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COMMENTARY

Racial and Ethnic Considerations Across Child and Adolescent Development

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The US Census Bureau estimates that currently over 50% of youth under the age of 18 belong to at least one racial or ethnic minority group. It is projected that ethnic and racial minorities will make up more than half of the total US population by the year 2060 [1], yet the pool of mental health professionals has been slower to diversify [2]. All child and adolescent psychiatrists must be able to consider how the intersectionality of social class, culture, ethnicity, race, and position of power within systems of care contributes to a child's developmental trajectory and presenting symptoms.

Additionally, the emphasis on intersecting social identities must be integrated with traditional core models of child development, theoretical formulations, and teaching [3]. Many of the conventionally taught theories in child and adolescent psychiatry have been studied in diverse populations. These theories, however, do not explicitly address how experiences of microaggressions, bias, and discrimination faced by racial and ethnic minority youth and families impact typical child development and how it should be assessed.

This commentary highlights some of the relevant factors that child and adolescent psychiatrists should consider when conceptualizing typical child development among racial and ethnic minority youth and families.

Infancy and Early Childhood

The predominant theory of development during infancy and early childhood, attachment theory, emphasizes the quality of attunement in the parent (typically mother)-infant dyad. However, in communities where it is the norm for a child to have multiple prominent caregivers and the typical relational overtures and responses may differ from those found in what is commonly accepted as a "securely attached" relationship, application of this paradigm risks mischaracterizing and overpathologizing relationships that are thought to be acceptable and normative in the child's culture of origin [4]. Unfortunately, when the sociocultural context of parenting styles and familial interactions has not been taken into account with regard to assessment and intervention, children and families have unnecessarily suffered the consequences of involvement with child protective services and foster care, despite the best intentions of those involved [4, 5].

Cultural factors can also influence whether or not a child gets diagnosed with autism spectrum disorder (ASD) at a young age [6]. Studies have demonstrated that Latino and African-American children are less likely than children from other racial and ethnic groups to be diagnosed with ASD at a young age and are more likely to receive the diagnosis at older ages when symptoms have increased in severity [7]. The reasons for this are certainly complex and include factors such as a family's culturally influenced beliefs about timeliness of developmental milestones and need for intervention, as well as access to and stigma around the use of specialty mental health services [7, 8]. However, studies have also shown that Spanish-speaking and African-American parents are less likely than white and English-speaking parents to be asked about their developmental concerns by providers [7, 9], and many of the commonly used autism screening tools were normed in populations without a significant number of ethnic and racial minorities [7]. Increasing awareness of unconscious biases may help address this gap.

In the shift from infancy to the preschool years (ages 3–6), children work toward developmental competencies such as prosocial behavior, emotion regulation, and memory consolidation. They grow these skills through observations of others and through their own play. When employing "play therapy" as a treatment modality for young children, child, and adolescent, psychiatrists should be mindful of the role that play has across different cultures. In their homes, children may be

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exposed to different levels of didactic, autonomous, and fantasy play [10], which can impact their style and facileness of symbolic play with their therapist. Play therapy supports the figurative and verbal expression of often very strong feelings, and yet for parents from cultures that place a larger emphasis on indirect expressions of emotion, these techniques may be viewed by parents as encouraging the child to be disrespectful [11]. Parents from different sociocultural perspectives have differing views on the value and benefits of play and the usefulness of non-directive therapeutic approaches [10, 11]. While these factors may affect engagement of families from any culture, they may more prominently impact cultures with an already high degree of stigma or skepticism around mental health services.

Middle Childhood

Middle childhood extends from 6 years of age to the onset of puberty, typically between ages 10 and 12 [12]. During this time, children increasingly think about themselves in relation to others, including observations of how people are treated according to differences in race, ethnicity, language, sexuality, and gender. Though children at this age are typically transitioning from preoperational to more concrete and logical thinking, they may still exhibit some more primitive ways of reasoning such as magical thinking and egocentricity that can interfere with their ability to take another person's perspective. Additionally, as children's cognition develops and their awareness of serialization grows, they make distinctions that can result in exclusion of others. Given this developmental context, young children may make comments or decisions that are unintentionally hurtful. For example, a student may concretely tell a Vietnamese-American student that his lunch with home-cooked food smells funny, when he is really trying to note that it is different. Similarly, an African-American girl may not be asked to join a kickball team because she has "too many beads in her hair." Although these instances are likely not intended to be harmful, they represent societally entrenched systems of bias, stereotypes, and cultural preferences. Between ages 3 and 6, black and white children display white-biased preferences, by 5 to 6 years of age; they are able to attribute societal labels to skin color (i.e., Black and White), and by age 10, children can identify racial stereotypes [13]. For children of color, the accumulation of these small, subtle, and often unintended acts of discrimination—microaggressions—can cause them to question the desirability of their cultural and racial background and negatively impact their sense of cultural identity and self-esteem.

Differentiating between developmentally typical hurtful and generally unkind comments from microaggressions can be challenging. It is clear that explicit racism, such as overt acts of violence or verbal racial slurs, results in both externalizing and internalizing psychological symptoms, such as challenges to authority and withdrawal [14]. However, even perceived experiences of discrimination may result in similar mental health outcomes. Children may lack the cognitive skills and awareness to identify microaggressions while still experiencing the feelings associated with the bias and social slights, such as sadness, anger, and confusion. They may exhibit externalizing symptoms of this distress, such as challenging authority, hyperactivity, and/or hypervigilance which can interfere with their ability to regulate their emotions and behaviors. These behaviors can hinder their learning in an educational system that places an emphasis on self-control, self-regulation, and higher cognitive and social demands. Negative experiences in the school setting can greatly affect a child's self-concept and self-esteem. Additionally, these symptoms can contribute to the diagnosis of attention-deficit hyperactivity disorder, oppositional defiant disorder, and/or conduct disorders, instead of consideration of mood and anxiety disorders that may be more accurate characterizations of the distress.

Adolescence

Adolescent identity development is influenced by parenting approaches, cultural beliefs, and subtle and overt messages received during preschool and middle childhood. For racial and ethnic minority adolescents, challenges associated with acculturative stress, racial/ethnic identity development, and race-related stress can place added psychological demands on the process.

Much research has focused on parent-adolescent relationships across cultures and the conflicts that may arise related to differential acculturation and cultural norms. In Diana Baumrind's classification of parenting styles, the authoritative style (high levels of support/warmth/responsiveness and control/demandingness) has been noted in research and generally accepted in popular culture to correlate with psychological well-being and academic success as opposed to an authoritarian style (low support/warmth/responsiveness and high levels of control/demandingness). However, many of these studies have been conducted based on the cultural standards of western, middle class, and white families [15] and may therefore not be as normative in other cultural contexts. Other studies comparing parenting styles among cultures have noted, for example, that first-generation Chinese American immigrants with authoritarian parents did just as well in school as those with authoritative parents [16]. Additionally, how the domains of warmth/support and control/demandingness are measured, displayed, and perceived in cultural context matters. For instance, many immigrant parents feel that they display their love for their children through instrumental supports (providing basic needs, supporting education) and sacrifice (working

several jobs, leaving their home country to provide a "better life" for their children) as opposed to displays of love through physical and verbal affection, compliments, and praise. Likewise, parenting approaches such as strictness and control are intended as ways to guide and protect their children, not to hinder their growth and independence [17].

For immigrant and second-generation adolescents (those who were born in the USA to immigrant parents), differences in acculturation, such as varying notions of individuation vs. collectivism, can contribute to conflicts in their relationships and present challenges for families trying to navigate and balance norms and expectations. For instance, a 17-year-old South Asian American female may feel like she has to keep her boyfriend secret from her parents, who anticipate being the ones to help find her a husband later in life. Immigrant-origin youth often struggle to integrate their home/native culture with the host/dominant culture. Their parents/caregivers are facing their own acculturative stressors, which can add further strain. Berry's model of acculturation highlights four aspects of this process: integration, marginalization, assimilation, and separation [18]. The goal is to reach integration, where both cultures are valued and expressed; however, some immigrant-origin youth assimilate (accepting the dominant culture over their native culture), some experience separation (immersed entirely in their native culture), and others experience marginalization (where they feel like they do not fit in anywhere). The process of navigating differing cultures can lead to acculturative stress: the psychological stress in response to the incongruence of beliefs, values, and other cultural norms between a person's culture of origin and mainstream/host culture [18]. These stress points may arise in frequent but subtle ways—for instance, deciding whether to wear clothing of one's ethnic background, the decision to straighten one's hair, whether or not to wear a headscarf or a turban, or whether wearing shorts is a sign of immodesty. The psychological stress is not necessarily in the act of making these decisions, but in the notion that reflection of one's host or home culture is somehow inferior or less desirable to those of the dominant or mainstream culture [19].

These stresses contribute to how adolescents navigate their racial and/or ethnic identity, which continues to take shape during this time period. Jean S. Phinney proposed a three-stage model for adolescent ethnic identity development: unexamined ethnic identity, ethnic identity search, and ethnic identity formation. These stages do not correspond to specific ages but can occur at any time during early to late adolescence. Individuals may spend their entire lives at a particular stage of ethnic identity development [20]. Although youth of color have likely faced racialized experiences, they may not have explored their own racial or ethnic identity.

According to Phinney, during the unexamined ethnic identity stage, minority adolescents may be disinterested in their ethnic background and accept the attitudes of the dominant culture. The impetus for beginning identity exploration is multifactorial but often follows a crisis, such as a time when one is called a racial slur. This encounter begins the process of ethnic identity search, a time marked by the formation of political or social consciousness and an exploration or immersion in one's own racial/ethnic groups. This immersion can lead to developing a greater sense of pride in one's racial/ethnic group [20], but some adolescents may struggle to reconcile multiple intersecting identities (i.e., sexuality, gender, immigrant status, race). This process, although normative, can be confusing and emotionally exhausting, which can contribute to changes in mood or increased anxiety. Ultimately, the goal is that adolescents achieve a sense of ethnic identity in which they accept membership in an identified group (not necessarily of biological origin), can identify both positive and less attractive aspects of their identity, and are accepting of other cultures and backgrounds [20].

The process of racial and ethnic identity development is complicated by minority stress. Minority stress is a result of chronic stress secondary to stigma associated with one's own minority group in addition to the imposition of values, expectations, and experiences from the majority group [21]. According to Meyer's minority stress theory, racial and ethnic minorities face distal and proximal stressors that may impede a positive sense of identity development. Meyer describes distal stressors as discrimination and violence and proximal stressors as secondary to one's internalization of stigma and view of belonging to a minority group [21]. Racial microaggressions—such as teachers continuously mispronouncing the names of students of color, students repeatedly being asked for identification cards when entering their schools, confrontations with security guards, and hypervigilance of students of color in the hallways—can communicate hostile, derogatory, or negative racial slights toward people of color [14]. These experiences can contribute to an expectation of rejection, concealing oneself, and internalized prejudice. This can hinder an adaptive sense of identity and ultimately negatively impact mental health [21].

In summary, when child and adolescent psychiatrists work with racially and ethnically diverse youth, it is important to assess their experiences with bias and prejudice and place these, along with the presenting symptoms, in the context of their developmental stage. In addition to creating an environment for the patient and their family that supports an open dialogue about experiences of discrimination, psychiatrists must also process any discomfort that may arise within themselves during these discussions. Additionally, not all minority youth who experience forms of discrimination become symptomatic, and psychiatrists should not assume that one's minority status and experiences with bias automatically contribute to psychopathology. Thus, when working with minority youth, it is equally important to assess elements of pride and strength in one's family and culture. Psychiatrists can inquire about family traditions, celebrations, positive views about

one's cultural identity, and the role of religious and faith communities as social support. For instance, a strength-based approach to working with families of color would recognize the protective effect that having a strong sense of bicultural or multicultural identity can have among minority youth in the USA with relation to issues such as substance use and overall psychological well-being [22, 23]. An evaluation of developmental competencies should be broadened to include competencies specific to the experience of persons of color, including resilience developed by dealing with individual and institutionalized racism, implicit bias and prejudice, as well as the ability to navigate bicultural identities [3].

It has long been acknowledged that the developmental lines contributing to the arc of a child's growth are multifactorial; however, the conventional frames in conceptualizing child development do not directly address the impact of bias, power, and privilege on youth development and mental health. Consideration for these significant and often destructive forces is imperative to best understand and respond to the child mental health needs of an increasingly diverse population.

Compliance with Ethical Standards

Disclosures On behalf of all authors, the corresponding author states that there is no conflict of interest.

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