Tips about treating Ethnic skin: Africans

I know that it is politically incorrect to highlight differences between “blacks” and “whites”. However, as skin care therapists, we would do our clients a great disservice if we ignored the real differences between those clients with dark type V or VI skin and treated them as though they have Type I, II or type III skin.

Many people make the mistake of thinking that African skin is thick and oily. They also say it is darker because it has many more melanocytes. Let’s examine these myths and find the truth. First of all, let’s look at the obvious difference in colour. African skin definitely has more melanin in it. Melanin is an amazingly powerful antioxidant and is unusual in that it absorbs almost all the different rays of light from red right up to Ultraviolet. Because of its absorption pattern, it reflects almost no colour and so we see it as black or very dark brown.

What advantages and disadvantages are there to having more melanin in the skin?

We already know that the darker the skin is, the less likely it is to become wrinkled. This then makes some people think that the African skin is more resistant to damage by the sun and that their skin is “tough.” Nothing could be further from the truth. African epidermis is very sensitive to solar damage even though the deeper layers are better protected and so wrinkles are less likely to occur. We have to remember that there are two types of UV rays: UV-B which affects the epidermis in both white and black skinned people, and UV-A which penetrates deeper into the dermis in lighter skinned people. Africans suffer from UV-B damage mainly, and get less UV-A damage to the dermis.

The number of melanin producing cells in the skin is the same, no matter whether you are light-white skinned or dark black! In all of us the number varies depending on the site on the body – we are all aware that our skin in some parts is darker than in others. In general, there are about 1000 to 2000 melanocytes per square millimetre of skin in all people.

If you expose an African skin to more sun, then it will become darker and even approach an ebony colour, as you can see in tropical Africa. That dark colour is simply because more granules of melanin have been made, more efficiently than in a white skin. The melanosomes (the granules of melanin) are larger, blacker and more resistant to oxidation than the melanin found in light skinned individuals. It is also important to know that these melanosomes become positioned above the nucleus of the keratinocyte. You could say that the melanin is being used as an umbrella to protect the vulnerable DNA in the nucleus. This could explain why skin cancer in all its forms is less common in Africans and dark skinned individuals than amongst Caucasians.
However, this tendency to make melanin easily sometimes becomes a problem because dark patches may occur post-inflammation or on sun-exposed areas. We have all seen the ugly acne or chicken pox scars that can occur on darker skinned people. We know that African skin reacts in a more exaggerated way than Western skins to inflammation.

Many skin care therapists consider pigmentation problems a good indication for skin peeling. Some of you may have tried it on an African client and then discovered, to your dismay, that African skin does not react the same way as the pale Caucasian. African skin is more acidic than Caucasian skin and I have found that when you peel an African skin, you have to use the gentlest peel. They frost quicker and the burn seems to go deeper and they are at real risk to develop post-inflammatory hyperpigmentation. If one peels too deeply then the horrible complication of hypo-pigmentation may occur. Fortunately that is uncommon, but a blotchy complexion can be very obvious in dark skinned people.

Here is where I feel it is important for us to realise that pigmentation problems arise because of exposure to the sun, and particularly to UV-A. Our best natural defence against UV irradiation is the epidermis and particularly the horny layer. So we should do as little as possible to disturb that horny layer. We need to thicken the horny layer especially in our darker clients. Therefore, avoid scrubs and exfoliation techniques as much as possible. This will surprise many people because they will have seen that pigmentation problems seem to rapidly lighten with strong AHA products. In African skin, melanin remains dark right up into the horny layer. When we use strong AHA products, the acid changes the melanin and makes it paler without in fact reducing the number of melanosomes, or reducing the production of melanin. The melanin is just less visible and the danger is that because the horny layer has been made thinner, the penetration of the UV rays can be deeper and eventually the pigmented mark can become larger. Peeling is also out! Not only is the skin thinner and more vulnerable, it may also become inflamed and lead to post-inflammatory hyperpigmentation. That way your client will really suffer.

We need to feed the skin with those particular nutrients that make a thicker skin: vitamin A, especially in the gentlest form of retinyl palmitate – is the most important. Nothing approaches vitamin A in its ability to thicken skin.

Black skin does not show any differences in sweat glands; sweat production or sebaceous gland activity. However, there is less severe nodular cystic acne in Blacks. Unfortunately, this can occur on the back of the neck in the hair and the scars may become keloids. Unfortunately African skin has a greater tendency to make keloid scars, or to produce hypertrophic (proud) scars. The hypertrophic scar may flatten in time but will be very noticeable.
Trauma in general, in African skins shows up in a more pronounced way. Many Africans from rural areas have dark pigmented scars on their legs where they have been bitten by insects or have had an infection. There is not much that you can do about these pigmented marks except to feed the skin with vitamin A and vitamin C to try and lighten the skin. Don’t do any aggressive procedure that may only aggravate the condition. Also be careful to not do any other procedure that might cause inflammation and subsequent hyperpigmentation. If it has happened in one area, then it is likely to happen in another area that becomes inflamed.

I have met therapists who think Africans don’t get dry skin. They do, but it is less common than amongst whiter skin. I believe they suffer less sun damage and as a result have higher levels of glycosaminoglycans in their skin. Dry skin shows up as grey flakes on the skin and tends to be associated with vitamin A deficiency. You can be surer that this is a deficiency of vitamin A if you notice follicular hyperkeratosis on the arms or legs. These are dry plugs of keratin surrounding the hairs that look as though they could be easily removed – but aren’t. So please make sure that your client is taking a healthy diet with sufficient natural vitamin A as found in fish oils, and animal livers. Treat the skin with mild doses of vitamin A.

Vitiligo is a major cosmetic problem in darker skins because it is seen so readily. The incidence of vitiligo is 2% of the population, which is the same as in whites. Beware of medicaments that can cause lightening of the skin. Benzoyl peroxide and azelaic acid which are both used for acne, can cause loss of pigment though this may only be temporary in the case of azelaic acid.

A really big problem is the damage that is caused to skin by skin-bleaching creams. A significant percentage of Africans have used or will use a bleaching cream. The most popular type contains hydroquinone, which is extremely effective but unfortunately has a high complication rate. Hydroquinone is banned as a cosmetic agent in my country because of the severe damage that black skinned people have suffered. It can cause permanent hypopigmentation, blotchy areas of dark and light pigmentation, or, after prolonged use, it may cause Ochronosis of the skin. Ochronosis is a severe problem because the skin is discoloured yellowish by the deposition of hydroquinone crystals in the dermis. The pigmentation is irregular and often very dark black. Associated acne may occur and the skin is inflamed. Generally considered to be irreversible. The problem is that hydroquinone products generally make a noticeable lightening of the skin and then when the applications are stopped or reduced, the pigmentation recurs and so the client uses the hydroquinone again and for longer, and after several sessions the client is left with a pigmentation blemish that exceeds the original mark. I advise all Africans to avoid using hydroquinone.
in any form. Rather use safe products containing vitamin A, C or azelaic acid, and kojic acid.

Retinoic acid has been shown to be effective in treating African skin for acne but it can produce inflammation and hyperpigmentation, but that lightens over about 12 weeks after stopping. It is safer to use retinyl palmitate in African acne skin because this will not cause hyperpigmentation. Acne is fortunately less common and less severe in Blacks, but it may cause more permanent hyperpigmented scars.

Your male clients with African skin may need advice about shaving because they have thicker hair that has a greater tendency to bend over and grow into the skin. This may also cause facial hyperpigmentation and I believe this is one indication for judicial, light peeling. I use a low dose acid (TCA 2.5% or 5.0% in a gel or cream base and only leave it on the skin for a short while. This seems to disinfect the problem area, and also softens and straightens the hair. Periodic use seems to prevent the problem and make shaving easier. You could also advise them to use an electric razor, which does not shave too closely.

I have tried to point out that people with African skin must be treated as gently as possible. Their skin reacts more than Caucasian skin and problems may leave permanent marks. They do not have tough, insensitive skin and they need highly skilled skin care therapists to keep their skin a beautiful even colour with no blemishes.