Perceived Racial Discrimination, Drug Use, and Psychological Distress in African American Youth: A Pathway to Child Health Disparities

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Experiences of racial discrimination and social inequality are related to higher levels of psychological distress and substance use that may contribute to health disparities among youth. This within-group quantitative survey study tested two alternative theoretical models of the relations between perceived racial discrimination, psychological distress, alcohol, and marijuana use in a sample of 567 African American high school students (61% female; mean age = 15.6 years).

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Path analyses indicated most support for a model linking perceived racial discrimination to more depressive symptoms that, in turn, were associated with greater past month alcohol and marijuana use. These findings expand our understanding of the direction of effects for exposure to racial discrimination in African American youth and reinforce the need for public health policies, research, and programs for African American youth that acknowledge and address the psychological effects of exposure to racial discrimination on alcohol and marijuana use.

Racial/ethnic health disparities may be significantly influenced by social experiences and environmental exposures in childhood (Ahmed, Mohammed, & Williams, 2007; Braveman & Barclay, 2009; Krieger, 2003). In particular, exposure to racial discrimination in childhood can be related to risk behaviors, such as drug use, and higher levels of psychological distress that may contribute to racial/ethnic disparities in mental and physical health among youth (Pachter & Coll, 2009; Sanders-Phillips, Settles-Reaves, Walker, & Brownlow, 2009).

Racial discrimination is a form of inequality in societies where specific groups do not have equal status based on racial or ethnic characteristics (Sampson, Morenoff, & Raudenbush, 2005). Racial discrimination may be legal and nonlegal, and occur at the personal level (e.g., individual exposure to prejudice) and/or institutional level (e.g., discrimination in housing and education; Jones, 2000). Legal and nonlegal systems of racial discrimination contribute to health disparities by creating dominant and secondary social groups that differ in levels of power (political, economic, and personal) and access to goods and services in the society (e.g., health care; Harrell, 2000; Kendall & Hatton, 2002). While institutional racial discrimination is a primary predictor of health disparities at the group level, racial discrimination at the personal level is associated with trauma and stress as well as poor mental and physical health (Bogart et al., 2011; Mays, Cochran, & Barnes, 2007; Ryff, Keyes, & Hughes, 2003; Sanders-Phillips et al., 2009).

African American Youth and Racial Discrimination

Awareness of racial discrimination begins early in life for African American children and they report higher levels of perceived racial discrimination in comparison to other groups of youth, such as Asians and Latinos (Sellers, Copeland-Linder, Martin, & Lewis, 2006). Personal experiences of racial discrimination for African American youth may increase during adolescence and include racial slurs and name-calling, rejection, threats of physical harm, exclusion from peer activities, and experiences, such as being accused of stealing or other negative behaviors by adults (Bynum, Best, Barnes, & Burton, 2008; Simons et al., 2006; Wong, Eccles, & Sameroff, 2003).
Perceptions of Racial Discrimination and Psychological Functioning

Higher overall rates of depression and higher numbers of depressive symptoms have been reported for African American youth exposed to racial discrimination (Banks, Kohn-Wood, & Spencer, 2006; Bynum et al., 2008; Caughy, O’Campo, & Muntaner, 2004; Neblett et al., 2008; Prelow, Danoff-Burg, Swenson, & Pulgiano, 2004; Simons et al., 2002, 2006; Wong et al., 2003). In a 5-year longitudinal study, Brody et al. (2006) concluded that perceived racial discrimination was significantly related to depressive symptoms in African American adolescents aged 10–12. Bogart et al. (2011) confirmed these findings in African American adult men and also found that racial discrimination, in conjunction with other perceived discrimination (e.g., HIV discrimination; sexual orientation), was related to higher levels of anxiety as indicated by symptoms of posttraumatic stress.

Perceptions of Racial Discrimination and Drug Use

Drug use, including the amount of alcohol consumed, is also higher in youth who report racial discrimination (Chapman & Perreira, 2005; Rosario, Salzinger, Feldman, & Ng-Mak, 2003; Terrell, Miller, Foster, & Watkins, 2006; Whitbeck, Hoyt, McMorris, Xiaojin, & Stubben, 2001; Whitbeck, McMorris, Hoyt, Stubben, & LaFromboise, 2002). Gibbons, Gerrard, Cleveland, Wills, and Brody (2004) and Gibbons et al. (2007) found that perceived racial discrimination in African American youth was prospectively related to greater alcohol use over a 5-year period and to a more general tendency toward risk-taking.

Drug Use and Psychological Distress

Ahmed et al. (2007), Gibbons et al. (2004), and Taylor (2011) reported that psychological distress (including depression) preceded behavioral changes, such as drug abuse in children and adults. In a rare study of posttraumatic stress in a largely African American sample of youth, Mason, Mennis, and Schmidt (2011) also found that symptoms of posttraumatic stress preceded drug use, including alcohol use. In contrast, Pahl, Brooks, and Koppel (2011) found that marijuana use early in adolescence is associated with later psychological distress in adult African American women. Green, Zebrak, Robertson, Fothergill, and Ensminger (2012) found that substance use (including alcohol and marijuana) in African American youth predicted psychological distress, including symptoms of depression and anxiety in adulthood.
Potential Pathways Between Racial Discrimination, Psychological Distress, and Drug Use in African American Youth

Based on current findings, it is possible that exposure to racial discrimination may be associated with psychological distress that, in turn, increases the likelihood of drug use in adolescents. Conversely, exposure to racial discrimination may be associated with drug use that fosters subsequent psychological distress in youth. Efforts to identify the mechanisms by which racial discrimination impacts risk behaviors, such as drug use, in African American youth requires within-group studies that examine the proximal versus distal effects of racial discrimination.

Identifying the proximal versus distal outcomes for African American adolescents exposed to racial discrimination may enhance the development of more successful and targeted prevention and/or treatment programs for these youth (Pachter & Coll, 2009) by, first, increasing awareness that African American youth exposed to racial discrimination may present clinically with symptoms of psychological distress and/or substance use. The failure of health professionals to acknowledge the central role of racial discrimination as a factor promoting psychological distress in African American youth may result in treating symptoms (e.g., depression, posttraumatic stress) rather than the underlying cause (racial discrimination). Second, since treatment approaches for drug use versus psychological distress may differ significantly (American Psychiatric Association, 2000; Slesnick, Bartle-Haring, Glebova, & Glade, 2006), identification of the proximal and distal effects of racial discrimination may help to establish more appropriate priorities for treatment and/or public health programs for African American youth. Finally, these findings may inform public health policies by reinforcing the importance of educating health care providers regarding the effects of racial discrimination and highlighting the need for collaborative efforts across social structures to address racial discrimination in our society (e.g., law enforcement, legal) to address the effects of racial discrimination on health.

This within-group study utilized path models to examine relationships between perceived racial discrimination, alcohol and marijuana use, symptoms of depression and symptoms of posttraumatic stress in a sample of African American adolescents aged 13–18. The path models were established a priori based on previous theory and conflicting findings regarding the order of effects of racial discrimination, psychological distress, and drug use. Therefore, in Model 1, we tested the hypothesis that perceived racial discrimination is associated with more frequent alcohol and marijuana use that is subsequently related to increased psychological distress. Model 2 tested the hypothesis that perceived racial discrimination is associated with higher psychological distress that, in turn, is associated with more frequent alcohol and marijuana use.
Methods

Participants

Participants included 567 African American high school students (61% female; mean age = 15.6 years, $SD = 1.1$) who were part of a larger study of drug use in African American youth. African American youth were recruited from a high school (grades 9–12) in a large East Coast city in the United States. The participation rate in this study was 84%. The school was located in a predominantly low-income, African American community and offered a large number of students (greater than 800) who were largely African American (greater than 90%).

Procedure

After obtaining consent from the University Institutional Review Board, the research team met with school personnel and parents to explain the goals of the study; address concerns; and stress that active parental consent was required.

To decrease anxiety, the survey was administered in all-male or all-female groups led by male or female African American graduate student interviewers in closed classrooms on school grounds. The survey took approximately 1 hour to complete. To avoid reading problems, the interviewer read questions and response choices aloud. Each student privately marked his/her response on the answer sheet that was identified by code number only. Students sealed their completed answer sheet in an envelope and all envelopes were stored in a locked cabinet in the research office. At the end of the survey session, students asked questions and were given a telephone number to call if needed. Participants were paid ($20) and escorted back to class.

Measures

Demographic information. Self-reported demographic information for each participant included age, place of birth, race/ethnicity, parent ethnicity and place of birth, average family income, household size, and parent and student work status.

Drug use. Questions regarding alcohol and marijuana use were taken from the Centers for Disease Control (CDC) Youth Risk Behavior Survey that has been widely used with African American populations (Centers for Disease Control and Prevention, 2001). Scores were based on two indicators of drug use—frequency of alcohol and marijuana use in the last 30 days. These measures were selected because alcohol and marijuana use have been consistently associated with exposure
to racial discrimination (Chapman & Perreira, 2005; Gibbons et al., 2004, 2007; Rosario et al., 2003) and the use of illegal drugs other than marijuana is generally lower in African American adolescents as compared to other groups (Swendsen, Burstein, Case, & et al., 2012).

**Depressive symptoms.** The CES-D 8-item version (Melchior, Huba, Brown, & Reback, 1993) was used to assess symptoms of depression during the past week. Seven depression questions (Blues, Depressed, Failure, Fearful, Lonely, Coping, Sad) and one question on Somatic Symptoms (Sleep) were included.

**Posttraumatic stress disorder (PTSD) symptoms.** Symptoms of PTSD were identified based on responses to 12 items from the Diagnostic and Statistical Manual for Mental Disorders’ (DSM-4; American Psychiatric Association, 2000). Using a technique employed by other studies (Mason et al., 2011; Prins et al., 2004) respondents were asked to recall an event that they considered traumatic. They were free to recall any event, including episodes of racial discrimination. Using the self-identified traumatic event as a reference point, participants indicated, using a yes/no format, whether they experienced any of the posttraumatic stress symptoms when thinking about the event. A higher score reflected a higher number of symptoms of posttraumatic stress. Cronbach’s alpha in the present study was .84.

**Perceived racial discrimination.** Perceived racial discrimination was measured using a composite score from two questions. The first question (Holmes & Rahe, 1967), asked youth to rank the most stressful events in their lives based on a list of 11 choices that were identified in focus groups conducted in the first phase of our study. The list included “racism” as well as violence at home, violence in the neighborhood, violence at school, family arguments, boy/girlfriend problems, problems with friends, school problems, problems with drugs or alcohol, health problems, and other problems. Youth who indicated that “racism” was a significant stressor in their life received a score of 1. The second survey question asked whether “I believe that many of the injustices that happen to people of my race, ethnicity, or skin color are caused by racism or prejudice rather than differences in social class” (Helms, 1997). Youth who agreed or strongly agreed with the statement received a score of 1. Responses to the two measures were correlated .16 ($p < .001$) and scores summed to generate a composite perceived racial discrimination score.
Table 1. Descriptive Information on and Correlations Among the Study Variables

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<td>1. Racism</td>
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<td>–</td>
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<td>2. CES-D</td>
<td>0.11**</td>
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<td>3. PTSD</td>
<td>0.09*</td>
<td>0.36***</td>
<td>–</td>
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<td>4. Past month alcohol</td>
<td>0.06</td>
<td>0.19***</td>
<td>0.12**</td>
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<td>–</td>
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<tr>
<td>5. Past month marijuana</td>
<td>0</td>
<td>0.09*</td>
<td>0.12**</td>
<td>0.49***</td>
<td>–</td>
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<tr>
<td>6. Gender (1 = female)</td>
<td>–0.05</td>
<td>0.20***</td>
<td>0.07</td>
<td>0.01</td>
<td>–0.10**</td>
<td>–</td>
<td>–</td>
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<tr>
<td>7. Age</td>
<td>0.09</td>
<td>0.01</td>
<td>0.03</td>
<td>0.03</td>
<td>0.04</td>
<td>–0.10*</td>
<td>–</td>
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<tr>
<td>Mean</td>
<td>0.65</td>
<td>4.66</td>
<td>3.91</td>
<td>0.45</td>
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<td>SD</td>
<td>0.70</td>
<td>5.11</td>
<td>3.29</td>
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Notes. N’s ranged from 547 to 567 due to missing data. CESD, Center for Epidemiologic Studies Depression Inventory; PTSD, posttraumatic stress disorder symptoms. *p < .05; **p < .01; ***p < .001.

Results

Correlations and Descriptive Information on the Study Variables

Correlations were generated to examine the degree of statistical relationship between the study variables (Table 1). “Racism” was associated with higher levels of depressive and posttraumatic stress symptoms, but not with alcohol or marijuana use. Depressive symptoms were associated with more alcohol but not more marijuana use. Posttraumatic stress symptoms were associated with higher levels of both alcohol and marijuana use, albeit not strongly.

Overall, half (50%) of the participants reported that they had tried alcohol in the past with 7% of males and 7% of females indicating that they used alcohol “regularly” (I use more than once per month but not every day). In addition, 15% of the participants reported trying tobacco while 34% reported trying marijuana. Sixteen percent (16%) reported that they used marijuana occasionally (I use once a month or less), 6% used it regularly, and 2% used marijuana daily. In comparison, 31% used alcohol occasionally, 6% used alcohol regularly, and less than 1% (.2%) used alcohol daily.

Nearly one third (29.6%) of the participants scored 7 or higher on the CES-D. This finding indicates high levels of depressive symptoms in this sample. A score ≥ 7 is associated with a clinically significant level of depressive symptoms that is reported for fewer than 20% of the general population (Huba & Melchior, 1995).

Approximately a quarter (26.9%) of the sample indicated that “racism” was a significant stressor in life. A total of 40% of the sample agreed or strongly agreed when asked “I believe that many of the injustices that happen to people of my race, ethnicity, or skin color are caused by racism or prejudice rather than differences in social class.”
Gender Differences in Study Variables

As seen in Table 1, and confirmed by $t$-tests, females had higher levels of depressive symptoms than males, $t(545) = 4.83, p < .001$, while males reported higher levels of past month marijuana use than females, $t(552) = 2.46, p < .01$.

Path Analyses

Path analyses were conducted using MPlus Version 4 (Muthen & Muthen, 1998) to test two alternative hypotheses about the relations between racism, psychological distress, and alcohol and marijuana use. In the first model, perceived racism was hypothesized to be associated with more frequent alcohol and marijuana use, which, in turn, is related to higher psychological distress. In the second model, perceived racism was hypothesized to be associated with higher psychological distress that, in turn, is related to more frequent alcohol and marijuana use. Since both gender and age may influence responses to racial discrimination and may covary with drug use (Terrell et al., 2006), gender and age were controlled in the models. Several goodness-of-fit indices were used to evaluate the measurements models, including the $\chi^2$ test, the comparative fit index (CFI), and the root mean square error of approximation (RMSEA). Models with a $\chi^2$ probability of .05 or greater, a RMSEA value below .08, and/or a CFI value of .90 or larger were considered to have good fit (Martens, 2005; Surh, 2003).

For Model 1, the overall fit was not acceptable, $\chi^2 (7) = 228.56, p < .001$, CFI = .349, RMSEA = .236. There were significant paths from racism to past month alcohol use ($b = .10$) and from past month alcohol use to depressive symptoms ($b = .14$), but no other paths were significant. For Model 2, the overall fit also was not acceptable, but the model was a closer fit to the data, $\chi^2 (7) = 103.84, p < .001$, CFI = .715, RMSEA = .156. There were significant paths between racism and both depressive symptoms ($b = .11$) and posttraumatic stress symptoms ($b = .09$). Further, depressive symptoms had significant associations with both past month alcohol use ($b = .19$) and marijuana use ($b = .11$). Thus, we respecified the model by removing posttraumatic stress symptoms from the model. The respecified model had an acceptable fit to the data, $\chi^2 (4) = 29.64, p < .001$, CFI = .904, RMSEA = .106 (see Figure 1).

Discussion

The results of this study confirm previous findings that the most proximal effect of perceptions of racial discrimination in African American youth is depressive symptoms. In turn, depressive symptoms are related to the more distal effect of increased use of alcohol and marijuana (Banks et al., 2006; Bynum et al., 2008; Caughy et al., 2004; Simons et al., 2002). Neblett et al. (2008) found that the
association between exposure to racial discrimination and depression persisted longitudinally, even after controlling for prior levels of psychological functioning. Our findings that girls were more likely than boys to report symptoms of depression is also consistent with findings from Neblett et al. (2008) and Ryff et al. (2003), who found poorer mental health (including depression) in girls and women exposed to racial discrimination. Ryff et al. (2003) suggested that cooccurring inequalities and traumas (i.e., gender and minority status) may increase depression and exacerbate the responses of women and girls to racial discrimination. In contrast, African American adolescent males may be more likely than girls to report aggression, anger, and violence subsequent to experiences of racial discrimination (Brody et al., 2006; Gibbons et al., 2007; Simons et al., 2006).

The high levels of depression in youth exposed to racial discrimination may also provoke physiological changes, including hyperarousal, as well as changes in neuroendocrine, autonomic, and immune system function (see Ahmed et al., 2007; Krieger, 2003; Mays et al., 2007; Sanders-Phillips et al., 2009 for comprehensive reviews) that increase the likelihood that youth will use alcohol or other drugs to self-medicate and regulate emotion (Chaplin et al., 2012; Cohen, Doyle, & Baum, 2006; Frewen & Lanius, 2006). In addition, relationships between depression and drug use in youth exposed to racial discrimination may be influenced by peer affiliations. Findings from Brook, Brook, Rubenstone, Zhang, and Saar (2011), Mason et al. (2011), and Gibbons et al. (2004, 2007) strongly suggest that African American children who experience racial discrimination may be more likely to affiliate with peers who use drugs.

**Study Limitations and Future Research Directions**

The findings of this study are limited by three factors. First, racial discrimination was assessed using a two-item composite measure and we could not examine the potential effects of personal versus institutional racial discrimination. Second, other indices of exposure to racial discrimination, such as chronicity and

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**Fig. 1.** Final model linking perceived racism, alcohol and drug use, and psychological distress. $\chi^2(4) = 29.64, p < .001, \text{CFI} = .904, \text{RMSEA} = .106.$ $^* p < .05; \quad ^* * p < .01; \quad ^* * * p < .001.$
severity, were not examined. Third, this study was correlational and, therefore, could not address causality. Future studies of racial discrimination and child outcomes should utilize more comprehensive measures of racial discrimination and include other ethnic groups.

Youth in this study also reported symptoms of posttraumatic stress in response to racial discrimination; although symptoms of posttraumatic stress were excluded from the final path model. This outcome may be related to several factors including the significant correlations between scores for racial discrimination, posttraumatic stress, and depression as well as findings indicating that increased drug use and symptoms of posttraumatic stress in response to racial discrimination may be cumulative and emerge in adulthood for African Americans (Bogart et al., 2011; Gil, Vega, & Turner, 2002; National Institute on Drug Abuse, 2003). In light of reports by Mason et al. (2011) of high levels of posttraumatic stress symptoms in response to self-identified stressors in a largely African American urban sample of youth, future studies are needed on posttraumatic stress in children exposed to racial discrimination.

**Implications for Public Health Policy**

Identifying the factors that precipitate health disparities across groups will require a greater understanding of the impact of institutional and personal racial discrimination on health in societies, such as the United States, that are stratified by race/ethnicity and characterized by dominant and secondary social groups (Jones, 2000; Sanders-Phillips et al., 2009). These conclusions underscore the need for programs that address individual responses to personal racial discrimination as well as interventions at the structural level of society to address the institutional foundations of racial discrimination. Thus, meeting the goals of successful public health policies and programs for African Americans may require changes in current public health policies, programs, interventions, and/or treatments that target African American youth as well as the assistance of social institutions, such as the legal, education, and law enforcement systems, to address racial discrimination and health in African American youth more effectively.

For example, at an individual level, the trauma associated with exposure to racial discrimination in African American youth should be addressed in drug treatment programs. Identification of the underlying factors related to the trauma that precipitates symptoms of depression in drug users—especially in women and girls—is a critical goal of treatment that is emphasized in the evidence-based integrated, trauma-informed drug treatment programs recommended by Substance Abuse and Mental Health Administration (SAMHSA) and other researchers (Amaro et al., 2007; Finkelstein et al., 2004; Gatz et al., 2007; SAMSHA, 2009). This particular drug treatment approach is effective because it specifically addresses the primary trauma as well as the symptoms of the trauma and may
be more appropriate for youth who are in early drug abuse recovery (Finkelstein et al., 2004). An integrated, trauma-focused approach to drug treatment for African American youth may also decrease the number of misidentified or misdiagnosed trauma-related symptoms that interfere with help seeking, limit engagement in treatment, lead to early dropout, and make relapse more likely (Brown, 2000).

The impact of exposure to racial discrimination on health and drug use at the individual level could also be addressed in family-centered and mental health programs that focus on fostering racial socialization. Racial socialization is the process by which parents and other adults convey their views and strategies to children to assist them in coping with racial discrimination (Hughes, 2003). It is a critical component of parenting in families of color and often includes parental messages that instill racial pride and prepare children for racism and bias (Harris-Britt, Valrie, Kurtz-Costes, & Rowley, 2007). Supportive parenting can attenuate the relationship between racial discrimination and psychological distress (Simons et al., 2002, 2006). Nebblett et al. (2008) found that racial socialization buffered the negative effects of racial discrimination on stress and problem behaviors in a sample of African American adolescents. Two types of messages, instilling racial pride and preparation for discrimination, from parents seem to be most important as moderators of the relationship between discrimination and self-esteem in African American youth (Harris-Britt et al., 2007).

Given the documented impact of racial discrimination on school performance (Wong et al., 2003), promoting positive and healthy racial socialization for all children may be a strategy that schools or other programs could use to address the potential effects of exposure to racial discrimination on health. Similarly, the concept of ethnic identity—a major milestone of healthy development for children of color that reflects the degree to which a child identifies with and takes pride in their membership in a racial, ethnic, or cultural group—could also be incorporated into school and other public health programs. A positive ethnic identity is associated with a lower level of psychological distress when exposed to racial discrimination (Alvarez & Kimura, 2001; Seaton, 2009; Sellers et al., 2006; Simons et al., 2002).

At the structural level, evidence that negative racial stereotypes may influence the behavior of health care providers (Van Ryn, 2002) and that perceptions of racial discrimination may influence health care decisions, such as whether one seeks care and/or the choice of health care provider (Galea, Nandi, & Vlahov, 2004; Pachter & Coll, 2009), suggest that better training in cultural competency and increased awareness of the effects of racial discrimination may be needed for health care workers (Randall, 2002, 2009). The number of primary care providers who screen adolescents for psychological distress should also be increased. Ozer et al. (2009) found that only one third of adolescents were screened or reported a discussion of emotional health during a primary care visit. Females were significantly more likely to be screened than males. Huff, Abuzz, and Omar
(2007) have recommended that health care providers should be trained to serve as “first responders” in terms of assisting adolescents with symptoms of depression and in the detection, etiology, symptoms, and possible treatment modalities for depression in adolescents.

The training of health care professionals in issues related to psychological distress and racial discrimination may also be particularly important to the physical and psychological health of African American adolescents who present with alcohol and marijuana. The potential health-damaging physical effects of alcohol abuse and marijuana use are well documented and may be exacerbated during puberty (Dees, Srivastava, & Hiney, 2001; Emanuele, Wezeman, & Emanuele, 2002a; Emanuele, Ren, LaPaglia, Steiner, & Emanuele, 2002b; National Institute on Drug Abuse, 2000, 2007). Similarly, the concept of allostatic load, which refers to the “wear and tear” of the body’s attempts to maintain physiologic homeostasis in the face of chronic stress or trauma like exposure to racial discrimination, suggests that psychological and physiological harm in childhood may contribute to long-term health damage and health disparities (Ahmed et al., 2007; Bartlett, Goldklang, Schleifer, & Keller, 2001; Gabbay et al., 2009; Lesperance et al., 2004; Miller, Freedland, Duntley, & Carney, 2005). These findings reinforce the importance of public health policies that address “how childhood experiences can shape health across an entire lifetime and potentially across generations and . . . direct attention to the role of social and physical contextual factors that underlie . . . racial/ethnic disparities in health” (Braveman & Barclay, 2009, p. 163).

In this regard, we should also recognize that institutions outside of the health care system must be recruited to address the impact of racial discrimination on health in African American youth. For example, racial discrimination at the institutional level (e.g., in housing, education, etc.) results in ethnic differences in poverty and access to resources that directly and indirectly influence health disparities through their impact on the material conditions of life as well as through their impact on how individuals respond to these conditions (Ahmed et al., 2007; Schnittker & McLeod, 2005). Perceptions of racial discrimination are also associated with conduct problems in youth (shoplifting, physical assault, fire setting, vandalism, aggression, burglary, and robbery) that may result in incarceration and increase interactions with law enforcement (Brody et al., 2006). Thus, the support of law enforcement may be crucial to our ability to successfully address the effects of racial discrimination on African American youth. As an example, law enforcement policies that appear to target youth of color and/or have a disparate impact on adolescents of color (e.g., NYPD Stop and Frisk policy; Florida’s Stand Your Ground law) may be perceived by youth as evidence of racial “profiling.” Based on our current findings, such interactions with law enforcement may increase psychological distress, aggression, and behaviors, such as drug use—especially in African American males. As noted by the American Psychological Association’s
Resolution on Racial/Ethnic Profiling and Other Racial/Ethnic Disparities in Law and Security Enforcement Activities (American Psychological Association, 2001), the field of public health may need to focus on the impact on health outcomes of current law enforcement policies that raise serious concerns regarding racial profiling and discrimination (Burris, 2011).

Successfully addressing racial discrimination and health in the larger society may also require the input and support of the legal system (Burris, 2006, 2011). For example, Randall (2002) has frequently cited the Health Policy section of the “International Convention on the Elimination of All Forms of Racial Discrimination Committee (CERD)” indicating that racial discrimination is a critical factor affecting health worldwide and public health policies and treatment strategies based on inadequate and/or inaccurate data on the impact of racial discrimination are “human rights violations” leading to disparities in health. Randall (2002) has subsequently argued that inequality in health outcomes reflects the impact of many factors including the cultural incompetence of health care providers, socioeconomic inequalities, the disparate impact of facially neutral legal, law enforcement, and public health practices and policies, and intentional racial discrimination that contributes to disparities in health status and access to health care services (Randall, 2002, 2006, 2009).

Experiences of racial discrimination and social inequality can profoundly impact a child’s perceptions of him/herself and the social environment as fair, equal, and just (Sanders-Phillips et al., 2009). Chronic exposure to racial discrimination, poor material and social living conditions, and lack of access to resources and services reinforce feelings of stigma and the conclusion among African American youth that their ethnic group is devalued in our society. Ultimately, in the absence of public health programs and policies that address this reality, exposure to racial discrimination at the personal and institutional levels may severely limit the degree to which poor African American children can successfully control their lives and negotiate their social environments as well as the extent to which they are motivated and/or enabled to control their health by engaging in health promoting behaviors (Schnittker & McLeod, 2005, p. 80).

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Racial Discrimination and Drug Use


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