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Talking about sunbed tanning: Social representations and identity-work

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ABSTRACT

Rationale: Despite the publicised health risks associated with its usage, sunbed tanning remains popular in many Western countries. Previous research indicates that knowledge of the harmful effects does not necessarily lead to a reduction in sunbed use.
Objective: The aim of this study was to develop a more extensive social psychological understanding of sunbed use, in the United Kingdom, by exploring the social representations of sunbed tanning held by both those who use and who have never used sunbeds.
Method: Semi-structured interviews were conducted with 15 sunbed users and 10 who had never used a sunbed.
Results: A thematic analysis identified two dimensions in the social representations of both the users and non-users; these were concerned with a) health and b) beauty. However, whereas non-users emphasised the health risks, users downplayed and minimised them, instead emphasising the health benefits. Similarly, whereas non-users emphasised the negative aspects of excessive concern with beauty, sunbed users challenged and distanced themselves from this negativity. Sunbed users were engaged in a form of identity-work to protect themselves from the wider negativity and disapproval of which they were aware.
Conclusion: Theoretically, social representations theory has provided a unique lens through which to explore this topic, highlighting the importance of taking into consideration the wider environment in which sunbed use takes place. Preliminary practical suggestions include that health workers should consider identity-work when designing interventions aimed at reducing sunbed use. Findings also suggest that, rather than continuing to educate sunbed users about the risks, campaigns and interventions should challenge the commonly drawn upon arguments about the health benefits. These benefits emerged as a particularly powerful discursive tool for the sunbed users in helping to justify their behaviour, but also to counteract negative stereotypes and assumptions they knew others held of them.
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Sunbed use, which involves artificial exposure to ultra-violet radiation (UVR), poses serious, potentially fatal health consequences associated with both malignant and non-malignant melanoma skin cancer (World Health Organisation (WHO), 2016a). Skin cancer is a significant problem globally, representing one in every three cancers diagnosed worldwide (WHO, 2016b). In the United Kingdom (UK) alone, more than 100,000 cases of non-malignant melanoma and around 3000 new cases of malignant melanoma are diagnosed annually (National Health Service (NHS) Choices, 2016a, 2016b). In terms of the specific link between sunbeds and skin cancer, sunbeds have been estimated to cause over 100 skin cancer deaths annually in the UK (Diffey, 2003) and be responsible for causing 440 malignant melanomas (Boniol et al., 2012), the deadliest form of skin cancer. A meta-analysis conducted by the International Agency for Research on Cancer (IARC) in 2006 concluded that the relative risk of developing malignant melanoma increased by 75% for those who used a sunbed for the first time before 35 years of age (El Ghissassi et al., 2009). As well as the potentially fatal skin cancer risk, sunbed use poses problems for an individual's appearance, both short term (skin burning) and long term (premature ageing) (Sinclair, 2003).

Sunbed use has increasingly come under scientific and public scrutiny and attracted considerable negative media attention;

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newspaper and magazine articles, for example, have frequently communicated the health dangers (Taylor, 2016). Despite increased communication of the risks, people continue to use sunbeds. In the UK, estimates indicate that around 7% of the adult population use them (Diffey, 2003). Public promotion of the dangers conflicts with the positive image of a tan as attractive and healthy, which arguably remains embedded within contemporary Western culture (Hunt et al., 2012). At the same time, the sunbed industry promotes claims regarding the specific health benefits of sunbed use by, including, for example, that using a sunbed can offer a protective 'base' tan, increase levels of Vitamin D, and offer treatment for skin conditions such as acne, eczema and psoriasis (The Sunbed Association UK, n.d.).

Numerous studies have found that, compared to those who do not use sunbeds and former users, sunbed users are relatively aware or more aware of both the skin cancer risk and the risk to appearance (e.g., Monfrecola et al., 2000; Knight et al., 2002; Schneider et al., 2009). A range of motivations for sunbed use have been identified, with appearance (e.g., Borner et al., 2009) and mood enhancement (e.g., Mawn and Fleischer, 1993) the most commonly cited. Social Cognition Models (SCMs), such as the Theory of Planned Behaviour (TPB) (Ajzen, 1991), have been used to explain and/or predict sunbed use (e.g., Dodd et al., 2012), assuming that behaviour can be explained by behavioural intentions, attitudes, perceived behavioural control and subjective norms (Ajzen, 1991). However, the inadequacies of the TPB, and other similar SCMs of health behaviour, have attracted increasing criticism (e.g., Mielewczyk and Willig, 2007; Sniehotta et al., 2014), partly because of their predictive assumptions; behaviour change is determined by an increased knowledge of the dangers associated with that behaviour (Conner and Norman, 2005).

Existing survey and qualitative research has shown that while acknowledging the risks, sunbed users rationalise and justify the dangers in different ways by, for example, expressing a fatalistic viewpoint and referring to the ubiquity of risk in everyday life (e.g., Murray and Turner, 2004; Banerjee et al., 2012; Lake et al., 2014). Other responses include describing the risks as a currently intangible concern and only significant if used excessively (e.g., Vannini and McCright, 2004; Carcioppolo et al., 2014). Health benefits, including obtaining optimum vitamin D levels and improving skin conditions, have also been mentioned in interviews with sunbed users (e.g., Murray and Turner, 2004; Lake et al., 2014).

One key criticism levelled at the application of SCMs to health risk behaviours is the limited reference to the wider socio-cultural context within which health practices occur (Murray, 2014). Furthermore, SCMs do not sufficiently account for the potentially powerful role of people's emotions (Joffe, 2002). While SCMs such as the TPB make reference to social influences in terms of subjective norms, focus remains on the individual, with the social confined to an individual's perceptions of the thoughts and ideas of others, as opposed to actually exploring the character of these thoughts and ideas (Joffe, 1996). The focus is on micro-level social influences, ignoring the broader socio-cultural backdrop within which individual thinking occurs (Joffe, 1996).

Despite the insight offered by existing survey and qualitative research, we argue that the broader socio-cultural context in which individual sunbed use is positioned has not been sufficiently considered. Previous qualitative research, for example, has typically conducted interviews or focus groups solely with a sample of sunbed users. Given the wider tensions between risks and benefits, it is important to position sunbed users within their wider socio-cultural environment. One way of doing this would be to explore the sunbed-related attitudes and behaviour of those who use sunbeds as well as those who do not. Boynton and Oxlad (2011) conducted focus groups with both sunbed and non-sunbed users but did not attempt to theorise the relationship between the two perspectives. Chamberlain (2000) has argued that descriptive, atheoretical qualitative research runs the risk of isolating people from their wider socio-cultural context similarly to quantitative research.

Social representations theory (SRT), a social psychological framework, offers a unique, alternative approach to exploring the topic of sunbed use. SRT is concerned with the everyday symbolic world of the lay person, and is used to explore the complexity of the shared 'common sense' understandings (social representations) that permeate the thoughts, feelings and behaviour of lay people within their specific social contexts (Joffe, 1999). Social representations have specific functions: They provide groups with ways of understanding and making sense of issues and phenomena that surround them, as well as communicating about them (Moscovici, 1973). One central tenet of SRT is that individual thinking and behaviour takes place within a wider socio-cultural environment in which social representations are already circulating (Joffe, 1996). SRT is thus particularly concerned with interactions between this wider environment and the individual; in "how the 'we' becomes sedimented in the 'I'" (Joffe, 1999, p. 91). Methodologically, individual thinking must be explored in conjunction with representations circulating in the wider environment (Jovchelovitch, 2007). In this study, we explored the individual thinking of the sunbed users in conjunction with representations of sunbed use held by those who do not use sunbeds.

Social representations have value connotations which can have implications for the individuals involved. It has been argued, for example, that negative and stigmatising representations can "damage identities, lower self-esteem, and limit the possibilities of agency" (Howarth, 2007, p. 133). Howarth (2002) conducted focus groups with teenagers from Brixton to explore the social psychological consequences of living somewhere which is stigmatised and surrounded by negativity. As well as limiting the social and employment opportunities of these young people, Howarth (2002) described how knowledge of the negativity and stigma contributed to a 'spoiled identity' (Goffman, 2009), which refers to the negative consequences of stigma for those being stigmatised. Sunbed use is something similarly surrounded by negativity, given the associated risks. Farrimond and Joffe (2006) have demonstrated how smokers were aware of the negative aesthetic and experienced the social disapproval that non-smokers associated with their social group, which had significant negative consequences for some smokers, who reported hiding their smoking from friends and family through fear of automatically being stereotyped (Farrimond and Joffe, 2006).

Rather than just passively accepting representations that circulate around them, people can actively engage with them in line with their own identity positioning (Joffe, 2003). Emotional and identity-related factors, for example, influence how people engage with ideas circulating in the wider socio-cultural context (Joffe, 1996). For example, people may cope with negative representations others have of them by drawing upon alternative, challenging representations that have particular identity-protective functions (Joffe, 2002). In doing so, they can 'manage' and resist the negativity they encounter. As Joffe (1995, p. 7) argued: "Blame, stigma and a consequent spoiled identity are not fixed and uncontested. On the contrary, they are marked by unconscious and conscious forms of resistance." Joffe has frequently drawn upon the 'not me' 'not my group' phenomenon to explain how and why social representations might be used to protect identity by projecting the risk elsewhere (e.g., Joffe and Haarhoff, 2002). In the specific context of health behaviours, Trocki et al. (2013) revealed how many of their participants separated their own acceptable alcohol and drug use from the unacceptable behaviour of others. According to Joffe (2003), the

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