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Skin Color as Health Pathology: The Implications of Eurocentrism for Social Work Practice and Education

Abstract

People of color live shorter lives than those of European descent and they are more likely to encounter significant health risk. As pertains to skin color cardio disease, hypertension, depression and skin bleaching suggest that the current level of study involving skin color as health pathology is acutely insufficient. That insufficiency relative to health pathology is sustained by intellectual influences of Eurocentrism. Eurocentrism manifests as a tendency to interpret and prioritize the world in Western terms, values and experiences. That is all matters including disease which pertain to other than a Eurocentric existence are by irrelevance determined to be non-existent. If Social Work health practitioners in the U.S. are to understand people of color, understanding the implications of skin color for their overall health and well-being will be imperative to the assessment and ultimate resolution of their presenting problems.

Skin Color as Health Pathology: The Implications of Eurocentrism for Social Work Practice and Education

Introduction

According to W.E.B. DuBois (2005), the American Dilemma is the dilemma of the color line. That assertion is equally apparent some sixty years later today. But as Stember (1976) notes the issue of skin color has never been acknowledged, merely construed as an inappropriate topic for polite conversation. As Hall (1994) notes the issue of skin color as health pathology among people of color i.e.: including African- and Latino-American is even less amenable to public scrutiny. After-all, as victims it would hardly serve the efforts of equality for people of color to acknowledge some role in the pathologies of skin color for themselves.

According to James Baldwin, the root of American difficulty is directly related to skin color (Hall, 1996). This would contradict much of the rhetoric of race. Furthermore as Bonilla-Silva (2006) notes the issue of skin color has never been subjected to rigorous debate. Said lack of

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rigor is apparent in a cursory review of the Social Work literature which attests to the trivialization of skin color as health pathology notwithstanding its salience among people of color.

According to the *Social Work Abstracts* database 1977-2001 twelve articles have been published on "skin color" in twenty-four years. In leading Social Work journals, skin color has been totally ignored in said time period accommodating the perpetuation of skin color as health pathology. In leading textbooks the issue of skin color as pertains to people of color is omitted from the index and the considerable pages of lexis which comprises the texts in toto (Robbins, Chatterjee & Canda, 2006). While Social Work authors may be cognizant of critical health issues, as scholars it is they who determine the priority of what reaches publication. The information disseminated then determines for people of color their existential realities in Social Work practice. What is omitted otherwise ceases to exist. The fact that mainstream Social Work authors of health content are typically of European descent cannot be dismissed as irrelevant to their Eurocentric perspective. Given the circumstances said omissions are tantamount to the most blatant distortion of facts: hence the facilitation of skin color as health pathology via Eurocentrism and Social Work practice (Dussel, 2009).

The objective of this paper is to inform. It will offer the Social Work readership and interested social science scholars insight to some of the health challenges which continue to prevail as pathological to people of color. It will reveal the role of Eurocentrism in sustaining such pathologies and accommodate an understanding of what people of color encounter as a consequence of Eurocentrism. Attention to skin color is also designed to enhance understanding of the unique blend of cultural experiences and behavioral dynamics involving non-European populations at-large—in particular those who reside in the U.S. This paper will also provide a framework for objectively differentiating the life experiences encountered by people of color otherwise irrelevant to their physical and psychological well-being. The aftermath will enable Social Work health practitioners to accommodate an environment for understanding, acceptance, and sensitivity to the stresses encountered by non-European peoples by adding insight to their unique circumstances in this the post-colonial era.

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67 *Skin Color as Health Pathology*

68 Medical research has established the fact that people of color live shorter lives than those
69 of European descent and they are more likely to encounter significant health risks (MDPH, 1995;
70 Bulanda & Zhang, 2009). For various reasons health care professionals including Social Workers
71 have yet to list stress by skin color as a cause of death. However some health care professionals
72 are beginning to acknowledge stress extended from skin color as a health hazard on par with
73 smoking and a high-fat diet (Staples, 1999). Among the day-to-day manifestations of stress that
74 affects people of color in particular are those racist acts committed by various branches of law
75 enforcement. What's more the health implications of racism, relative to law enforcement, among
76 people of color are largely invisible to other than people of color. Among the Eurocentric
77 mainstream the complaints of such persons are seen as a function of what author Norman
78 Podhoretz once described as "paranoid touchiness" (Staples, 1999). But numerous police
79 assaults—some fatal—forms a distinct contrast between perception and reality (Fried, 1999).

80 In 2007 Borrell, Crespo and Garcia-Palmieri conducted an investigation to determine the
81 association between skin color and cardiovascular disease. They were interested in mortality risks
82 prior to and following adjustment for selected variables. Their subject population consisted of
83 data from 5,304 men which included a measure on skin color from exam number three of the
84 Puerto Rico Heart Health program (PRHHP). The objective of this secondary data was a
85 longitudinal study involving the incidence of cardiovascular disease in Puerto Rican men. The
86 mortality of men in the study was gleaned from hospital and doctor's records, postmortem
87 records, death certificates, and subjective data from family members. The results indicated that
88 dark-skinned Puerto Rican men displayed higher age-adjusted mortality rates than did light-
89 skinned Puerto Rican men (10.1 vs. 8.8/10,000 population). While there did not exist an
90 association between skin color and cardiovascular mortality there was an association between
91 skin color and area of residence (p for interaction = 0.05). Of Puerto Rican men residing in urban
92 locations, the risk of cardiovascular disease was 28% (95% confidence interval, 1.02–1.61)
93 greater among dark-skinned Puerto Rican men when compared to their light-skinned

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94 counterparts. This was so following adjustment for age, education, BMI, physical activity, and
95 whether or not there existed a history of diabetes. Ultimately such findings suggest that skin
96 color via environmental dynamics is not irrelevant to mortality risk among Puerto Rican men and
97 as a little acknowledged variable in health pathology (Borrell, Crespo & Garcia-Palmieri, 2007).

98 Earlier cardio studies in Puerto Rico document similar conclusions to those found by
99 Borrell, Crespo and Garcia-Palmieri in 2007. In the analysis of skin color 3,366 Puerto Rican men
100 residing in urban areas took part in a similar investigation. Said investigation was an
101 epidemiologic study of coronary heart disease. All participants were thoroughly examined for
102 measures of blood pressure, relative weight, physical activity, cigarette smoking, left ventricular
103 hypertrophy (as determined by ECG), and lastly for measurements of skin-fold thickness.
104 Subjects were studied relative to mortality for six years. Results indicated that dark-skinned
105 Puerto Rican men displayed a higher incidence of both definite and possible LVH-ECG. This was
106 so following stratification levels for hypertension, relative weight, physical activity, number of
107 cigarettes smoked, and skin-fold thickness. Furthermore subsequent to multivariate adjustment
108 of the aforementioned factors, dark-skinned Puerto Rican men suffered approximately twice the
109 level of both definite and possible LVH-ECG when compared to their lighter-skinned counterparts.
110 Ultimately the risk incurred by dark-skinned Puerto Rican men was significantly higher than that
111 encountered by the light-skinned (Sorlie, Garcia-Palmieri & Costas, 1988).

112 Other investigations conducted in Puerto Rico during the same time period was
113 administered by Costas, Garcia-Palmioeri, Sorlie and Hertzmark in 1981. An attempt was made to
114 determine the association of skin color with coronary heart disease. The suspected risk factors
115 were analyzed using a sample of 4,000 urban residing Puerto Rican men. To get a consistently
116 accurate measure of skin color the subject's inner upper arm was measured relative to the von
117 Luschan color tiles scale. By way of this scale subjects were separated into a dark- and light-
118 skinned group. As expected, members of the dark-skinned group exhibited a lower
119 socioeconomic status as determined by income, education, and occupation levels. They also
120 maintained a slight but significant higher mean of systolic blood pressure measures. Their mean

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121 serum cholesterol levels were lower but, the relative weights and cigarette smoking habits for
122 both the light- and dark-skinned participants was similar. In controlling for disparities and socio-
123 economic status between the groups a statistically significant association with blood pressure was
124 substantiated (Costas, Garcia-Palmioeri, Sorlie & Hertzmark, 1981). This substantiation is
125 precedent of another health pathology via skin color: hypertension.

126 The racial heritage of Puerto Ricans and African-Americans differ significantly. However
127 skin color may pose similar health consequences between those light- and darker-skinned
128 regardless of ethnic group. Relative to racism skin color was assessed as a marker for handling
129 anger pertaining to experiences of racial discrimination and other forms of subjugation.
130 Participants included a sample of both African-American men and women totaling 1,844. All were
131 between the ages of 24 to 42 years old. Such demographic data was collected at two intervals of
132 1990-1991 and 1992-1993. Said data collection was a part of the Coronary Artery Risk
133 Development in Young Adults (CARDIA) study. The results indicated a moderate association
134 between darker skin and the following: being working class and having low income or low
135 education. There was also an association between internalizing anger and passively reacting to
136 discrimination as a fact of life (Krieger, Sidney & Coakley, 1998).

137 The medical measure of blood pressure is determined by the exertion of human blood as
138 the heart forces it through the body's arteries. One way in which blood pressure can rise is
139 caused by constriction of the arteries. The sympathetic branch of the autonomic nervous system
140 is stimulated and, stimulation leads to contraction of the muscles of the arterial walls (Mosby,
141 1998). In the case of humans, the skeletal muscle, and the heart muscles receive increased
142 supplies of blood which is vital when in the midst of a crisis situation. When the crisis is resolved,
143 the muscles inform the nervous system to decrease blood supply. Then blood pressure returns to
144 normal. The situation is arguably different for people of color. Seldom is there a crisis that would
145 call for instant increase in muscular effort. But the fact that the lives of people of color are filled
146 with any number of stressful racist situations mimics a state of permanent crisis. But the human
147 autonomic nervous system is not equipped with logistical apparatus. And so given the prevalence

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148 of racism, the blood pressure of people of color, without intervention, may remain constantly
149 high, some more than others, but all to some extent (Mosby, 1998). As a result, blood pressure is
150 sustained at abnormally high levels, creating unnecessary health risks, which correlates directly
151 with having dark skin. That increase in melanin (skin color) correlates with increase in
152 hypertension rates among African-American and other dark-skinned people of color. Conversely
153 decrease in melanin correlates with decrease in hypertension rates among the same groups.

154 In severe cases, sustained autonomic exertion eventually takes its toll upon health.
155 Contributing factors include a gradual thickening of the arterial muscle walls. This, together with
156 an increased sensitivity to stimulation, makes these wall muscles overreact to normal neural
157 impulses. As a result, the wall muscles of people of color are in an almost constant state of
158 constriction (Beckett, 1983). The more constricted the walls, the thicker and more sensitive they
159 become. The end effect of this thickening cycle is hypertension. Symptoms of hypertension
160 include headaches and dizziness. If serious and prolonged, the disease may cause lesions in the
161 arteries that supply the kidneys, the brain, and the heart. This may result in eventual kidney
162 failure, cerebral stroke, coronary disease, and heart attacks (Lipowski, 1975).

163 Hypertension is a by-product of sustained sympathetic arousal (Barst, 2008). Thus,
164 people of color would expect its incidence to go up with increasing amounts of social condition
165 stress. This is indeed the case as a matter of historical fact. For example, there was a marked
166 increase in the incidence of hypertension among the inhabitants of Leningrad after the siege and
167 bombardment of that city during World War II (Henry & Cassel, 1969). Similar effects can be
168 produced by the socioeconomic stress extended from the social conditions people of color
169 encounter. Thus, hypertension is much more common among people of color being poorer as a
170 group than their mainstream racial counterparts; and it is especially prevalent in inner-cities
171 marked by high population density, poverty, and crime (Lipowski, 1975). The end results will
172 frequently manifest as various forms of coronary disease not irrelevant to psychological health as
173 well.

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174 Codina and Montalvo (1992) provide rigorous scientific evidence of the links between skin
175 color and the disease of depression i.e.: psychological well-being. In reporting their data is
176 illustrated the means for phenotype, socioeconomic status (SES), language proficiency, and
177 depression indicators separately by the four gender and nativity groups. Said calculations were
178 accommodated by an analysis of variance (ANOVA) which was based upon the preceding
179 variables as per gender and nativity. The results suggest apparent differences existent between
180 the groups. As pertains to the depression index, Latino men appeared to be less often depressed
181 than did women, U.S. born less than Mexican born. The U.S. born men were the least depressed
182 and the Mexican-born women the most depressed. What's more men were somewhat darker-
183 skinned than women which may have been the result of working conditions. There were no
184 nativity differences.

185 Illustrated by the same data were the unstandardized and standardized coefficients for
186 depression which were regressed by phenotype, education, family income, and English and
187 Spanish language skills. The calculated regressions were executed individually for men and
188 women by nativity. As was expected dark skin was significantly correspondent to decreased
189 mental health and/or depression as relates to psychological disease for men born in the U.S.
190 Ironically skin color was not associated with depression for women born in the U.S. or
191 Mexican-born males. Not anticipated was the fact that darker skin was significantly associated
192 with psychological well-being among Mexican-born women.

193 Finally when controlling for family income, educational attainment did not appear to be
194 relevant to mental health. More family income correlated to less depression for all gender and
195 nativity categories. While English language skills did appear relative to psychological health,
196 decreased Spanish language skills were significantly correlated to more depression among U.S.
197 born men and women. Thus percentages of variance calculated by the regression formulas
198 (ranging from .03 to .09) are frequent when assessing the associations between structural
199 factors and psychological health. It is apparent that mental health indicators tend to be more
200 receptive to individual psychosocial measures than environmental (1992).

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201 The results of the Codina Montalvo (1992) investigation reinforced the phenotype and
202 acculturation hypotheses considering that the mental health of dark-skinned Chicano males born
203 and raised in the U.S. was more susceptible to depression. This was so based upon their
204 lightness or darkness in skin color. The darker the skin, the more often subjects reported feeling
205 depressed regardless of levels of education, family income, and their language skills in Spanish or
206 English. The relationship was significant and believed to be a product of the greater exposure of
207 darker-skinned Chicanos to more frequent discrimination and thus decreased life chances. Light-
208 skinned, more European looking Latino males were much more fortunate arguably attributed to
209 their better quality of life and less subjection to the stresses of discrimination.
210 Dark-skinned people of color worldwide suffer similarly to those in the U.S. and its
211 territories despite living in countries where they are the majority. In Africa skin color as health
212 pathology is manifested via skin bleaching among dark-skinned people who desire idealized light
213 skin. In more extreme reactions to skin bleaching African women incur increased risks to their
214 health leading to the disruption of organ performance. "There is suspicion of an increased risk of
215 renal failure as a result of the mercury contained in some of the products that people use for
216 bleaching," according to African Dr. Doe (Opala, 2001). Unfortunately too many women who
217 bleach do not seek medical help until it's too late. This has spurred an effort on the part of
218 doctors to promote public service announcements in hopes of educating the public to the dangers
219 of bleaching. As per Maama Adwoa she has encountered the "stop bleaching" announcements in
220 the media. "They say we should stop bleaching because of skin cancer and skin disease. But
221 people don't want to listen because they don't know …" (Opala, 2001). In the end they develop
222 such bad skin problems that they can no longer go out into the sun without risking more
223 problems. The extent of such persons in Africa is becoming so widespread that some of the
224 governments are beginning to exercise caution. For example in Gambia, the government has
225 decided to outlaw all skin-bleaching products including Bu-Tone, Madonna Cream, Glo-Tone, and
226 the American-made Ambi. They decided to be lenient on those caught with bleached skin.
227 Furthermore officials in Europe have also begun to take issue with the practice as Denmark has

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228 also banned skin bleaching creams and soaps. Officials there have traveled to a number of local
229 African shops and gathered up the products. Unfortunately, Tura, which is a product outlawed by
230 Danes is still popular in Ghana and other African countries. While the business community may
231 find these actions extreme, doctors concur that they're not without reason (Opala, 2001).
232 Subsequently, as pertains to skin color the aforementioned results of cardio disease,
233 hypertension, depression and skin bleaching in toto suggest that the current level of study in
234 Social Work involving skin color as health pathology is acutely insufficient.

235 *Eurocentrism*

236 The acutely insufficient study of the aforementioned health pathology is sustained by
237 intellectual influences of Eurocentrism. Eurocentrism in the U.S. is an extension of Western
238 colonization. Western colonization is a form of racism according to Banton (2000) which, refers to
239 the efforts of a dominant race group to exclude a dominated race group from sharing in the
240 material and symbolic rewards of status and power. Western colonization of subjugated groups
241 including people of color is extremely stressful and differs from various other forms of racism in
242 that subjugation is contingent upon observable and implicit physiological traits such as skin color
243 (Hall, 2006). By skin color i.e.: dark is implied the inherent superiority of dominant race groups,
244 which in the post-colonial era induces health pathologies by virtue of solipsism as a natural order
245 of the biological universe.

246 Eurocentric frames of reference in the post-colonial era are pathological as pertains to
247 the physiological and psychological health status of people of color. Exacerbating the problem is
248 the fact that Eurocentrism defines pathology content relative to dominant group proximity. In an
249 effort to serve objectivity the definition of Eurocentrism may be determined by consultation of
250 the most recent scholarly literature. As per Kanth's (2009) *The Challenge of Eurocentrism,*
251 Eurocentrism is a worldview grounded in a European perspective that manifests as a tendency to
252 interpret and prioritize the world in Western terms, values and experiences. That is all matters
253 including disease which pertain to other than a Eurocentric existence are by irrelevance
254 determined to be non-existent. Therefore the relative unknown existence of skin color as health

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255 pathology among people of color may prevail despite its contrast with existential realities in non-
256 European communities. Thus the conscientious Social Work professional must challenge the
257 Eurocentric paradigm, which has without necessarily intending trivialized a critical aspect of
258 health pathology as pertains to people of color (Cox, 2001).

259 Relative to pathology content of the Social Work knowledge base Eurocentrism is a post-
260 colonial perspective that has dominated its literature throughout history of the social sciences
261 (Monteiro, 2000). This otherwise obvious assumption is not the least subject to challenge as
262 indicated by contemporary databases. Between 1965 and 2004 the ensuing topics are prioritized
263 by the volume of peer-reviewed publications via the *Social Work Abstracts* database. The Social
264 Work profession is reviewed as per its professed emphasis upon diversity: AIDS=2,628,
265 Children=20,529, Domestic Violence=492, Elderly=2,683, Foster Care=1,541, G/L=468,
266 Gender=2,599, Handicap=281, Homeless=622, Immigrants=740, Mental illness=3,985, Poor
267 people=507, Poverty=2,242, Refugees=281, Skin color=23, Spousal abuse=157, Substance
268 abuse=1,587, Women=7,086. The selected years between 1965 and 2004 were chosen as a
269 dramatic display of the tenacity of Eurocentrism spanning four decades. Of particular note are
270 the numbers of journal articles on women (7,086) relative to the number of articles on skin color
271 (23). Consequently of the 23 journal articles published on skin color none appear in the two
272 Social Work journals supposedly dedicated specifically to women's issues despite its health
273 pathology pertaining to women of color. The result is establishment of the need for a critical
274 assessment of Social Work's ability to operate independent of limited frames of reference.

275 *Implications for Social Work*

276 As per the aforementioned, skin color is health pathology in the lives of people of color.
277 This is so, particularly as pertains to women of color whose worth is too often defined by cultural
278 traditions based upon physical attributes. Yet the profession of Social Work remains unprepared
279 to address the issue of skin color as health pathology due to the Eurocentric influence upon
280 content priorities. The fact that Social Work priorities are less diverse than the population the
281 profession serves has escaped recognition. While scholars may be cognizant of and sensitive to

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282 the health issues pertaining to people of color, Social Work practitioners as authors must be
283 amenable to acknowledge health pathologies which prevail beyond their existential experiences
284 personally. To do otherwise via information disseminated then limits the direction and
285 (in)accuracy of the professional knowledge base. What is omitted otherwise ceases to exist
286 within the realm of a Eurocentric universe.

287 What is the pathological significance of skin color among women and people of color in
288 general in the way they perceive, assess, and evaluate certain health criteria? How different are
289 those who perceive themselves as light-skinned from those who perceive themselves as dark,
290 and what is the basis for the presumptions Social Work health practitioners make about skin color
291 differences? Lastly, is the skin color of the health practitioner likely to impact their perception of
292 clients and the client's perception of them? A substantial portion of the research suggests that
293 the perception of another person's skin color may consciously or subconsciously elicit certain
294 assumptions, expectations, and interpersonal responses on the part of an observer (Hall, 2004).
295 Due to the fact that skin color is such a primal component of one's personal identity,
296 comprehension of the implication is critical. If Social Work health practitioners in the U.S. are to
297 understand people of color, understanding the implications of skin color for their overall health
298 and well-being will be imperative to the assessment and ultimate resolution of their presenting
299 problems.

300 For health practitioners eager to enhance their practice skills with people of color, it is
301 imperative to consider the social context in which the skin color of the client is defined. A light-
302 skinned African- or Latina-American woman of color may in fact be defined as dark-skinned in a
303 biracial community (Renn & Shang, 2008). Biracial communities comprise a composite group with
304 enough feelings of solidarity to aid in forming coalitions which could foster resentment of some
305 form on the part of an outsider and vice-versa. In other situations this sense of solidarity need
306 not be called into play such as in a middle-class community where skin color is associated with
307 familial and/or personal wealth.

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By adhering to professional tradition, Social Workers are forced to view people of color from a generic perspective. This facilitates the marginalization of their issues, presenting problems and overall healthy well-being. Under such circumstances the continuation of a homogeneous Eurocentric view of the human health universe is reinforced. The most research grounded realities pertaining to people of color is then overlooked accordingly. To reverse this trend and enable more encompassing health content in the reduction of health pathologies for people of color worldwide it will be helpful to:

* determine the class, social and familial circumstances of the client
* be sensitive to the possibility that people of color who are in crisis or who are experiencing powerful emotions may have issues with the skin color of the practitioner or self aside from race
* seek relevant support systems if such action seems appropriate
* review the literature pertaining to the history and traditions associated with skin color

Conclusion

Since the first case workers carried forth the profession of Social Work, Social Work has evolved into a skilled and learned occupation (Hall, 2000). Workers today are required to have earned a master's or doctorate degree and in many cases a significant number of clinical experience hours. Earning clinical hours is required under supervision of at least a graduate degree and a minimum of 2 years postgraduate supervised Social Work employment. Once such requirements have been satisfied the Social Worker is prepared to work in private practice, medical facilities, mental health clinics, child welfare agencies, and school settings among other areas. Thus now more so than ever before in a diverse client environment Social Workers must engage training, education, and experience as a permanently ongoing process.

In various areas of the Social Work profession the implications of Eurocentrism are not yet resolved but only brought to greater clarity via skin color as health pathology. The formidable

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335 challenge introduced by a myopic Eurocentric knowledge base where disease is validated in
336 proximity to a Eurocentric reality cannot prevail to the extent that it is affectually limited
337 (Hassouneh, 2008). By way of a loosely defined academic conspiracy Social Work's surface
338 strategy is to be critical of Eurocentrism; to deny that it has validity and then contradict the logic
339 of such positions in actions, textbooks, peer-reviewed publications and policy (Luty, 2009).
340 Hence, inevitably Eurocentric efforts represent a contradiction without the ability to arrive at an
341 objectively calculated destination relative to the dissemination of information. Concealed within
342 Eurocentric rhetoric is the implied paradox of an attempt to sustain the prejudices of outdated
343 Western colonialism. It is paradoxical in the promotion of ideas that seek to stimulate debate
344 despite seeking to limit such debate. The limitations it would bestow on alternative views
345 including those pertaining to people of color exclusively prevent it from substantiating its own
346 existence in an emerging diverse era where Eurocentrism has become increasingly obsolete. In
347 the traditions of controversy and challenge Eurocentrism must then reverse in one moment what
348 it proposes in the next. It contends that the generation of knowledge is about multifaceted fact-
349 finding and then that there are no facts other than those arrived at by mainstream Eurocentric
350 operatives (Schiele, 2002).
351 Lastly, struggle being centrifugal to people of color in a racially alien post-colonial
352 environment helps define and determine their health pathology. Their role in the therapeutic
353 process includes the decoding of Eurocentric concepts, illumination of racial inequalities, and if
354 necessary moves to political action. Via the prescripts of activism their efforts have not been
355 ahistorical. Those efforts are not without precedent but in fact exist as a continuum wedded to
356 the larger construct of humankind. Inevitably Social Workers must become cognizant of their
357 unique role; that of articulating the obstacles to human health visited upon mankind via the
358 confines of Eurocentrism. Enabled by such efforts they will then contribute significantly to the
359 effort to purge pathology from human health and make a significant contribution to the civil
360 evolution of humanity worldwide.
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