Shades of Skin, Shades of Power: Social Constructionism as the Grand Theory for the Structure/Agency and Reality/Identity Conundrums

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Abstract

Various aspects of or associated with the skin, such as color, ethnicity and race, play a substantial role in health disparities and the limitation of agency, which is the capacity or power to act in order to obtain beneficial outcomes. Although many mechanisms by which these disparities manifest themselves have been proposed, the processes by which the agency of patients develops and is socially constructed surrounding issues of the skin are understudied. This paper analyzes the micro-social factors that sustain and contribute to the proliferation of disparities in healthcare systems by socially constructing the capacity of different patients to act within these systems, based on perceptions of their skin color or disease. The paper examines the evidence from the literature on the processes by which the agency of individuals interacting with the healthcare system has been socially constructed using the characteristics of the human skin, whether the latter presents itself in its biologically normal form or in a pathological state. Expanding on Berger and Luckmann's social constructionist model, the author concludes that within healthcare systems, objective reality can be socially constructed through the transformation of perceptions into values, values into behaviors, behaviors into norms, and norms into institutions, and that individual identity or subjective reality can also be socially constructed by reversing this flow. This stepwise pathway is proposed as a possible theoretical mechanism that may explain how reality and identity can be socially constructed, using the skin as one of many modulators of social interactions. The implications of this proposed mechanism of social construction for healthcare systems and other social institutions, as well as individual agency and identity, are emphasized.

Nuances de la peau, nuances de pouvoir : le constructivisme social en tant que théorie de la gestion des systèmes de santé et des énigmes de réalité / identité

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Résumé

Divers aspects de la peau ou associés à la peau, tels que la couleur, l'origine ethnique et la race, jouent un rôle important dans les disparités en matière de santé et les contrôles de la sécurité sociale, autrement dit la capacité ou le pouvoir d'agir afin d'obtenir des résultats en matière de santé. Bien que de nombreux mécanismes par lesquels ces disparités se manifestent aient été déjà proposés, les processus par lesquels la gestion des patients se développe et se construit socialement autour des questions de peau sont ici étudiés en trame de fond. Cet article analyse les facteurs microsociaux qui soutiennent et contribuent à la prolifération de disparités dans les systèmes de santé en construisant

socialement la capacité des différents patients à agir au sein de ces systèmes, en fonction des perceptions de leur couleur de peau ou de leur pathologie. L'article examine des preuves tirées de la littérature sur les processus par lesquels la gestion des particuliers interagissant avec le système de santé a été socialement construite en utilisant les caractéristiques de la peau humaine, si celle-ci est dans un état biologiquement sain ou dans un état pathologique.
S'appuyant sur le modèle de construction sociale de Berger et Luckmann, l'auteur conclut qu'au sein des systèmes de santé, la réalité objective peut être construite socialement par la transformation des perceptions en valeurs, des valeurs en comportements, des comportements en normes, et des normes en institutions, et que l'identité individuelle ou la réalité subjective peuvent également être socialement construites en inversant ce flux. Cette voie progressive est proposée comme un possible mécanisme théorique qui pourrait expliquer comment la réalité et l'identité peuvent être construites socialement en utilisant la peau comme l'un des nombreux modulateurs d'interactions sociales. Cette recherche souligne également les implications de ce mécanisme proposé de construction sociale pour les systèmes de santé et autres institutions sociales, ainsi que les rapports entre organismes individuels et identité.

Sombras de Piel, Sombras de Poder: El Construccionismo Social como la Gran Teoría para la Estructura/Agencia y Realidad/Enigmas de Identidad

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Resumen

Varios aspectos de la piel o asociados con ella, como el color, el origen étnico y la raza, juegan un papel importante en las disparidades de salud y la limitación de la agencia, que es la capacidad o el poder de actuar para obtener resultados beneficiosos. Aunque se han propuesto muchos mecanismos por los cuales se manifiestan estas disparidades, los procesos por los cuales la agencia de los pacientes se desarrolla y se construye socialmente alrededor de los problemas de la piel son poco estudiados. Este artículo analiza los factores micro-sociales que sostienen y contribuyen a la proliferación de disparidades en los sistemas de salud al construir socialmente la capacidad de diferentes pacientes para actuar dentro de estos sistemas, en base a las percepciones del color de su piel o enfermedad. El artículo examina la evidencia de la literatura sobre los procesos mediante los cuales la agencia de individuos que interactúan con el sistema de salud se ha construido socialmente utilizando las características de la piel humana, ya sea que esta última se presente en su forma biológicamente normal o en un estado patológico. Ampliando el modelo construccionista social de Berger y Luckmann, el autor concluye que dentro de los sistemas de salud, la realidad objetiva puede construirse socialmente a través de la transformación de percepciones en valores, valores en comportamientos, comportamientos en normas y normas en instituciones, y esa identidad individual o realidad subjetiva también se puede construir socialmente invirtiendo este flujo. Esta vía gradual se propone como un posible mecanismo teórico que puede explicar cómo la realidad y la identidad pueden construirse socialmente, utilizando la piel como uno de los muchos moduladores de las interacciones sociales. Se enfatizan las implicaciones de este

mecanismo propuesto de construcción social para los sistemas de salud y otras instituciones sociales, así como la agencia individual y la identidad.

Sombras da Pele, Sombras de Poder: construcionismo social como Grande Teoria dos enigmas de estrutura/operação e realidade/identidade

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Sumário

Diversos aspectos atribuídos à pele (ou a ela associados), tais como cor, etnicidade e raça, desempenham um papel substancial nas disparidades de saúde e na limitação de controle de seguridade social, que é a capacidade ou poder de agir de modo a obter-se resultados benéficos. Embora muitos mecanismos pelos quais essas disparidades se manifestam tenham sido propostos, os processos pelos quais o gerenciamento de pacientes se desenvolve e é socialmente construído ao redor de questões de pele permanecem pouco estudados. Este artigo analisa os fatores microssociais que apóiam e contribuem para a proliferação de disparidades nos sistemas de saúde, construindo socialmente a capacidade de agir de diferentes pacientes no interior desses sistemas, baseada nas percepções de suas cores de pele ou doenças. O artigo analisa as evidências a partir da literatura que trata dos processos pelos quais o manejo de indivíduos que interagem com o sistema de saúde tem sido construída socialmente pelo uso de características da pele humana – se esta última se apresenta em sua forma biológica normal ou se em estado patológico. Expandindo-se sobre o modelo construcionista social de Berger e Luckmann, o autor conclui que, no seio dos sistemas de saúde, a realidade objetiva pode ser socialmente construída pela transformação de percepções em valores, de valores em comportamentos, de comportamentos em normas e de normas em instituições, e que a identidade individual ou a realidade subjetiva também podem ser socialmente construídas revertendo-se esse fluxo. Este caminho traçado passo a passo é proposto enquanto possível mecanismo teórico capaz de explicar como a realidade e a identidade podem ser socialmente construídas utilizando-se a pele como um dos muitos moduladores de interação social. As implicações deste mecanismo proposto de construção social para sistemas de saúde e outras instituições sociais, assim como organização e identidade individual, são enfatizadas.

Hautdifferenzierungen, Kraftabstufungen: gesellschaftliche Konstruktionismus als großer Theorie für das Rätsel Struktur/Handlungsfähigkeit und Realität/Identität

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Zusammenfassung

Die Haut in ihren verschiedenen Aspekte und Assoziationen wie z.B. Farbe, Ethnizität und Rasse trägt im hohen Maße zu Gesundheitsunterschiede und zu Aktionsbegrenzungen, bzw. zur Fähigkeit oder Kraft günstige Ergebnisse zu erlangen, bei. Obgleich viele Mechanismen, die diese Unterschiede nachweisen, vorgestellt

wurden, sind dennoch die Vorgänge, die zur Entwicklung der Handlungsfähigkeit des Patienten beitragen, und der gesellschaftliche Kontext der Haut nicht genügend untersucht. Diese Abhandlung untersucht die mikrosozialen Faktoren, die dazu beitragen, die wachsende Ungleichheit im Gesundheitswesen zu vermehren. Bei verschiedenen Patienten soll die Fähigkeit zum Agieren innerhalb Systeme, die nach Hautfarbe oder Krankheit unterscheiden, gesellschaftlich aufgebaut werden. Hier werden auch die Prozesse der Interaktion zwischen dem Individuum und das Gesundheitswesen, die aus der Fachliteratur stammen, untersucht. Sie beziehen sich auf dem gesellschaftlichen Aufbau des Gesundheitssystems, das auf den Charakteristiken der menschlichen Haut beruht und wobei der Patient sich in einem biologischen normalen oder in einem pathologischen Zustand befindet. Erweiternd zum gesellschaftlichen konstruktionistischen Model von Berger und Luckmann folgert der Autor, dass innerhalb der Gesundheitssysteme objektive Gegebenheiten gesellschaftlich gestaltet werden können. Dies ist möglich indem Empfindungen in Werte, Werte in Verhalten, Verhalten in Normen und Normen in Institutionen verwandelt werden und auch indem individuelle Identität oder subjektive Realität durch Umkehrung der Reihenfolge gesellschaftlich gestaltet werden kann. Dieser Methode, die schrittweiser verlauft, wird vorgeschlagen als ein möglicher theoretischer Mechanismus, die erklären könnte, wie, anhand der Haut, eine von vielen Modulatoren des gesellschaftlichen Interagierens, Realität und Identität gesellschaftlich gestaltet werden kann. Die Auswirkungen dieses vorgeschlagenen Mechanismus der gesellschaftlichen Gestaltung für Gesundheitssysteme und andere soziale Einrichtungen sowie für individuelles Handeln und Identität sind hier hervorgehoben.

The Role of the Human Skin in Shaping Social Reality and Agency

There is ample evidence, both historically and contemporarily, that various aspects of or associated with the skin, such as color, ethnicity, and race play a substantial role in determining life courses and choices of individuals as well as populations. For example, the persistence of many social inequities across many realms in the United States, such as racial residential segregation (Avila & Rose, 2009), the achievement gap among Black and Latino students as compared to White and Asian students (Anyon, 2005; Berliner, 2011; Ladd, 2012), and the greater burden of chronic diseases among individuals of Black or Latino ancestry (Kevin Fiscella, Franks, Doescher, & Saver, 2002; Williams & Jackson, 2005) leave no doubt on the matter. The macro-social reasons for these phenomena are not only well known but are also among the hardest to change for disadvantaged populations: they are, primarily, the inter-generational and multi-dimensional poverty, and the perennial political disempowerment of historically disadvantaged groups. In essence, these two factors are the main social determinants of health and play the principal role in the perpetuations of health inequities.

Paradoxically, at the social policy and decision-making level, these same macro-social factors tend to be glossed over, and what is emphasized instead is the linkage of life courses with life choices only, the latter of which relate to individual behavioral elements that are thought to be within the control of disadvantaged populations. Thus, while it is true that macro-social factors are thought to play key roles in promoting disparities in

healthcare systems as well as other institutions, the prevailing view in much of the current world is that the primary responsibility for addressing or mitigating their consequences rest mainly on the shoulders of the individuals affected. This is seen across multiple realms of policy and decision-making, particularly in the United States, including the persistent belief in the "Horatio Alger" myth of successful participation and ascension in the labor market by members of immigrant and ethnic groups learning to "pull themselves up by their bootstraps" (Sarachek, 1978), the perceived role of student competence in academic performance in schools, the "work-first" mantra in social welfare programs that require acquisition of a job before receipt of social assistance (Andersson & Wärvik, 2012), and the view that adherence to treatment or preventive strategies and patient personal responsibility are the critical factors influencing health outcomes (Horwitz & Horwitz, 1993). In all cases, it is thought that the individual ought to possess the ability to steer his or her own life course by making the right choices. Individuals are thought to have agency, which is the capacity or power to act in order to obtain beneficial outcomes, whether in securing housing, improving health and quality of life, or succeeding academically, for example.

In the healthcare sector, although many mechanisms by which inequities manifest themselves in all aspects of the lives of disadvantaged populations have been proposed and sometimes empirically validated (Berkman & Glass, 2000; Dressler, Oths, & Gravlee, 2005), the processes by which the agency of patients develops and is socially constructed are understudied. This is particularly true of healthcare systems worldwide, whose explanatory framework of disease and illness are based on the Western biomedical model, where the role of the patient's individual responsibility and autonomy in the adoption of beneficial or harmful health choices and behaviors is central.

The purpose of this paper is to analyze the micro-social factors that sustain and proliferate inequities in healthcare systems by socially constructing the capacity of different patients to act within these systems, based on perceptions of their skin color or disease. In particular, the processes by which the agency or capacity of individuals and social groups to extract beneficial resources from healthcare systems has been socially constructed using the characteristics of the human skin, whether the latter presents itself in its biologically normal form or in a pathological state, will be examined. The paper also proposes a plausible explanatory model and grand theory that addresses the reality/identity and structure/agency conundrums that rest at the intersection of the discipline of philosophy and the social science fields of psychology, sociology and anthropology. Using the evidence from the literature on this phenomenon, this paper asks the following questions: by what mechanisms are human thoughts translated into and are created by social contexts? How does perception of the human skin create objective social realities? What are the implications of this social construction of reality for individual and group agency?

A Stepwise Theoretical Framework on the Social Construction of Agency in Healthcare Systems Based on Skin Characteristics

An analysis of the discourse in the scientific literature on this topic has revealed that although no researchers have provided a definitive response to these questions with regards to the role of the human skin in the social construction process, many have sought to provide a response to these questions in more general terms. For example, Brickell (2006) examined the role of historicism, symbolic interactionism, ethnomethodology and materialist feminism as four dominant theoretical perspectives, in an attempt to uncover their unique contributions to the social construction of gender and sexuality. More relevantly, Dressler (2005) uncovered 5 primary models on the role of race and ethnicity in explaining inequities in the healthcare system: the racial-genetic model, the health behavior model, the socio-economic status model, the psychosocial stress model, and the structural-constructivist model.

While the topics addressed by these authors differ substantially, they nevertheless uncovered similar findings with regards to social constructionism, including the importance of institutions, social norms, and value judgments. More importantly, both recognize the duality of social reality as originally proposed by Berger and Luckmann (1966). All of these authors acknowledge the systematic role of institutionalization and legitimization of perceptions or values, and the role of internalization and identity formation based on institutional and individual behavioral expectations or social norms, or respectively, society as objective reality and society as subjective reality (Berger & Luckmann, 1966). In essence, these dual forces act in opposition to each other to create social realities: together they promote the social construction of reality for a particular phenomenon.

Berger and Luckmann (1966) make an additional and critical addition to understanding social constructionism that is helpful in building the author's theoretical model. They discuss the fact that social realities, or what is regarded as real and meaningful, are created through reciprocal, fluid and flexible social interactions on a constant basis. These social interactions consist of various type of activities, the most important of which is the "face-to-face situation" of everyday life (Berger & Luckmann, 1966, p. 43), that modulate the consciousness or perceptions of individuals and social groups. In this sense, these authors define two components of the proposed model: first, that social construction begins with the modulation of perceptions, and second, that perceptions are molded by social interactions, the most obvious, proximal and immediate of which being face-to-face encounters. This then also suggests that there must be other types of social interactions that may play a role in the social construction process.

In this paper, the author argues that there is a need to pick up from where Berger and Luckmann and other prior researchers have left off, in pursuit of a fuller depiction of the social construction process. First, it is important to expand on the other types of social interactions, particularly those that relate to perceptions of the human skin. The literature on racial health inequities research suggests that these interactions should include: social group labeling and the associated visibility and invisibility of ethnic and migrant groups

(Sankar et al., 2004; Van Ryn & Fu, 2003), social ostracism or isolation, stigmatization (Weiss, 2008), the use of language, discourse and the dominant narrative, social control by biomedicine (Lupton, 2000), internalized, individualized, and institutionalized racism (K. Fiscella & Williams, 2004), and marginalization of social groups. This list is not exhaustive but represents only a sample of social interactions at various levels (i.e. personal, familial, informal, formal, professional, or structural) that are relevant to understanding the role of the skin in the social construction of objective and subjective reality. All of these can be viewed as instances of social interactions because they in fact typify the way both individuals as well as groups often behave towards or interact with each other. *This paper proposes that these social interactions work along a stepwise social construction pathway of agency to either constrain or facilitate the life choices and courses of different individuals and social groups.* While studies that look at these phenomena as they relate specifically to healthcare systems will be emphasized, the author uses supporting evidence from other social institutions/structures when relevant to help answer the questions being addressed in this paper.

Second, since the process of social construction of reality involves the institutionalization and legitimization of perceptions, there should be evidence of additional steps in the social construction process between perceptions and social institutions or structures. *This paper proposes that these additional steps include opinions and values, expectations and associated behaviors, and socio-cultural norms, which then become embedded in institutions.* A similar stepwise model has been proposed by Van Ryn and Fu (2003) to explain the role of health care providers in the social construction of healthcare inequities, including the formation of provider beliefs and values about the patient, which influence provider behaviors during the clinical encounter and further modulate the norms of the profession in terms of diagnosis and treatment. Strasser et al. (1993) formulated a similar stepwise approach using social cognitive theory to propose a comprehensive model on the formation of patient satisfaction, beginning with stimuli and "perceptual screens", followed by values and beliefs, and concluding with attitudes and behaviors. Examples will be provided to fully illustrate the impact of each of these phenomena on the social construction of agency for people with and without skin diseases.

Finally, prior to providing illustrations of the theoretical model, it is important to operationalize several terms. The term “shades of skin” here refers to the variety of skin types, tones, colors, growths and appendages of both normal skin as well as biologically diseased skin. The use of this term captures the full spectrum of variety that exists in socially visible aspects of the human body. Note that the hair and nails are biologically part of the human skin and are typically socially visible, thus examples will be provided to illustrate their role in the social construction process as well. In addition, “shades of power” refers to the differential agency that individuals acquire within healthcare systems. *This paper uses the existing body of literature to show that there is a link between shades of power and shades of skin: that is, individuals with varying shades of skin, whether normal or diseased, are socially assigned different levels of agency.* The term “power” is used throughout this paper interchangeably with the terms “agency” and “capacity” which are widely studied in the social sciences literature. Figure 1 depicts the

author's expanded conceptual model of social constructionism as the grand theory that explains the phenomenon of shades of skin and shades of power in healthcare systems. Figure 2 presents a more generalizable version of this proposed grand theory as a plausible explanation for the social construction of reality/identity and structure/agency in all societies and social institutions, as well as across all historical eras. This visual model emphasizes the cyclical and reciprocal nature of the relationship between the author's five proposed steps of social constructionism (i.e. perceptions, values, behaviors, norms and institutions). This paper proposes that this model may serve as a grand theory at the intersection of philosophy (which examines the nature of reality and knowledge, both subjective and objective), psychology (which studies the role of the mind and perceptions in identity formation and human behaviors), sociology (which focuses on the relationship between the values, behaviors and norms of individuals or social groups, relative to the society in which they live and its embedded social institutions), and anthropology (which seeks to examine the totality of the human experience and provide a holistic account of humans and human nature).

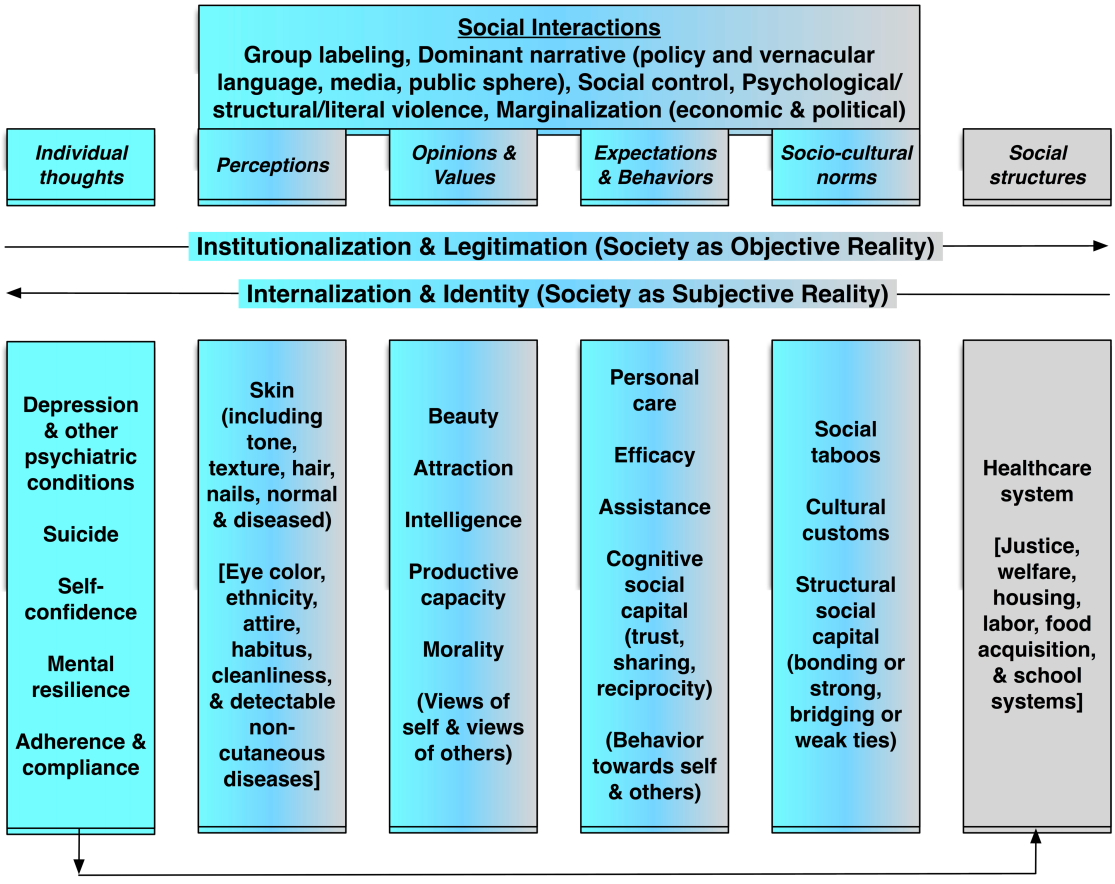

Figure 1. Author's illustration of the proposed theoretical model for the role of shades of skin in the social construction of shades of power in healthcare systems. Items in parentheses are elaborations of aforementioned concepts. Items in brackets are not part of the model but serve as useful illustrations of how this model can help explain the social construction of agency in other institutions and for other social groups and diseases.

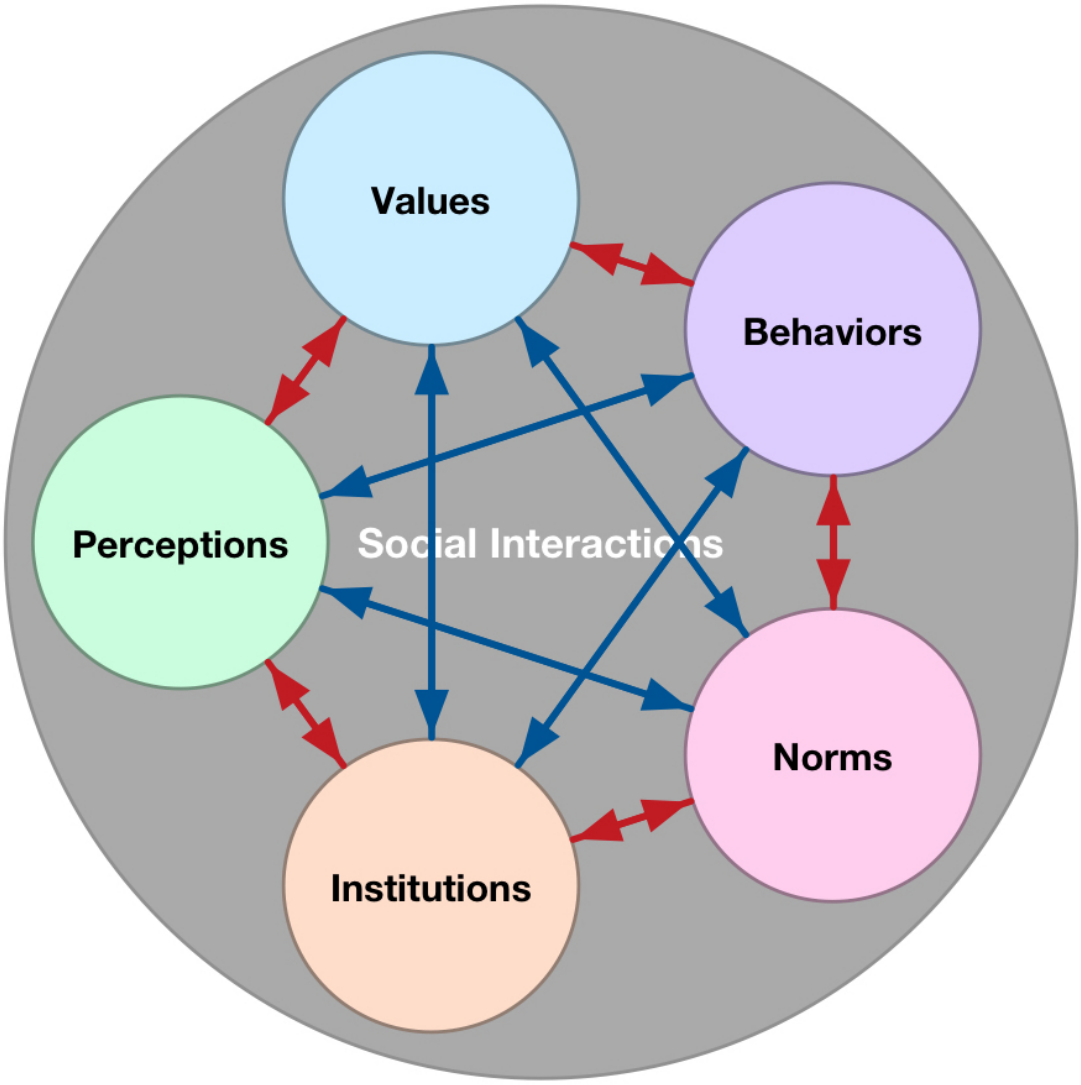

Figure 2. Author's simplified depiction of the proposed general mechanism for the social construction of reality/identity and structure/agency via the five key steps of perceptions, values, behaviors, norms and institutions.

Shades of Normal Skin vs. Diseased Skin: Similarities and Differences Relevant to the Social Construction of Shades of Power

The mechanisms by which the different shades of normal skin have emerged are well known. Biological differences in skin pigmentation are directly related to the expression of melanin, the pigment molecule embedded in the upper layer of the skin: these gradations of skin color have evolved namely in response to the need to protect the body

from UV radiation at latitudes close to the equator (Nina G. Jablonski & Chaplin, 2000; Nina G. Jablonski & Chaplin, 2010). But other potential factors include culturally based sexual preferences, availability of vitamin D in staple diets, variability in the seasons and temperatures of locality of residence, and mass migrations (Barsh, 2003). Thus, while the protection of the body against harmful external environmental stimuli remains the dominant natural explanation for the existence of different skin colors, it seems highly unlikely that there would be a natural reason for the existence of culturally based sexual preferences for different shades of skin, yet this appears to be the case. Already this can be seen as evidence of the social construction of the perceptions of the color of the human skin, which eventually translates into real physical differences over several generations. For example, Jablonski and Chaplin (2000) found that when compared to men within their own geographic regions, women generally have lighter skin, and this applies across cultures and nations worldwide. This serves as potential evidence of the social construction of beauty, which in large part defines sexual attractiveness, based on the perception of skin color. At the same time, it implies that, all other things being equal, females of lighter skin color have a broader choice of willing male mates, which is in fact a form of social power.

On the same token, the mechanisms that give rise to the wide variety of skin pathologies are also well known (Lever, 1949) and have been the subject of study of the medical profession for centuries. The main concern in this paper is also the ways in which skin diseases are often used to assign different degrees of power to different people. Given that a great number of human skin diseases actually are contagious (Lever, 1949), it is certainly understandable that the drive to survive and preserve personal integrity could explain, though not justify, the discriminatory behavior of societies and their institutions towards individuals with such diseases, especially if they are not equipped to contain and cure them. This is perhaps for good reasons, given the number of virulent infectious diseases with visible skin manifestations that have affected various societies throughout history, the most notorious of which being the bubonic plague which killed more than a third of Europeans during the fourteenth century (Kelly, 2012). Lupton (2000), for example, writes that “leprosy in medieval times […] evoke[d] the meanings of horror, contamination, corruption and blame”. It is reasonably conceivable that leprosy would cause fear of contamination and result in the social isolation of lepers. Yet what is unclear, at least without taking a social constructionist approach, is how this fear then translates into the labeling of people with the disease as being corrupt or deserving of blame for immoral acts or character. Biologically plausible contagion risk does not always inform the social construction of the reality of a disease. In fact, in most societies, people with skin diseases that have visible manifestations are generally assumed to be or treated as being contagious by virtually everyone other than healthcare professionals (Martini & Giorgini, 1984), and as we will see, in some societies, these diseases become imbued with socially construed meanings that then limit the ability of the ill to seek assistance in various realms. This too serves as evidence of the social construction of power based on the skin.

A number of similarities emerge from comparing the social construction of power based on perceptions of normal skin and biologically diseased skin. The most important

commonality is that across societies, they are both seen as inescapable social evidence (Lopez, 1994). That is, they make the individual or social group physically visible, and the characteristic under consideration cannot be hidden. As such, they serve as very powerful targets for the social construction of meaning. The second commonality is that both have been linked to various construed meanings that have no relevance to any intrinsic characteristic of the entity itself. For example, while skin color and tones have now been scientifically shown to be unrelated to intelligence, productivity, morality or other social values, they have been linked to these incorrect beliefs in the general social consciousness worldwide. The same is true of skin diseases.

In essence, these two factors are responsible for the duality of social construction of power based on the skin. Because the skin is readily visible and amenable to linkage with human flaws, it becomes a tool for social differentiation, discrimination, dominant narrative discourse and other social interactions, which then perpetuate these perceptions all the way to their solidification in social institutions. This is what Berger and Luckmann referred to as institutionalization and legitimization. Simultaneously, social structures, having been setup in this way, essentially force individuals to subscribe to the social norms, endorse the behaviors, defend the values and interpret daily stimuli within an all-encompassing social reality. Social interactions are thus also responsible for perpetuating the process of human social identity formation, which Berger and Luckmann referred to as internalization. While it is clear from the literature *why* these links persist, although to varying degrees, the author's theoretical model proposes a stepwise mechanism for *how* the skin has been made into a tool for power allocation in various societies worldwide.

Step 1 - Perceptions: Construed Evidence of Truths

The first step in this social construction pathway is the modulation of perceptions, which can be defined as "an awareness of the physical environment through the physical senses, a mental image, or a quick, intuitive cognition" (Merriam-Webster's Dictionary). These form the first step in the social construction process as they are the earliest link between individuals, their innermost thoughts, which are more within the realm of psychology and theosophy, and the social context. Like all other steps in the social construction pathway as defined by Berger and Luckmann (1966), and expanded here, they are subject to modulation by repeated social interactions. The author is certainly not suggesting that social interactions can supplant the individual's own free will in choosing what to believe as truth. However, it is clear that both true and false perceptions can help create a reality from which it is hard to escape, and this process begins as early as infancy.

For example, with regards to perceptions of skin color, research has found that its tone is an important marker of stereotype perception starting in childhood (Averhart & Bigler, 1997). Children showed better memory for stereotypes than counter-stereotypes about skin tones, and this related to degree of negative perceptions of both the self as well as of African-Americans. Viewed from the social constructionist perspective, it seems as though children begin to perceive the color of the skin not only as a mechanism of differentiation among people, but more importantly, as a marker of negative characteristics among different people. Another author who also studied this phenomenon

in children suggests that the mechanism by which these negative perceptions develop are not culturally bound (Hirschfeld, 1988), signifying that there may be a common process that allows them to emerge across cultures and societies.

This paper argues that this common underlying process is the social construction of skin color as a marker of otherness. Hirschfield (1988) supports this idea when he says that the "social classifications [of people] vary cross-culturally, but critical acquisition of these concepts do not" (p. 611), and "how we come to acquire something may vary relatively little with respect to variation in what we ultimately acquire" (p. 612). He also points out that children are not necessarily perceiving skin color in racial terms, but rather they are first and foremost perceiving it as literally different skin tones. An interpretation of this finding from the model could be that children have simply not had sufficient social interactions to transform their perceptions into beliefs, but they do in fact perceive a difference between individuals based on their skin color. What is striking is that both Averhart and Bigler (1997) and Hirschfield (1988) have found that both White and Black children had negative perceptions of dark skin. One can already see how this could be problematic: if these perceptions continue unabated by more positive social interactions, the development of issues with emotional health is clearly in the forecast in greater proportion for one group as compared to the other. This is certainly what is seen in children with skin diseases as well. For example, very young children with atopic dermatitis (i.e. eczema) have poor self-perceptions (Aghaei, Sodaifi, Jafari, Mazharinia, & Finlay, 2004; Chamlin, 2006; Chamlin, Frieden, Williams, & Chren, 2004). Atopic dermatitis is a disease that tends to occur as early as infancy. Viewed from a social constructionist perspective, it is not unlikely that these children's poor self-perceptions are based on the perception of others as being normal and the self as abnormal.
This process not only continues into adulthood but its severity accelerates as well, with substantially negative consequences for the individual and his or her health. For example, Borrell et al. (2006) found that perceived discrimination is associated with perceived physical and mental health in adult African Americans. This finding suggests two ideas relevant to the author's theoretical model. First, it serves as striking evidence of internalization of skin color as embodiment of poor self-perception: those who see themselves as belonging to a socially disadvantaged group also believe that they have worse physical and mental health outcomes. Even if the reality shows that they are in fact in poorer health, the more important point is that they have in essence embodied the disadvantage mentally and physically. This is one of the major consequences of the social construction of power, based on skin color, on health outcomes.

Second, it points to discrimination as one of the social interactions that is most responsible for negative health outcomes in individuals with darker skin tones. While not often interpreted in this light, discrimination is one of the social forces that modulates the perceptions of individuals, particularly that of those who are at the receiving end of the discriminatory action. It is important, however, to recognize that discrimination is not the only social interaction that influences patient perceptions. Another major force in this process is the discourse or dominant narrative. Numerous scholars have addressed this issue, but in the realm of biomedicine, Lupton (2000) puts it best when she says that

Black bodies were not initially perceived as normal but rather as “inferior”, “dirty”, “diseased”, “savage”, and “uncivilized” (p. 58).

Last but not least, within the realm of perception and the effect of the skin on the social construction of power and agency, researchers have found that while the location of the skin disease does not determine the patient’s self-perception, it is in fact critical to the social perceptions of the patient (Barankin & DeKoven, 2002), with visible lesion (such as on the face or arms) having greater social implications than others. This reinforces two points relevant to the theoretical framework discussed in this paper. First, it suggests that regarding the modulation of social perceptions via social interactions with the diseased individual, the visibility of the skin disease to the outside world is what is most important (Kent & Keohane, 2001). Second, in contrast to skin diseases, which may not always occur in areas readily visible to everyone, it is impossible to hide skin color while still participating in the affairs of society. Thus, skin color serves as an inescapable social marker of perceived otherness, even more so than skin diseases, which can at times be hidden from society.

The conclusion here is that perceptions form the initial stage in the social construction of any phenomenon, and like all stages in this process, they are subject to various types of social interactions that seek to steer them in one direction or another. These social interactions, when negative, can create both poor self-perceptions in the individual as well as deleterious perceptions of the individual by the broader society. This then has the ultimate effect of synergistically constraining individual agency.

Step 2 - Opinions and Values: Perceptions Encoded as Experiential Truths

Values, in this context, can be construed as “a quality that gives something special worth”, while opinions signify “a position arrived at after consideration” (Merriam-Webster's Dictionary). These are thought to form the second stage in the social construction process because in essence they are an extension of perceptions, yet they are different because they can be placed further along in the social construction pathway. Opinions and values or beliefs are more than just perceptions in that they have come to be seen as valid truths, not only for the individual but also for the broader society as well. In the realm of normal skin, there is ample literature to demonstrate that different values and beliefs have been assigned to different skin tones, both by the individual on him or herself, and by society. One of the most striking empirical demonstrations of this phenomenon was a recent study by Dixon (2006) on the differential perception of potential criminals by news viewers. The study found that heavy news viewers were more likely to assign greater culpability to ambiguously guilty Blacks than ambiguously guilty Whites, with a gradual lessening of perceived culpability for Blacks as the skin toned lightened from dark to medium to light. Initially this may appear to be just a simple expression of perceptions, but several important points arise that are relevant to the proposed conceptual framework. First, the fact that only heavy news viewers made this verdict as compared to other news viewers suggests that the former have had greater exposure to mass media as a form social interaction than the latter. It also confirms the power of the media in helping to socially construct public opinion on race, ethnicity and

skin tone. Second, the fact that there was a direct correlation between the skin tone and perceptions of guilt implies the existence of the underlying value judgment among the heavy viewers that skin darkness is a determinant of criminality and other deviancies. These results are corroborated by other studies in the criminal justice field (Levinson & Young, 2010).

These types of beliefs are widespread and have been demonstrated in the literature. For example, several authors have shown how race has long been seen as a marker of deficiency, how this idea has been socially constructed over centuries, how different races are seen as having different deficiencies, and how this phenomenon has become and remains a social value in certain societies (Krieger, 1987; Saldanha, 2006). Breland (1998) has demonstrated that among African Americans, there is a general belief that those with lighter skin are not only more attractive, but also more competent, which are two value judgments that have been socially constructed by a society that values physical attractiveness based on European standards.

With regards to diseased skin, there is ample evidence for the social construction of agency around values and beliefs about the disease. For example, patients with onychomycosis, an infection of the nail beds that can be very unsightly, experience significant embarrassment (Drake et al., 1999; Drake et al., 1998). Certainly this is more than a simple perception of self. Upon closer examination, it becomes clear that these patients are in fact making a value judgment about themselves and their beauty. While it is true that the latter is a type of social value, one whose most desirable manifestation may differ across societies, it is nonetheless socially constructed. Other skin diseases have similar effects on self-perceived beauty, but they can also lead to social problems originating from outside the individual's realm of control that are directly tied to the societal perception of the loss of beauty (Van Der Donk, Hunfeld, Passchier, Knegt-Junk, & Nieboer, 1994).

Another social value that has previously been associated with the perception of skin diseases is the morality of patients as well as their families. Evidence of this abounds in the medical literature, but the most striking contemporary examples occur in developing countries, especially in patients with neglected tropical diseases (Weiss, 2008). While the author points out that stigmatization is the major contributor to the perpetuation of these value judgments on morality, he also suggests that they are perpetuated by the chasms in political power that exist between the poor and the rich, both in tropical and temperate nations. Viewed in the context of this model, it can be said that both stigmatization and socioeconomic marginalization are important social interactive mechanisms that perpetuate these beliefs.

Thus, it can be said that values are perceptions that have become so critical to the social reality of the individual that they have effectively stopped questioning their validity as real phenomena. This has been shown here by dissecting the social views on values such as beauty and morality, and it has been shown that these can be constructed around gradations of skin color or disease.

Step 3 - Expectations and Behaviors: Values Acted Out as Axiomatic Truths

Behaviors can be defined as "the manner of conducting oneself", while expectations can be defined as "the consideration of something as probable, certain, reasonable, due or necessary" (Merriam-Webster's Dictionary). They are thought to form the third step in the social construction process because, in essence, they represent the enactment of values by individuals as well as social groups. This moves social constructionism out of the realm of the mind and into the objective or physical world. The same types of social interactions that influence the formation of perceptions and values are also the ones that begin to institutionalize perceptions and values by promoting individual and collective behaviors reflective of these values.

One of the most interesting examples of this phenomenon is the finding that healthcare provider behaviors relative to patients of different races and ethnicities have a direct influence on the perpetuation of health inequities (Van Ryn & Fu, 2003). What is particularly important to note is that these authors essentially describe a social constructionist model of this phenomenon: they show how provider beliefs (about social and behavioral characteristics of the patient), behaviors (such as participatory style and warmth during the clinical encounter), and professional norms (regarding diagnosis and proposed treatment course) interact to influence the agency of patients within healthcare systems in ways that perpetuate racial inequities in health.

In the realm of diseased skin, there is ample evidence of values acted out as behaviors as well. For example, atopic dermatitis is a disease that often manifests on the face, and children afflicted by it are often avoided by other children (Aghaei et al., 2004; Chamlin, 2006; Chamlin et al., 2004), leading to their social isolation from their peers and all the potential repercussions that this implies. If we interpret this behavior in the context of the proposed conceptual model, we can deconstruct the steps of this behavior as follows. First, children are taught to perceive differences, particularly in the skin, whether normal or abnormal. Next, these perceptions become encoded as values related to beauty, normality, or deviance. Finally, these values guide behaviors regarding the diseased individual, and in the above example, the social response is the isolation or ostracism of the individual from the group.

The consequences of the social isolation of individuals can be devastating for the patients and their families. For example, the stigma of untreated tropical diseases (especially those with skin symptoms) has a tremendous influence on the social isolation and efficacy of those affected and their families (Weiss, 2008). The agency of the patient and his or her family is severely constrained not only by the shame of the stigma, but also by the literal loss of social interactions that could have been beneficial to the prompt resolution of the problem.

On the other hand, there is also evidence of the acquisition of potentially beneficial social interactions related to perceptions of the skin. For example, it was found that lighter skinned women are more likely to have greater "high status" social capital than darker skinned women (Hunter, 2002). This, in essence, means that, all else being equal, having

lighter skin results in a greater willingness of other people and of institutions to collaborate with and assist the individual. It also implies a greater likelihood to share, trust, and reciprocate, which are the 3 components of cognitive social capital (Islam, Merlo, Kawachi, Lindstrom, & Gerdtham, 2006).

Thus, it becomes evident why behaviors are the next logical step in the social construction pathway. People generally behave in accordance with their socially constructed beliefs about skin color and its implications for the personal characteristics of the individual. The integrated threat theory (Stephan, Ybarra, & Bachman, 1999), which seeks to predict prejudice towards immigrants, actually fits well within the framework of this paper. Its four components (i.e. realistic and symbolic threat, stereotypes and in-group anxiety) are in fact instances of values that have become expectations and behaviors.

Step 4 - Sociocultural Norms: Expectations and Behaviors Sanctioned to Protect Universal Truths

Norms are "patterns or traits taken to be typical in the behavior of a social group" (Merriam-Webster's Dictionary). They form the fourth step in the proposed model of social construction because they represent expectations and behaviors that have become solidified as social truths, to be accepted by everyone even at the risk of being imposed upon them. This stage is also different from prior stages because here, the "truths" are not only taken to be self-evident, but individuals and groups face the threat of non-institutional social reprimand should they question these. Still, the same social interactions continue to modulate norms as well, and this then has implications for the healthcare system and all social institutions and their patrons.

For example, the literature on racialization has shown this process to be particularly prevalent in the United States (Duany, 1998), with inevitable socio-structural consequences for all who reside within the borders of the nation. Racialization is the process of creating a racial identity where one may not have existed beforehand. Studies have shown that Dominican immigrants to the US are quickly racialized into the categories of Black and White, and that the resulting categorizations relegates each group to its corresponding racial group in the labor market and other social structures. Racialization, in turn, can be seen as one of the many social interactions that drive social constructionism by reinforcing the norms of superiority of Whites.

Another social norm that has taken hold of the US is the colorblind perspective that insinuates that class and culture, not institutionalized racism, are responsible for inequality (Gallagher, 2003). This idea has become even more normative since the election of President Obama, with many Americans now perceiving that the nation has entered a post-racial phase of its history, in spite of the evidence to the contrary when blatant racial inequities continue to exist across all social structures. Part of this norm is the failure to recognize whiteness as a culture, which facilitates ignoring White privilege as the normative order (Hyde, 1995). Another race-based social norm in the US is the gradually greater acceptability of inter-racial marriage. Yet even then, there are still some

socially constructed disparities related to skin color. For example, lighter-skinned women have higher educational attainment/incomes and marry higher status husbands, controlling for other variables (Hunter, 1998). They are also more likely to marry lighter-skinned or White spouses (Gullickson, 2005).

Medicalization is a type of social interaction whereby the medical establishment acts to make a previously social issue a medical one, and it has the capacity to normalize behaviors surrounding the disease. It is interesting to note that, in part, the early attempts at the medicalization of skin color, via its biological classification as races in the medical and social science discourse, played a major role in the social construction of race-based power in world history (Witzig, 1996). On the other hand, the medicalization of skin diseases (or any other disease for that matter) has often had the beneficial effect of at least mitigating social stigma by using the political power of biomedicine to change social structures (Goodman & Goodman, 1987). For example, the medicalization of leprosy in Westernized nations has been shown to not only help control the infectious spread of the disease, but has also led to some decrease in the social stigma of the disease, at least at the institutional phase (Obregon, 2003). The stigma of leprosy, however, has long been and remains a substantial obstacle to seeking treatment in many countries (Arole, Premkumar, Arole, Maury, & Saunderson, 2002).

Nevertheless, what is striking is that even medicalization and the power of biomedicine cannot immediately overcome entrenched stigma in the broader social realm. This theoretical model provides a glimpse as to why this is the case. First, when a condition is recognized in the scientific literature as being stigmatized, according to this model, it is a sociocultural norm, which implies that various social interactions have modulated the perceptions, values and beliefs, attitudes and behaviors of the population in question. They have already been conditioned to not only believe that the people with the disease have some sort of moral or other deficiency, but they have also been trained to react negatively towards these individuals. As such, while medicalization can begin to reverse the stigma, it does so primarily at the level of the healthcare system as the social structure within its grasp. Eventually this may begin to change the sociocultural norm of stigma, but it should not be expected that medicalization, as an intervention at the socio-structural level, would lead to immediate changes in sociocultural norms, since these are two very distinct steps in the social construction process.

Similarly, there is evidence that the sociocultural norms of the profession of medicine can impact patient agency. For example, there is a common belief among healthcare providers that atopic eczema is a relatively minor, biologically self-limiting condition and thereby not worth the trouble of treating (Fennessy, Coupland, Popay, & Naysmith, 2000). One could say that this is perhaps one of the most deleterious norms within the medical profession that impede the ability of clinicians and their patients to work efficiently and successfully to control and cure this disease. Making matters worse, research has already demonstrated that the social isolation of the child with atopic eczema and other visible skin conditions is well-known and not uncommon (Chamlin et al., 2004). The presence of health professional norms promoting the view that some skin diseases are banalities certainly encourages healthcare provider behaviors during the

clinical encounter that are unsupportive of the patient's needs, with untold consequences on clinical care outcomes.

Step 5 - Social Structures and Institutions: Norms Encoded into the Fabric of Objective Reality as Socially Protected Truths

Institutions are "significant practices, relationships, or organizations in a society or culture" that "are firmly established" (Merriam-Webster's Dictionary). It is at this stage in the social construction spectrum that one arrives at the full embodiment of thoughts into the very fabric of objective reality. What makes these different than social norms is that they are politically and economically supported physical entities whose functioning is socially sanctioned and protected. While they are not part of the social construction process per say, they are the endpoints of the social construction of society into objective reality via institutionalization and legitimization, and they are the starting points of the social construction of society into subjective reality via internalization and identity formation, as described by Berger and Luckmann (1966). Thus, it is important to explore the impact of shades of skin at that level as well.

It is clear that structural inequalities are often embedded in social structures, but what is often not clearly stated is that these inequalities can be independently associated with skin color (Lovell & Wood, 1998), irrespective of socioeconomic status or other measures of individual agency that can become embedded in race. For example, studies have found that the darkness of the skin is inversely proportional to wages among Latino men in the United States (Gómez, 2000), and the same is true among African Americans of different skin tones (Goldsmith, Hamilton, & Darity, 2007). Another study suggests that White supremacy and domination in all social structures is inherently tied to White privilege, meaning it lies beyond discourse, but rather is embedded in the political processes, policies, and social decisions that make it the default social reality (Leonardo, 2004). The implication of all of these findings is that shades of normal skin, whether perceived as race, ethnicity, or color, are embedded at the very foundation of social institutions. Therefore, they too serve as starting and end points for the social construction of reality.

The way society handles skin diseases also becomes entangled in social structures. For example, the stigma related to chronic diseases, such as leprosy or Kaposi sarcoma in the acquired immunodeficiency syndrome (AIDS), has had tremendous implications for public health programs (Van Brakel, 2006), even in developed nations. The history of the AIDS epidemic and outward markers of the syndrome, such as Kaposi sarcoma's purple skin lesions, should leave no doubt in anyone's mind as to the ramifications of socially constructed reductions in patient agency (Alonzo & Reynolds, 1995). In some countries, particularly in the developing world, patients with certain skin diseases can even lose their civil rights and be barred from protection under the law (Weiss, 2008). In essence, when encoded into social institutions, skin diseases can actually become more than just objects of negative self-perceptions and in fact may turn into sources of oppression that are sanctioned by governmental entities.

Implications of Skin-Based Social Construction of Agency for Healthcare Systems

This paper suggests that there may exist a stepwise mechanism that delineates the paths of social construction of phenomena from individual thoughts to social structures and back. While it is well supported by the literature, which shows the existence of prior models that are similar in scope as well as evidence in support of its component parts, this model certainly needs to be empirically tested before serving as a tool to study the social construction of healthcare or other phenomena. Nevertheless, it has a number of implications for healthcare systems.

From the perspectives of healthcare researchers, whether their interests lie in the disciplines of social psychology, sociology, anthropology, philosophy, medicine and other fields, or in topics relevant to health disparities, health equity or health services, there is a need to study the mechanisms of social construction of healthcare phenomena, whether these are definitions, categorizations, diagnostics, treatments, caring patterns and roles, regulations and policies, or patient and provider agency. Research is already demonstrating that the structural-constructivist model, also known as the social constructionist model, holds great promise in truly explaining variations in healthcare delivery processes and outcomes (Dressler et al., 2005), regardless of the disciplinary perspective taken.

Also notable is the fact that this paper demonstrated the usefulness of research on skin types to inform the study of skin diseases and the social construction of reality for those affected. It has shown that while normal skin types and skin diseases are biologically different, the social construction mechanisms, which guide the life experiences, courses and choices of the people affected, are the same whether one looks at the stepwise stages of social construction, or the social interactions that modulate these stages. One observation that arises by studying these entities together is how at various points in history, what are now considered normal skin types were actually viewed, that is socially constructed, as diseased and inferior skin.

Another useful observation is the deconstruction of race into its component parts, including hair, nails, eye color, and in particular skin color. This is important because research has shown that while policy and social justice efforts have focused on the difference between races, there is evidence of discrimination on the basis of skin color within races (Jones, 2000). Social constructionism helps to uncover areas of research disparity and new interpretations of existing knowledge because it emphasizes the importance of contextualizing data from the micro to the macro level. In this way, the social constructionist approach helps to deconstruct the processes of decision-making in healthcare, elucidating not only the patient's role, but also that of the providers and other social actors in the perpetuation of social inequities in healthcare.

Finally, this paper demonstrates that the concept of "shades of skin" is useful in the study of skin diseases because it allows the study of gradations at all levels, whether individual, informal, formal, social, or structural, which more closely reflect both current and historical evidence on this phenomenon. It revealed one possible process by which the

gradations in the human skin themselves have translated from the perceptions of individual people and groups into the very fabric of social reality, by progressively being embedded into values, behaviors, norms and social structures. From this vantage point, decision makers in societies worldwide would have to accept that this gradation still persists, and that even though it may appear to be dissipating, it may be that its explicit expression in daily discourse, whether at the policy or vernacular level, is no longer outwardly evident but instead lies dormant (La Torre-Mac Neill, 2011).

Conclusions on Social Constructionism as a Grand Theory Explaining the Reality/Identity and Structure/Agency Conundrums

The scientific literature on racial or ethnic disparities in health generally discusses the impact of individual thoughts and behaviors on health outcomes (i.e. public health, medicine and nursing) or the impact of social structures on health outcomes (i.e. health disparities research); however, little research exists on how individual thoughts and behaviors are simultaneously constructed by and influence healthcare systems and outcomes. By looking for evidence of how both of these mechanisms operate at a micro level, we can begin to uncover some pathways of the inner workings of individual, group and social dynamics. For example, this paper suggests that the social construction of a phenomenon proceeds in a stepwise fashion and is propelled by various social interactions that affect groups of people differently than others. It has also shown how the social construction of different phenomena (i.e. skin color, race and ethnicity, compared with skin diseases) actually proceeds along the same logical pathways.

There is a need for further research on the processes by which individual and group perceptions become institutionalized and by which institutions modulate the life experiences of individuals and groups. While the allocation of power within healthcare systems using shades of skin serves as an illustration of this stepwise pathway of social constructionism, an equally important contribution of this paper is the proposed mechanism itself, which could potentially be applied to the study of other socially constructed phenomena. Still, by demonstrating how the social construction of shades of power begins with perceptions of shades of skin and ends with the encoding of inequality into social structures, this paper sought to peel away the shades that mask the unfortunate reality of skin-based inequity within healthcare systems and other social institutions. In addition, using the ample literature available on the role of the skin in human social interactions, this paper not only describes one phenomenon, among the infinite many that can be socially constructed: it also proposes a plausible conceptual model with widespread scientific applications and philosophical implications. In essence, the author's social constructionist model may be the grand theory that addresses the longstanding reality/identity and structure/agency conundrums.

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