Black Adolescent Females’ Perceptions of Racial Discrimination When Accessing Reproductive and General Health Care

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Abstract
Adolescents, like adults, frequently experience discrimination, which can be particularly salient in the context of reproductive health care. We examined urban Black adolescent females’ perceived experiences of racial discrimination during reproductive health care encounters. Structured face-to-face interviews were conducted with female African American patients, from age 13 through 20, who obtained reproductive health care services at a single site. Twenty-four participants were enrolled. All were in or graduated from high school, with a mean age of 16.8 years. These young Black women reported infrequent race-based discrimination in the health care setting; however, many reported commonly experiencing discrimination in other places. An awareness of the discrimination that minority young women experience in non–health care settings can help providers demonstrate cultural humility when addressing such concerns with their patients. With this information, providers can provide anticipatory guidance and the tools necessary to navigate complex social systems.

Keywords
African American, adolescents, discrimination, family planning, health care

The Institute of Medicine defines health disparities as “racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention” (Smedley, Stith, & Nelson, 2003). In this case, discrimination at the individual patient–provider level is thought to manifest as differences in care resulting from biases, prejudices, and stereotyping in clinical communication and decision making.

There is evidence that patients who perceive racial discrimination are more likely to report adverse health outcomes. Previous work has found that minority adults who report ever experiencing discrimination, being prevented from doing something, being hassled, or made to feel inferior in various situations have greater physical and psychiatric symptoms than their counterparts who did not report this experience (Borrell, Kiefe, Williams, Diez-Roux, & Gordon-Larsen, 2006). In addition, individuals who report experiencing discrimination at any time during their lifetime have been found to have poor adherence to treatment, worse health outcomes, and delays in seeking medical care (Casagrande, Gary, LaVeist, Gaskin, & Cooper, 2007).

The work of Dr. David Williams (2012) and others has continued to demonstrate a clear relationship between minority race and poorer health outcomes. Racial inequities and disparities are evident in the timing of disease onset (earlier for minorities), severity and progression of disease (more severe for minorities), the effects of some risk factors (less exposure to the risk factor has a greater impact on minorities), and the persistence of health disparities over time (resulting in a lower life expectancy for minorities vs. non-minorities).

Racial discrimination is reported frequently by African American adolescents, similar to their adult counterparts (Fisher, Wallace, & Fenton, 2000; Sellers, Copeland-Linder, Martin, & Lewis, 2006). Among adolescents, racial discrimination is
associated with poorer psychological functioning as measured by perceived stress, depressive symptomatology, and psychological well-being (Sellers et al., 2006).

While previous work has provided valuable insight into adolescents’ general experiences with discrimination, little has focused on this population’s health care system encounters, which are often in the context of reproductive health or family planning care (Ma, Wang, & Stafford, 2005). Given the sensitive nature of care that is provided in these settings, reproductive care encounters can be prone to discriminatory practices based on imposed stereotypes or judgments about patients, such as what was described by the African American women in Benkert and Peters’s (2005) study who reported experiencing race-based discrimination when seeking family planning care. For example, provider beliefs about the number of sexual partners, history of sexually transmitted infections (STIs), or contraceptive use may differ depending on the race of the patient. Thorburn and Bogart (2005) found that among African American women ages 15 to 44 who had received family planning services, the majority (67%) reported having experienced race-based discrimination. Among those 15 to 20 years of age, there was a greater association with stereotype-related discrimination. In addition, having a stronger Black identity was correlated with a greater perception of general health care discrimination.

Jo Valentine (2008) provided an overview of barriers to the diagnosis and treatment of STIs and the relationship to the heavy STI disease burden in the Black community. Constructs such as stigma, shame, and mistrust, as well as the historical legacy in which these constructs are rooted and their contribution to the negative perceptions of Black sexuality were explored and evaluated.

It is imperative that as few obstacles as possible exist when adolescents are seeking reproductive care because they comprise a population at risk of suffering great health-related consequences. Notably, young African American women suffer disproportionately from reproductive morbidity, highlighting the need for health care providers to recognize barriers that impede this population from seeking reproductive health care (Augustine, 2010; Centers for Disease Control and Prevention [CDC], 2012; Kost & Henshaw, 2013; Tuan, 2006). This disparity underscores the importance of health care providers’ understanding the barriers to care, including those related to discrimination, which may prevent this cohort from obtaining reproductive or other health care services.

Discrimination results from processes of social inequity in which there is an imbalance of power and control, and a devaluation, stigmatization, and rejection of a group of people who possess specific attributes. There are varying responses to the experience of rejection, prompting a need to consider contextual, relational, and dispositional factors (Smart Richman & Leary, 2009). Patients who have negative perceptions of health care encounters, possess limited coping skills, and have inconsistent health care follow-up may have significant health-related consequences. There is an under-mining of the therapeutic relationship and a lack of patient empowerment that can occur if a young person perceives discrimination from a clinician. The diagram in Figure 1 represents the cycle that can occur when patients interact with providers whom they perceive as discriminatory and the resultant avoidance of potential distress or discomfort at future encounters, followed by the negative impact on health outcomes if care is not sought in a timely fashion. When Slaughter-Acey, Culdwell, and Misra (2013) examined the relationship between prenatal care entry and experiences of personal and group racism among low-income, African American women, they concluded that a delay in accessing prenatal care may be grounded in an attempt to avoid a discriminatory experience. Using this context as a conceptual framework upon which this study is based, the objective was to use qualitative techniques to examine young Black women’s perceptions of racial discrimination during reproductive health care encounters and in non–health care settings.

Method

Study Design

We conducted in-depth, semi-structured, face-to-face interviews with adolescent females, age 13 to 21 years, seeking care at an urban family planning clinic, serving predominantly African American females, between June and December of 2008. Study protocol and consent procedures were approved by the hospital’s institutional review board and the regional Family Planning Council. Adolescent women who met the study eligibility criteria provided written informed consent. Parental consent was waived given that participants were obtaining confidential reproductive health care.

Participants

Eligible participants met the following criteria: (a) female and having received reproductive health care at the recruitment site, (b) 13 to 21 years of age, (c) able to speak and write in English, and (d) self-identified as Black or African American. Exclusion criteria included the following: (a) having discussed transition to an adult provider because of age during the last clinic visit (indicating the young woman would receive health care elsewhere in the future); (b) being pregnant, as confirmed prior to the visit and/or on the day of the interview; and (c) having cognitive impairment that prevented participation in ongoing dialogue or written feedback.

Participants were recruited through direct contact with a trained research assistant (RA) at the clinic or through recruitment flyers. The RA approached young women following their reproductive health care encounters with medical providers, and invited them to participate in a research study to discuss their beliefs about race and health care.
Participants were also recruited through recruitment flyers that were posted in the clinic with general information about the study and contact details. After screening and eligibility for participation were confirmed, a convenient time was arranged for the participant to return for the face-to-face interview. Informed written consent was obtained before the interview.

**Data Collection**

Participants were interviewed in a private exam room by a trained interviewer—an African American female. A detailed semi-structured interview guide was developed from a thorough literature review about race and ethnic identity development as well as research about minority populations’ perceptions of stereotypes and their impact on discriminatory behaviors (Sellers et al., 2006). Each interview lasted for approximately 60 min, until saturation of key themes was achieved.

The semi-structured interview enabled participants to tell their “stories” about their experiences of discrimination, either personally or vicariously (awareness of others’ experiences), in a variety of contexts. The participants were first asked demographic questions to assess age; self-reported ethnicity, skin color, educational level; personal work status; parental educational level and work status; other sources of household income; and health insurance status. The interview guide included questions to elicit the participants’ definition of discrimination and to assess their opinions about the impact of skin color (light- vs. dark-skinned) on discrimination, the directionality of discrimination (i.e., within race vs. out-of-race discrimination), the presence of discrimination in the health care setting (both reproductive and general medical care), and its influence on the intention to return for medical care, discrimination in non-medical settings, vicarious discrimination, and degree of Black identity.

After their interviews, participants were asked to complete a brief questionnaire in private to provide feedback about their comfort level with the questions and the interviewer. To ensure anonymity of feedback, participants were instructed not to include identifying information on feedback response sheets and to seal the form in a blank envelope. The principal investigator (PI) reviewed the feedback, reporting results in aggregate to the research team. Participants were given a choice between two US$20 gift cards to one of two local merchants as compensation for their time. The interviews were audio recorded and transcribed professionally.
Table 1. Demographic Data.

| Characteristic                                      | n (%)  |
|-----------------------------------------------------|--------|
| Age (range = 13-20 years old)                      | 16.8 years |
| In or graduated from high school                    | 24 (100) |
| Households that receive cash assistance or social security income | 10 (42) |
| Health insurance (private, or publicly funded)      | 22 (92) |
| Mother’s educational level ≥ 12th grade             | 17 (72) |
| Father’s educational level ≥ 12th grade             | 13 (54) |
| At least one biological parent deceased             | 7 (29)  |
| African American with mixed ethnic heritage*        | 5 (21)  |
| Self-reported skin color                            |        |
| Light-skinned Black                                 | 3 (12.5) |
| Medium-skinned Black                                | 14 (58.3) |
| Dark-skinned Black                                  | 7 (29.2) |

*Mixed ethnic heritage includes Native American, French, Puerto Rican, and Jamaican.

Interviewer training consisted of multiple meetings to develop the interview guide, integrating feedback from participant pilot data. An emergency medicine physician and investigator with expertise in qualitative methodology oversaw and guided the training process. The PI conducted three pilot interviews in which only she, as the interviewer, was videotaped (with the participant’s authorization) to assist with training on non-verbal cues and standardization of interview technique. These videos were used to train the one RA, who conducted the remainder of the interviews, the first three of which were also videotaped (again, only she was filmed). In addition, mock interviews were conducted among the interviewers themselves to enhance their interview skills. During the period of data collection, the PI and RA met weekly to discuss the study’s progress.

Data Analysis

Descriptive statistics were used to summarize demographic variables. Transcript text was entered into Microsoft Word for organization and coding. A priori (conceived beforehand) codes based on the interview guide were used to group and label specific blocks of text and phrases from the interviews. The first three interviews were coded by two members of the research team to develop mutually agreed-upon definitions for each code. These initial interviews were coded multiple times by these same two reviewers to refine and clarify the terms and definitions of the coding library; any disagreements in coding were resolved by consensus. Each interview was then coded separately by two reviewers on the study team. These two reviewers discussed the coding results, and discrepancies were resolved by consensus. The third reviewer coded every third interview and provided supervision and assistance in coming to consensus, if necessary. Notes of coding decisions were kept to facilitate member communication and maintain coding consistency. Transcripts were then reviewed by the study team to identify patterns of emergent and recurrent themes. Theme development continued as an iterative process, with review of transcripts as additional interviews were ongoing, to assess when theme saturation had been achieved.

Results

Interviews were conducted with 30 subjects. Three of these were pilot interviews and were excluded from analysis. Three additional participants were excluded because of incomplete data due to audio recording failure (n = 2) or cognitive delay that was not detected until the interview was initiated (n = 1; see Table 1).

Interview Themes

Table 2 provides additional illustrative quotes for each of the themes described below.

Definition of discrimination. Most participants described people who discriminate as those who dislike, look down upon, or treat an individual or group differently for a variety of reasons. Race, skin color, and ethnicity were reasons mentioned by the majority (n = 17, 71%); other reasons stated were age, gender, sexual orientation, religion, and appearance. Many participants also used terms such as “feeling judged” and expressed that recipients of discrimination or prejudice lacked a sense of being valued and were made to feel unworthy by others. Specifically, discrimination was associated with a quality that works “against you because of the person you are,” and “restriction,” or having limited opportunities. Discrimination was associated with disadvantage for Blacks and advancement for Whites. Participants also mentioned other specific discrimination dyads: older persons against younger ones, and teachers against (Black) students.

Experiences of racial discrimination in health care settings. Participants reported that they infrequently experienced discrimination in the health care setting. Regarding family planning care, two participants reported past experiences in which providers made assumptions about their sexual history. One young woman was encouraged by her male provider to begin a birth control method because her mother assumed she was interested in becoming sexually active and took her to the doctor for this purpose; she emphasized that he did not confirm with her, as the patient, if birth control was truly the reason she was there. Another young woman perceived that her family planning provider assumed she was sexually active, but she had come to the clinic only to learn about birth control methods. In general health care encounters, one participant reported feeling as if she was treated worse by a Black female physician (as compared with a non-Black health care provider) when she brought her younger
sister for general pediatric care. She believed that the reason for this differential treatment was that her sister was lighter skinned and she and the provider were darker skinned, representative of a viewpoint that individuals with lighter skin receive better treatment than those with darker skin. The perceived assumption that these young Black women were seeking contraception when they were not may be grounded in historical perspectives about the sexuality of Black women. During times of slavery, Blacks were seen as the property of slave owners; they were not viewed as human and, therefore, were not entitled to rights befitting a human. What accompanied these views was the inhumane treatment of slaves as evidenced by the commission of horrific acts of violence toward them, one of which was the rape of Black women. Black female slaves were seen as objects of sexual exploitation for White men. Women had no right to resist their slave owners’ advances; compliance with the owners’ quest for sexual gratification was not only commonplace, but expected (Collins, 2005). Furthermore, because Blacks had no rights, this was not seen as a criminal act. Jezebel, a term used to justify the sexual relations between White men and Black women, emerged during slavery times and depicts a Black woman with an overwhelming need and strong drive for sex that could only be satiated by a White man, endorsing the perspective that interracial sex was, in fact, desired by these men view Black women as “sexual freak[s].” Relating to pregnancy, one young woman shared, “To some people, I think, when they see a Black girl, they automatically assume that I got three or four kids or I am running around and all wild and loud and—I am this off the wall . . .” These experiences and perceptions may indicate that the belief that Black women are hypersexual, promiscuous, or breeders still prevails today.

**Experiences of racial discrimination, non–health care related.** Participants reported experiencing discrimination in a variety of settings, including the workplace, school, stores, and their neighborhoods (see Table 3). Events at work and school were particularly common, especially with regard to being hired or maintaining employment and interactions with peers, respectively. This was the case for one participant who heard that a hiring manager where she submitted her application told her non-Black friend “Every time a Black person comes and fills out an application I throw it away.”

Another frequently described event was racial profiling, or being targeted by an individual purely on the basis of racial or ethnic characteristics. The context in which these events were most likely to occur was in stores (e.g., being followed) and observations of or interactions with law enforcement officials (e.g., harassment, use of unnecessary force, being stopped in a vehicle without clear justification). Interviewees described similar events that were experienced by family members or friends, with the majority of witnessed incidents involving police and Black males. Young women described both emotional and action-based responses when these events occurred. Anger, hurt, disgust, and discomfort were among the emotional responses commonly reported. Verbal expression of these feelings toward the perpetrator or
leaving the setting where the incident took place represented examples of actions taken in response to a discriminatory event.

**Stereotypes.** Many of the participants reported that Blacks are viewed negatively by non-Blacks. The young women gave examples of feeling that Blacks are thought of as less intelligent, being poor, having many children, living in violent areas, or participating in criminal acts. These ideas were captured in quotes such as the following:

Because, like usually when people think about Black people, or like their neighborhoods, they’re like, “Oh, don’t go down there because you’re going to get shot.” Or they think of Black people, they’re like, “They’re dirty” or “They’re poor.” “They’re not better than us.” Like if a White person—like if you ask a White person, like “What do you think when you hear the word, like African American?” They’ll probably say a whole bunch of negative stuff. But I don’t know.

In addition, a common sentiment shared by interviewees was “acting Black or White.” References made to these behaviors were usually in the context of speech, or using colloquial terms or slang specific to Blacks. For example, one participant spoke of being “bona fide ghetto” (ghetto being a description of predominantly Black, low-resource areas in some communities) as “loud, obnoxious, cussing all the time” (cussing refers to swearing or use of profanity). Alternatively, young women also described times when Blacks or Whites told them they were “acting White” because they participated in certain activities or spoke in a way that was perceived as being associated with “Whiteness.” One young lady said, “I don’t know what I want to be, I don’t know if I want to act White or if I want to act Black . . . White people who don’t know me, they may say I’m just a confused soul.”

The inverse was also noted when White friends or acquaintances of some participants “acted Black” by speaking a certain way or using specific terms only in the presence of Black people. In spite of being part of these different cultural realms, the participants made it clear that they knew what behavior was appropriate at any given time. For example, participants believed that slang could be used with friends, but speaking in a professional tone and using proper English is expected during an interview.

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**Table 3.** Participants’ Descriptions of Non–Health Care Related Discriminatory Events.  

| Setting         | Event                                                                 | Person(s) involved | Characteristics of perpetrator | Perceived reason(s) for discrimination | Response of participant |
|-----------------|------------------------------------------------------------------------|--------------------|--------------------------------|----------------------------------------|------------------------|
| Recreational setting | Avoidance. “We got into the pool with them, and she looked and was like, ‘Come on we are going back to the beach, we don’t want to be up here.” | Passersby | White Same age Female | Race | None |
| Neighborhood | Sexual solicitation, Black women as sexual objects | Men | White — Male | Race, appearance | Feelings—disgust, action-based—verbal response |
| Street | Holding bags tightly, walk quickly when she passes | Passersby | White Adult female | Race | None |
| Workplace, store | Patrons go to another cashier to ring them. “It’s like, ‘I don’t want her to ring me . . .’” | Customers | — | Race | None |
| School | Racial incident—hung Black baby doll in a noose with epithets | — | — | — | None |
your hair like that? It looks dirty” whereas long, straight hair is viewed as “beautiful.” In general, these young women illustrated that the ways in which they expressed their ethnic culture through styles of hair, dress, or language were very powerful, and their choices could either make others around them—Black or White—feel comfortable in their presence, or not.

**Skin color.** Many young women, regardless of self-reported skin color, perceived that light-skinned Blacks are regarded more positively and receive better treatment than those who are dark-skinned, and that this differential treatment is practiced by both Blacks and Whites. This perception was evidenced by the following comments:

...if you’re light-skinned you’re better no matter if you’re dark-skinned or you’re light-skinned but like better jobs if you’re light-skinned. Like, people will like you better or you’ll come—you’ll come off better than people who are dark-skinned.

...Light, like you have your-you’re better, you’re just everything is just going to be given to you, like you’re just better than the next person.

Not only did they report this belief system being held among members of general society but also prevailing among members of their family in which lighter skinned individuals were more highly valued or preferred over darker skinned individuals. One exception to this “rule” is when light-skinned Blacks think of themselves as “better than” others, resulting in poorer treatment and exclusion from the dominant Black group.

Most young women, regardless of their self-reported skin color classification, believed that for them personally, their skin color did not affect the way they were treated by others. However, some young women who self-identified as dark-skinned gave vivid accounts of hurtful personal experiences relating to their skin color, which had a negative impact on how they viewed themselves. An example of this was a quote from a young lady who recounted childhood experiences of bullying:

When I was younger I would get bullied and stuff, they used to call me tar baby and all this other stuff...yeah it used to make me cry and feel bad about myself, but now I don’t pay no attention to things like that.

Another young lady recounted, “And I didn’t like being so dark, like they be like ‘Blackie,’ . . .”

**Positive outlook on race relations.** Many young women expressed that, although they are aware discrimination exists, they do not believe there is a role for it in today’s world and do not endorse the idea that anyone should receive different treatment on the basis of race or skin color. There is a reassuring sense of tolerance and the embracement of diversity. One young woman expressed,

Just do you, don’t worry about nobody else, come together, be a big family. I go and eat spaghetti and meatballs with my Italian friends all the time. I eat at the Jamaican store all the time; I even eat Jewish food. We do the same things. Cut it out, right . . . So it’s like be friends with everybody you know.

**Discussion**

The findings of this study indicate that young Black women did not frequently perceive discrimination in the health care setting, contrary to what other studies have reported. An example of such a study is Benkert and Peters’s (2005) work in which they found that African American women reported experiencing discrimination when seeking family planning services.

It is for this reason that our finding of young women not endorsing discrimination in a clinical setting warrants further examination. To better understand why this may have been the case in our clinic, it is necessary to first provide some context by describing the racial composition of the personnel who staffed the clinic as well as the patient population that was served there. The majority of patients served at the clinic were Black (the clinic is embedded in an urban community that is predominately Black). In contrast, the staff represented a heterogeneous mix of both Black and White (in general, there were more White than Black staff). The front-line staff, such as receptionists and medical assistants, who made initial contact with patients were Black; however, the nurses and physicians were predominately White (with the exception of one Black physician). There were no cultural competence trainings provided to staff, but it is reasonable to consider that with the clinic being located in a Black community, serving mostly Black youth, with Black front-line staff, the non-Black staff may have had a heightened awareness of issues related to cultural bias and would be more likely to engage in self-monitoring of behaviors that may be perceived as discriminatory. In addition, perhaps by first interacting with Black reception staff and same-race peers in the waiting room, patients’ perceptions of the clinical encounter with non-Black clinicians that followed were positively influenced (priming effect). Alternatively, it may be that the presence of Blacks in the clinic enhanced comfort levels among patients, enabling them to be more receptive to care they received from non-Black clinicians.

Alternatively, the race or skin color of the medical provider may be one of many complex factors that a patient considers when assessing the degree of discrimination experienced during a health care encounter. Support for this supposition comes from one participant who described feeling as though she was discriminated against even though she and the physician with whom she was interacting were the same race and same darker hue. This suggests that the
therapeutic bond goes beyond “skin deep” and may, in fact, be more influenced by the perception of respect that the provider shows the patient. Previous studies examining what Black youth value in their relationships with health care providers have shown that being respectful and non-judgmental, as well as maintaining the confidentiality of their information, is more important than sharing physical attributes or characteristics with a provider (Ginsburg, Menapace, & Slap, 1997; Ginsburg et al., 1995).

We did discover that discrimination, although not necessarily perceived as being present in the clinic, is a common element in the lives of these young Black women. The settings in which they are most likely to spend their time are the places that they reported having negative experiences of race-based discrimination: school, the workplace, stores, their neighborhoods, recreational venues, and their own homes. The perpetrators of these incidents are individuals from the same race, as well as those from different racial backgrounds. The events may be subtle, such as an askance glance, or overt, such as a directed racial slur or epithet. Incidents may involve someone with whom they have a close relationship, like a family member, or someone from whom protection is expected, such as a law enforcement official. For some, it has negatively affected how they view themselves, or how they believe others view them and Blacks as a group.

Our findings suggest that intra-racial dynamics were at play in the perceptions of these young women. We chose to explore the degree to which the young women identified with being Black, as some studies have shown that, the stronger one’s Black identity, the more likely one is to perceive an event as discriminatory (Sellars et al., 2006; Thorburn & Bogart, 2005). Young women reported that the more they expressed their ethnicity or elements of their Black culture, the more they were viewed negatively by members of other racial or ethnic groups. Interestingly, skin color—the degree of lightness or darkness—was a factor that had an impact on the perception of discrimination and affected self-image in these participants. Among these young women, there is a belief that being lighter skinned confers a degree of protection against discrimination and, in fact, is a more highly valued attribute among both non-Blacks and Blacks. It is worth providing a historical overview to understand the origin of these beliefs and their prevalence among young Black women.

During slavery, Whites placed greater economic value on those who possessed lighter skin—they were sold at higher prices and were preferred by Whites to perform personal services. These lighter skinned individuals were more likely to be house servants and were not subject to the hard field labor of their darker skinned counterparts, thus enabling them to develop marketable skills and gain social capital. These preferential practices stemmed from a belief that the lighter skin hue more closely paralleled the Euro-centric view of beauty in which White was more aesthetically appealing than Black, and that those with evidence of mixed racial heritage (lighter skin), were intellectually superior to those of pure African ancestry. Our findings, as evidenced by the comments of some of the participants, suggest that this historical perspective, rooted in the legacy of slavery, racism, and discrimination that was commonplace in this country for centuries, has been perpetuated and is still embedded in the belief systems of Black youth today (Keith & Herring, 1991).

It was encouraging to learn that many of the young women we interviewed had not adopted such views and, although they or others had experienced discrimination, their perceptions of the world around them had not been tainted. Participants’ racial identity and ways that they identify with their ethnic culture may help to promote their positive outlook. This concept, known as racial socialization (based on race pride and preparation for bias), is believed to be a potential protective factor that buffers African American youth from the negative impacts of perceived discrimination (Harris-Britt, Valrie, Kurtz-Costes, & Rowley, 2007). However, for those youth who do not possess those protective factors, we must not overlook the potential negative impact on their emotional and physical well-being, in both the short- and long-term. A 5-year longitudinal study of African American adolescents (enrolled between 10 and 12 years of age) found that increases in perceived discrimination were associated with increased conduct and depressive symptoms (Brody et al., 2006). Nurturing, involved parenting was a protective factor; conduct problems were more prevalent among boys, but there were no gender differences in depressive symptoms. Although this study gives some preliminary data about the consequences of early exposure to discrimination, more research is needed to assess the relationship between discrimination, health status, and protective factors in youth who are exposed to discrimination over an extended and prolonged period of time, and how these impacts manifest in adulthood. The more recent Adverse Childhood Experience work of Wade, Shea, Rubin, and Wood (2014) has taken into account the impact of discrimination on youth and demonstrates that urban-specific traumas during childhood predisposes to poor health outcomes as adults. However, there is an acknowledgment that future work is required to understand these complex relationships in more depth and how they manifest in adulthood.

Among the issues with which young people must contend, and which should be included and addressed during the health care visit, is the topic of racial discrimination. Approaching the subject in a culturally sensitive way and focusing on pertinent issues (e.g., safety in one’s neighborhood) is only one aspect of competent care. A broader understanding of institutional barriers that exist for an adolescent woman can help the clinician understand her perspective and assist in developing strategies to overcome future barriers. This group of urban, minority young women provided insight into their perceptions and experiences of racial
discrimination. Although valuable, the study findings may be specific to the sampled population and not generalizable to other adolescent populations. Future studies in other health care settings, particularly targeting other demographic populations, will be useful to further delineate the experiences of discrimination among young minority women and men.

Conclusion
During in-depth, semi-structured interviews, Black adolescent females reported infrequently experiencing race-based discrimination in the health care setting. However, in other domains of their lives, this was a common occurrence. An increased awareness of and understanding that minority young women experience discrimination in non–health care settings can be acquired through cultural sensitivity training. However, the providers in this clinic had not received any such training and yet were still able to demonstrate a level of cultural awareness, responding sensitively to their racially diverse patients and meeting their health care needs in an environment of comfort and safety. It may be that, while the staff did not receive formal cultural sensitivity training, they developed an implicit understanding—through their medical training, clinic philosophy, and expectations established in the provision of adolescent reproductive health care—about the cultural constructs and context of adolescent sexuality, resulting in improved health outcomes for this population.

A high level of cultural awareness that is seamlessly integrated into the clinic setting, and perhaps a willingness to learn from patients’ non-clinical discriminatory experiences, can facilitate health providers’ demonstration of cultural humility, enabling them to provide some of the tools necessary for youth to navigate complex social systems. Inquiries of discriminatory events or experiences can be made by providers during the social history portion of an encounter, creating a space for open dialogue about these sensitive issues. This can provide an opportunity for reciprocal learning and allow a provider to lay a framework for anticipatory guidance and problem solving around these issues. Equally important is the reinforcement that these young people are valued and the clinic is a place where their diversity and contributions are readily embraced and supported.

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