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 **the i**ntellectual 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-, **Asian-, Native**- Latino-American and other **non-Europeans** 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

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. **and elsewhere in the West**. 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.

Skin Color as Health Pathology

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

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

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

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

Other investigations conducted in Puerto Rico during the same time period was administered by Costas, Garcia-Palmioeri, Sorlie and Hertzmark in 1981. An attempt was made to determine the association of skin color with coronary heart disease. The suspected risk factors were analyzed using a sample of 4,000 urban residing Puerto Rican men. To get a consistently accurate measure of skin color the subject's inner upper arm was measured relative to the von Luschan color tiles scale. By way of this scale subjects were separated into a dark- and light-skinned group. As expected, members of the dark-skinned group exhibited a lower

socioeconomic status as determined by income, education, and occupation levels. They also maintained a slight but significant higher mean of systolic blood pressure measures. Their mean serum cholesterol levels were lower but, the relative weights and cigarette smoking habits for both the light- and dark-skinned participants was similar. In controlling for disparities and socio-economic status between the groups a statistically significant association with blood pressure was substantiated (Costas, Garcia-Palmioeri, Sorlie & Hertzmark, 1981). This substantiation is precedent of another, health pathology via skin color: hypertension.

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

The medical measure of blood pressure is determined by the exertion of human blood as the heart forces it through the body's arteries. One way in which blood pressure can rise is caused by constriction of the arteries. The sympathetic branch of the autonomic nervous system is stimulated and, stimulation leads to contraction of the muscles of the arterial walls (Mosby, 1998). In the case of humans, the skeletal muscle, and the heart muscles receive increased supplies of blood which is vital when in the midst of a crisis situation. When the crisis is resolved, the muscles inform the nervous system to decrease blood supply. Then blood pressure returns to normal. The situation is arguably different for people of color. Seldom is there a crisis that would call for instant increase in muscular effort. But the fact that the lives of people of color are filled

with any number of stressful racist situations mimics a state of permanent crisis. But the human autonomic nervous system is not equipped with logistical apparatus. And so given the prevalence of racism, the blood pressure of people of color, without intervention, may remain constantly high, some more than others, but all to some extent (Mosby, 1998; **Reed & Hudson, 2002**). As a result, blood pressure is sustained at abnormally high levels, creating unnecessary health risks, which correlates directly with having dark skin. That increase in melanin (skin color) correlates with increase in hypertension rates among African-American and other dark-skinned people of color. Conversely decrease in melanin correlates with decrease in hypertension rates among the same groups.

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

Hypertension is a by-product of sustained sympathetic arousal (Barst, 2008). Thus, people of color would expect its incidence to go up with increasing amounts of social condition stress. This is indeed the case as a matter of historical fact. For example, there was a marked increase in the incidence of hypertension among the inhabitants of Leningrad after the siege and bombardment of that city during World War II (Henry & Cassel, 1969). Similar effects can be produced by the socioeconomic stress extended from the social conditions people of color encounter. Thus, hypertension is much more common among people of color being poorer as a group than their mainstream racial counterparts; and it is especially prevalent in inner-cities marked by high population density, poverty, and crime (Lipowski, 1975). The end results will

frequently manifest as various forms of coronary disease not irrelevant to psychological health as well.

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

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

Finally when controlling for family income, educational attainment did not appear to be relevant to mental health. More family income correlated to less depression for all gender and nativity categories. While English language skills did appear relative to psychological health, decreased Spanish language skills were significantly correlated to more depression among U.S. born **Latino** men and women. Thus percentages of variance calculated by the regression formulas (ranging from .03 to .09) are frequent when assessing the associations between

structural factors and psychological health. It is apparent that mental health indicators tend to be more receptive to individual psychosocial measures than environmental (1992).

The results of the Codina Montalvo (1992) investigation reinforced the phenotype and acculturation hypotheses considering that the mental health of dark-skinned Chicano males born and raised in the U.S. was more susceptible to depression. This was so based upon their lightness or darkness in skin color. The darker the skin, the more often subjects reported feeling depressed regardless of levels of education, family income, and their language skills in Spanish or English. The relationship was significant and believed to be a product of the greater exposure of darker-skinned Chicanos to more frequent discrimination and thus decreased life chances. Light-skinned, more European looking Latino males were much more fortunate arguably attributed to their better quality of life and less subjection to the stresses of discrimination.

Dark-skinned people of color worldwide suffer similarly to those in the U.S./**West** and its territories despite living in countries where they are the majority. In Africa skin color as health pathology is manifested via skin bleaching among dark-skinned people who desire idealized light skin. In more extreme reactions to skin bleaching African women incur increased risks to their health leading to the disruption of organ performance. "There is suspicion of an increased risk of renal failure as a result of the mercury contained in some of the products that people use for bleaching," according to **Africa-born** Dr. Doe (Opala, 2001). Unfortunately too many women who bleach do not seek medical help until it's too late. This has spurred an effort on the part of doctors to promote public service announcements in hopes of educating the public to the dangers of bleaching. As per **commentator** Maama Adwoa she has encountered the "stop bleaching" announcements in the media. "They say we should stop bleaching because of skin cancer and skin disease. But people don't want to listen because they don't know …" (Opala, 2001). In the end they develop such bad skin problems that they can no longer go out into the sun without risking more problems. The extent of such persons in Africa is becoming so widespread that some of the governments are beginning to exercise caution. For example in Gambia, the government has decided to outlaw all skin-bleaching products including Bu-Tone, Madonna

Cream, Glo-Tone, and the American-made Ambi. They decided to be lenient on those caught with bleached skin. Furthermore officials in Europe have also begun to take issue with the practice as Denmark has also banned skin bleaching creams and soaps. Officials there have traveled to a number of local African shops and gathered up the products. Unfortunately, Tura, which is a product outlawed by Danes is still popular in Ghana and other African countries. While the business community may find these actions extreme, doctors concur that they're not without reason (Opala, 2001). Subsequently, as pertains to skin color the aforementioned results of cardio disease, hypertension, depression and skin bleaching in toto suggest that the current level of study in Social Work involving skin color as health pathology is acutely insufficient. **This pertains to all people of color residing in the West or subject to Western influence vis-à-vis Eurocentrism.**

Eurocentrism

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

Eurocentric frames of reference in the post-colonial era are pathological as pertains to the physiological and psychological health status of people of color. Exacerbating the problem is the fact that Eurocentrism defines pathology content relative to dominant group proximity. In an effort to serve objectivity the definition of Eurocentrism may be determined by consultation of the most recent scholarly literature. As per Kanth's (2009) *The Challenge of Eurocentrism,*

Eurocentrism is a worldview grounded in a European perspective that 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. Therefore the relative unknown existence of skin color as health pathology among people of color may prevail despite its contrast with existential realities in non-European communities. Thus the conscientious Social Work professional must challenge the Eurocentric paradigm, which has without necessarily intending trivialized a critical aspect of health pathology as pertains to people of color (Cox, 2001).

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

Implications for Social Work

As per the aforementioned, skin color is health pathology in the lives of people of color. This is so, particularly as pertains to women of color whose worth is too often defined by cultural

traditions based upon physical attributes. Yet the profession of Social Work remains unprepared to address the issue of skin color as health pathology due to the Eurocentric influence upon content priorities. The fact that Social Work priorities are less diverse than the population the profession serves has escaped recognition. While scholars may be cognizant of and sensitive to the health issues pertaining to people of color, Social Work practitioners as authors must be amenable to acknowledge health pathologies which prevail beyond their existential experiences personally. To do otherwise via information disseminated then limits the direction and (in)accuracy of the professional knowledge base. What is omitted otherwise ceases to exist within the realm of a Eurocentric universe.

What is the pathological significance of skin color among women and people of color in general in the way they perceive, assess, and evaluate certain health criteria? How different are those who perceive themselves as light-skinned from those who perceive themselves as dark, and what is the basis for the presumptions Social Work health practitioners make about skin color differences? Lastly, is the skin color of the health practitioner likely to impact their perception of clients and the client's perception of them? A substantial portion of the research suggests that the perception of another person's skin color may consciously or subconsciously elicit certain assumptions, expectations, and interpersonal responses on the part of an observer (Hall, 2004). Due to the fact that skin color is such a primal component of one's personal identity, comprehension of the implication is critical. 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.

For health practitioners eager to enhance their practice skills with people of color, it is imperative to consider the social context in which the skin color of the client is defined. A light-skinned African- or Latina-American woman of color may in fact be defined as dark-skinned in a biracial community (Renn & Shang, 2008). Biracial communities comprise a composite group with enough feelings of solidarity to aid in forming coalitions which could foster resentment of some

form on the part of an outsider and vice-versa. In other situations this sense of solidarity need not be called into play such as in a middle-class community where skin color is associated with familial and/or personal wealth.

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 challenge introduced by a myopic Eurocentric knowledge base where disease is validated in proximity to a Eurocentric reality cannot prevail to the extent that it is affectually limited (Hassouneh, 2008). By way of a loosely defined academic conspiracy Social Work's surface strategy is to be critical of Eurocentrism; to deny that it has validity and then contradict the logic of such positions in actions, textbooks, peer-reviewed publications and policy (Luty, 2009). Hence, inevitably Eurocentric efforts represent a contradiction without the ability to arrive at an objectively calculated destination relative to the dissemination of information. Concealed within Eurocentric rhetoric is the implied paradox of an attempt to sustain the prejudices of outdated Western colonialism. It is paradoxical in the promotion of ideas that seek to stimulate debate despite seeking to limit such debate. The limitations it would bestow on alternative views including those pertaining to people of color exclusively prevent it from substantiating its own existence in an emerging diverse era where Eurocentrism has become increasingly obsolete. In the traditions of controversy and challenge Eurocentrism must then reverse in one moment what it proposes in the next. It contends that the generation of knowledge is about multifaceted fact-finding and then that there are no facts other than those arrived at by mainstream Eurocentric operatives (Schiele, 2002).

Lastly, struggle being centrifugal to people of color in a racially alien post-colonial environment helps define and determine their health pathology. Their role in the therapeutic process includes the decoding of Eurocentric concepts, illumination of racial inequalities, and if necessary moves to political action. Via the prescripts of activism their efforts have not been ahistorical. Those efforts are not without precedent but in fact exist as a continuum wedded to the larger construct of humankind. Inevitably Social Workers must become cognizant of their unique role; that of articulating the obstacles to human health visited upon mankind **via dark**

skin and the confines of Western Eurocentrism. Enabled by such factors they will then contribute significantly to the effort to purge pathology from human health and make a significant contribution to the civil evolution of humanity worldwide.

References

Banton, M. (2000). Combating Racial Discrimination: The UN and its Member States. London, UK: Minority Rights Group International.

Barst, R. (ed.). (2008). Pulmonary Arterial Hypertension: Diagnosis and Evidence-Based Treatment. Hoboken, NJ: John Wiley & Sons.

Beckett, A. (1983). The relationship of skin color to blood pressure among Black Americans. Atlanta, Georgia: Atlanta University.

Bonilla-Silva, E. (2006). Racism without racists: Color-blind racism and the persistence of racial inequality in the United States. Lanham: Rowman & Littlefield Publishers.

Borrell, L., Crespo, C. & Garcia-Palmieri, M. (2007). Skin color and mortality risk among men: The Puerto Rico Heart Health Program. Annals of Epidemiology, 17(5), 335-341.

Bulanda, R. & Zhang, Z. (2009). Racial-ethnic differences in subjective survival expectations for the retirement years. Research on Aging, 31(6), 688-709.

Codina, E. & Montalvo, F. (1992). Chicano Phenotype and Depression. Unpublished Manuscript, Our Lady of the Lakes University, Worden School of Social Serevices, San Antonio, TX.

Costas, R., Garcia-Palmieri, M., Sorlie, P. & Hertzmark, E. (1981). Coronary Heart disease risk factors in men with light and dark skin in Puerto Rico. American Journal of Public Health, 71(6), 614-619.

Cox, E. (2001). Community practice issues in the 21st century: questions and challenges for power-oriented practitioners. Journal of Community Practice, 9(1), 37-55.

Dubois, W. (2005). The illustrated Souls of Black Folk/W.E.B. DuBois. Boulder, CO.: Paradigm Publishers.

Dussel, E. (2009). "Being-in-the-world-Hispanically": A world on the "Border" of many worlds. Comparative Literature, 61(3), 256-274.

Fried, J. (May 7, 1999). In Louima's first day on stand, he tells of brutal police assault. New York Times, A, 1(2).

Hall, R. (2006). The Bleaching Syndrome Among People of Color: Implications of Skin Color for Human Behavior in the Social Environment. Journal of Human Behavior in the Social Environment, 13(3), 19-31.

Hall, R. (2004). From psychology of race to issue of skin color: Western trivialization and peoples of African descent. Psychologia, 12(1), 7-17.

Hall, R. (2000). The "Warmth" Profession: Societal perceptions of Social Work Practice. The International Journal of Continuing Social Work Education, 3(3), 9-17.

Hall, R. E. (Spring, 1996). Impact of skin color upon occupational projection: A case for Black male Affirmative Action. Journal of African American Men 1(4), 87-94.

Hall, R. (1994). The bleaching syndrome: Light skin, psychic conflict and the domination model of western assimilation. The Indian Journal of Social Work, Tata Institute of Social Sciences, Deonar Bombay, India.

Hassouneh, D. (2008). Reframing the diversity question: Challenging Eurocentric hierarchies in nursing education. Journal of Nursing Education, 47(7), 291-293.

Henry, J. & Cassel, J. (1969). Psychosocial factors in essential hypertension. American Journal of Epidemeology, (90), 171.

Kanth, R. (2009). The Challenge of Eurocentrism: Global Perspectives, Policy, and Prospects. New York: Palgrave Macmillian.

Krieger, N., Sidney, S. & Coakley, E. (1998). Racial discrimination and skin color in the CARDIA study: implications for public health research. Coronary artery risk development in young adults. American Journal of Public Health, 88(9), 1308-1313.

Lipowski, Z. (1975). Psychophysiological cardiovasular disorders. In Freedman, A., Kaplan, H., & Sadock, B. (eds.), Comprehensive Text Book on Psychiatry II vol 2 1660-68, Baltimore: Williams & Wilkins.

Luty, J. (2009). Preferential publication of editorial board members in medical specialty journals. Journal of Medical Ethics, 35(3), 200.

Michigan Department of Public Health, (1995). Challenges of a lifetime, 1, 11. Okemos, MI.

Monteiro, A. (2000). Being an African in the world: the DuBoisian Epistemology. The Annals, 568, 220-234.

Mosby, (1998). Mosby's Medical, Nursing, & Allied Health Dictionary, Edition 5.

Opala, K. (2001). Cosmetics Ban: Did standards body err? Retrieved April 12, 2003, from http://allafrica.com/stories/printable/200105290458.html

Reed, J. & Hudson, H. (2002). High Blood Pressure: The Black man and woman's Guide to Living with Hypertension. Roscoe, IL.: Hilton Publishing Co.

Renn, K. & Shang, P. (eds.) (2008). Biracial and Multiracial students. San Francisco: Jossey-Bass.

Robbins, S., Chatterjee, P. & Canda, E. (2006). Contemporary Human Behavior Theory: A Critical Perspective for Social Work. Boston: Allyn & Bacon.

Schiele, J. (2002). Mutations of Eurocentric domination and their implications for African American resistance. Journal of Black Studies, 32(4), 439-463.

Sorlie, P., Garcia-Palmieri, M. & Costas, R. (1988). Left ventricular hypertrophy among dark- and light-skinned Puerto Rican men: the Puerto Rico Heart Health Program. American Heart Journal, 116(3), 777-783.

Staples, B. (May 2, 1999). When the "Paranoids" turn out to be right. Times Fax, Editorial, p 8.

Stember, C. (1976). Sexual racism. New York: Elsevier Scientific.