

Moving Beyond the Trickle-Down Approach: Addressing the Unique Disparate Health Experiences of Adolescents of Color

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PURPOSE. *Health disparities in adults have received significant attention and research, yet the healthcare experiences of adolescents of color have been ignored. The purpose of this paper is to identify the shortcomings of our state of knowledge regarding adolescent health disparities and argue for the use of an intersectional, contextually embedded understanding of healthcare experiences.*

CONCLUSIONS. *To understand health disparities, deficit-based models should be replaced with the framework proposed in this paper.*

PRACTICE IMPLICATIONS. *Using the proposed model in practice will aid in identifying and preventing the health disparities experienced by adolescents of color.*

Search terms: *Adolescents of color, healthcare disparities*

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The most current U.S. census data indicate a 15% increase in the adolescent population. It is projected that by the year 2020, nearly 50% of American children from birth to 19 years of age will belong to racial and ethnic minority groups (U.S. Census Bureau, 2004). These changing demographics, coupled with the growing health disparities between White adolescents and adolescents of color, call for innovative approaches to achieve the central goal of Healthy People 2010 of eliminating health disparities between ethnic and racial groups within the United States (U.S. Department of Health and Human Services [USDHHS], 2000).

Background

Only a paucity of documented data about health disparities among adolescents exists, despite having just 5 years left to achieve the Healthy People 2010 goal. Nursing literature remains devoid of information that identifies, prevents, or proposes a plan to address health disparities among adolescents. In addition, very few documented theoretical frameworks have been identified that have the potential to guide responsive nursing care to an ethnically diverse adolescent population. The goal of this paper is to provide an intersectional and contextual framework for pediatric nurses to use in clinical practice and in their research endeavors related to addressing and eliminating health disparities among adolescents of color. This framework provides the necessary integration of principles across practice and research to address the multidimensional facets related to health disparities among adolescents of color.

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Relevant Definitions

To assure a common point for understanding health disparities among adolescents, the term *health disparities* is here defined as the result of such ongoing experiences of unfairness or injustice in education, physical and social environments, social position, income, stereotyping or predetermining of one's biologic and genetic endowment; intellectual, physical, and mental abilities; and/or access to, utilization of, and quality of care, health status, or a particular health outcome (Baquet, 2002). This definition is congruent with Williams' (2002) perspective of health disparities as being embedded within the social context of everyday life. By this, Williams is referring to the importance of understanding how the positional factors of race, ethnicity, gender, and social class influence disparate health experiences and how the interplay of these four positional factors has even a greater impact on the health and well-being of adolescents of color who are at the critical stage of identity development.

Similarly, Link and Phelan (1995) point to the importance of individual-based risk factors being contextualized. This requires the examination of factors that put people at risk for engaging in compromising health behaviors. Consideration of social factors, such as socioeconomic status and social support, is essential because these factors are likely to be the fundamental causes of most health disparities and because they embody access to important resources, opportunities, and options that have the potential to lead to multiple disease outcomes through various mechanisms.

To address health disparities, pediatric nurses must identify and address the fundamental social determinants of health that include the specific physiologic mechanisms, environmental contexts, and sociocultural and political pathways that link social exposures to disparate health outcomes. This approach to understanding and addressing health disparities moves the discourse beyond the medical consequences of health disparities toward a definition of health disparities that do not just happen or occur within a vacuum but

rather are manifestations of the integral and complex life course tapestry that reflects differential treatment of youth because of their educational preparation, social position, biologic and genetic endowment—including physical or mental abilities, race or color of skin, immigrant status, religion, age, or place of residence.

The other terms requiring definition are race and ethnicity. These two terms are often used interchangeably when, in fact, each term has a distinct meaning. Race is a politically charged and socially designated term that has a long history of being used to explain disadvantages and/or to legitimize inequality of power and opportunity. In fact, race is an artifact of the human culture (Kreiger & Williams, 2001; Williams, 1997) and is considered static. Ethnicity also is a socially designated term that reflects self-identification and a sense of belonging to a specific group in which one interacts with and shares values, norms, and behavioral patterns (Phinney & Landin, 1998). Ethnicity is not static, but rather is fluid and constantly changing as individuals and groups evolve over the life span (Jackson & Sellers, 2000). Therefore, ethnicity and race are not interchangeable terms.

To summarize, race is an externally imposed social construct, whereas ethnicity is a self-imposed social construct. Both terms need to be conceptualized as more than and different from variables that are stratified in research studies of health disparities. Understanding the differences between these two terms is essential to appreciating the complexity of health disparities. Therefore, instead of using race or ethnicity, the term *of color* is used here because this term embraces a sense of unification of a critical mass of people bonded simply by not being of Northern European descent (Stover, 2002). Additionally, the term evokes a visual and descriptive image that focuses on the language of race. Such evoked images and racial language continue to be necessary in order to call attention to the disparities in the quality of health care received that result in inequalities in health status because of color of skin that, in turn, result in adolescents

being treated differently (Stover, 2002). Thus, the use of the term *of color* acknowledges the potential for differential health experiences based on skin color without allowing the use of a specific racial term that is used to stereotypically explain health outcomes.

Trickle-Down Approach to Disparate Health Experiences for Adolescents of Color

Although the Institute of Medicine's landmark report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" (Smedley, Stith, & Nelson, 2002), raised the consciousness of healthcare researchers and providers about racial disparities in adult health care and healthcare providers' participation in cocreating these health disparities, adolescents were absent from consideration despite their increased likelihood of experiencing disparate health. As a result, the report has led many researchers and healthcare providers to what the authors have termed the trickle-down approach to addressing health disparities among adolescents. The trickle-down approach is described as a model where experiences of health and illness by adults serve as the basis for understanding the health experiences of adolescents, thereby negating the unique developmental period of adolescence.

The unique aspects of adolescents' health experiences generally are not explored because it is assumed that the experiences of adults are generalizable to adolescents. Although this approach has been widely criticized when male models of health and disease are used to understand a female's experiences of health and disease (Pinn, 2003), scholars persist in using this approach to make inferences about adolescents. Furthermore, the lack of appreciation for racial and ethnic differences in studies of health has contributed to the health disparities that exist today for both adolescents and adults. In addition, using a retrospective frame of reference to estimate the disparate health experiences among adolescents is seriously flawed.

The Institute of Medicine report (Smedley et al.), however, was the catalyst for generating not only increased

awareness but also the abundance of research aimed at furthering the understanding of the factors associated with health disparities of select racial and ethnic groups in the following areas: disease outcomes, health systems that deliver acute care, adult-related data, and disparate health experiences of different ethnic and racial groups. If there is any hope of closing or eliminating health disparities both across the life span and more specifically during adolescence, a more concentrated examination of adolescents and health disparities is essential. Although there is not an abundance of documented studies that focus solely on health disparities in adolescents of color, several proxy indicators strongly point to the existence of some level of disparate health status.

Highlighted Health Profile for Adolescents of Color

To demonstrate the existence of disparate health status in adolescents of color, highlights from a recent report entitled "The Health Status of Youth of Color" (National Association of Social Workers, 2001) are described below.

- The leading cause of death for African Americans between the ages of 15 and 24 years is homicide (Centers for Disease Control and Prevention [CDC], 2000a).
- African American adolescents (12.4%) as compared to White students (7.4%) are more likely to report dating violence (CDC, 2000c).
- Adolescents of color are disproportionately infected with sexually transmitted infections (STIs), and adolescents of color who are between the ages of 13 and 19 years represent 84% of new HIV infections (CDC, 2000b).
- Close to 42% of all children in foster care are adolescents. More specifically, 36% are Hispanic and 42% are African American (Child Welfare League of America, 2001). These adolescents have poorer physical health and mental health status (Brindis, Hamor, Raiden-Wright, & Fong, 2000). Additionally, these adolescents of color are more likely to use and

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abuse alcohol and other drugs, become infected with STIs and HIV, and become teen parents (Child Welfare League of America, 2001).

- American Indians have the worst health (Brindis et al.).
- African American children are roughly three times more likely to be hospitalized for asthma than are White children—55.9 per 10,000 African American children were hospitalized in 2001 versus 16.2 per 10,000 White children ages from birth to 17 years of age (Agency for Healthcare Research and Quality, 2004).
- Compared to White high school students, African American and Hispanic students are less likely to report regular participation in physical activity. This provides a backdrop for understanding the disproportionate number of African Americans and Hispanics who have, or are at risk for, diabetes, obesity, and cardiovascular disease (CDC, 2000d).

A growing number of adolescents of color are experiencing unequal opportunities, access, and options.

Although these statistics provide a point of reference, they are devoid of contextual information and assume that African Americans and Hispanics are a homogeneous group. What the aforementioned statistics do reflect is that a growing number of adolescents of color are experiencing unequal opportunities, access, and options.

Relevant Literature Review

One systematic, documented review of racial and ethnic disparities in the health care of adolescents (Elster, Jarosik, VanGeest, & Fleming, 2003) included

65 published studies that were conducted with national, regional, state, or school district samples. The findings from this review suggest that racial and ethnic disparities in health care for adolescents persist after accounting for access to health care and socioeconomic status. Elster and colleagues also found racial and ethnic disparities in adolescents' use of mental health services, but when racial identity was considered, these findings were more consistent for African Americans than for Hispanics. This may primarily be because of the small aggregate samples of Hispanics. Finally, Elster and colleagues found an inverse relationship between socioeconomic status and chronic diseases such as asthma as well as engagement in compromising health behaviors (e.g., early sexual debut). However, these findings should be viewed with caution because of limitations in the study design. Specifically, the review only included studies conducted in White, African American, and Hispanic samples; in addition, only studies that focused on disease outcomes were included.

These findings mirror the limitations of the Institute of Medicine report in that the study focused mainly on disparities in health care, access to health care, and disparate disease outcomes. In addition, because it was a retrospective review of health conditions rather than a prospective theory-driven review of health experiences, the study findings raise questions about the lack of specific longitudinal studies that examine the normative developmental patterns of African American, Hispanic, Native American, and Asian Pacific Islander youth from diverse economic backgrounds. In addition, these reviews do not address the magnitude and causes of health disparities among adolescents generally, and more specifically, among various subpopulations of racially and ethnically diverse adolescents.

Because adolescence is known as the period of transformation, it is an ideal time not only to identify and address but also prevent potential health disparities commonly found in adults. In addition, adolescents themselves must not be considered as downward extensions of the adult population with similar needs and experiences. This approach not only

fails to recognize the unique developmental tasks that adolescents must negotiate but also translates into the use of the trickle-down process for allocating resources and providing health care and treatment (Guthrie, Caldwell, & Hunter, 2000).

The most common approach to understanding, promoting, and providing health care and health programs to adolescents generally, and to adolescents of color in particular, has been that of a “problem-focused” and/or deficit-based approach, centering on such health problems as substance use and abuse, teen pregnancy, depression, and violence. According to McLoyd (1998), deviance and negative developmental and health outcomes of racially and ethnically diverse adolescents that are devoid of understanding such high-risk contexts as poverty, parental unemployment, low parental education, and dangerous neighborhoods have been the dominant foci of both clinical practice and research on ethnically diverse adolescents of color. Although much research to date that has focused on deficits or problems has yielded statistically significant results, these research studies or programs more often than not were designed and implemented in isolation of understanding and examining the importance of the embedded sociocultural and historical contexts in which diverse groups of adolescents might reside.

No one is advocating that this approach be totally eliminated; rather, before researchers are able to identify whether or not something is a problem, more research is needed on the diversity inherent in the healthy developmental trajectory among various subpopulations of adolescents of color. For this reason, Jackson and Sellers (2000) suggest that to understand the health status and disparate health experiences of racial and ethnically diverse adolescents, healthcare providers need to consider health from a broad contextual and intersectional perspective. This approach should be used to guide practice as well as the development and evaluation of any health-related services or programs. The authors further posit that this perspective takes into account the multilevel and integral influences of race, ethnicity, and gender, as well as his-

torical factors, such as birth cohort and structural lag, on health and health disparities (Jackson & Sellers, 2000).

To understand the health status and disparate health experiences of racial and ethnically diverse adolescents, healthcare providers need to consider health from a broad contextual and intersectional perspective.

Birth cohort refers to the fact that an already-born cohort of ethnically and racially diverse youth have been (from conception, gestation, and beyond) and currently are being exposed to life conditions and sociocultural situations that influence their physical and mental abilities, education, social and health status, and health experiences (Elder, 1998). As several scholars (Barresi, 1987; Klein, Slap, Elster, & Schonberg, 1992) posit, variation within and across different birth cohorts of adolescents of color is influenced by the nature, quality, intensity, and duration of health care received, exposure to risk factors, and presence of exogenous environmental factors (toxic environmental pollution). The variations related to birth cohort experiences also are likely to be confounded by such stressors as discrimination, prejudice, and environmental segregation that may differ in nature, duration, form, and intensity (Amick et al., 2002; Williams, 2001). Structural lag refers to developmental tasks, life experience, and role opportunities that are asynchronous in nature in that one or the other lags behind.

Riley and Riley (1994) propose that birth cohort succession and structural lag are integral components of

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the life-course perspective. They further indicate that as adolescents of color evolve from conception through adulthood, the age-specific developmental tasks (balancing independence and dependency, multidimensional identity—ethnic, racial, cultural, adolescent, and gender, relationships, and changing role opportunities—child, student, sibling, peer, and intimate friendships) are interconnected and integral with the existing economic, social, political, historical, and cultural life experiences in which the youth of color reside. Hence, the nature, degree, intensity, and duration of a particular cohort's health and disparate health experiences must be considered in light of allocating such things as healthcare access, health promotion or prevention programs, and education opportunities over the life span.

Therefore, a unique perspective is needed, which combines an appreciation of developmental tasks of ethnically diverse adolescents and includes a lens toward prevention of health disparities. Furthermore, this perspective addresses the complex social, physiologic, and environmental contexts that interplay with an individual's genetic, ethnic, racial, and gendered identities.

Intersectional and Contextual Perspective for Addressing Adolescents and Health Disparities

An adolescent's life is integrally embedded in the lives of family, peers, community, and the society at large. As a result, as they navigate the multiple contexts toward healthy adulthood, adolescents are always balancing autonomy and connectedness. The cumulative, interlocking, and historically embedded influences of race, gender, social position, and abilities help to shape health and health behaviors (Caldwell, Guthrie, & Jackson, 2005). However, viewing race, gender, and social class solely as demographic variables negate their historical, cumulative, and interlocking impact on health and health disparities. An intersectional and contextual perspective is necessary for conceptualizing the multifaceted and fluid interlocking processes associated with health disparities generally, and in particular, with health disparities among adolescents

of color. Solely using factors such as poverty, race, or gender to consider health outcomes without considering the contextual aspects that create the experience of poverty or the effects of discrimination based on race or gender negates the complexity of factors that create health risks across the life span. This is especially crucial, given that adolescence represents a critical developmental period and metaphorically is considered the bridge that connects childhood with adulthood (Guthrie & Low-Kane, 2005).

Intersectionality and contextual perspective refers to understanding the interlocking fluidity of two or more social identities within an historical frame of reference (Collins, 1998; Crenshaw, 1995). Social identities, such as race, gender, and class, are defined as attributes that societies use to stratify or to place individuals in a hierarchy position that often leads to the creation of different meanings for life experiences (Harding, 2004). Furthermore, this approach can be likened to a kaleidoscope, with each social identity (gender, race, ethnicity, environmental contexts, social position, birth cohort, immigrant status, and educational achievement) representing a color that is contextually embedded and constantly changing from foreground to background. The underlying guiding principles associated with intersectional and contextual embedded perspective are that lives are lived interdependently, and individuals coconstruct their lives within evolving sets of social constraints and stressors. The cumulative effect of social constraints and stressors, such as discriminatory policies and health practices, have an impact from conception and beyond on the adolescent's development as well as their health status. Finally, an individual's health and health history is best understood by asking questions about the adolescent's sense of ethnic heritage and its influence on norms, beliefs, attitudes, and behaviors associated with being a female or a male adolescent.

The fluctuating nature of this process makes it impossible to predetermine or prescript a universal approach to health care or to program design. Rather, this approach calls for pediatric nurses to transform their health practice

and research studies so that they are more responsive and their programs more tailored toward addressing the disparate health experiences of adolescents of color.

Need for Better Practice Setting Data Regarding Adolescents of Color

In addition to transforming nursing practice, as a step toward closing the gaps between the health experiences of adolescents of color and those of majority culture, the collection of reliable data on adolescents from all areas of practice and research is required. From practice settings, pediatric nurses should collect data that reflect the differing definitions (social construction and social designation) of race, ethnicity, gender, and social position. Pediatric nurses also should collect contextual data such as socio-demographic information (e.g., socioeconomic status, educational achievement, number of people in the household); health-related behaviors such as teen pregnancy and sexually transmitted infections; information about youth who are physically and mentally challenged; and characteristics of the adolescents' neighborhoods, as well as on the communities they serve and those that are not served by their practices.

The use of GEOCODING software has the potential to enable pediatric nurses to obtain neighborhood, county, or state socio-demographic characteristics through a link to current census data. This technology can provide information on indicators, including household income, educational achievement, occupation, and health status, as well as adolescents' hospital admissions and reasons and frequency for use of the emergency room. Such data can be used by pediatric nurses and advanced nurse practitioners to design health promotion and prevention programs along with targeted outreach to those subpopulations absent from the client rolls of a given practice (National Research Council, 2005). The collection of broader, contextual data regarding adolescent health will lead to greater opportunities to conduct nursing research that addresses the complexity of health disparities.

Implications for Transforming Pediatric Nursing Research

Transforming pediatric nursing research also calls for the use of principles to guide the design of studies and analytic strategies for programs of research addressing adolescent health. Research studies that explore health disparities among adolescents of color should address the rationale for why a particular theory was chosen in relation to the proposed population to be studied. For example, we need to ask such questions as: What population group was the theory originally developed for? How has the theory been adapted to the unique characteristics of the targeted population and the context within which they are integrally interwoven? These guiding principles also have relevance for the methods selected for the research generally, particularly for sample selection, data analysis, and interpretation of the results.

With regard to sample selection, pediatric nurse researchers need to become more cognizant about the construction of a study's sampling framework. Every effort should be made to have a sample that includes representation from all socioeconomic groups. Such sampling efforts would help to eliminate the assumption that adolescents of color are a homogeneous group (Steinberg & Fletcher, 1998). If, however, this is not possible or feasible, the pediatric nurse researcher should explicitly describe the limitations involved in drawing a sample that represents only one socioeconomic status in a subpopulation of adolescents of color.

Pediatric nurse researchers also should identify how such terms as race and ethnicity are used in designing their studies. Finally, whenever possible, the use of broad categories such as Hispanic, African American, and Asian Pacific Islander should be avoided. Instead of assuming that the groups placed under these broad categories are homogeneous in nature, research studies should disaggregate these broad categories so that they reflect the actual group included in their study. For example, if the adolescents of color in the targeted group are Mexican American, they should be referred

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to as Mexican Americans. Similarly, African Americans should not be aggregated (e.g., non-Hispanic blacks). The question that needs to be asked of each subject is whether they are African American or are of Caribbean, Haitian, or African origin. By disaggregating these broad rubrics, the research findings will provide more accurate information about the respondents and yield rich data that can be used for tailoring prevention strategies to the unique attributes of a subpopulation of adolescents (Steinberg & Fletcher, 1998).

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The way that race and ethnicity are used in analyses of data also needs to be addressed. Specifically, when race/ethnicity is used as a category or variable to control for any differences in outcome or relationships of variables, this limits the potential understanding and advancement of science. As a category, ethnicity (an independent variable) is often used to contrast mean scores or differences between ethnic groups using several statistical techniques, such as analysis of variance; this results in several conceptual and methodologic problems (LaVeist, 1994).

The attempt to identify purely ethnic effects is inadequate for several reasons. Ethnicity tends to always be correlated with more variables than any researcher can reasonably hope to assess or control. For example, in the United States, ethnic groups differ not only in socioeconomic status but also in household composition, community of residence, patterns of language use, and other characteristics that are more difficult to identify and assess (LaVeist, 1994; Steinberg & Fletcher, 1998). Additionally, using ethnicity/race in

this way raises questions about whether or not a given measurement of confounding factors, such as socioeconomic status, is equally appropriate for different ethnic groups. Generally, social class indices of parental education, occupation, or income may have different validity as a measurement. For instance, parents of color historically may have been denied access to quality primary and high school education; therefore, parental education may be a poor marker of socioeconomic status because the educational achievement was artificially restricted (Steinberg & Fletcher).

Additionally, if categories are used as a standard of comparison, one ethnic group generally is viewed as "normal" whereas the other group (adolescents of color) is viewed as abnormal. Such a comparison of different ethnic groups does not take into account cultural, contextual, and historical differences within the respective ethnic groups. Finally, most research comparing different ethnic groups seldom includes how important the interactions of social positional factors are for influencing the identified outcomes. Such comparisons are thought to merely describe a particular difference at a given time and place without any consideration for the interplay of differing social processes.

When ethnicity is used as a controlling variable, the underlying assumption is that ethnicity affected the developmental outcome of interest. In this instance, however, ethnicity is viewed as being of less importance than other factors that are simultaneously examined. Specifically, a researcher who views ethnicity as a nuisance variable is attempting to reduce the nuisance effect in order to move closer to a homogeneous developmental process (LaVeist, 1994; Steinberg & Fletcher, 1998). This again negates the ethnic and contextual aspects of development for any subpopulation or group.

By controlling for ethnicity, researchers are introducing different and often unknown confounding factors. Therefore, Steinberg and Fletcher (1998) argue for researchers to become more aware and to acknowledge the existence of known confounding factors, rather than to statistically control the factor, which in turn inadvertently introduces a different set of

confounding factors whose effects are indeterminate. Finally, when researchers do control for ethnicity, they usually are basing this on the assumption of providing an estimate of what the phenomenon under examination might be if the individual did not have an ethnicity (LaVeist, 1994; Steinberg & Fletcher). For all individuals, their values, attitudes, perceptions, and/or behaviors are embedded and unfold implicitly or explicitly in the context of ethnicity. Furthermore, the major problem with using ethnicity as a categorical or controlling variable is that the results tend to generate preconceived and/or stereotypical differences associated with characteristics or behaviors of adolescents of color. In the absence of a gender and ethnic responsive theory, these preconceived or stereotypical differences continue to be perpetuated in pediatric nursing research. Hence, pediatric nurse researchers should begin to envision ethnicity as a contributor to or a moderator of their respective phenomenon of interest. These guiding principles and strategies are not meant to stifle the pediatric nurse's research with adolescents of color, but are rather meant to become a catalyst for the transformation of pediatric nursing research.

The major problem with using ethnicity as a categorical or controlling variable is that the results tend to generate preconceived and/or stereotypical differences associated with characteristics or behaviors of adolescents of color.

The word *transformation* here is used to describe actions that may be taken by pediatric nurses to help

close the gaps in disparate health experiences of adolescents of color. The word *transformation* was used intentionally to denote a need for a change of form, appearance, nature, disposition, condition, and character related to nursing practice, research, and eventually, policy related to identifying, addressing, and providing responsive health care and programs targeted at reducing adolescent health disparities. Using a phrase borrowed from Fredrick Douglass' (Melzer, 1995) closing words of the 1852 July Fourth Independence Day speech, the nursing profession must "be driven" to eradicate disparate health experiences of adolescents of color through the transformation of pediatric nursing practice, research, and policies.

How Do I Apply This Information to Nursing Practice?

If an intersectional and contextual approach to addressing health disparities is used, pediatric nurses must transform their practice from a discourse on disease outcomes toward a more broad-based sociopolitical and contextual perspective that has the potential to produce substantial health benefits for adolescents, irrespective of the color of their skin. This requires a broader consideration of the factors that influence health and health outcomes beyond the individualistic focus that is pervasive in traditional biomedical models that take a disease-oriented perspective. This approach warrants incorporating questions into the individual healthcare encounter that explore adolescents' sense of ethnicity, gender relations, and the contextual influences of family and peers on their health. It also calls for consideration of the historical and sociopolitical context in which the adolescent was born and lives. This means that pediatric nurses and advanced pediatric nurse practitioners should be aware of, or explore during the patient encounter, the influences of neighborhood, peers, family, and popular culture, as well as the tensions between the adolescent developmental tasks of individuation and connectedness. Asking questions first about an adolescent's general

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life experiences of discrimination and injustice, rather than asking questions about whether they take drugs or smoke, provides some contextual considerations that then can be followed with specific ways this experience has or might lead to engagement in compromising health behaviors such as smoking.

Another critical change in pediatric nursing practice that would result from using an intersectional and contextual framework is the opportunity to address prevention rather than focusing retrospectively on health outcomes. With this opportunity for prevention, however, comes a responsibility for broadening efforts that address changes in access to health care to the contextual factors that influence health experiences for adolescents. It no longer is enough to tell an adolescent to avoid risky situations, such as the use of guns, drugs, and violence. If pediatric nurses are not willing to identify how the risk of becoming involved in these situations is cocreated by intersections of poverty, racism, and injustice. When faced with constraining sociopolitical environments, it is a valuable exercise for pediatric nurses who want to move away from a deficit- or problem-based approach to identify evidence of strengths of the adolescent, their family, and their environment when thinking about the disparate health experiences of adolescents of color. Finally, the intersectional and contextual framework reinforces the importance of pediatric nurses incorporating social action as a strategy for change that moves beyond an individual focus to societal interventions that have the potential to ensure more universal and equitable access to health and health resources for adolescents of color.

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