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A systematic review of studies examining the relationship between reported racism and health and wellbeing for children and young people

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ABSTRACT

Racial discrimination is increasingly recognised as a determinant of racial and ethnic health inequalities, with growing evidence of strong associations between racial discrimination and adult health outcomes. There is a growing body of literature that considers the effects of racial discrimination on child and youth health. The aim of this paper is to provide a systematic review of studies that examine relationships between reported racial discrimination and child and youth health. We describe the characteristics of 121 studies identified by a comprehensive search strategy, including definitions and measurements of racial discrimination and the nature of reported associations. Most studies were published in the last seven years, used cross-sectional designs and were conducted in the United States with young people aged 12–18 years. African American, Latino/a, and Asian populations were most frequently included in these studies. Of the 461 associations examined in these studies, mental health outcomes (e.g. depression, anxiety) were most commonly reported, with statistically significant associations with racial discrimination found in 76% of outcomes examined. Statistically significant associations were also found for over 50% of associations between racial discrimination and positive mental health (e.g. self esteem, resilience), behaviour problems, wellbeing, and pregnancy/birth outcomes. The field is currently limited by a lack of longitudinal studies, limited psychometrically validated exposure instruments and poor conceptualisation and definition of racial discrimination. There is also a need to investigate the complex and varying pathways by which reported racial discrimination affect child and youth health. Ensuring study quality in this field will allow future research to reveal the complex role that racial discrimination plays as a determinant of child and youth health.

Introduction

The importance of social determinants of health (including historical, cultural, environmental, and political factors) as key to understanding and addressing health inequalities is now well established (Commission on Social Determinants of Health, 2008; Wilkinson & Marmot, 2003). It is widely accepted that a range of social factors are implicated in ill-health and the persistence of health inequalities in societies, with considerable evidence of links between existing forms of social stratification and health inequalities in numerous contexts (Marmot, 2005).

Expanding the social determinants agenda to include a more explicit emphasis on social determinants of child health across the life course has been identified as a priority (Li, Mattes, Stanley, McMurray, & Hertzman, 2009). This includes greater recognition of the importance of early life conditions to later health, education and social outcomes in adulthood as well as the ways in which skills, capabilities and resilience across individual, family, neighbourhood and socio-political contexts influence accumulation of advantage and disadvantage throughout life (Maggi, Irwin, Siddiqi, & Hertzman, 2010). Moreover, the Eurocentric focus of social determinants of health inequalities research has also been critiqued (Bonnefoy, Morgan, Kelly, Butt, & Bergman, 2007), with recognition of the need for research on child health inequalities to consider a broader range of cultural and geographical contexts (Maggi et al., 2010). In particular, exploration of developmental processes for

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children from indigenous (Priest, Mackean, Davis, Waters, & Briggs, 2012) and minority racial and ethnic groups (Quintana et al., 2006) is currently underdeveloped.

Racial and ethnic inequalities in child health and wellbeing have been described across population groups and contexts, particularly in developed nations such as the United Kingdom, the United States, Canada, Australia and New Zealand (Quintana et al., 2006). The bulk of existing scholarship on racial/ethnic disparities investigates the relative contribution of genetics, health behaviours, cultural practices and beliefs and socioeconomic position (Dressler, Oths, & Gravlee, 2005).

However, racism and racial discrimination are increasingly receiving attention as determinants of racial/ethnic inequalities in health (Braveman, Egerter, & Williams, 2011). Defined as a phenomena that results in avoidable and unfair inequalities in power, resources and opportunities across racial or ethnic groups; racism can be expressed through beliefs (e.g. negative and inaccurate stereotypes), emotions (e.g. fear/hatred) or behaviours/practices (e.g. unfair treatment), ranging from open threats and insults (including physical violence) to phenomena deeply embedded in social systems and structures. The behavioural or practice-based forms of racism are commonly known as racial or race-based discrimination. Racism can occur at three levels: internalised (i.e. the incorporation of racist attitudes, beliefs or ideologies into one's worldview), interpersonal (interactions between individuals) and systemic racism (production, control and access to labour, material and symbolic resources within a society) (Berman & Paradies, 2010; Paradies, 2006a).

Within the literature, the terms racism and racial discrimination are at times used interchangeably (Giscombe & Lobel, 2005) and often poorly defined (Paradies, 2006b). In this review we use the term 'racial discrimination' for consistency and brevity, and in recognition that discrimination as unfair treatment is generally the most common form of racism to be perceived and reported. In using the term 'racial discrimination', we include discrimination due to race, ethnicity, culture and religion, acknowledging the overlapping nature of these categories within popular and academic discourse, rather than as an endorsement of 'race' as an essentialist biological category. While the inclusion of religion in such definitions is debated, we do so in recognition that religion is often conflated with ethnicity and culture in popular culture (Hartmann, Winchester, Edgell, & Gerteis, 2011). Scholars are also increasingly describing the racialised nature of religious identity, noting that many markers used to discriminate against racial/ethnic groups are identical to those applied to religious groups; thus making it difficult to disentangle these forms of discrimination (Dunn, Klocker, & Salabay, 2007; Hartmann et al., 2011).

Experiences of racial discrimination can be subtle, unintentional, unwitting and even unconscious. Events caused by other factors may be misconstrued as racial discrimination while racist events may go unnoticed. However, research suggests that respondents are more likely to under than over report experiences of racial discrimination (Kaiser & Major, 2006). Moreover, given that internalised racism is, by its very nature, unrecognised by those suffering from it while systemic racism is often so pervasive that it is invisible and/or taken for granted, these forms of racial discrimination are particularly difficult to perceive. As such, it is important to note that the studies included in this review are unlikely to capture the full extent to which racial discrimination and racism impact on health and wellbeing for children and young people.

Racial discrimination can affect health and wellbeing through several pathways: (1) restricted access to social resources such as employment, housing and education and/or increased exposure to risk factors (such as unnecessary contact with the criminal justice system); (2) negative affective/cognitive and other patho-psychological processes; (3) allostatic load and other patho-physiological processes; (4) reduced uptake of healthy behaviours (e.g. exercise) and/or increased adoption of unhealthy behaviours (e.g. substance misuse) either directly as stress-coping or indirectly via reduced self-regulation; (5) direct physical injury caused by racist violence (Brondolo, Brady, Libby, & Pencille, 2011; Brondolo, Hausmann, et al., 2011; Gee, Ro, Shariff-Marco, & Chae, 2009; Harrell et al., 2011; Paradies, 2006b; Pascoe & Smart Richman, 2009).

A growing body of epidemiological evidence shows strong associations between self-reported racial discrimination and poor adult health outcomes across diverse minority groups in developed countries (Brondolo, Brady, et al., 2011; Brondolo, Hausmann, et al., 2011; Harrell et al., 2011; Lee & Ahn, 2011, 2012; Paradies, 2006b; Pascoe & Smart Richman, 2009; Williams & Mohammed, 2009). There is also emerging research examining the impact of racial discrimination on the health and wellbeing of children and young people who are considered particularly vulnerable to its harmful effects (Pachter & Garcia Coll, 2009; Paradies, 2006b; Sanders-Phillips, 2009; Williams & Mohammed, 2009). Childhood exposure to either direct (Coker et al., 2009; Nyborg & Curry, 2003; Simons et al., 2002; Szalacha et al., 2003) and/or vicarious racial discrimination (Kelly, Becares, & Nazroo, in press; Priest, Paradies, Stevens, & Bailie, 2010) has been linked to poor child health, wellbeing and development. Experiences of racial discrimination due to structural racism also impact on children's wellbeing through access to resources needed for optimal health (Sanders-Phillips, 2009) and internalised racism has been associated with poor child health outcomes (Chambers et al., 2004). Racial discrimination has the potential to negatively affect the development and adjustment of children and young people, with potential consequences throughout the life course. In addition, children of parents affected by racial discrimination (i.e. children experiencing vicarious racial discrimination) are at increased risk of developing emotional and behavioural problems through less supportive parenting and/or changes in racial socialisation (Mays, Cochran, & Barnes, 2007; Sanders-Phillips, 2009).

Experiences of racial discrimination have been negatively associated with outcomes as diverse as birth weight and gestation (Collins, David, Handler, Wall, & Andes, 2004), socio-emotional wellbeing (Coker et al., 2009; Kelly et al., in press), childhood illnesses (Priest et al., 2010), cognitive development (Kelly et al., in press) and indicators of metabolic disease (Chambers et al., 2004). Previous reviews suggest that research to date has largely focused on African American adolescents in the United States to the exclusion of other age groups, populations and national contexts (Pachter & Garcia Coll, 2009; Sanders-Phillips, 2009).

Understanding of pathways and processes by which racial discrimination impacts on health and wellbeing outcomes for children and young people, and indeed for adult populations, is highly complex and at present relatively under-developed (Brondolo, Hausmann et al., 2011; Williams & Mohammed, 2009). While pathways by which direct, vicarious and group experiences of racial discrimination influence health and wellbeing outcomes for children and young people are all likely to differ, there may also be commonalities. It is also suggested that such processes may not only differ by the target or perceiver of racial discrimination, but may also vary within and between population groups, different ages, and type and duration of exposure to racial discrimination (Sanders-Phillips, Settles-Reaves, Walker, & Brownlow, 2009). Given the lack of current evidence regarding these processes, in this present review we have considered a diverse range of child and youth health wellbeing outcomes associated with exposure to racial discrimination of children and young people themselves, as well as vicariously by their parents and caregivers. While this unavoidably covers a range of aetiological pathways by which racial discrimination