



## Original article

## Maternal experiences of ethnic discrimination and child cardiometabolic outcomes in the Study of Latino Youth



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## ABSTRACT

**Purpose:** Limited research has examined maternal experiences of racial/ethnic discrimination in relation to child cardiometabolic health. In this study, we investigated whether maternal experiences of ethnic discrimination were associated with cardiometabolic risk in Hispanic/Latino youth several years later.

**Methods:** Our sample included 1146 youth (8–16 years) from the Study of Latino Youth (2012–2014), who were children of the Hispanic Community Health Study/Study of Latinos participants (2008–2011). We used regression models to examine the prospective associations between maternal report of ethnic discrimination in relation to her child's body mass index (BMI) z-score, metabolic syndrome score (MetS), and high sensitivity C-reactive protein (hsCRP) levels 2 years later.

**Results:** Maternal ethnic discrimination was associated with youth hsCRP, but not BMI or MetS ( $P$ -values  $>.05$ ). Adjusting for age, nativity, and national background, maternal ethnic discrimination was associated with higher (log) hsCRP levels ( $\beta = 0.18$ , 95% CI = 0.04 to 0.32) in children. This association was robust to adjustment for maternal and household characteristics ( $\beta = 0.17$ , 95% CI = 0.04 to 0.31), as well as maternal depression and maternal BMI.

**Conclusions:** Maternal ethnic discrimination is associated with inflammation among Hispanic/Latino youth, and not BMI z-score or MetS. Studies are needed to address temporality and pathways.

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## Introduction

Cardiometabolic disorders begin in childhood [1] and are among the leading causes of death among adults in the United States [2]. The American Heart Association has acknowledged the large public

health burden of cardiometabolic disorders in Hispanic/Latinos in the United States [3], a large and rapidly growing minority group [3]. There are persistent racial/ethnic and socioeconomic disparities in the incidence, treatment, and outcomes of cardiometabolic disorders that are shaped by social determinants [4]. Racial/ethnic discrimination, defined as differential or unfair treatment based on actual or perceived membership in a racial/ethnic group, is now recognized as a social determinant of health for both children and adults [5,6]. Research with Hispanic/Latino adolescents shows that discrimination

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is associated with mental health and behavioral problems [5,7]. In the present study, we extend this work to examine the association between maternal experiences of ethnic discrimination and youth cardiometabolic risk factors in a diverse Hispanic/Latino population. This study builds on the integrative model for minority youth [8], which emphasizes the role of discriminatory experiences in the health of minority youth, and the concept of “linked lives” [9]. This model directs researchers to consider the connectedness among individuals within families and across generations (i.e., discriminatory experiences in parents’ lives would be expected to have implications for the health of their children and vice versa).

A substantial body of research has documented that stressful environments are associated with poorer child outcomes [10], including a variety of physiological factors related to the development of cardiometabolic disorders [11,12]. Maternal experiences of racial/ethnic discrimination may be an important, yet underexplored, form of childhood adversity [13] which could influence development via a number of pathways, including elevated stress in the household that could erode capacity for supportive and sensitive parenting [5]. Furthermore, by definition, maternal experiences of discrimination are likely to be associated with difficulties that follow from unfair experiences, including restricted access to high-quality health care, housing, or employment. Previous studies that have examined a parent’s experiences of discrimination [14–19], including the related construct of acculturative stress [20,21], have documented strong associations with child socioemotional and behavioral outcomes and overall family functioning.

Only a few previous studies have examined parental experiences of racial/ethnic discrimination in relation to nonmental health outcomes (e.g., [22,23]), and most of these studies have relied on parent-reported body mass index (BMI) or history of illness, have largely examined young children [16,18,22,23], and have rarely focused on Hispanic/Latinos (see [16,17] for exceptions). To our knowledge, there are no previous studies of parental experiences of racial/ethnic discrimination in relation to cardiovascular risk outcomes among youth in the United States or elsewhere.

Using data from the Study of Latino (SOL) Youth, we examined the association between maternal experiences of ethnic discrimination and Hispanic/Latino youth cardiometabolic risk outcomes approximately 2 years later, including BMI, metabolic syndrome (MetS) score, and inflammation (indicated by high sensitivity C-reactive protein level [hsCRP]). Given the sex and age differences documented in SOL for a range of CVD risk outcomes [24], and the potential for sex or age differences in response to maternal experiences of ethnic discrimination, we also examined whether associations differed by sex or age. The results from this investigation may be used to (1) generate hypotheses for future prospective studies on factors that influence the emergence of racial/ethnic health disparities in cardiometabolic outcomes, (2) illustrate the importance of gathering data on discriminatory experiences of parents to better understand and devise strategies to improve cardiometabolic health among racial/ethnic minority youth over the life course, and (3) support structural-level strategies to reduce discrimination against Hispanics/Latinos in the United States.

## Methods

### *Study design and data collection*

The SOL Youth is a population-based study of youth aged 8–16 years recruited between 2012 and 2014 from four communities in the United States (Bronx, NY; Chicago, IL; Miami, FL; San Diego, CA). Details of recruitment and study design have been previously published [24,25]. Briefly, SOL Youth enrolled a subset of the offspring of participants in the Hispanic Community Health

Study/Study of Latinos (HCHS/SOL), a comprehensive multicenter community-based cohort study of Hispanics/Latinos in the United States. HCHS/SOL participants ( $n = 16,415$  from 9872 households) were recruited through a 2-stage area probability sampling design, as described previously [26]. The HCHS/SOL baseline interviews and clinical evaluation were conducted in English or Spanish at in-person clinic visits during 2008–2011.

Of 6741 screened households of HCHS/SOL participants, 1777 eligible children aged 8–16 years were identified and 1466 were enrolled in SOL Youth, representing a participation rate of 82%. Participants were instructed to fast for 10 hours before the SOL Youth baseline visit, which was conducted in 2012–2014 and included in-person interviews of youth participants and their accompanying parent or caregiver, height and weight measurements of the parent/caregiver, and a clinical examination that included a blood draw. Both studies were approved at the institutional review boards for each participating center. All HCHS/SOL participants gave written informed consent, and all youth and adults in SOL Youth provided written informed assent and consent, respectively.

The present study excluded 270 youth (18.42%) for whom the SOL participant living in their household was not their mother (to improve homogeneity of the exposure variable), and an additional 48 youth were excluded because their mother did not respond to the item on ethnic discrimination ( $n$  excluded = 318;  $n$  eligible for inclusion = 1148). Of the remaining 1148 youth, a total of 1085 children had valid data for all components required to create the MetS score (59 children were missing a required measurement, 18 did not fast at least 8 hours before the clinic visit), and 1144 children had a valid BMI value. There were 1093 children with a valid hsCRP value (41 children had missing hsCRP, and 14 children were excluded due to hsCRP levels greater than 10 mg/L). A total of 1146 youth had at least one of the three outcomes.

### *Maternal ethnic discrimination*

At the HCHS/SOL parent examination in 2008–2011, which was on average 2.6 (SD = 0.9) years before the SOL Youth visit, parents/guardians were asked “How often do people treat you unfairly because you are Hispanic/Latino?”, taken from the Perceived Ethnic Discrimination Questionnaire–Community Version [27]. The response options included “often,” “always,” “sometimes,” and “never” and this item was treated as a continuous variable.

### *Youth cardiometabolic risk*

Youth body composition was assessed using standardized protocols. Weight was measured to the nearest 0.1 kilogram with a digital scale (Tanita Body Composition Analyzer, model TBF300; Tanita, Tokyo, Japan). Standing height was measured to the nearest centimeter in triplicate by stadiometer (Seca model 222; Seca, Hamburg, Germany). BMI was calculated as weight divided by mean height squared. Youth BMI z-scores according to 2000 growth charts were computed using the SAS Macro provided by the Centers for Disease Control and Prevention.

hsCRP was measured on either a Roche/Modular P (before January 1, 2014) or Roche cobas 6000 chemistry analyzer (starting January 1, 2014; Roche Diagnostics Corporation) using the same methodology, calibration, and control for all samples. Details for measurement of triglycerides, high-density lipoprotein cholesterol, and fasting plasma glucose have been described previously [24]. Seated systolic blood pressure was measured in triplicate by sphygmomanometer after 5 minutes rest, with the average of the last two measures used in analyses. The MetS z-score was calculated using validated gender-specific equations for Hispanic youth [28,29] (Appendix 1). This score advances on the traditional

approach to calculating MetS by avoiding use of thresholds and assumptions that each MetS component has an equal weight and accounts for how MetS may manifest differently across sex and racial/ethnic groups [30].

### Covariates

Other covariates were assessed through interviews with mothers at the SOL Youth study visit, including youth's age, sex, and

caregiver/household characteristics (age, language preference, educational attainment, annual household income, employment/student status, nativity, and marital status). Youth reported their place of birth as within or outside the 50 U.S. states, and reported their Hispanic/Latino background. All covariates were treated as categorical variables; please see Table 1 for the categories for each covariate. Maternal depression and maternal BMI were included as covariates in secondary models given that each could function as a confounder (i.e., a temporally prior cause of reported discrimination

**Table 1**  
Mother's reported level of discrimination at the SOL/HCHS interview (2008–2011) and characteristics of SOL Youth participants (n = 1146 adolescents, 2012–2014)

	Overall n (weighted %) <sup>†</sup>	By mother's reported discrimination (SOL/HCHS 2008–2011)			P-value <sup>‡</sup>
		Never (n = 514)	Sometimes (n = 515)	Often/always (n = 117)	
		Weighted column percent (95% CI)			
<b>Adolescent characteristics</b>					
Body mass index, z-score <sup>‡</sup>	1144	0.69 (0.56, 0.82)	0.80 (0.63, 0.97)	0.89 (0.64, 1.15)	.26
MetS score, z-score <sup>‡</sup>	1085	−0.13 (−0.23, −0.04)	−0.06 (−0.18, 0.07)	−0.20 (−0.36, −0.04)	.34
hsCRP, mg/dL <sup>‡</sup>	1093	0.45 (0.40, 0.51)	0.48 (0.42, 0.55)	0.73 (0.55, 0.96)	.008
Sex					.96
Male	585 (50%)	258 (50%)	261 (50%)	66 (51%)	
Female	561 (50%)	256 (50%)	254 (50%)	51 (49%)	
Age group (y)					.66
8–9	259 (21%)	107 (20%)	125 (23%)	27 (22%)	
10–11	269 (22%)	127 (22%)	116 (21%)	26 (21%)	
12–13	287 (22%)	125 (21%)	137 (25%)	25 (17%)	
14–16	331 (35%)	155 (37%)	137 (31%)	39 (40%)	
Born outside of U.S. mainland					.21
Yes	235 (20%)	111 (19%)	97 (18%)	27 (29%)	
No	903 (80%)	400 (81%)	413 (82%)	90 (71%)	
Hispanic/Latino background					.61
Mexican	518 (48%)	226 (51%)	236 (46%)	56 (44%)	
Central American	92 (6%)	33 (4%)	46 (7%)	13 (10%)	
Cuban	72 (5%)	45 (5%)	24 (4%)	3 (3%)	
Dominican	125 (13%)	58 (12%)	52 (13%)	15 (18%)	
Puerto Rican	103 (10%)	47 (11%)	48 (10%)	8 (7%)	
South American	56 (4%)	26 (4%)	26 (4%)	4 (4%)	
Other/>1	149 (14%)	64 (12%)	68 (16%)	17 (14%)	
<b>Household and maternal characteristics</b>					
Highest parental education					.25
No H.S. Diploma/GED	421 (38%)	168 (36%)	202 (38%)	51 (48%)	
High school diploma/GED	358 (31%)	168 (32%)	154 (28%)	36 (33%)	
> H.S. diploma/GED	367 (31%)	178 (32%)	159 (33%)	30 (19%)	
Total household income					.009
≤\$20,000	556 (52%)	247 (50%)	244 (49%)	65 (69%)	
\$20,001–\$40,000	377 (32%)	161 (33%)	177 (33%)	39 (27%)	
>\$40,000	144 (16%)	66 (17%)	71 (18%)	7 (4%)	
Maternal depressive symptoms					.007
CES-D <10	702 (65%)	359 (72%)	288 (63%)	55 (43%)	
CES-D ≥10	424 (35%)	145 (28%)	218 (37%)	61 (57%)	
Maternal BMI, mean (95% CI)	1144	30.0 (29.0, 31.0)	29.8 (28.9, 30.8)	32.0 (29.7, 34.3)	.22
Mother's age (y)					.31
24–34	353 (34%)	148 (32%)	162 (36%)	43 (39%)	
35–49	733 (63%)	346 (66%)	317 (60%)	70 (60%)	
50–73	60 (3%)	20 (2%)	36 (4%)	4 (1%)	
Mother's language preference					.71
Spanish	975 (84%)	441 (86%)	432 (83%)	102 (85%)	
English	171 (16%)	73 (15%)	83 (17%)	15 (15%)	
Maternal employment status					.68
Not employed or in school or retired	592 (56%)	272 (58%)	265 (55%)	55 (51%)	
Employed or in school	535 (44%)	230 (42%)	244 (45%)	61 (49%)	
Maternal marital status					.61
Single	243 (23%)	99 (20%)	114 (24%)	30 (29%)	
Married or living with a partner	715 (62%)	326 (65%)	325 (62%)	64 (53%)	
Widowed, divorced or separated	187 (15%)	89 (15%)	75 (14%)	23 (18%)	
Born outside of U.S. mainland					.77
Yes	979 (86%)	448 (87%)	431 (85%)	100 (83%)	
No	166 (15%)	66 (13%)	83 (15%)	17 (17%)	

Percentages may not sum to 100 because of rounding.

CES-D = Center for Epidemiologic Studies Depression.

\* May not sum to sample total because of missing data.

† P-values indicate any difference between groups.

‡ N's for BMI z-score, metabolic symptom (MetS) score and high sensitivity C-reactive protein are smaller than total N because of missing values or abnormal values.

and child cardiometabolic outcomes) or pathway variable. Maternal BMI was assessed following the same protocol followed for youth, described previously, and maternal depressive symptoms were assessed using a 10-item version of the Center for Epidemiologic Studies Depression scale [31]. We used a cut-point of  $\geq 10$ , which is a common cut-point for probable depression using this version of the Center for Epidemiologic Studies Depression [32].

### Statistical analysis

All analyses, accounting for household clustering, study site, other design effects, and sampling weights, were performed using SAS version 9.3 (SAS Institute, Cary, NC) and SUDAAN release 11.0.1 (RTI International, Research Triangle Park, NC). Descriptive statistics for the overall sample and across levels of maternal ethnic discrimination were computed; differences in distributions of classification variables were assessed using Rao-Scott  $\chi^2$  tests and differences in means were evaluated using Wald F statistics from survey linear regression models.

Before conducting our multiple variable models, we tested for effect modification by sex and age to examine whether stratified models were appropriate. No age or sex interactions were identified at  $P < .10$  (see Appendix 2 for interaction tests) so all models used data pooled across age and sex.

The conceptual model that we used to develop our analyses is presented in Appendix 3. Multiple variable survey linear regression models were constructed for each dependent variable of interest: BMI-z, MetS z-score, and hsCRP. Initial models adjusted for youth sex, age, nativity, and Hispanic/Latino background. Subsequent models adjusted for maternal and household characteristics, including educational attainment, annual household income, mother's age, language preference, employment/student status, nativity, and marital status. We selected this set of potential confounders based on the existing literature. We did not use a priori criteria for a variable to be considered a confounder. We present results for the minimally and fully adjusted models. Beta estimates were derived from models treating maternal ethnic discrimination as a continuous variable. If associations were observed at  $P < .05$ , we evaluated the degree to which maternal depressive symptoms and maternal BMI explained the association by including these variables in subsequent models. We did not conduct formal mediation analyses given the cross-sectional design.

Incomplete data for adjustment variables ranged from one participant for parent marital status to 3.6% of the analytic sample for maternal BMI, and based on Little's MCAR test, the missing covariates were not missing at random ( $\chi^2 = 110.76$ ,  $df = 66$ ,  $P < .001$ ). Missing values on covariates were multiply imputed with logistic regression for binary and ordinal variables, predictive mean matching for continuous variables, and discriminant function methods for Hispanic/Latino background. Imputation models included all covariates noted previously, as well as the design variables sampling strata and weight, and all dependent variables.

Primary analyses were performed on 10 imputed data sets. Parallel analyses were also conducted in which only participants with complete data for all variables were included, and results were substantively the same. In addition, all analyses were repeated with the sample expanded to include youth with nonmother caregiver respondents.

### Results

Our sample of youth included an equal proportion of females and males, with 20% born outside of the United States. Nearly half of the sample (48%) identified as having Mexican background, and over half of the sample lived in a household earning less than \$20,000 a year (52%). Over a third of the youth's mothers reported depression symptom scores above a threshold indicative of risk for a clinical depression disorder (35%), and most of the youth's mothers were married or living with a partner (62%) (Table 1). At the HCHS/SOL interview, 45 percent of the mothers reported that they were never treated unfairly, whereas 44 reported that they were sometimes treated unfairly, and the remaining 10% reported that they often or always treated unfairly because of their ethnicity. Reports of maternal ethnic discrimination were more common for mothers with lower household incomes ( $P = .009$ ) and for mothers with elevated depressive symptoms ( $P = .007$ ).

In bivariate analyses (Table 1), maternal ethnic discrimination showed a dose-response relationship with hsCRP, with reports of more frequent discrimination associated with higher level of hsCRP ( $P = .008$ ), whereas the bivariate trends for maternal ethnic discrimination and BMI and MetS were not significant ( $P = .26$  and  $.34$ , respectively). Consistent with the bivariate results, in multiple variable linear regression models reports of maternal ethnic discrimination were not associated with youth BMI and MetS score at  $P < .05$ , although for the effect estimate for the association between maternal ethnic discrimination and BMI z-score was in the hypothesized direction (Table 2). In models adjusted for youth's age, nativity, and national background, maternal ethnic discrimination was associated with elevated levels of (log) hsCRP (model 1,  $\beta = 0.18$ , 95% CI = 0.04 to 0.32). The association remained similar with sequential adjustment for additional covariates including maternal and household characteristics (model 2,  $\beta = 0.17$ , 95% CI = 0.04 to 0.31). Full model results to display associations for all covariates are presented in Appendix 4. There are only a few notable associations between the covariates and outcomes, including a protective (i.e., inverse) association between U.S. mainland birth and MetS score (model 2,  $\beta = -0.18$ , 95% CI =  $-0.36$  to 0.01). Similarly, youth of parents with a college education or more had lower BMI z-score (model 2,  $\beta = 0.28$ , 95% CI =  $-0.54$  to 0.02) and MetS score ( $\beta = -0.20$ , 95% CI =  $-0.38$  to 0.03) relative to youth with parents who had less than a high school education.

Finally, we considered several additional models with variables that could be on the causal pathway linking maternal ethnic discrimination to levels of hsCRP in youth, including maternal

**Table 2**  
Multiple variable adjusted associations between maternal ethnic discrimination\* and youth cardiometabolic outcomes

Models	BMI		MetS z-score		Log hsCRP	
	Beta (95% CI)	P-value	Beta (95% CI)	P-value	Beta (95% CI)	P-value
Model 1						
Maternal discrimination	0.11 (−0.01, 0.23)	.08	0.01 (−0.09, 0.10)	.89	0.18 (0.04, 0.32)	.01
Model 2						
Maternal discrimination	0.10 (−0.03, 0.22)	.14	−0.01 (−0.10, 0.09)	.91	0.17 (0.04, 0.31)	.01

Model 1: adjusted for youth's sex, age, nativity, and national background.

Model 2: Model 1 + mother and household characteristics, including highest parental education, total household income, and mother's age, language preference, employment/student status, nativity and marital status.

\* HSHC/SOL maternal-report discrimination (2008–2011).

depression and maternal BMI. When maternal depression was added to the adjusted model (i.e., model 2), the coefficient for maternal ethnic discrimination was unchanged ( $\beta = 0.17$ , 95% CI = 0.04 to 0.31) and maternal depression was not associated with youth hsCRP ( $\beta = -0.02$ , 95% CI =  $-0.20$  to 0.17). When maternal BMI was additionally included in the adjusted model, the coefficient for maternal ethnic discrimination was slightly attenuated ( $\beta = 0.16$ , 95% CI = 0.02 to 0.29) although maternal BMI was not associated with youth hsCRP ( $\beta = 0.04$ , 95% CI =  $-0.03$  to 0.05). Given that maternal ethnic discrimination was not associated with youth BMI, youth BMI was not considered as a potential pathway linking maternal ethnic discrimination and youth hsCRP.

As a sensitivity analysis, we replicated our analyses with the sample expanded to additionally include youth with nonmother caregiver respondents (data not shown); results were similar.

## Discussion

### Summary

Drawing on data from a large sample of Hispanic/Latino youth of diverse national backgrounds, we documented elevated levels of hsCRP among children whose mothers had experienced higher levels of ethnic discrimination. However, we did not observe a relationship between maternal ethnic discrimination and youth BMI or metabolic syndrome severity score. The association between maternal ethnic discrimination and hsCRP levels in youth was robust to adjustment for maternal depression and maternal BMI.

A growing body of research has linked adverse social conditions, including low socioeconomic status and maltreatment, to elevated inflammation among youth [11]; our study extends this literature to include maternal ethnic discrimination. The current findings are of public health significance, as inflammation is known to track from childhood into adulthood [33], is associated with other cardiovascular risk factors among youth (e.g., disturbed endothelial function, intima media thickening [34]), and is correlated with subsequent diabetes and CVD in adults [35]. Previous studies suggest that maternal ethnic discrimination could impact adolescent well-being through a variety of intermediate pathways that were not directly tested in our study, including stress in the household, health behaviors (e.g., diet, sleep), and activation of arousal and vigilance [36]. These processes may influence hypothalamic pituitary adrenal axis or sympathetic nervous system dysregulation [37] and contribute to low-grade chronic inflammation [11,38].

The findings from this study only partially align with previous research on parent's experiences of discrimination and child physical [22,23] and socioemotional outcomes [14–19], given that we did not observe associations for BMI or MetS. To our knowledge, no other studies have examined parent's experiences of discrimination in relation to children's inflammation levels; however, two previous studies of U.S. Hispanic/Latino youth have documented associations between parent's discrimination and youth mental health [16,17]. In a 2-week daily-diary study of 138 parent-child dyads (children ages 3–5 years) in a southeastern city, Mexican immigrant parents' report of workplace discrimination was associated with children's internalizing and externalizing behaviors [16]. Similarly, in a one-year prospective study of 344 Mexican American high school students in Los Angeles, CA, parental experiences of discrimination was associated with lower self-esteem and higher internalizing symptoms [17]. Similar to our study, a cross-sectional analysis of the UK Millennium Cohort Study data at age 5 years documented a positive association between maternal experiences of racism and child obesity, but the effect estimate was not significant at  $P < .05$  [23].

There are several limitations to consider. First, this is an observational design; accordingly, we are only able to demonstrate associations, and despite adjustment for potential individual- and family-level confounders, our results are susceptible to unmeasured confounding by either contemporary unmeasured variables or pre-/post-natal characteristics (e.g., depression symptoms or weight during pregnancy, birthweight, etc.) Related, missing data were not missing completely at random. However, we controlled for variables associated with missingness, and also used multiple imputed data sets. Second, the sample is not representative of the Hispanic/Latino youth population in the United States, which has implications for external validity of the findings. Notably, the sample originates from four communities that are among the 15 areas with the largest concentrations of Hispanic/Latinos in the United States [24]. Third, although maternal ethnic discrimination was assessed temporally before assessment of the offspring outcomes, which is a strength of the study, discrimination was measured using a single item which limited precision for the assessment of discrimination. In addition, this item relied on self-report, which may have introduced bias, and the item did not include a timeframe. Fourth, the validation analysis for the MetS score [29] was based on data from adolescents 12–19 years old. We opted to use this score, based on research suggesting that this continuous approach is advantageous for identifying individuals at risk for developing CVD and type II diabetes, even when including children younger than 12 years [28]. Finally, information on maternal ethnic discrimination was obtained exclusively from maternal report, and we did not include information on paternal experiences of discrimination. Moving forward, it will be valuable to use longitudinal studies with repeated measures of discrimination, and to comprehensively assess and combine maternal and paternal reports with child reports [13].

This study makes a number of contributions to the literature on vicarious racism and child health and development, given that we utilized a large sample of youth from four metropolitan areas with large Hispanic/Latino populations, which enabled recruitment of youth from diverse national backgrounds, and tests of age and sex interactions. In addition, HCHS/SOL and SOL Youth included detailed assessments of maternal and household characteristics, which allowed us to adjust for an array of potential confounders. Of the existing studies on parental discrimination and child health, this is the first to consider multiple biomarker assessments of cardiometabolic risk rather than subjective reports of child health. In using biological measures of health as outcomes in this study, we avoid biases inherent to self-report or parent report that may depend on physician diagnoses, and gain insights on preclinical or presymptomatic processes implicated in the development of cardiometabolic disorders. Our study suggests that the impact of maternal discrimination may extend beyond psychological and behavioral health in youth, to levels of inflammation, before adulthood.

In conclusion, maternal experiences of ethnic discrimination were associated with higher hsCRP among Hispanic/Latino youth, and did not relate to BMI z-score or MetS score in this population. Although our results were not consistent across all outcomes that we examined, similar to studies from around the world, including the United States [14–18], Australia [22], the United Kingdom [23], and New Zealand [39], our results suggest that interventions to improve health outcomes for racial/ethnic minority youth, including cardiometabolic outcomes in adolescence and throughout life, should consider influences beyond individual health behaviors [19,23]. It may be beneficial for future interventions to attend to parental experiences of racism, at the individual and institutional levels [40]. In light of the current national climate toward immigrants and racial/ethnic minorities in the

United States and around the world [41], it is critical to improve our understanding of the association between parental discrimination and child cardiometabolic health to inform social policies as well as targeted interventions to prevent racism [42,43] and improve outcomes for youth affected by vicarious racism [13].

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