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Does Resilience Moderate the Impact of Children's Experiences of Racial and Ethnic Discrimination on Internalizing Problems?

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Abstract

This study's objectives were to investigate how children's experiences of discrimination impact the severity of their internalizing symptoms, and whether the relation between discrimination and internalizing symptom severity is moderated by resilience. It was predicted that children who had experienced more discrimination would have more severe internalizing symptoms, especially when they have low levels of resilience. Children [N=20; Mean (SD) age= 11.83 (2.50)] receiving low-cost music lessons in northern Manhattan were recruited into a larger study examining how learning music affects cognitive and emotional development. Children were interviewed in-person about experiences of discrimination because of their race/ethnicity using the Perceptions of Racism for Children and Youth. Children's music teachers completed the Behavioral Assessment Scale for Children, Third Edition. The Anxiety, Depression, Somatization subscales were used to assess internalizing symptom severity, while the Resiliency subscale measured children's resilience. The majority of children described being discriminated against at least once. Younger children's experiences were across a range of situations, while adolescents' experiences tended to be clustered around verbal disparagement. Children expressed negatively-valenced emotional responses and displayed active coping where they confronted the problem. Children with Low resilience tended to have more Somatization symptoms when they experienced discrimination in two or more contexts rather than zero or one context, whereas number of experiences of discrimination did not impact Somatization scores for children with High Resilience. Findings highlight the need to promote young people's resilience to react, deal, and cope with experiences of discrimination.

Keywords: racism, discrimination, depression, anxiety, somatization, resilience, children

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Introduction

Significant disparities in health, education and criminal justice outcomes emerge among the different racial/ethnic groups in the US (Maxwell, 2020). A racial/ ethnic groups' position in society impacts these outcomes due to the variety of social experiences and environmental risks to which people of color are exposed (Sanders-Phillips, Settles-Reaves, Walker, Brownlow, 2009). Racism influences policies and practices at all levels of a child's environment, resulting in the disparities observed between minority and majority groups (Sue, Capodilupo, Torino, Bucceri, Holder, Nadal, Esquilin, 2007). It has been proposed that exposure to racial discrimination may be considered a form of traumatic stress (Carter, 2007), which is associated with poorer mental health outcomes (US Department of Health and Human Services, 2012). Although in the US much of the research has been carried out in adult populations (Kirkinis, Pieterse, Martin, Agiliga, & Brownell, 2018), some studies of pediatric populations have shown that among children and adolescents, racial and ethnic discrimination is associated with depressive symptoms, low self-esteem or self-worth, and anxiety (Pachter, Szalacha, Bernstein & Coll, 2010). Identifying factors that protect against the negative effect of racial discrimination on children's mental health is essential.

The Environment as a Context for Development

Development is shaped by dynamic, complex, reciprocal interactions between a child and the people, objects and symbols in their environment. The form and magnitude of these processes are affected by the child, their environment, and the outcome being studied (Bronfenbrenner & Ceci, 1994). Bronfenbrenner and Ceci (1994) conceptualized the

"environment" as highly differentiated. He proposed five nested structures, which are closer or further away from the child, but whose forces impact development. The Microsystem is the child's immediate environment (e.g., the family, peers). The Mesosystem is the interaction between two or more different settings containing the developing person (e.g., communication between parents and teachers). The exosystem is a setting that does not contain the developing child, but which indirectly affects them through its impact on the microsystem (e.g., parent workplace stress affects the child through parenting behaviors). The macrosystem is the cultural and economic conditions in which a person grows up; this encompasses the belief systems, knowledge base, opportunities and hazards within each of the structures. Finally, the chronosystem represents time, not only at an individual level (i.e., the child getting older), but the sociohistorical context in which the child is developing (e.g., during a pandemic) (Bronfenbrenner & Ceci, 1994).

Bronfenbrenner and Ceci's (1994) focuses not only on individual factors, but the wider environmental context in which they are developing helps to provide a framework for understanding how children's developmental outcomes may vary so widely as a function of sociodemographic factors. Recently, there has been a large focus on understanding social determinants of health; that is, "conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (World Health Organization, 2020). These infuse all levels of Bronfenbrenner's model. Examples of social determinants of health include health care access and quality, education access and quality, food security, housing, access to healthy food, safety, and discrimination (Centers for Disease Control, 2020).

In many countries around the world, social determinants of health vary systematically as a function of race and ethnicity. That is, these societies are characterized by social inequality, whereby specific groups do not share equal social status based on their ethnicity, gender, and other characteristics (Sanders-Phillips et al., 2009). Social inequality for minority-identifying children, especially children of color, can create risk factors that may negatively impact their mental health. Therefore, Garcia Coll and colleagues (1996) suggested that specialist models are needed to focus specifically on child development within the minority community. Their model included eight domains considered to affect development of children of color; Social Position (i.e., Race, Social Class, Ethnicity, Gender), Racism (i.e., Prejudice, Discrimination, Oppression), Segregation (i.e., Residential, Economic, Social and Psychological), Promoting/Inhibiting Environments (i.e., Schools, Neighborhoods, Healthcare), Adaptive Culture (i.e., Tradition and Cultural Legacies, Economic and Political Histories, Migration and Acculturation), Child Characteristics (e.g., Age, Temperament, Health Status), Family (e.g., Structure and Roles, Family Values, Beliefs and Goals, Racial Socialization, Socioeconomic status), and Developmental Competencies (e.g., Cognitive, Social, Emotional, Linguistic, Biculturalism, Coping with Racism).

Central to Garcia Coll et al.'s (1996) integrative model is Social Position (e.g., race, ethnicity, gender and social class; Garcia Coll et al., 1996) because society uses these individual characteristics to place someone on a social hierarchy. External physical characteristics, such as the color of one's skin and hair texture, are used as determinants of race (Garcia Coll et al., 1996) and have been used to grant dominance to some classes over others, with darker skin color associated with greater social penalties (Garcia Coll et al., 1996). Although race is not a biological construct, the classification of individuals in this way has become institutionalized

(Trent et al. 2019), with devastating disparities in health, education, socioeconomic, and criminal justice outcomes for people of color. According to Garcia Coll et al.'s (1996) theory, the impact of race and ethnicity, as well as other individual characteristics, on developmental outcomes is mediated by a host of factors, one of which is Racism.

Racism

"Racism is a system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call "race"), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources" (American Public Health Association, 2020). These systems create dominant and secondary social groups that differ in levels of power in a variety of systems including political, economic, social and personal as well as access to goods in those environments (Sanders-Phillips et al., 2009). Racism can operate through three main levels (Jones, 2000): institutionalized racism; personally-mediated (or interpersonal) racism; and internalized racism. While it may seem that racism may have declined throughout the years, research indicates the contrary. Evidence suggests that over recent years, racism has actually increased. This has been observed at the institutional level (e.g., voter disenfranchisement; Shelby County v. Holder, 2013) and at the individual level (e.g., anti-immigrant social media posts; Muller & Schwartz, 2020). Furthermore, there appears to be an interaction such that when institutions signal that this behavior is tolerated or acceptable, then racially-discriminatory acts are more likely. For example, it has been shown that after reading then-Republican nominee (now U.S. President) Trump's negative remarks about immigrants, individuals with higher levels of prejudice were more likely to engage in discriminatory behavior (Newman, Merolla, Shah, Lemi, Collingwood & Ramakrishnan, 2020). Similarly, Facebook's

tolerance of right-wing anti-refugee sentiments has been associated with an increase in violent crimes against refugees (Muller & Schwartz, 2020).

As racial discrimination is widespread, occurring at multiple levels, studying its impact may be crucial to understanding its influence on the health outcomes of children of color (Sanders-Phillips et al., 2009). Based on the ecological theory, the relationship between a child and their immediate environment and larger social environment must be studied in order to fully understand development (Sanders-Phillips et al., 2009).

Institutionalized (Systemic) Racism

Institutionalized racism is the systemic distribution of power, resources and opportunity as a function of race/ethnicity (Jones, 2000). "Institutional racism is structural in that it has been codified in society's institutions, customs, and laws." (Sanders-Phillips et al., 2009). The availability of resources does not exclude the fact that minority children may not have access to them. Macrosystem variables such as banks, schools, biased curriculum and textbooks, and the media can affect economic well-being and promote stereotypes of minority groups, which may influence microsystem variables such as family functioning, and neighborhood conditions impacting children's development (Sanders-Phillips et al., 2009). Not only has racial discrimination influenced and characterized life options for the majority of children of color, but at the institutional level, it has led to group differences in material conditions such as poverty, education, employment, and access to medical care (Sanders-Phillips et al., 2009).

Personally-Mediated (Interpersonal) Racism

Personally-mediated racism is prejudice (differential beliefs and assumptions about a person's abilities and intentions as a function of race/ethnicity) and discrimination (differential actions towards a based on their race/ethnicity) (Jones, 2000). Personally-mediated racism can be

overt (e.g., calling somebody a racial slur) or subtle (e.g., racial microaggressions) (Sue et al., 2007). Microaggressions are everyday exchanges that can consist of dismissive looks, gestures and tones and are commonly dismissed or glossed over as being innocent slip ups (Sue et al., 2007). In many cases, perpetrators may be unaware that they are engaging in such form of communication during their interaction with racial/ethnic minority-identifying individuals (Sue et al., 2007).

Personally-mediated racism may be explicit or implicit (Trent et al., 2019). Explicit racism refers to beliefs about another group that are at the conscious level, whereas implicit racism lies outside conscious awareness (Trent et al., 2019). Even among individuals who explicitly state that they believe in equality among racial groups, they may hold assumptions of how an individual from a certain racial group will act or about their abilities, which may have critical implications for minoritized groups (Garcia Coll et al., 1996). For example, even when educational institutions are as accessible to minority children as they are to White children, children of color may still face subtle forms of racism displayed in lower teacher expectations, testing and tracking (Garcia Coll et al., 1996). Given that children are raised in highly socially stratified cultures, it is not surprising that implicit beliefs about outgroup members develop. In fact, this begins very early in development - children as young as preschoolers make judgements based on ethnicity, race and social categories, while identifying themselves as members of particular groups competing and segregating themselves based on social class and physical attributes (Garcia Coll et al., 1996). These ideas and behaviors are reinforced over time through messages from institutions, friends and family members.

Internalized Racism

Internalized racism is when a person from a marginalized group accepts and believes the negative messages about their abilities and self-worth (Jones, 2000). “Research has shown that the psychological internalization of the devalued status and feelings of oppression can tend to limit the mobility of families and individuals and lead to the adoption of integrating views and judgements both about themselves and others in their racial and ethnic group” (Garcia Coll et al., 1996).

Developing children are introduced to inference making skills which allow them to learn attitudes towards stereotypes about groups in their society that can result in negative perceptions of their own group, as well as “socializing into lower expectations and inferior jobs” (Garcia Coll et al., 1996; Sanders-Phillips et al., 2009). At that stage, being exposed to racial discrimination can increase self-consciousness, decrease self-esteem and self-efficacy (Sanders-Phillips et al., 2009). It can also lead to the development of anger, depression and anxiety symptoms, which can have enduring effects on mental and physical functioning in adulthood (Sanders-Phillips et al., 2009). Racial discrimination has a potent effect on children’s self-efficacy, which is the cognitive orientation and belief in their ability to affect their future outcomes and can be damaging considering how much of a critical component self-efficacy is to mental health and also to healthy behavior.

Discrimination is a Common Occurrence for Racial/Ethnic Minority Youth

Not surprisingly given the highly stratified society that children grow up in, youth of color commonly report experiencing discrimination because of their race and/or ethnicity. Simons and colleagues (2002) recruited a large number of African American families from Georgia and Iowa. A majority of the African American youth experienced racial discrimination. Two thirds (67%) of children reported being insulted because of their race; nearly one half of

children (43%) reported being suspected of doing something wrong; one third (33%) of participants said they were excluded from an activity because of their racial identity; and nearly one fifth of participants (18%) had been threatened with physical harm. Many of the youth also reported seeing their family members and friends having been treated unfairly because of their race (Simons, Murry, McLoyd, Lin, Cutrona & Conger, 2002). Pervasive discrimination at all levels of society against people of color has led to a growing call for leaders to acknowledge that racism is a public health issue. So far, more than 145 state and local bodies have done so (American Public Health Association, 2020). This is a small, but critical start to address the issue at a systemic level, especially given the adverse effects of discrimination on children's and adolescents' mental health.

Impact of Racism on Children's Mental Health: Internalizing Symptoms

Previous studies on the impact of racial discrimination on health disparities among minority children were influenced by three theoretical models: ecological theory, social-stratification theory and theory of racial inequality and social integration (Sanders-Phillips et al., 2009). Bronfenbrenner and Ceci's (2004) bioecological model was described above. "The social-stratification theory" refers to the historical and current social, political, and cultural processes that result in a society's hierarchy of groups. An example of this is portrayed among Black Americans who despite significant gains, have lower social status in the United States resulting from their history of legal segregation (Sanders-Phillips et al., 2009). A group's position in a social system can play a part in its exposure to risk factors, including racial discrimination that leads to stress and which may directly or indirectly affect health (Sanders-Phillips et al., 2009). Lastly, the theory of racial inequality and social integration addresses the psychological pathways associated with the influence of discrimination on mental and physical health (Sanders-

Phillips et al., 2009). The term "Anomie," which is defined by feelings of hopelessness and perceptions of little control over one's life outcomes, develops when children perceive contradictions between opportunities in the larger society and the lack of in their own lives (Sanders-Phillips et al., 2009).

A great number of studies have examined the link between racial discrimination and its impact on health outcomes (Paradies et al., 2015; Sanders-Phillips et al., 2009). A meta-analysis of nearly 300 studies that involved both children and adults showed that racial discrimination was negatively related to poorer physical (r= -.09) and mental health (r= -.23; Paradies et al., 2015). Perceived racial discrimination has been associated with higher levels of depressive symptoms, psychological distress and a decrease in levels of social connectedness in minoritized youth (Fisher, Wallace & Fenton, 2000). Fisher et al. (2000) examined the experiences of perceived racial discrimination of 177 adolescents from different ethnic groups, and the extent of their distress during those experiences. Findings showed that students' experiences of perceived racism were often situations of discrimination that involved teachers' prejudice towards a student's racial background (Fisher et al., 2000). The findings indicated that perceived discrimination negatively impacts academic achievement and psychological resilience, while also being associated with greater delinquent behavior (Fisher et al., 2000).

A longitudinal study of 714 adolescents showed how discrimination impacts children's mental health over the critical transition from childhood to adolescence. Participants were evaluated three times over a 5-year period. The authors hypothesized perceived discrimination from late childhood to early adolescence would be linked to increased conduct problems and depressive symptoms (Brody et al., 2006). More than a quarter of the African American youth participating in this study reported being excluded from a group activity because of their race

(Brody et al., 2006). Exclusion from activities in addition to slurs and false accusations are likely to undermine a child's sense of worth and control, while implanting mistrust of others, especially the majority population (Simons et al., 2002). As anticipated, perceived discrimination increased risk for later conduct problems and depressive symptoms among African American youth. Findings also showed the importance of intersecting identities; a stronger positive correlation between perceived racism and behavioral problems was observed among African American boys than for African American girls (Brody et al., 2006).

Similarly, in Simons et al.'s (2002) study of Georgia and Iowan families, a great sum of the youth (88%) had at least one symptom of depression. Of great concern, one third of young people experienced thoughts of death (34%) or suicidal ideation (35%). Minority children did not have to be the direct target of discrimination to experience distress; they were often stressed when witnessing incidents of discrimination against members of their ethnic or racial group (Simons et al., 2002).

Racial discrimination, even in subtle forms, can have far reaching effects on many aspects of a child's functioning. A study conducted by Fordham and Ogbu (1986) that reviewed explanations for the under achievement of Black-identifying students, highlighted the negative implications that worrying about future experiences of discrimination can have on a developing child's well-being. Their results suggested that ethnic minority youths' inner vigilance can lead to a constant state of alertness, which can lead to chronic tension and stress, which in turn negatively affects academic outcomes (Fordham & Ogbu, 1986).

Resiliency

Children of color, particularly, Black and Latinx males face many adversities due to discrimination (Dulin-Keita, Iii, Fernandez and Cockerham, 2011). In light of the adverse effect

of racial/ethnic discrimination on children's mental health, it is important to explore how children's resilience may affect their outcomes. Resilience is a "dynamic process encompassing positive adaptation within the context of significant adversity" (Luthar, Cicchetti, & Becker, 2000). Resilience encompasses two common factors: first, experiencing stress or adversity, and second, achieving a positive outcome during or after that adversity (Gartland, Riggs, Muyeen, Giallo, Afifi, MacMillan, Herrman, Bulford & Brown, 2019). Thus, the theory of resilience can provide a framework for understanding how youth successfully adapt and thrive to life challenges (Kubiliene, Yan, Kumsa, & Burman, 2014).

Currently, research has interpreted resilience as a process whereby an individual draws on their personal characteristics as well as resources in their environment helps them withstand and negotiate adversity (Gartland et al., 2019). Thus, resilience can be conceptualized as multifaceted and may be conferred by protective factors external to the child, such as family characteristics, school environment, and the community itself (American Psychological Association, 2012), as well as internal characteristics of the child.

With respect to internal characteristics, a variety of factors including coping style, cognition, optimism and self-esteem have been identified as supporting resilient outcomes in youth (Gartland et al., 2019). In addition, the capability to build and maintain healthy interpersonal relationships, efficient problem-solving skills, as well as realistic goal-setting have been associated with greater resilience (Pettoello-Mantovani et al., 2019). Finally, much research has focused on a child's ethnic and racial identity (ERI), with findings consistently showing that an individual's commitment to their identify is positively associated with protection from discrimination (Simons et al., 2002; see Yip, 2018 for a review). Taken together, these factors cut across several critical areas of functioning including socioemotional and cognitive domains.

Of external factors, two of the most influential contexts for children and adolescents' processing of adversity to achieve (or not achieve) positive adaptation are families and communities (Kubiliene et al., 2014). For example, a study conducted on immigrant and refugee children revealed that their well-being is largely dependent on their connectedness with their parents, extended family and peers from the same ethnic group (Werner, 2012). While perceived racism was one of the many adversities they faced, in their review of longitudinal studies of resilience, these social connections were found to have positive protective implications on the development of adolescents in overcoming challenges as they transitioned into adulthood (Werner, 2012).

Finally, coping, although not synonymous with resilience, shares a number of similarities. Coping involves how an individual deals with challenges while resilience refers to their positive adaptations to said challenges (Kubiliene et al., 2014). While not all coping strategies lead to resilience, coping is an important contributor in building resilience (Kubiliene et al., 2014).

Taken together, resilient adaptation is not only a relational process, but a form of self-healing in which minority youth seek ways to construct and reconstruct themselves to heal from harmful social relations (Kumsa, Chambon, Maiter & Yan, 2013). Building resilience is essential to establishing and maintaining good health (Pettoello-Mantovani et al., 2019).

The Current Study

The present study aims to extend current research by investigating how children's resilience impacts the relation between their experiences of racial and ethnic discrimination and severity of internalizing problems. While there is not necessarily a scarcity of studies on racial discrimination, fewer have been conducted with children, or focused on the effects of racism on

the mental health of children and how resilience can help them overcome it. The majority of instruments used to measure perception of discrimination have been developed for adults or teenagers (Lee at al., 2010). However, the PRaCY (Perceptions of Racism in Children and Youth) a self-report instrument that is suitable for use with younger children, and has been utilized in this study. The BASC-3, in addition to assessing clinical symptomatology (anxiety, depression, and somatization levels), also allows us to assess resilience in youth, with specific focus on children's accesses to internal and external resources in order to overcome adversities (Reynolds & Kamphaus, 2015).

In this study we aim to observe the perceptions of experiences of discrimination experienced by a group of youth musicians as well as the impact of these experiences on children's internalizing symptoms. In addition, we aim to examine whether children's resilience moderates the association between discrimination and anxiety, depression and somatization. It was hypothesized that ethnic and racial discrimination will be associated with higher levels of depression, anxiety and somatization, especially in the context of low resilience.

Method

Participants

Children and adolescents learning music through a low-fee music program in Northern Manhattan were recruited to this study (N=20). The ages of the children ranged from 8-16 years old (Mean = 11.83, SD = 2.50). Most of the sample were female (n=13) and identified as Hispanic[1] (n=17). To be included in the study children had to be: (i) aged 2-17 years; (ii) enrolled in a low-fee music program in northern Manhattan; and (iii) fluent in English. (iv) Parents had to be fluent in English or Spanish, in order to read and sign consent forms.

[1] Ethnicity data was not available for two participants.

Participation in this study was on a voluntary basis and parents' decision to take part or to decline participation had no impact on their children's ability to receive music lessons. Parents signed informed consent forms, which provided participants with information regarding the procedures, the purpose of the study, benefits and risks of participating, and an explanation on how and when to request the results of the study. Children completed oral and written assent procedures. While the children were not compensated, their parents and teachers received a $5.00 Starbucks gift card after completing forms. This study was approved by the CUNY Institutional Review Board. This study utilizes data from children aged 8 years or older, who were old enough to complete the measure on racial and ethnic discrimination.

Materials

The Perceptions of Racism Among Children and Youth (PRaCY) *(*Pachter et al., 2010*).*

The PRaCY (Pachter et al., 2010) assesses children's experiences of discrimination. In the current study, a trained research assistant worked one-on-one with each child aged 8 years or older, asking them if they have been treated differently because of their race/ethnicity in one of 10 different situations listed in the measure (e.g., "Watched closely or followed around by security guards or store clerks at a store or the mall") (Pachter et al., 2010). Any item to which the child responded "yes" was followed up with four open-ended questions about frequency of episodes, the child's attribution for the event, how it made the child feel, and how they coped with it. Two different forms of the measure are available depending on children's age range: 8-13 years and 14-18 years. The PRaCY has been shown to be a reliable and valid instrument to measure perceptions of racism and discrimination among youth aged 8-18 years old from diverse racial/ethnic backgrounds (Pachter et al., 2010). The PRaCY was developed by Pachter et al. (2010) who gathered information on prevalence, attribution, emotional response, and coping

responses to 23 situations collected from a proto-questionnaire, which was administered to 277 children with ages between 8- and 18-years-old.

Behavior Assessment Scale for Children, Third Edition (Reynolds & Kamphaus, 2015).

The BASC-3 is a reliable and valid questionnaire, which measures the behavioral, emotional, and adaptive functioning of children and adolescents aged 2-21 years. In the current study, children's music teachers completed this questionnaire, from which four subscales were used: Depression, Anxiety, Somatization, and Resiliency. Forms are specific for a child's age. In the present study, music teachers completed the Child version (Child Form, 6-11 years old) or Adolescent version (Adolescent Form, 12-21 years). For all items, teachers rated children's behavior over the "past several months" on a 4-point scale, Never to Almost Always.

Anxiety. The Anxiety subscale assesses a child's tendency to be nervous, fearful or worry excessively. Both the child and adolescent scales are composed of 9 items.

Depression. The Depression subscale assesses a child's tendency to feel sadness, to be unhappy and experience stress, which interfere with daily functioning. The child and adolescent scales have 11 and 12 items respectively.

Somatization. This scale measures a child's tendency to be oversensitive to, and complain about or overreport minor physical problems. The child scale has a total of 8 items and the adolescent scale has 7 items.

Resiliency. Resiliency assessed a child's ability to access internal and external support systems to help alleviate stress and overcome adversity. The items incorporate cognitive and emotion regulation skills (e.g., abstract reasoning, flexibility when plans change) and communication skills. The child scale comprises 13 items for child, while the adolescent scale is made up of 12 items.

Procedure

The researchers attended music classes and spoke to parents to inform them about the study. All parents took home packets comprising information about the study as well as consent forms. These packets were in English or Spanish, depending on the parent's language preference. Once the consent form was returned to the researcher, the child's assent was obtained. A trained graduate-level researcher interviewed each child one-on-one about their experiences of discrimination in a private space immediately after their music lesson. Children's music teachers completed a pencil-paper copy of the BASC-3 and then returned it to the research team.

Data Analysis

Children's reports of their experiences of discrimination were coded for major themes and subthemes. Teachers' responses to the BASC3 were summed and age-normed T scores obtained for Depression, Anxiety and Somatization. The Resiliency subscale does not have age-normed scores and so the mean score across all items was obtained given that the child and adolescent subscale have different numbers of items. The Resiliency scores were not normally distributed. A median split was performed to categorize children as High or Low Resilience.

As depression, anxiety and somatization accuracy was not normally distributed, an aligned rank transform (Wobbrock Findlater, Gergle & Higgins, 2011) procedure was carried out, in which each main effect and/or interaction not of direct interest is considered to be a confounding factor, and its effect is removed from the dependent variable, leaving only the effect of interest. Data points are then ranked, and averaged in the case of ties. Following this processing of the data, a between-subjects ANOVA was carried out. Of note, separate full-factorial ANOVAs were carried out for each main effect/interaction of interest (Wobbrock, et al., 2011). The aligned rank procedure for a non-parametric 2-way ANOVA has been shown to have

greater power than an ANOVA on data that has not undergone the aligned rank transformation (Oliver-Rodriguez & Wang, 2015). Effect sizes are reported using partial eta square. Where a significant interaction was obtained, follow-up post-hoc comparisons using Mann Whitney U for independent samples were carried out. Glass's rank biserial correlation was calculated as a measure of effect size (Wuenschk, 2020).

Results

Children's Experiences of Racism

Frequency of Episodes

The majority of children (n=16, 80%) described being discriminated against at least once (see Figure 1). Only 4 (20%) children reported that they had not personally experienced or witnessed any discrimination. There was a marginally significant linear trend with strong effect size for adolescents to report more experiences of discrimination than younger children, M^2 =3.10, df = 1, p = .078, Cramer's V = .58. Of the children who reported no experiences of discrimination, 75% (n=3) were younger than 12 years of age. All of the participants who reported experiencing discrimination in five different contexts were adolescents.

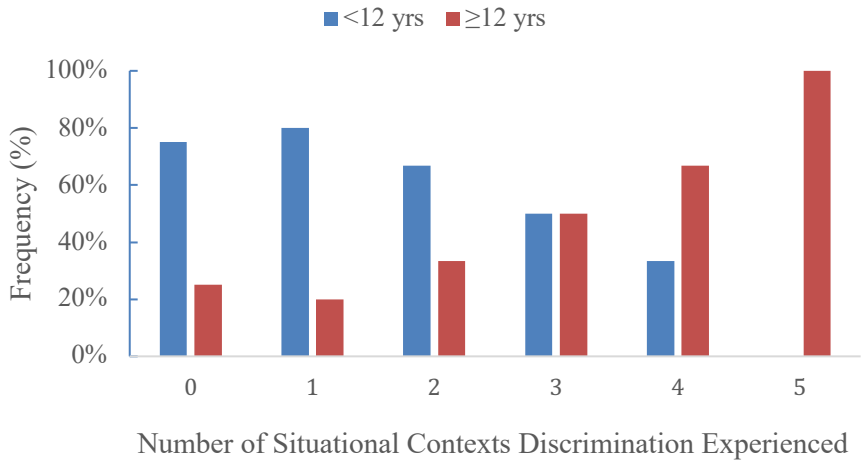

Figure 1. Number of contexts in which children experienced discrimination as a function of age (younger than age 12 years; 12 years or older).

The children experienced instances of discrimination in many different situational contexts (see Figure 2). For younger children, experiences were across a range of situations from being treated poorly in a store or restaurant or at school, or being disrespected verbally (e.g., someone was rude, someone made an insulting remark about them). For adolescents, experiences tended to be clustered around verbal disparagement (e.g., they were insulted, someone made a bad or insulting remark about their race, or someone was rude to them). Adolescents were also more likely to report witnessing others' being subjected to discrimination, such as seeing a loved one being treated unfairly or badly because of their skin color, accent, language.

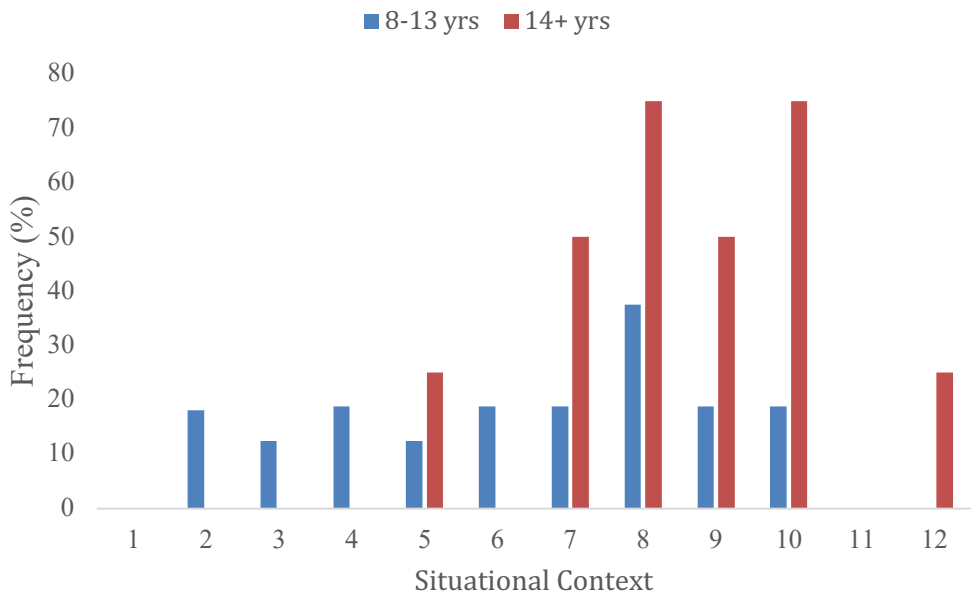

Figure 2. Situations in which children experienced discrimination.
Note: 1 = Watched closely or followed around by security guards or store clerks at a store or the mall; 2 = Got poor or slow service at a restaurant or food store; 3 = Got poor or slow service at a store; 4= Accused of something didn't do at school; 5 = Treated badly or unfairly by a teacher; 6 = Had the feeling that someone was afraid of you; 7 = Called an insulting name; 8 = A bad or insulting remark made about one's race, ethnicity, or language; 9 = Someone was rude to you; 10 = Witnessed parents or other family members treated unfairly or badly because of the color of their skin, language, accent, or because they come from a different country or culture; 11= Treated unfairly by a police officer; 12 = Assumed not smart or intelligent.
Items #2 and #3 administered to participants aged ≤13 years of age only; items #11, #12 administered to participants aged 14 yrs and older only

Attributions for Experiences of Racism

When children reported experiencing discrimination in a particular context, they were asked to say why they thought it happened. The responses were coded into several themes related to the participants' experiences (see Table 1).

Table 1.

Themes and examples emerging from attributions children made to explain experiences of discrimination.

Major Theme	Subtheme	Example
Racial and Ethnic Identity	Ethnicity	"Culture"
		"Latinx"
		"Race"
	Nationality	"Dominican"
		"Mexican"
	Language	"speaking Spanish"
		"accent"
	Skin Color	"color of skin"
		"dark skin"
Self-Expression	Music	"music [they] listen to"
Physicality	Size	"smallest in the class"
		"small"
	Medical Problems	"medical condition"
		"disability"
Gender Identity	Dress	"masculine"
Religion		"culture"

For each of the major themes will be discussed, example verbatim quotes from the children's responses are included.

Racial and Ethnic Identity/Ethnicity. The majority of participants claimed to have been discriminated against due to their race and/or ethnic identity. One participant between the age of 14-18 years old reported that because of her ethnic identity and language, when she was speaking Spanish on the streets she was yelled at and told to "speak in English with family". In another

example, a child between the age of 8- and 13-years-old experienced discrimination in their school environment by an adult member. It was a situation where he acknowledged that he had pushed another student who would not get out of the way for a girl. When he was called to the Dean's office, he perceived that he was unfairly treated because he was "Latino".

Nationality. Children also perceived that they may have been discriminated against because of their or nationality. One child attributed their experience of discrimination to being Mexican, while another attributed it to their Dominican heritage.

Skin Color. Children have also experienced racism based on their physical appearance. One child aged between 14- and 18-years-old was discriminated against, along with a loved one, "because of the color of [her] skin and language." She saw her father treated differently and/or poorly because of his "dark skin".

Language. Many of the children in the sample are bilingual English and Spanish speakers. For children of immigrant parents, their first language may not be English and language may be a reason they or their family members are targeted (Toppelberg & Collins, 2010). Consistent with this, multiple children within our study claimed to have been discriminated against because of their "language" or "accent". A teenager between the age of 14- and 18-years-old stated that she felt she was being discriminated against because she was "speaking Spanish on the streets and was yelled at and told to speak in English with family."

Gender Identity. Some participants were discriminated against due to their gender identity and behaviors not conforming to gendered stereotypes. For example, one participant expressed that her dress attire, which is more stereotypically masculine, was the reason for her being discriminated against. She also felt that because of the way she self-expresses herself, she is yelled at in the streets.

Self-Expression. Music can be used by children to express themselves (Sarrazin, 2016). A child between the age of 8- and 13-years-old perceived they were discriminated against because of the "music [they] listen to".

Religion. One's own personal beliefs and practices are a form of self-expression (Kim, 2010). A child between the age of 8 years old and 13 years old claimed to have been discriminated against due to their "culture" and "religion".

Physicality. Several children were discriminated against due to their physicality.

Size. A child between the age of 8-13 years old experienced discrimination from her peers for being the "smallest in the class".

***Medical Conditions*.** Children described feeling discriminated against due to having medical problems or a disability that were out of their control. A child between the 8- and 13-years-old expressed being discriminated against for their "accent and medical condition"**.** Two children between the age of 8- and 13-years-old were excluded because of their "medical condition" and/ or their "disability."

Emotional Responses to Experience of Racism

Next**,** children were asked to report how the experience of discrimination made them feel. Children reported a range of emotional responses to their experiences of discrimination (see Table 2).

Table 2

Themes and examples emerging from children's emotional responses to experiences of discrimination.

Major Theme	Subtheme	Examples
Negatively-Valenced Emotions	Discomfort	"Didn't feel great
		"Weird"
	Fearful/Anxious	"Bad"
		"Intimidating"
		"Scared"
		"Worried"
	Anger	"Angry"
		"Frustrated"
		"Mad"
		"Annoyed"
	Disrespect	
	Shame	"Ashamed"
	Sadness	"Upset"
		"Sad"
		"Hurt feelings"
		"Depressed"
		"Tearful"
Neutral/Positively-Valenced Emotions	Confident	"It's not true"
		"Proud"
		"People expect me not to be confident"
		"Glad to be own self"
		"No-one should mess with my friends from my culture"
		"Didn't care"
	Surprised	
	Understanding	

Negative-Valanced Emotional Reponses. For most children, their emotional response was characterized by distress.

Discomfort. One child between the age of 8- and 13-years-old expressed feeling "weird" after being discriminated against.

Fearful/Anxious. Being discriminated against, especially when alone, can be a very scary experience for a child (Richman & Leary, 2009). They may not know how to react or what will happen (Richman & Leary, 2009). One child between the age of 8- and 13-years-old expressed feeling "scared" when discriminated against. One child between the age of 14- and 18-years-old said, "It doesn't feel good" and that it made her feel "insecure and angry a little bit."

Anger. Several children felt angered when discriminated against. A child aged 8- to 13 years old stated that after being discriminated against, they felt "mad" because "no one should mess with friends from my culture." Another child between the age of 8- and 13-years-old claimed to have felt "annoyed" when discriminated against.

Disrespect. A child between the age of 8- and 13-years-old said that after being discriminated against, they had felt "disrespected".

Shame. Discrimination can at times leave a child feeling shameful of who they are (Matheson & Anisman, 2009). Consistent with this, in our sample, one child between the age of 8- and 13-years-old expressed feeling "ashamed" after being discriminated against.

Sadness. Children who were discriminated against expressed feelings of sadness. A child between the age of 8 to 13 years old expressed feeling "sad" and that his feelings had been hurt after being discriminated against.

Neutral/Positive Valanced Emotional Responses. A smaller minority of participants reported more neutral or positive affective responses.

Confident. A good support system can help children develop confidence (Petrovic et al., 2019). One child between the age 8- and 13-years-old expressed that you should be "glad to be

yourself" after being discriminated against. Another child between the age of 8- and 13-years-old said they "found it funny" because they knew that what was being said to them was not true.

Surprised. Some children who were discriminated against were taken aback by the experience. One child between the age of 8- and 13-years-old expressed feeling "surprised" after experiencing discrimination.

Understanding. Some children grow up understanding that their ethnicity may be associated with particular assumptions (Burt, Simons, & Gibbons, 2012). One child between the age of 14- and 18 expressed they were "understanding" when asked how they felt when discriminated against.

Coping with Experiences of Racism

When asked how they dealt with their experiences of racism, children expressed a variety of different coping mechanisms. Themes and examples emerging from children's responses are in Table 3, with more detail provided below.

Table 3

Themes and examples emerging from interviews with children about how they coped with discrimination.

Major Theme	Subtheme	Example
Disclosure to a trusted person	Told a Relative	"talked to sister and aunt"
		"told parents"
	Told an Authority Figure	"told teacher"
		"reported the person"
	Told a Peer	"told a friend"
Self-Advocacy		"talked back to [him]"
		"speak up"
		"corrected him but didn't work"
		"talked to the kid that made fun [of them]"
		"talked with students to work with each other"
Concealment	Said nothing	"kept it to themselves"
		"kept my mouth shut"
	Withdrew	"stayed in room"
		"accepted it"
De-escalation	Leave situation	"just left"
		"left school"
		"walked away"
		"went home"
		"left classroom crying"
	Ignore	"People expect me not to be confident"
		"tried to ignore it"
		"don't acknowledge it"
	Help another/self to manage emotions	"told mom to calm down"
		"de-escalate"
Creative Self-Expression	Writing	"write down poetry"

Disclosure to a Trusted Person. Having someone to talk to can help a child be more expressive and self-confident (Department of Health & Human Services, 2012). For example, a

child between the age 8- and 13-years-old, said they told their parents after they were discriminated against.

De-escalation. In some cases, children who were discriminated against found chose to de-escalate the situation. This involved defusing the encounter by leaving the situation or ignoring what was being said. For example, one child between the age of 8- and 13-years-old expressed that when they are discriminated against, they "Don't acknowledge it". Another child between the age of 8-and 13-years old who had been discriminated against said that they, "Left the classroom crying".

At other times, de-escalation involved trying to help another person manage their emotional reaction to the encounter. A child between the age of 14- and 18-years-old, said that when they were in a situation, they were being discriminated against they tried to de-escalate the situation with his mom. The child stated that they, "Told mom to calm down" and "tried to de-escalate".

Creative Self-Expression. Self-expression in creative ways is has shown utility in relieving stress and painful emotions (Stuckey & Nobel, 2010). One child between the age of 8- and 13-years-old who had been discriminated against said that they stayed in their room to think and "write down poetry".

Self-Advocacy. When discriminated against, some addressed the situation through communication with the perpetrator of the aggression, with mixed success. One child between the age of 8- and 13-years-old, said when they were discriminated against, they "Corrected him, but it didn't work".

Concealment. Many individuals choose to conceal instances of discrimination because sometimes it comes in small inconveniences from others (Jhangiani, Tarry, & Stangor, 2014) and

youth from certain racial/ethnic groups such as African American males are less likely to express themselves emotionally to others (Lindsey, Brown & Cunningham, 2017). One child between the age of 8- and 13-years-old said that after being discriminated against they, “kept it to themselves”.

The Moderating Effect of Resilience of the Association between Discrimination and Internalizing Symptoms

Music teachers evaluated children’s resilience levels, as well as severity of their internalizing problems: somatization, anxiety and depression (see Table 4). Most children were reported to have levels of internalizing symptoms that were within the normal range; that is, age-normed T score 41-59. Three children had Somatization scores in the At Risk or Clinical range (i.e., T≥60); three children had Depression scores in the At Risk or Clinical range and two children had Anxiety scores that were in the At Risk or Clinical range. The non-parametric Mann Whitney U test was carried out to examine whether differences in severity of scores were seen as a function of number of experiences of discrimination. All were non-significant, although a marginally significant trend was seen for Somatization, such that the mean rank Somatization score was higher for children who had experienced more episodes of discrimination (mean rank =10) compared to peers who had fewer such encounters (mean rank = 7).

Table 4

Median (IQR) Teacher-Rated Resilience and Internalizing Severity as a Function of Experiences of Discrimination (≤1 context vs. ≥2 contexts).

Variable	Discrimination ≤1 Context (N=7)	Discrimination ≥2 Contexts (N=10)	U (N)	*p*
	Median score (Interquartile Range)	Median score (Interquartile Range)		
Resilience	2.92 (2.15-3.00)	2.73 (2.35-2.94)	31.99 (17)	.74
Somatization	43.00 (43.00-44.00)	45.00 (43.75-81.75)	53.50 (17)	.07
Anxiety	42.00 (39.00-52.00)	43.50 (39.00-53.00)	41.00 (17)	.60
Depression	42.00 (41.00-45.00)	43.00 (41.75-52.5)	42.50 (17)	.48

A series of analyses were carried out to determine whether reliance moderated the association between experiences of discrimination and internalizing problems.

Somatization

A 2 x 2 between-subjects ANOVA was carried out to examine the interaction of experiences of discrimination x children's resilience on teacher-rated Somatization (see Figure 3). First, no main effect of number of experiences of discrimination was observed. $F(1, 13) = 1.97$, $p = .18$, $\eta_p^2 = .13$, but there was a main effect of resilience, $F(1, 13) = 5.04$, $p = .04$, $\eta_p^2 = .28$. Children with Low resilience had higher mean rank Somatization score in comparison to children with High resilience. This was qualified by a significant 2-way interaction, $F(1, 13) = 4.77$, $p = .048$, $\eta_p^2 = .27$. Follow-up Mann Whitney U tests were carried out to examine the interaction. For children with High Resilience, mean rank Somatization scores did not differ for children experiencing discrimination in 0/1 (mean rank = 4.75) or 2 or more contexts (mean rank =6), U (N) = 15 (10), $p = .61$, $r_{rb}=.25$. There was a non-significant trend with strong effect size for children with Low Resilience to have higher teacher-rated Somatization (mean rank = 5.38)

when they had experienced discrimination in 2 or more contexts than when they had experienced discrimination in 0/1 contexts (mean rank = 2.17), U (N) = 11.5 (7), p =.057, r_{rb} = .92.

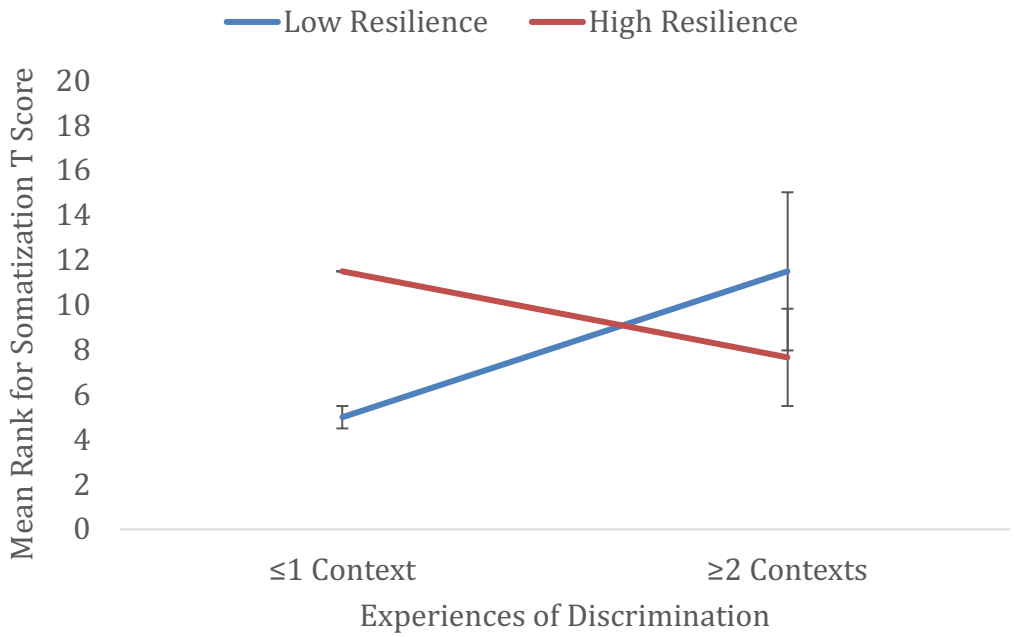

Figure 3. 2: Experiences of Discrimination (≤1 context vs. ≥2 contexts) x 2: Resilience (Low vs. High) between-subjects ANOVA for Mean Rank Somatization T Score.

A 2 x 2 between-subjects ANOVA was carried out to examine the interaction of experiences of discrimination x children's resilience on teacher-rated Anxiety (see Figure 4). First, no main effect of number of experiences of discrimination was observed. $F(1, 13) = 0.002$, p =.97, $\eta_p^2 < .01$, but there was a main effect of resilience, $F(1, 13) = 8.34$, p =.013, $\eta_p^2 = .39$. Children with High resilience had higher mean rank Anxiety scores in comparison to children with Low resilience. There was no significant interaction, $F(1, 13) = 0.006$, p =.94, $\eta_p^2 < .01$.

Figure 4. 2: Experiences of Discrimination (≤1 context vs. ≥2 contexts) x Resilience (Low vs. High) between-subjects ANOVA for Mean Rank Anxiety T Score.

A 2 x 2 between-subjects ANOVA was carried out to examine the interaction of experiences of discrimination x children's resilience on teacher-rated Depression (see Figure 5). First, no main effect of number of experiences of discrimination was observed. $F(1, 13) = 3.69$, $p = .077$, $\eta_p^2 = .22$, although there was a marginally significant trend in the direction of higher depression scores for those who had experienced discrimination in 2 or more contexts (mean rank T score = 11) compared to those who had experienced discrimination in one or fewer contexts (mean rank =6.14). Analyses also revealed a main effect of resilience, $F(1, 13) = 6.91$, $p = .021$, $\eta_p^2 = .35$. Children with High resilience had higher mean rank Depression score in comparison to children with Low resilience. There was no significant interaction, $F(1, 13) = 0.778$, $p = .394$, $\eta_p^2 = .06$.

Figure 5. 2: Experiences of Discrimination (≤1 context vs. ≥2 contexts) x 2: Resilience (Low vs. High) between-subjects ANOVA for Mean Rank Depression T Score.

Discussion

In this study we aimed to observe the perceptions of experiences of discrimination experienced by a group of youth musicians as well as the impact of these experiences on their internalizing symptoms. It was hypothesized that experiencing discrimination would be associated with more severe internalizing problems. We also aimed to study whether children's levels of resilience would moderate the association between discrimination and internalizing problems. It was hypothesized that the association between discrimination and internalizing problems would be stronger for children with lower levels of resilience.

First, the experience of discrimination was pervasive in this study. Almost all children had experienced discrimination in some form. This is consistent with literature showing that from Australia (Priest, King, Becares, & Kavanagh, 2016) to the United Kingdom (Read et al.,

2018) to New Zealand (Crengle, Robinson, Ameratunga, Clark & Raphael, 2012) to the United States (e.g., English, Lambert, & Ialongo, 2016), minority-identifying children around the globe are targets of racial and ethnic discrimination.

Although not reaching threshold for statistical significance, a linear trend with strong effect size was observed for adolescents to report more experiences of discrimination than younger children. One of the reasons behind this may be that younger children are not fully aware that they are being discriminated against, or that they are witnessing acts of discrimination, particularly if those acts are more covert. As a consequence, they underreport the number of episodes to which they are exposed. For example, consider a teacher who comments that a child of color "speaks quite well." A child whose thinking is more concrete, characteristic of the Concrete Operations stage of cognitive development, may think that they are being paid a compliment. The connotations of the comment - that the teacher is surprised by the child's ability and that performance exceeds lowered expectations held for that student – may not be picked up on by the child until they have developed stronger abstract reasoning capabilities. This advance in cognition is seen once children have progressed to the Formal Operations stage of cognitive development at approximately 11 years of age (see Crain, 2011, for a review). It may also be the case that the difference in frequency seen by age is a real difference and that minority children encounter higher levels of discrimination as they get older. In fact, it has previously been reported that Black youth in particular, are more likely to be discriminated against as they get older, especially from adults in positions of authority (Sanders-Phillips et al., 2009). Due to children's young age and the protective role played by parents, perpetrators may be less likely to target younger children than adolescents (Upton, 2011). When children are still young, their parents are their primary social agents and they have relatively fewer interactions with adults

(who are more likely to be discriminatory). As the majority of the time parents are around, the child may be less likely to be targeted by a perpetrator (Dishion & Patterson, 2006). As children get older and are more independent of their parents, they may be more likely to be exposed to racial and ethnic discrimination (Upton, 2011). Furthermore, as they get older and they gain more experience in a racialized society, they become more fluent in society's perception of racial biases. Due to this, the adolescents may have been able to pinpoint discriminatory behavior in comparison to the younger children in our study.

Children experienced discrimination in a variety of settings, although some differences in patterns were seen for younger versus older children. For younger children, experiences were across a range of situations form being treated poorly in a store or restaurant or at school, or being disrespected verbally (e.g., someone was rude, someone made an insulting remark about them). This is consistent with the findings of Marcelo and Yates (2019), who interviewed 7-year-olds identifying as Black, Latinx, and Multiethinc-racial about their experiences of discrimination. Participants in their study similarly endorsed experiences across a wide range of settings.

For adolescents, experiences tended to be clustered around verbal disparagement (e.g., they were insulted, someone made a bad or insulting remark about their race, or someone was rude to them). Adolescents were also more likely to report witnessing others being subjected to discrimination, such as seeing a loved one being treated unfairly or badly because of their skin color, accent, language. According to research, children developing into their adolescence become increasingly curious about their ethnic identities (Phinney & Tarver, 1988). A study by Phinney and Tarver (1988) exploring social identity theory, discusses that along this process, they begin to understand the influence of their ethnic group to "thought processes, perceptions,

feelings and behavior" (Phinney & Tarver, 1988). Cognitively, according to the Piagetian perspective, children's advances in abstract thinking equips them with the tools necessary for more sophisticated representations of self and others (Crain, 2011). Additionally, the heightened attentiveness to and understanding of social experiences that is characteristic of adolescent development may mean that these experiences in these settings are more salient, and potentially also better remembered (Steinberg, 2008).

Children and adolescents made several attributions to explain why they or their family members were being discriminated against. The majority of perpetrators were perceived by the children to have targeted them because of their own or their loved one's ethnic and racial identity (ERI). As part of this broad theme, children spoke about being targeted for linguistic characteristics (e.g., language, accent), their culture, and physical characteristics (e.g., skin color). The literature has shown that these experiences can have adverse effects on children. For example, children who display an accent when speaking English become more reluctant to express themselves because they are perceived (by themselves or others) to be speaking in a non-native accent, which may lead them feel as if they are not part of society (DeJesus, Hwang, Dautel, & Kinzler, 2017). Discrimination can also impact development of ERI. Such experiences may lead minors to learn more about their racial or ethnic group and identify more strongly with it, while for others, it may lead to rejection of ERI in order to gain acceptance from the majority group (see Yip, 2018, for a review).

Experiences of discrimination can produce a variety of emotional response among children. The majority of children in our study expressed negatively-valanced emotional responses (e.g., discomfort, fear, anxiety, anger, disrespect, shame, sadness). This is highly

consistent with the literature, which has shown that negative emotions such as anger, disrespect or outrage are common reactions to experiences of discrimination (Sanders, 2020).

Experiencing direct, overt racism or witnessing it happen to a loved one may be more traumatic than a more indirect form of discrimination (such as a microaggression), which may go underreported due to its subtlety from a child's perspective. Research shows that youth who witnessed or were victims of a discriminatory act recalled the experience similarly to that of first responders after a major disaster, which had left a significant physiological or psychological impact (Trent et al., 2019).

Although our sample size was too small to look at how age interacts with discrimination to affect internalizing symptoms, this may be critical. Adolescence is pivotal for identity formation (see Crain, 2011 for a review of Erikson's stages of psychosocial development). The distress that accompanies the attacks on minority youths' developing identities in forms of demeaning messages can take a toll on their mental health (Phinney & Tarver, 1988). Longitudinal studies have shown how perceived discrimination can increases risk long-term for behavioral and emotional difficulties (Brody et al., 2006).

Although the young people in our study reported experiencing negatively-valenced emotions in response to acts of discrimination, there was no main effect of discrimination on overall depression and anxiety; a finding that is inconsistent with the literature. A 3-year longitudinal study correlating perceived discrimination with development among Black, Latino, and Asian American adults and children linked discrimination with increased depressive symptoms over time (Greene, Way, & Pahl, 2006). In another study exploring childhood depressive symptoms in an African American sample, one of the variables associated with depressive symptoms was racial discrimination (Simons et al., 2002). A study on Puerto Rican

youths' development and consequences of perceived racism produced similar results in terms of perceptions of discrimination being positively associated with depression and stress (Szalacha, Erkut, Coll, Alarcon, Fields & Ceder, 2003). Additionally, the youths' anxiety about being discriminated against may serve as a risk factor over their mental health (Szalacha et al., 2003). Our finding may reflect that depression and anxiety was rated by children's teachers. For non-clinical, community samples of school children, teachers have been shown to report significantly fewer internalizing symptoms than the children themselves (Epkins, 1993). Child self-report may have yielded stronger associations. It may also be the case that the small sample size limited power to detect findings.

A small minority of children expressed neutral/positive valanced emotional responses (confidence, surprise, understanding), which has been less commonly reported in the literature. However, these responses may be evidence of the development of children's resilience. While low resilience was associated with higher somatization as expected, higher resilience was associated with greater anxiety and depression. These results are contrary to most research which indicates that higher levels of resiliency are associated with lower mental health difficulties (Shrivastava & Desousa, 2016).

When confronted with discrimination, children in our study coped in a variety of ways such as telling somebody, de-escalating the situation, creatively expressing themselves, advocating for themselves and concealing the experience. The majority of children displayed active coping where they confronted the problem (Brittian, Toomey, Gonzales & Dumka, 2013). Children who de-escalated the situation or spoke up displayed active coping, which includes doing something to solve the problem and focusing on the positive aspects of one's life (Brittian et al., 2013). Children who told somebody were practicing support seeking coping where they

sought emotional support from someone else (Brittian et al., 2013). Only a minority of the participants practiced avoidant coping, where children avoided having contact with the problem (Brittian et al., 2013). Children who practiced this form of coping concealed the experience by not telling anyone or withdrawing (Brittian et al., 2013). It is important to note that judgment is not passed on whether avoidant coping is a positive or negative strategy. Avoidant coping may be adaptive where the child is trying to either keep themselves or a loved safe in a situation that may seem risky. For example, speaking out may lead to a physically aggressive response from some perpetrators. Or, when the perpetrator holds a clear position of power over the child (e.g., a teacher or a Dean), the child may not want to risk retribution. Children who expressed themselves creatively, like writing poetry for example, practiced distraction coping where they engaged in recreational activities that would serve as a distraction from the immediate problem (Brittian et al., 2013). Being that our sample is derived from a variety of different minority groups, the appropriateness of particular ways of coping in particular cultures may explain the differences in coping across the sample. Gender roles may also play a role in the way children cope. Future studies should assess how different aspects of a child's identify, such as culture and gender, can affect children's coping.

Finally, the study looked at whether children's resilience moderated the association between experiences of discrimination and internalizing symptom severity. Surprisingly, main effects of resilience were seen for Anxiety and Depression such that higher resilience was associated with higher depression and anxiety. In part this may reflect that resilience is not a trait, but a process (Luthar et al., 2000). While building resilience is essential in helping children and adolescents overcome adversity, it does not diminish the emotional pain, sadness or anxiety that may come from an experience (American Psychological Association, 2012).

In our study, there was a significant interaction between experiences of discrimination and children's resilience on Somatization. Follow-up multiple comparisons showed a non-significant trend with large effect size for more experiences of racism to be related to higher somatization when children had low levels of resilience. When children had high levels of resilience, there was no association between experiences of discrimination and somatization. Somatization is the manifestation of emotional pain into physical symptoms, and is commonly how low mood and anxiety is manifested in children (APA, 2013). Somatization can manifest itself in many ways such as pain, fatigue, shortness of breath, coughing, and so on. (Kingery, Ginsburg, & Alfano, 2007). Stressful situations can leave children feeling uncomfortable emotions such as sadness, anxiety, embarrassment, fear and anger, similar to that expressed by the children who encounter discrimination or watch a loved one be discriminated against (Kingery et al., 2007). Kingbery et al. (2007) assessed somatic symptoms and its association with anxiety among African American youth. Youth who were in the "High Anxiety" group were more likely to report somatic symptoms than youth on the "Low Anxiety" group (Kinghery et al., 2007).

The findings highlight the importance of building children' resilience. Children who display confidence, curiosity, adaptation to new situations and better skills are deemed to be resilient (Carrasco-Sanz, Nigri, Namazova-Baranova, Vural & Çokuğraş, 2019). There are many ways in which adults can foster these attributes. Teaching children to set goals for themselves will allow children to focus on specific tasks, which helps them become more resilient to overcome challenges they may encounter in the future (American Psychological Association, 2012). Resiliency can also come from relaxation and self-care (American Psychological Association, 2012). Teaching children to focus on things they can control in times of distress

may help to reduce their anxiety, while teaching them self-care may prepare them to better deal with stressful situations (American Psychological Association, 2012). Building a positive outlook in children can also help them look at the positive aspects of negative situations, helping them move forward during difficult times (American Psychological Association, 2012).

Close personal connections can build a support system for children in times of stress or when faced with adversity (American Psychological Association, 2012). Children and adolescents who have the support of parents, extended family networks, healthcare professionals, and other social connections such as friends, teachers and school administrators, can better overcome a condition of stress and become more emotionally and psychologically stable (Carrasco-Sanz et al., 2019; Gartland et al., 2019).

Among other factors, a child's community plays a major role in protecting children from health disparities. The interactions with other individuals that the child has on a daily basis can give the child a sense of community, which contributes to the reduction of disparities among minority youth. Previous research suggests adult mentors and role models have a positive impact on youth resilience (Liu et al., 2019). Participation in organizational activities has been associated with positive influence on youth development (Liu et al., 2019). Critically, these promotive factors have to be equally available to youth, irrespective of race and/or ethnicity.

The development of ethnic and racial identity (ERI) can also build resilience in youth (Rivas-Drake et al., 2014). Research has shown ethnic affirmation to be beneficial to mental health. Studies have shown it to be positively correlated with self-esteem (Mandara, Gaylord-Harden, Richards, and Ragsdale, 2009). Mandala et al. (2009) also found that in early adolescence, affirmation and belonging is associated with fewer depressive symptoms. A positive ERI is also associated with positive coping strategies (Rias-Drake et al., 2014). ERI is

also highly positively associated with successful academic outcomes among African Americans, Latinos, Asian Americans and Pacific Islanders (Rivas-Drake et al., 2014). Interestingly enough, positive feelings about youths' own ERIs has been associated with positive psychosocial adjustment among the African American, Asian American and Latino populations in particular (Rivas-Drake et al., 2014). An individual's family plays an important role in teaching youth to form a positive ERI, by teaching them values and behaviors that allow them to adapt to a particular environment (Parke & Buriel, 2007).

There are several clinical implications from this study. First, racial bias is ubiquitous. Socialization into a racist society begins early. From an early age, children are exposed to racial differences and racial bias from their first teachers and parents (Anderson & Dougé, 2020). Six-months into their development, a baby is capable of perceiving race-based differences (Anderson & Dougé, 2020). As they get older, in preschool and early elementary-school age, children can internalize racial bias (Clark & Clark, 1947). Once a child has reached the age of 12, they have developed set beliefs on racial biases influenced by parents, peers and society (Anderson & Dougé, 2020). Parents and educators need to work hard to counter these forces: some strategies include teachers encouraging diversity within the classroom, such as a whether it is through an educational or creative perspective. Parents should talk to their children about different cultures and encourage their children to ask and learn about different cultures.

It is imperative for minority youth to have social support. Building positive and trusting relationships can positively influence their ability to cope and give them comfort to ask for help if need be. Additionally, providing minority youth with the opportunity to help each other in the community may nourish a sense of accomplishment and allow for the connections with role models or mentors outside of the home and school environment. Not only is it important to be

part of a group or build relationships within the community, but it is essential for minority youth to feel a sense of belonging within these groups allowing them to exercise free expression.

Access to care is important for the healthy development of children. As previously mentioned, the availability of resources does not necessarily mean that minority-identifying children have access to them. For instance, countless African American youth find it difficult to connect with a mental health professional in order to be treated for their depression as well as other precursor issues that increase risk for suicidality (Lindsey et al., 2017).

Recent research has indicated that African American youth were less likely to directly reach out to a loved one regarding their mental health issues and wanted their symptoms to be noticed by individuals within their immediate social network (Lindsey et al., 2017). Possible reasons behind this behavior can be due to the common assumption that African American youth must "tough it out" with regards to their emotional pain (Lindsey et al., 2017). While some African American youth fear burdening their caregivers, others may not have the safe space or relationships embedded with trust and understanding in order to express themselves, leading them to keep their concerns to themselves (Lindsey et al., 2017).

There were several limitations that were faced in this study. The first limitation was sample size, which limited power to obtain significant findings. The present study utilized the PRaCY, and thus the contexts in which children and adolescents experienced discrimination were limited to those asked about on this measure. It does not reflect all of the possible contexts of discrimination in the general population which serves as another limitation of this study.

Future research should look at how having a sense of community can impact children's resilience. All children in this study learned music through an organization in New York City. The strong social connections forged in this environment may have served as a protective factor

against adverse effects of discrimination on mental health. Future studies should also look into the impact a situation or perpetrator (authority figure vs. peer) can have on the type of response a child has when being discriminated against.

In summary, children and adolescents continue to experience discrimination in a number of contexts. It begins at a young age and appears to increase in frequency as children get older, and may have a negative impact on their mental health, particularly in the physical manifestation of distress. However, building resilience may help children and adolescents to positively adapt despite these adverse experiences. It is important that we teach our youth the importance of valuing their identities and help them gain the appropriate skills in order to properly react, deal and cope with experiences of discrimination.

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