</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you stay in the sun too long?</th>
<th>When was your last tan?</th>
<th>Score</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Painful blisters, peeling</td>
<td>0. +3 months ago</td>
<td>35+</td>
<td>Skin Type VI</td>
</tr>
<tr>
<td>1. Mild blisters, peeling</td>
<td>1. 2–3 months ago</td>
<td></td>
<td>Never burns (deeply pigmented dark brown to black skin)</td>
</tr>
<tr>
<td>2. Burn, mild peeling</td>
<td>2. 1–2 months ago</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Rare</td>
<td>3. Weeks ago</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. No burning</td>
<td>4. Days</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix B: Kashechewan Social Media Images

This is my niece she got a cold now and oxygen level is low due to from her heart valves repairs I guess. But I'm bringing my brother and his wife out since no one couldn't help. I'm not trying to make anyone look bad even the nurses or council, just concerned about my niece. Peace out. Forgive me if I offend anyone.

This is our drinking tap water that's our infants, children, adults, and elders drink and bath and shower with daily.
Appendix C: Face Mapping

TEMPLES/ EYEBROWS
- Poor circulation
- Gallbladder problems
- High-fat diet
- Drinking too much alcohol

What to do
- Reduce alcohol intake.
- Skip processed foods.

NOSE
- Poor diet
- Constipation
- Bloating
- Indigestion
- Poor blood circulation

What to do
- Eat less spicy food.
- Avoid late-night eating.
- Reduce salt intake.

MOUTH
- Constipation
- Spicy and fried foods
- Some toothpastes

What to do
- Eat fibre-rich food.
- Try changing your toothpaste.

FOREHEAD
- Digestive problems
- Liver issues
- Stress
- Irregular sleep
- Poor diet

What to do
- Drink lots of water.
- Eliminate foods with high sugar and fats.
- Exercise. Find a hobby to relieve stress.

CHEEKS
- Lungs
- Liver issues
- Stress
- Overeating
- Stomach

What to do
- Change pillow covers.
- Avoid using cheap cosmetics.

CHIN
- Hormonal problems
- Gynecological issues
- Kidney-related imbalances

What to do
- Adopt healthy eating habits.
- Do plenty of exercise.

EARS
- Kidney-related issues

What to do
- Drink lots of water and green tea.

Source: http://www.jabong.com/juicestyle/magazine/acne-face-mapping/