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Risk and Resilience in Minority Youth Populations

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minority, majority, oppression, risk, resilience, youth

Abstract

This review presents current theory and empirical research that address the interplay between risk and resilience processes among minority youth in the United States. To move the clinical sciences forward in their research and treatment approaches to solving minority–majority health and well-being disparities, ecological, intersectional, and emic (within-group) approaches must be adopted. We discuss the consequences of systematic oppression and marginalization for children in the United States, focusing primarily on research regarding xenophobia, discrimination, and racism. Lastly, we provide examples of recent interventions that take emic approaches to closing minority–majority gaps in developmental outcomes.

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> The attempt to develop a sense of humor and to see things in a humorous light is some kind of a trick learned while mastering the art of living. Yet it is possible to practice the art of living even in a concentration camp, although suffering is omnipresent.
>
> Viktor E. Frankl, *Man's Search for Meaning*

INTRODUCTION

Understanding the interplay of risk and resilience in minority youth populations is of paramount importance to the health and well-being of the US population. In the year 2044, the United States is projected to become a minority majority nation, in which people of color will outnumber white people. As this trend is driven largely by differing birth rates among ethnic/racial groups, the youth population of the United States is expected to reach this milestone in the year 2020 (US Census Bur. 2018).

For decades, scholars have documented disparities in physical and mental health between minority and majority social group members. Among adults in the United States, racial and ethnic identity–based discrimination, xenophobia, and environmental disadvantage, all of which disproportionately affect people of color, are linked to cardiovascular risk indicators, inflammatory markers, chronic social stress, substance use, and other indicators of low psychological well-being (Albert et al. 2008, Berger & Sarnyai 2015, Cobbinah & Lewis 2018, Cunningham et al. 2012, Gibbons et al. 2004, Kershaw et al. 2016, Landrine & Klonoff 1996, Lewis et al. 2010, Sawyer et al. 2012, Schmitt et al. 2014, Smedley 2012). Among youth, adolescents, and emerging adults in the United States, similar health disparities are linked to minority status. Experiences of identity-based discrimination are predictive of increased inflammatory markers of chronic stress and other physical markers of disease, high-risk alcohol use and sexual behaviors, depression, and other indicators of low psychological well-being (Brody et al. 2006, 2014, 2015; Hope et al. 2015; Kogan et al. 2015; Metzger et al. 2017; Sellers et al. 2006; Simons et al. 2002; Tobler et al. 2013).

Initially, these disparity observations were made without clear recognition of the systemic oppression that caused and perpetuated such disparities (García Coll et al. 1996). Researchers continuously documented differences in performance or health between white and black, Latinx, or American Indian children without situating those differences in the larger contextual picture. The result was a propensity for clinicians, researchers, educators, and policy makers to adopt deficit models in their understanding of why these minority–majority disparities exist (Helms et al. 2005). Research conclusions and implications from deficit model ideology often took the following type of form: Black children have greater behavioral problems in the elementary

classroom environment compared with white children and are therefore less likely to succeed in school (see, e.g., Boykin 1978). Although on its surface such a conclusion may be statistically valid, it lacks the identification of the underlying social mechanisms that continually place black children at a disadvantage for success in school compared with white children. By assuming homogeneity among the experiences of black children, there is a failure to attend to the different social contexts and resilience experiences that inform individual differences in black children's academic trajectories (i.e., within-group explanations) (Slaughter-Defoe et al. 1990). In other words, after decades of documenting between-group racial disparities in education, mental health, and physical health without attention to context, it has become commonplace to implicitly and erroneously believe that children of color suffer from some innate deficits that make them less fit for academic success (Slaughter-Defoe et al. 1990). Further, when traditional behavioral interventions, often developed by white researchers and/or for predominantly white samples of children and again not situated in the contexts of marginalization or systemic oppression, fail to close race-based behavioral problem gaps in school, researchers and interventionists are left wondering why traditional intervention approaches did not work (Anderson 2016).

More recent theoretical and empirical approaches to disparity research have focused on the underlying social and economic marginalization and oppression that create disparities in the first place (Adams et al. 2008). For example, several researchers have identified individual experiences of racism, discrimination, and/or xenophobia as chronic stressors that contribute significantly to a wide range of negative outcomes for minority individuals (e.g., Brody et al. 2014, 2015; Metzger et al. 2017; Tobler et al. 2013). On a population level, researchers have identified structural racism and policies that create, maintain, and promote marginalization, segregation, and oppression of minority groups as significant contributors to public health disparities among minority groups (Cobbinah & Lewis 2018, Riley 2018). Experiences of discrimination and structural racism in the form of anti-immigrant policies have also been linked to immigrant health disparities in the United States (Marks et al. 2018, Viruell-Fuentes et al. 2012). Economic marginalization and poverty create and maintain systems of oppression, leading to disproportionate lack of access to high-quality education, health care, safe housing, and employment among minority group members (Saegert & Evans 2003). Research consistently shows that experiencing poverty during childhood in the United States increases biological indicators of chronic stress and inflammation, both of which negatively impact long-term physical and psychological health and result in limited access to high-quality education and nutrition (Pascoe et al. 2016). New theories are being developed to capture these systemic and global forces that interact with local contexts, such as neighborhoods, families, and schools, to shape both risk and resilience among minority youth (see, e.g., Suarez-Orozco et al. 2018).

As these and many other researchers suggest, moving the clinical sciences forward in their research and treatment approaches to solving minority–majority disparities requires us to adopt ecological, intersectional, and emic (within-group) approaches to understanding the interplay of both risk and resilience among minority youth. The inclusion of resilience perspectives is of critical importance not just for their relevance in supporting well-being throughout the life span, but also for counterbalancing the tendency of researchers and practitioners to adopt or perpetuate deficit models that focus on minority–majority youth comparisons. This article therefore offers a review of theoretical advances including ecological, intersectional, and risk/resilience perspectives on child development. We then emphasize the consequences of systematic oppression and marginalization for children in the United States, focusing primarily on research regarding discrimination and racism. Lastly, we provide examples of recent interventions that take emic approaches to closing minority–majority gaps in developmental outcomes.

WHAT IT MEANS TO BE A US MINORITY YOUTH

In the social sciences, the term minority refers to individuals who are members of marginalized or disadvantaged social groups. These individuals are not necessarily minority in number. For example, females tend to make up just over half of the US population in number but have long been recognized as financially and socially disadvantaged compared with males (Bowleg 2012, Hacker 1951). In this review, we use the word minority to designate an individual or group of individuals who belong to a social group that has been historically disadvantaged compared with a majority group [see original minority youth theoretical framework by García Coll and colleagues (1996)]. For children and youth in the United States, this often means having an ethnic/racial identity as a member of an ethnic/racial group that is not white. These children and youth of color are usually also at a social and economic disadvantage or minority status because of social and political systems of oppression and racism that have historically privileged white individuals and oppressed black, Latinx, Asian, Arab, and other ethnic/racial minority group members (Feagin 2013). Such systematic oppression based on race and skin color is traceable to the earliest days of North American colonization, through practices of indigenous genocide, African slavery, and detention of Asian individuals during WWII, and to today's Muslim travel ban, Latinx immigrant family border separations, and migrant child imprisonment (Bouza et al. 2018, Gray 2018, Jordan 1974, Ray et al. 2017, Wood 2018). This history—and the present-day policies and attitudes that are outgrowths of this history—has created a social and political system of oppression that must be actively attended to in all research and clinical intervention that includes marginalized and minority children and youth.

Note, too, that intersectionality—or a child's categorical membership in multiple marginalized groups—is highly important to consider in minority children's development. Minority group membership not only is based on race, ethnicity, or income but also can come from non-Christian group membership (e.g., oppression and discrimination against Jewish and Islamic groups), from being differently abled, and/or from being an individual who identifies with a sexual or gender minority group. Being a member of multiple minority groups—for example, being a bisexual, language-minority Asian female—presents compounding social and economic hardships throughout an individual's development (Chun & Singh 2010, Shramko et al. 2018). This tradition of understanding intersectionality stems from black feminist theory and from Crenshaw's (1991) seminal research about violence against women of color whose gender and racial identities position them in dually marginalized groups. Although most research has focused on single minority groups, increasing attention focuses on intersectionality in theory and presents an important horizon for new clinical efforts to embrace (e.g., Graham & Schiele 2010).

RISK AND RESILIENCE AMONG MINORITY YOUTH POPULATIONS

Situated within this historical and systemic perspective, we can begin to more fully understand how risk and resilience pathways unfold for minority children across a variety of developmental outcomes. Risk is often defined on both individual (e.g., high impulsivity) and contextual (e.g., poverty, exposure to violence) levels, and both have been shown to cumulatively harm children's and adolescents' well-being (e.g., leading to increased internalizing and externalizing problems) (Day et al. 2016). There are myriad individual-level and contextual factors that come into play to determine how and why some children struggle in the face of environmental challenges while others prevail. These individual differences in adaptation to stress and hardship have historically been the focus of resilience theory and research, with growing attention now given to contextual supports for promoting resilience as well (see, e.g., Pieloch et al. 2016). For example, in a sample of over 1,000 five-year-old twins, exposure to socioeconomic deprivation had a lower-than-expected

effect on individual children who exhibited outgoing temperaments (e.g., high self-confidence, ease in social interactions) and whose mothers exhibited more warmth and provided stimulating activities (Kim-Cohen et al. 2004). Such studies demonstrate the interplay between biological factors, individual-level factors, and family contextual socialization, which together promote resilience in environments with prolonged hardship.

Risk and resilience are not simply opposite sides of the same coin; risk is not the absence of resilience, nor is resilience the absence of risk. They each offer unique information for understanding the developmental strengths and challenges of minority youth, and in many ways they coexist and inform one another. Recent ecological advances in risk theory emphasize the importance of taking a positive, strengths-based and preventive approach to economically disadvantaged minority youth development and encourage a greater focus on identifying resilience-promoting assets within children's school, family, and community ecologies (Henderson et al. 2016). A commonplace definition of resilience emphasizes the psychological adaptations that take place to overcome hardship. Ann Masten (2001), a pioneer of resilience research in child development, stresses how "ordinary" resilience is, as resilience adaptations can be readily made by most children when their environmental supports and assets are intact. Indeed, risk often places individuals in situations of increased exposure to and severity of hardship, thereby increasing opportunity for building individual resilience as long as other resources are present to support the child. Resilience researchers are therefore increasingly embracing the potential of positive psychology to directly oppose the deficit models of minority youth development that historically prevailed in the field (Motti-Stefanidi & Masten 2017).

Despite the ordinariness of resilience in development, it is very important to emphasize that minority youth—by their definition of membership in perhaps multiple marginalized and oppressed social groups (e.g., black girls)—must often overcome more numerous, frequent, and severe hardships than majority peers. Immigrant children and youth, for example, must adapt to commonplace developmental hardships plus the additional demands stemming from prolonged and challenging migration experiences; family separations; learning new languages and cultural customs (i.e., acculturation); and responding adaptively to racism, discrimination, xenophobia, and other social threats unique to the immigrant experience (Motti-Stefanidi & Masten 2017, Suarez-Orozco et al. 2018). In other words, not all hardship is created equal (Cent. Dev. Child 2019). Some hardships may be experienced by all children; for example, dealing with first-day-of-school anxiety, getting a vaccine shot, and losing a high-stakes sports game are commonplace hardships that provide opportunities for children to build personal resilience skills. In situations like these, the child's own interpersonal skills (e.g., self-regulation and perspective taking) supported by various contextual forces (e.g., responsive parenting or peer support) aid in their ability to overcome their feelings of hardship without experiencing extreme or prolonged physiological stress. The presence of a caring adult or caregiver can facilitate such adaptive responses from the child, and this positive caregiver socialization is paramount to building children's strong interpersonal resilience skills (Wright & Masten 2015, Wyman et al. 1999). More extreme situations, such as repeated harassment/bullying, exposure to violence, or loss of a close loved one, are hardships that can cause greater challenge and detriment to a child. These types of hardships take longer for the child to physiologically recover from, especially if no supportive adult caregiver is consistently present to promote adaptability in the child.

Given their membership in historically oppressed social groups, minority children systematically are exposed to greater frequency and severity of hardships—from violence, to poverty, to hate crimes and family deportation—compared with their majority same-age peers (Archambault et al. 2017). To address these increased risks, research must focus on understanding the individual and contextual factors that promote resilience among minority youth. Of critical importance to

promoting child and adolescent resilience is the presence of caring and skilled adults and/or peer relationships to help children self-regulate and respond adaptively to such hardships. Social bonding, for example, has been demonstrated to be a protective factor against dropping out of school for marginalized youth (Peguero et al. 2016). For first and second generation immigrant youth, family cultural capital, including immigrant optimism, has been linked to lower rates of school dropout (Perreira et al. 2006). Without the combination of adaptive interpersonal and self-regulation skills and secure relationships from their environment, children may exhibit maladaptive behaviors in response to these hardships over time (Gerard & Buehler 2004). Here is where we can turn to our theory and research on environmental stressors—the inhibitors and accelerators of minority youth development—that tend to place undue risk and hardship differentially on minority youth.

ENVIRONMENTAL INHIBITORS AND FACILITATORS OF DEVELOPMENT

According to García Coll and colleagues (1996), contexts such as schools, families, and communities can act as both inhibitors and facilitators of the hardship that is presented to minority youth from systemic oppression. In this original theoretical framework, oppression, segregation, and other systemic and historical acts of segregation are placed front and center in the model of minority child development, because these hardships are more commonly experienced by minority youth (e.g., health and spatial segregation) (Pearce et al. 2010). In response to these larger hardships are the inhibitors of development—practices and relationships that make it challenging for a child to develop strong resilience skills and that place children at increased risk for poor health and lower educational attainment. Inhibitors can include unfair detention or punishment practices at school, bullying from peers, unresponsive parenting, and other environmental challenges (including disproportionate exposure to pollutants; see Judy 2018, Morello-Frosch et al. 2011) that stress the child further. On the other hand, facilitators of development are the positive supports and equalizers in an environment that promote positive adaptation to hardship and help children reach their developmental potential. Such facilitators may be seen in strong teachers acting as advocates and mentors on behalf of children, positive parent–child relationships, and community resources intended to promote equity in access to after-school care programming for minority youth (Wright & Masten 2015).

Of the many types of systemic oppression that exist in the United States, discrimination is the inhibitor that is most commonly studied in youth, with a particular emphasis on racism. Discrimination and racism are environmental inhibitors of positive minority youth development. They can be observed in many contexts and are reflected and perpetuated by negative societal attitudes toward immigrants, increasing rates of hate crimes, white supremacist rhetoric on social media, and the direct one-on-one bias incidents and harassment that may occur on a daily basis in schools and neighborhoods (Am. Bar Assoc. 2019, Fed. Bur. Investig. 2017). Children and adolescents experience discrimination in many forms, from microaggressions (i.e., brief and commonplace derogatory indignities related to one's minority status) to overt and dangerous acts of hatred based on their membership in a minority group (Marks et al. 2015).

Given discrimination's and racism's prevalence as developmental inhibitors, minority children must learn to adaptively respond to both of these issues (Graham & Schiele 2010). Among minority youth, adaptive responses to discrimination and racism are most commonly fostered through ethnic/racial socialization, a process by which parents or caregivers educate youth about their ethnic/racial identity and prepare them for experiences of discrimination (Hughes et al. 2006). Ethnic racial socialization is linked to high levels of ethnic/racial identity consolidation in minority youth, which in turn promotes self-esteem and is protective against psychological

distress (Bracey et al. 2004, Phinney et al. 2001, Rivas-Drake et al. 2008, Yip et al. 2006). However, if minority youth are unsupported or unable to build the necessary coping skills to adaptively respond to discrimination, or if the discrimination is too pervasive and severe to manage, many developmental problems can arise.

DEVELOPMENTAL CONSEQUENCES OF DISCRIMINATION

Negative outcomes associated with experiencing discrimination as ethnic/racial minority youth in the United States are significant and broad. In terms of physical health risks, longitudinal research with African American adolescents shows that high levels of exposure to interpersonal racial discrimination increase serum inflammatory markers, known as cytokines, 3 years later (Brody et al. 2015). Elevated serum cytokines are risk factors associated with accelerated aging, cardiac disease, and stroke. As such, chronic experiences of racial discrimination significantly impact children's and adolescents' long-term physical health. A broader measure of physical well-being, allostatic load—which includes indicators of inflammation, acute stress response hormones, blood pressure, and body mass index—also increases with past-year experiences of racial discrimination among African American adolescents (Brody et al. 2014).

Experiencing racial discrimination as a young person can lead to high-risk behaviors that can in turn impact physical and mental health. Among racial/ethnic minority adolescents, those who report racial/ethnic discrimination are also more likely to engage in high-risk sexual behaviors and delinquency (i.e., getting in fights at school, skipping school, getting in trouble with parents/guardians or the police) (Burt et al. 2012, Tobler et al. 2013). Metzger et al. (2017) found that among African American college students, those who drank alcohol and engaged in high-risk sexual behavior more frequently were also more likely to experience more frequent racial discrimination than their peers who did not engage in these behaviors. Further, research suggests that drinking alcohol is often used to cope with the stress and feelings of lack of control that can accompany the chronic experiences of discrimination (Cooper 1993, Harris 1992).

Mental health problems are common consequences of experiencing discrimination for many ethnic/racial minority youth. Among racial/ethnic minority adolescents, increasingly frequent instances of racial/ethnic discrimination are linked to increasing symptoms of depression, including suicidal ideation, perceived stress, and lower overall psychological well-being (Sellers et al. 2006, Tobler et al. 2013). Longitudinal research also supports these findings; across late childhood and early adolescence, increasing experiences of perceived discrimination among ethnic/racial minority youth have been positively associated with depressive symptoms (Brody et al. 2006). This finding remained significant among those with psychologically protective factors (i.e., nurturant-involved parenting, prosocial peers, and academic success), highlighting the significant contributor of discrimination in the developmental trajectory of ethnic/racial minority youth even in relatively protective circumstances (Brody et al. 2006). Similarly, experiencing racial discrimination during adolescence among African American males predicted increased symptoms of depression by emerging adulthood (Kogan et al. 2015). However, this relationship was attenuated by feelings of pride toward participants' racial identity and feelings of self-control—a finding that highlights potential targets for intervention among youth who experience or are at increased risk for experiencing racial discrimination (Kogan et al. 2015). Moreover, both individual experiences of racial discrimination and average rates of reported racial discrimination within neighborhood communities were significantly correlated with increased depressive symptoms among African American children (Simons et al. 2002).

Immigrant-origin minority youth in the United States also face experiences of discrimination and xenophobia that are linked to negative developmental consequences. Youth who have most

recently immigrated to the United States appear to be most vulnerable to perceiving discrimination experiences as serious threats, and such perceptions are linked to decreased self-esteem and increased symptoms of depression (Patel et al. 2015). Discriminatory harassment from peers directed toward immigrant youth has also been shown to increase feelings of marginalization and increase internalizing symptoms, such as depression (Benner et al. 2018, Cavanaugh et al. 2018).

Xenophobia, a unique form of discrimination specifically targeted at those perceived to be outsiders, is also linked to negative outcomes among immigrant-origin youth. Latinx youth with lower English language proficiency are more likely to face harassment and be identified as foreigners by peers, and these experiences are linked to decreased self-esteem and increased risks for symptoms of internalizing and externalizing mental disorders (Kiang et al. 2019). On a systems level, anti-immigrant policies and complex and discriminatory systems contribute to increasing numbers of mixed-legal-status families in the United States (i.e., family members of different legal statuses living together postmigration). Youth living in mixed-legal-status families face an increased risk of marginalization, which is linked to symptoms of anxiety, depression, and lower educational achievement among children (Landale et al. 2015, Yoshikawa 2011). Finally, immigrant youth with minority religious identities can also face religious discrimination. Muslim youth in the United States often face Islamophobia at school in the form of bullying, and Islamophobia has been identified as a major contributor to poorer public health outcomes among Muslim Americans of all ages (Britto 2011, Samari 2016).

INTERVENTIONS THAT PROMOTE RESILIENCE AMONG MINORITY YOUTH

Given the consequences of unmitigated hardships such as discrimination and racism on minority youth, many researchers have sought to develop interventions that specifically target minority youths' resilience building in response (see review by Jones & Neblett 2017). A prominent emphasis has included efforts to ameliorate the psychological effects of discrimination on child and youth development, and recent efforts have emphasized several aspects of resilience resources to do so. One intervention, the Identity Project, seeks to use the process of ethnic/racial identity development to promote identity consolidation—a known buffer of the effects of discrimination. This multicultural, school-based intervention includes in-school workshops, student homework, and team-building/interpersonal components (Umaña-Taylor et al. 2018). The intervention specifically targets ethnic/racial minority youths' exploration of their identities with an emphasis on consolidating their identities (i.e., reconciling their sense of self currently with whom they wish to become in the future) (Erikson 1968) over the course of the multiweek project. Through randomized controlled trial studies, the Identity Project has been demonstrated as effective for improving psychological well-being, self-esteem, and academic grades among minority youth (Umaña-Taylor et al. 2018). Such interventions that promote ethnic/racial identity consolidation, either in a targeted form or naturally (but with "conscious engagement"), hold promise for increasing psychological resilience resources among minority youth as well as reducing intergroup biases (Rivas-Drake & Umaña-Taylor 2019, p. 214).

In another intervention, individual-level coping skills are targeted through supportive relationships within the family and youth's own racial coping skills. Based on the RECAST (Racial Encounter Coping Appraisal and Socialization Theory), the intervention was designed for African American youth with the goals of increasing youth coping skills when encountering racism and reducing race-related trauma (Anderson & Stevenson 2019). This model combines elements of cognitive-based therapeutic approaches, including reappraisal, decision making, and resolution of the discriminatory experience. Family socialization practices and behaviors are also emphasized in

this intervention, which incorporates critical resilience resources and supports for youth as they build these essential resilience-promoting psychological skills.

Collectively, these intervention programs seek to harness resilience assets and resources to mitigate the effects of risk associated with minority status on child development. However, we also know that public policies must be put into place that support access to resources and reduce inequities for minority families. Without systemic policy and practice reform, oppression and inequities across intersecting minority groups will continue to negatively impact minority youth development. For example, recent research has shown that, at the national level, countries that promote positive multicultural attitudes and values toward immigrant groups through policies and practices (as opposed to assimilation-oriented policies) have not only healthier foreign-born youth populations but also healthier native-born youth populations (Marks et al. 2018). In the United States, state-level policies that provide access to welfare support for immigrant families have higher high school graduation rates among immigrant adolescents. Greater attention to and research on the health and well-being effects of policy on minority youth development are sorely needed.

FUTURE DIRECTIONS

As minority youth are more likely to experience more prolonged, frequent, and severe social and economic hardship than majority youth, future clinical science research is needed to help close minority–majority health and education disparities. Policy makers and interventionists would do well to consider this "differential vulnerability" across social groups and embrace equity perspectives over equality perspectives in both policy and practice (see Graham & Schiele 2010, p. 240). Moreover, new research and intervention should attend to intersectionality of multiply marginalized individual experiences. Policy, practice, and research initiatives must be context based and examine the underlying oppressive systems that perpetuate disproportionate risk among minority youth. At the same time, attention to resilience and awareness to avoid deficit models are paramount.

SUMMARY POINTS

1. Oppression associated with minority statuses varies across individuals and across historical contexts.
2. Increasing attention to the multiple ways individuals can be oppressed and marginalized has given rise to research efforts that consider both the intersectionality of children and adolescents' identities as well as the intensity of oppression experienced.
3. Depression and xenophobia have clearly documented and lasting negative effects on children's development; these effects are particularly strong in communities that are multiply marginalized or oppressed.
4. Risk and resilience processes among minority youth must be attended to for their unique contributions to minority child development outcomes, and these processes must be situated within the larger historical and present-day contexts of oppression and inequity that disproportionately impact minority youth developmental outcomes.

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