From Childhood to Adulthood: Examining the Long-Term Effects of Racial Discrimination on Mental and Physical Health

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“Racial discrimination is a fundamental determinant of health, and public health has a responsibility to actively confront and challenge these systemic issues, advocate for health equity and social justice and foster inclusive environments.“

Racial discrimination is increasingly being recognised as a social determinant of health, with growing evidence suggesting an association between racial discrimination and mental and physical health outcomes across all life stages [1]**.** Children and adolescents are particularly vulnerable to the adverse health effects of racism, since childhood and adolescence are critical developmental phases in which young people are particularly susceptible to stress. As a fundamental determinant of health, racism manifests at different levels which affect health outcomes through different pathways; the **interpersonal**, **institutional** and **structural** level. Whereas the interpersonal or individual level occurs between individuals and refers to the actions, beliefs or attitudes that support or perpetuate racism [2], institutional racism refers to explicit manifestations of racism at the direction-, policy-, or organisational level [3]. Structural racism is understood as the “structures that create and maintain vulnerability, harm and precarity aligned to racial difference” [4].

It is essential to note that racism is not always explicit but can be hidden, subtle or disguised. There is plenty of evidence that suggests that racial disparities observed in adulthood may be attributable to racial stressors in adolescence and childhood. Therefore, it is imperative to explore the association between racial discrimination and health outcomes in these life stages of earlier development. For my bachelor thesis, I analysed the impact of racial discrimination on physical and mental health outcomes in children and adolescents in Europe and the USA and found that racial discrimination has detrimental impacts on several measures of physical and mental health.

Particularly robust and significant associations were found for the relation between **racial discrimination** and **depression** and/or **depressive symptoms** in cross-sectional and longitudinal analyses across countries and across different ethnic groups. According to these findings the prevalence rates of depression and depressive symptoms in children and adolescents who experience discrimination were higher compared to children

and adolescents who did not experience discrimination. Moreover, longitudinal analyses showed that experiences of discrimination at young age predicted depressive symptoms later in life. Similar associations were identified for the link between racial discrimination and self-esteem, sleep disorders and conduct disorders, such as ADHD and ODD. When faced with stressors like racial discrimination, our psychological responses aren't isolated events. Instead, reactions to primary stressors can trigger lasting psychological effects and lead to changes in sociocultural adaptation.

For instance, chronic feelings of helplessness might trigger feelings of frustration, resentment, or depressive symptoms which, in turn, can influence to coping responses. Moreover, the analysis showed that racial discrimination affects NCD-risk behaviours such as alcohol use *initiation* and smoking, while also impacting sexual and reproductive health, more specifically through risky sex behaviour. Considering these examples, it becomes evident that the impact of racism and discrimination in health extends beyond isolated instances. Instead, it is an integral component of embedded racialised social structures.

Results of the study signal that understanding and addressing a structural problem like racial discrimination demands structural solutions, action, commitment and responsibility on every level to effectively combat systemic issues and tackle policies in various domains. A proactive and preventive measure on the organisational level would be to implement anti-bias training for (healthcare) professionals and adopt an anti-racist curriculum. Anti-racist education is a crucial measure to address (the narrative around) structural causes of racism, health inequity and conscious and unconscious biases. Further, to measure and quantify discrimination and (health) inequalities, reliable and comparable equality data disaggregated by racial or ethnic origin is needed in Europe. This is an essential premise for understanding and addressing existing issues, as qualitative and quantitative equality data informs us about trends and patterns in discrimination against marginalised and racialised groups that are invisible in national statistics and surveys. Moreover, equality data allows policymakers to more effectively reach out to marginalised communities to enhance social participation in policymaking. Lastly, it is essential to mention and acknowledge that that though anti-racism action on the EU and international level is crucial, we must remember that a substantial part of the work takes places on the ground, in the community. Therefore, it is fundamental to strengthen social participation to systematically incorporate and provide leadership to racialised and marginalised communities in the development and evaluation of legislative initiatives. This is crucial, as active participation of racialised groups enhances policy relevance and effectiveness by providing a deeper understanding of the context, barriers, and facilitators from the community. Further, racialised and marginalised groups are a critical source of expertise that should be consulted across all levels of governance as the solutions needed are best understood by the populations directly affected.

Racial discrimination is a fundamental determinant of health, and public health has a responsibility to actively confront and challenge these systemic issues, advocate for health equity and social justice and foster inclusive environments.