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Trauma-Related Cognitions and Discrimination as Predictors of Maladaptive Coping Among Marginalized Maltreated Youth

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TRAUMA-RELATED COGNITIONS AND DISCRIMINATION AS PREDICTORS OF MALADAPTIVE COPING AMONG MARGINALIZED MALTREATED YOUTH

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ABSTRACT

Maltreated youth are at an increased risk for engaging in direct or indirect self-injurious behavior to cope with the aftereffects of a traumatic event. These behaviors are often associated with negative health outcomes, substance use and premature death. Existing research proposes a link between child maltreatment and indirect self-harm but the mechanism into why this occurs is unclear. The present study examined two key research questions: (1) which specific trauma-related cognitions, sexual identity and cultural factors predict direct self-injurious behavior (previous suicide attempt(s) and NSSI) among marginalized maltreated youth?; and (2) which specific trauma-related cognitions, sexual identity and cultural factors predict indirect self-injurious behavior (recklessness, intentional misbehavior, delinquent behavior, problematic sexual behavior, substance use, and running away) among marginalized maltreated youth? A classification and regression tree (CART) analysis identified predictors of direct and indirect self-injurious behaviors. Participants included 133 sexual and racially/ethnically diverse maltreated youth in Department of Family Services (DFS) custody following removal from their home after substantiated child maltreatment. Hypothesis 1 was partially supported. The final models identified several predictors that best determined previous suicide attempt(s) and/or NSSI: (1) negative cognitions of self, (2) sexual orientation, (3) negative cognitions of world, (4) race/ethnicity, and (5) self-blame. Hypothesis 2 was partially supported. The final models identified several predictors that best determined one or more forms of indirect self-injurious behavior: (1) sexual orientation, (2) negative cognitions of self, (3) race/ethnicity, (4) self-blame, (5) experience cultural identity discrimination, (6) age, and (7) gender identity. The findings offer important implications for understanding the relationship between maltreatment, discrimination, trauma-related cognitions, and self-injurious behaviors to better inform assessment and treatment of marginalized maltreated youth.

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DEDICATION

Shadie circa 2018, we did it!

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CHAPTER 1

INTRODUCTION

A long-standing relationship exists between child maltreatment and engagement in risky or self-injurious behaviors (Angelakis et al., 2020; Arens et al., 2012; Niu et al., 2021; Pérez-Balaguer et al., 2022). Maltreated youth may utilize maladaptive strategies such as risky or self-injurious behaviors to cope with the aftereffects of a traumatic event (American Psychiatric Association, 2022; Hooley & St. Germain, 2014; P. K. Kerig, 2019). These strategies include direct (e.g., suicide attempts and non-suicidal self-injurious behavior; NSSI) and indirect (e.g., oppositional and conduct disordered behaviors, unsafe sexual behaviors and substance use) methods (Angelakis et al., 2020; Kugler et al., 2019; Leeb et al., 2008; Muniz et al., 2019; Stedt, 2018; Thornberry et al., 2010).

Lesbian, Gay, Bisexual, Transgender (LGBT) and racially/ethnically marginalized maltreated youth are susceptible to risky or self-injurious behaviors due to exposure to multiple traumatic events and frequent experiences of sexual and cultural identity rejection (Camp et al., 2020; Hatzenbuehler, 2017; Priest et al., 2013a; Sosoo et al., 2020; Taliaferro et al., 2019). Identity rejection encapsulates experiences of discrimination and/or invalidation towards one's marginalized identity at the individual (e.g., internalized racism/homophobia) and environmental (e.g., peer and family rejection, discrimination) levels (Dyar et al., 2018; Fleischmann & Op De Weegh, 2021; London et al., 2012; Yip, 2018).

For LGBT youths, sexual identity rejection by their peers or family through bullying or microaggressions increase their risk of homelessness, suicide, and engagement in risky behaviors (Gartner & Sterzing, 2018; Ream & Peters, 2021; Ryan et al., 2009). For LGBT youth of color, the risk for suicide, non-suicidal self-injurious behavior (NSSI) and engagement in risky

behaviors is heightened as they encounter peer and family rejection, maltreatment, and discrimination towards both their sexual and racial identities (English et al., 2022; Hatchel et al., 2021; Hightow-Weidman et al., 2011; Katz-Wise et al., 2016; Schnarrs et al., 2019).

Cultural identity refers to an individual's identity, sense of belonging or self-conception and its relation to various cultural or social groups (e.g. nationality, race, ethnicity, gender, religion, social class or locality) (Usborne & de la Sablonnière, 2014). Cultural identity acts as a protective factor against poor mental health outcomes (Forrest-Bank & Cuellar, 2018; Serrano-Villar & Calzada, 2016). Racially/ethnically marginalized youth with a strong sense of ethnic identity display elevated self-esteem and psychological well-being (Lardier Jr., 2018; Lardier Jr. et al., 2018; Wang et al., 2020). Ethnic identity refers to an individual's identification, belongingness, and/or self-conceptualization with an ethnic group(s) (Newman & Newman, 2020). Threats towards cultural identity through peer/family rejection, microaggression, and discrimination significantly increase risk of mental health issues, suicide, and risky behaviors (Brooks et al., 2020a; Fisher et al., 2019; Starck et al., 2020; Trent et al., 2019; Walker et al., 2017). Additionally, cultural identity rejection may lead to mandated reporters' failure to understand cultural factors, thus making ill-informed CPS reports and causing the removal of marginalized youth from their homes (L. Chen, 2019; Sue et al., 2019).

The overrepresentation of marginalized maltreated youth in the child welfare system increases the likelihood of transracial/ethnic foster home placements (Kalisher et al., 2020; Pinderhughes et al., 2019). Transracial/ethnic foster home placements refers to the placement of a child of one race/ethnicity to guardians of a different race/ethnicity (Kalisher et al., 2020; Smith, 1994). Transracial/ethnic placements may contribute to marginalized maltreated youth's experiences of identity rejection and discrimination (Ferrari et al., 2015; Montgomery & Jordan,

2018; Rauktis et al., 2016). Identity rejection at the individual or environmental level can have a detrimental impact on an individual's mental health and quality of life (Camp et al., 2020; Trent et al., 2019).

Research identifying risk factors for suicide attempts, NSSI, and risky behaviors must start by examining intersectionality among youth with multiple marginalized identities (i.e., gender, sexual and race/ethnicity) (Cooper et al., 2022; Standley & Foster-Fishman, 2021; Wiglesworth et al., 2022). A lack of understanding currently exists regarding predictors and current models of suicide and self-harm that incorporate culturally relevant suicide and risk prevention (Coley et al., 2021). These models require focus on unique predictive factors specific to those of marginalized identities, such as identity rejection related to experiences of cultural and sexual identity rejection, sexual and gender discrimination, caregiver and peer rejection, failure to connect with similar identity peers, and perceived stigma (Coley et al., 2021).

The current study explored the potential underlying mechanisms that predict marginalized maltreated youth's engagement in previous suicide attempts, NSSI, and risky behaviors. The present study aimed to provide clinicians and researchers with an increased understanding of the impact of trauma as well as cultural and sexual identity rejection (e.g., internalized racism, family rejection discrimination) for individuals with intersecting marginalized identities. The clinical implications of the current study aimed to provide a more culturally sensitive trauma-informed prediction model of previous suicide attempts, NSSI, and risky behaviors, and further existing knowledge of the behavioral response to maltreatment among marginalized maltreated youth. The following sections review the literature on identity development among youth from historically excluded groups in the U.S. (racial/ethnicity, gender identity and sexual orientation) and the effects of trauma on decision-making and behavior.

CHAPTER 2

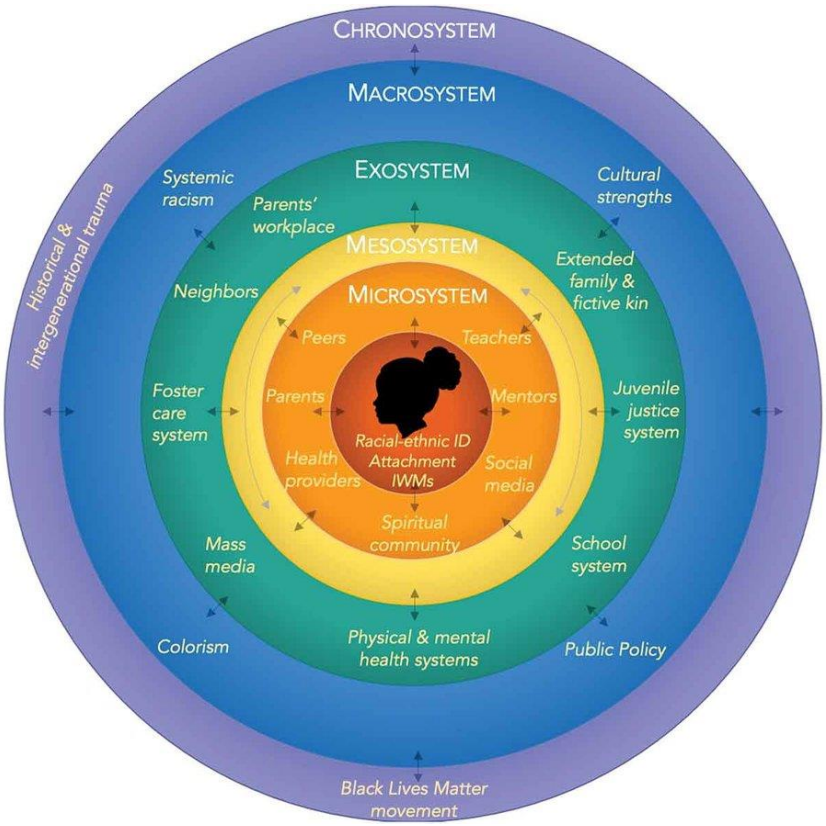
REVIEW OF RELATED LITERATURE

Adolescent Identity Development

Adolescence is a time consisting of developmental, social and identity growth and exploration (Branje, 2022). Interactions within the child's relationship with their surrounding environment, family, school, cultural values, laws, and customs influence identity development (Bronfenbrenner, 1979). According to Bronfenbrenner's Ecological System five levels of relationships impact an individual: microsystem (immediate surroundings), mesosystem (interpersonal), exosystem (community), macrosystem (societal), chronosystem (sociohistorical) (Bronfenbrenner, 1974, 1979; Noursi et al., 2021). Youth experiencing rejection or invalidation within these systems can have a detrimental impact on healthy identity development. Stern et al. (2021) updated Bronfenbrenner's model to be more reflective of marginalized children's experience with respects to systematic racism, colorism, and historical trauma (Figure 1).

Despite being one of the dominant theories of youth development, Bronfenbrenner's Ecological System was developed primarily under the influence of White youth experiences (West et al., 2023). Stern et al. (2021) updated model offers a culturally informed adaptation that incorporates larger social and historical context of marginalized youth development. Thus, providing a more comprehensive examination of the unique experiences of marginalized youth transition to young adulthood to better address arising disparities. The following sections discuss the impact of identity acceptance and rejection across relationships within ecological systems of child identity development. The following sections covers the impact of identity acceptance and rejection on behavioral symptoms among marginalized maltreated youth within the ecological system of identity development.

Figure 1. Adapted Bronfenbrenner's Ecological System



Note: From Stern, J. A., Barbarin, O., & Cassidy, J. (2022). Working toward anti-racist perspectives in attachment theory, research, and practice. *Attachment & Human Development*, *24*, 392-422. https://doi.org/10.1080/14616734.2021.1976933

Identity Acceptance

Sexual Orientation and Gender Identity

Self-acceptance among sexually marginalized youth acts as a protective factor, predicting better overall mental health outcomes and wellbeing (Camp et al., 2020; Rostosky et al., 2018; Su et al., 2016). Additionally, for lesbian, gay, bisexual (LGB) and gender, non-conforming youth, an accepting surrounding environment can protect them against negative mental health and suicide (Padilla et al., 2010; Ryan et al., 2010). Within the microsystem acceptance from

peers and family members can significantly reduce rates of previous suicide attempts in transgender and nonbinary youth (Price & Green, 2021). For transgender youth, having at least one peer or one adult accept their gender identity significantly lowers risk for a suicide attempt (Price & Green, 2021). Caregiver and siblings' acceptance of sexual orientation and gender identity acts as a protective factor against depression, anxiety, substance use, and suicidal ideation (Pariseau et al., 2019; Ryan et al., 2010).

An inclusive and protective school climate for LGBTQIA+ youth may also protect against negative mental health outcomes. Schools with Gay-Straight Alliance programs and LGBTQ focused policies reportedly foster elevated feelings of classmate and teacher support and less bullying for sexually marginalized students (Day et al., 2020). Furthermore, high schools with anti-bullying policies, inclusive of lesbian and gay students, report less peer victimization and lower rates of student suicide attempts (Hatzenbuehler & Keyes, 2013).

At the macrosystem level, an inclusive environment may promote positive sexual and gender identity development and better mental health outcomes. Transgender students having access to bathroom and gender-appropriate housing in college can dramatically decrease suicidality (Sutton, 2016). Moreover, the use of gender-affirming language, particularly correct pronoun and name usage, promotes identity validation, feelings of support, reduced stress, lower rate of depression, and decreased suicidal ideation and behaviors (C. Brown et al., 2020; Russell et al., 2018). States with fewer anti-LGBT laws reported greater utilization of correct pronouns and names for transgender youth (Renley et al., 2022).

Identity acceptance can act as a “double-edge sword.” For LGBT youth, acceptance of sexual and gender identity decreases the impact of negative mental health symptoms but can also leave them vulnerable to discrimination, homophobia, and sexism (Wernick et al., 2017).

Additionally, LGBT youth may engage in transactional sex to affirm their sexual and gender identity and live openly as their true self (Lutnick, 2016). When adopting societal practices of inclusion and acceptance, the practices should not lead to the forced disclosure of sexual and gender identities and should remain sensitive to the safety risks encountered by LGBT+ youth who are navigating their sexual and gender identities (Frost & Bastone, 2008; Ong et al., 2021).

Race/Ethnicity

Agents within a youth's microsystem and exosystem can protect against negative health outcomes. Acceptance of one's ethnic identity acts as a protective factor against negative mental health outcomes and experiences of discrimination for racially/ethnically marginalized youth (el Bouhaddani et al., 2019; Forrest-Bank & Cuellar, 2018; Serrano-Villar & Calzada, 2016). For racially/ethnically marginalized youth, a strong sense of ethnic identity acted as a protective agent against substance use (Fisher et al., 2017; Lardier Jr., 2019). Furthermore, for Black and Hispanic youth, having a strong sense of community within their neighborhoods as well as community participation directly impacted positive ethnic identity development and overall well-being (Lardier Jr., 2018; Lardier Jr. et al., 2018). Moreover, parents who encouraged ethnic-racial and cultural socialization of their marginalized youth saw positive outcomes in their adolescents' self-perceptions, interpersonal relationships, and internalizing symptoms (Wang et al., 2020). Ethnic-racial socialization may also protect Black youth from the harmful effects of school-based discrimination on academic achievement (Banerjee et al., 2018). Lastly, implementing anti-racism and discrimination policies bolsters protection against negative mental health outcomes and health disparities (Miranda et al., 2020).

Intersectionality

Intersectionality theory was first published by Black Feminist scholar Kimberlé Crenshaw in 1989. The theory explains how one's social identities contribute to privilege and discrimination through the interlocking systems of oppression experienced simultaneously (Carastathis, 2014; Crenshaw, 1989). The social identities at the micro level have the ability to reflect marco level influences, like discrimination (Bowleg, 2012). Youth with multiple marginalized identities face compounding negative factors such as discrimination, family rejection, cultural biases, and social rejections (Grooms, 2020; Kaasbøll et al., 2022). Gendered racial socialization promoted positive feelings of being Black, which led to a reduction of depressive symptoms in Black girls (Stokes et al., 2020). For transgender individuals of color, societal oppression contributes to decreased access to gender affirmation. Consequently, feelings of distress increased the need for gender affirmation leading to identity threats (Sevelius, 2013). Thus, seeking gender affirmation to address identity threats may lead transgender women of color to engage in high-risk behaviors to affirm gender (Sevelius, 2013).

Identity Rejection

During adolescence, youth rely heavily on how others' perceive them to aid in the development of their self-identity (Pfeifer et al., 2009). Therefore, experiencing rejection, discrimination, or invalidation of a developing sense of self can have lasting negative impacts on healthy identity development (Green et al., 2021; Katz-Wise et al., 2016).

Sexual Orientation and Gender Identity

Among LGBQ+ youth, lack of self-acceptance of sexual identity is a risk factor for negative mental health outcomes and internalized homophobia (Camp et al., 2020). Youth's delayed acceptance of their sexual identity significantly predicts substance use, suicidal ideation,

delayed coming out to family and peers, and internalized homophobia (Ong et al., 2021). Furthermore, internalized homophobia and transphobia increase rates of substance use, suicide attempts, intimate partner violence, high risk sexual behavior, and disordered eating (Badenes-Ribera et al., 2019; Panza et al., 2021; Parker & Harriger, 2020; Poštuvan et al., 2019; Puckett et al., 2017).

Within the microsystem, LGBT youth frequently report high rates of being bullied by peers due to their sexual and gender identity (Earnshaw et al., 2016). Prejudice, homophobia, and youth with a strong sense of heterosexual identity are frequent precursors to LGBT bullying (Poteat et al., 2013). Moreover, experiencing bullying for being LGBT predicted heightened rates of depression, anxiety, suicidal ideation/attempts, low self-esteem, physical violence, and engaging in high-risk behaviors (e.g. drunk driving, high risk sexual behaviors) (Bogart et al., 2014; Hatchel et al., 2021; Kosciw et al., 2020; M. J. Li et al., 2014; Reisner et al., 2015; Russell et al., 2012). McCormick et al. (2017) found that the psychological and behavioral impact of family and peer rejection of sexual and gender identity can mirror the symptoms seen in PTSD. LGBT youth who experience school victimization are at risk for lower self-esteem and grade point average as well as greater suicidality, depression, and school absenteeism (Ancheta et al., 2021; Colvin et al., 2019; Kosciw et al., 2013).

Parental rejection of youth's sexual identity leads to youth rejecting their sexual identity and higher rates of reported internalized homophobia (Bregman et al., 2013; Hatzenbuehler & Pachankis, 2016). Family rejection of sexual identity for LGBT+ youth significantly increased their risk of homelessness, mental health problems, and risky behaviors (Gamarel et al., 2020; Johnson et al., 2019; Ream & Peters, 2021). For homeless LGBT youth, high risk sexual behaviors may be a means for survival (Dank et al., 2015; McCormick et al., 2018). Ryan et al.

(2009) found that LGB youth experiencing family rejection are 8.4 times more likely to have a previous suicide attempt and 3.4 times more likely to use drugs and have unprotected sex than peers with lower levels of family rejection. For nonbinary and transgender youth, parent rejection in the form of microaggression, maltreatment, and significantly predicted suicidality compared to peers (Gartner & Sterzing, 2018; Price-Feeney et al., 2021). Moreover, family rejection influenced higher rates of parental verbal and emotional abuse and rejection of atypical gender expression during childhood for LGB youth (Baams et al., 2015).

Within the macrosystem the structural stigma experienced by LGB youth can have a detrimental impact on healthy psychological development. LGBT youth who experience stigma are at an increased risk for depression, anxiety, substance use, suicidality, bullying, and emotional dysregulation (Corliss et al., 2010; Earnshaw et al., 2016; Haas et al., 2011; Hatzenbuehler, 2017; Hatzenbuehler et al., 2008; McCabe et al., 2021). Experiences of biphobia contribute to difficulties in attachments, increased emotion dysregulation, PTSD, and dissociative symptoms (Keating & Muller, 2020). Additionally, experiencing transphobia increased PTSD and dissociative symptoms, while homophobia increased emotion deregulation, PTSD, and dissociative symptoms (Keating & Muller, 2020). Frequent heterosexism discrimination predicted later PTSD symptom severity among sexually marginalized women. More importantly, heterosexism discrimination may lead sexually marginalized women to hold negative trauma-related cognitions about themselves that worsen or maintain PTSD symptoms (Dworkin et al., 2018). Lastly, sexual and gender minority (SGM) youth experiencing chronic and traumatic invalidation from structural and systemic discrimination are at heightened risk of emotion dysregulation and use of maladaptive coping skills (Cardona & Sauer, 2021; Clark et al., 2022; McCabe et al., 2021).

Race/Ethnicity

Internalized racism leads to a slew of mental health difficulties and propensity for violence (Bryant, 2011; Sosoo et al., 2020; Trent et al., 2019). Additionally, racially/ethnically marginalized youth are at an increased risk for sexual exploitation due to internalized racism or colorism (Hurst, 2015). The internalizing experiences of colorism or racism may impact youths' self-worth, leaving them vulnerable to exploitation. Furthermore, skin tone dissatisfaction in Black and Latinx youth contributes to lower self-esteem and less feelings of attractiveness/ desirability (Abrams et al., 2020; Adams et al., 2020; Telzer & Vazquez Garcia, 2009; Young-Hyman et al., 2003). Negative attitudes towards one's own skin tone or darker skin tones impacts healthy racial identity development (Adams et al., 2016; Fegley et al., 2008). This may lead darker skinned youth of color to harbor negative biases and leave them vulnerable to the harmful effects of racial discrimination (Adams et al., 2016; Breland-Noble, 2013; Stevenson & Arrington, 2009).

Within the microsystem racially/ethnically marginalized youth experiencing racial discrimination from peers are more likely to use proactive aggressive coping skills (e.g. talking it out, addressing misconception or stereotypes, using positive affirmation or responding rudely) compared to White peers (Montoro et al., 2021). Additionally for Black girls, wearing their natural hair texture is an expression of their racial identity (Opie & Phillips, 2015; Seaton & Tyson, 2019). Unfortunately, Black girls are more likely to receive negative and inappropriate comments from their peers about their natural hair texture and feel pressure to conform to White beauty hair standards compared to White peers (Bankhead & Johnson, 2014; Onnie Rogers et al., 2021). Furthermore, Black adolescent girls may struggle with interracial dating due to experiencing racial discrimination by their White male peers (Seaton & Tyson, 2019).

Multiracial/ethnic youth may feel forced to identify with a singular racial/ethnic identity leading to difficulties in healthy racial/ethnic identity development, ingroup social exclusion, discrimination, and mental health concerns (J. M. Chen et al., 2019; Ho et al., 2017; Rauktis et al., 2016; Stepney et al., 2015; Törngren et al., 2021). Multiracial youth with poorly developed ethnic identities have heightened risk for lower self-esteem, substance use, and internalizing symptoms (Fisher et al., 2014, 2017, 2019).

Racially/ethnically marginalized students frequently report discrimination and microaggression targeted at their culture and racial/ethnic identity, which can have a negative impact on mental health (Starck et al., 2020; Steketee et al., 2021; Wintner et al., 2017). Experiencing discrimination and microaggressions in school relates to higher rates of mental health difficulties, poor academic performance, poor self-esteem, conduct problems, and substance use (Arora, Alvarez, et al., 2021; Assari & Caldwell, 2018; DeLapp & Williams, 2015; Fernandez et al., 2019; Guerra et al., 2019; Jelsma & Varner, 2020; Keels et al., 2017; Morris et al., 2020). For students of color, experiencing school-based racial discrimination negatively impacted healthy racial identity development (C. S. Brown, 2017; Butler-Barnes et al., 2019). Additionally, Holter et al. (2020) found that middle school history textbooks in Montana contained racist themes towards the depictions of Indigenous peoples' culture, spirituality, and historical figures. Bilingual students often report experiencing microaggressions when they speak a language other than English (Steketee et al., 2021). Students of color may feel the need to distance themselves from their culture to avoid negative interactions with their peers at school.

Parents of multiracial youth and transracial/ethnic adoptees that failed to adequately racial/ethnically socialize their marginalized children contributed to their worse health outcomes (Atkin & Yoo, 2019; Montgomery & Jordan, 2018; Stokes et al., 2020). Transracial/ethnic

adoptees and multiracial youth may struggle to develop a healthy ethnic identity if they feel like their caregivers are rejecting their racial/ethnic identity and fail to affirm their racial/ethnic backgrounds (Atkin & Yoo, 2019; Basow et al., 2008; Ferrari et al., 2015; Mohanty, 2013). Furthermore, discrepant views of youth's race/ethnicity significantly predicted delinquency among transracial adoptees compared to peers (K. N. Anderson et al., 2015). Most transracial/ethnic adoptions are children of color adoptees to White adoptive parents (K. N. Anderson et al., 2015; Kalisher et al., 2020; Vandivere & Malm, 2009). White parents of children of color often downplay the importance of racial/ethnic identity (Hamilton et al., 2015; Samuels, 2009). Thus, transracial/ethnic adoptees are at heightened risk for discrimination and loss of culture as well as harmful mental health effects (Mohanty, 2013). Acculturation stress can lead to disordered eating behaviors and poor self-esteem in racially/ethnically marginalized youth and young adults (Claudat et al., 2016; Rodgers et al., 2018). Rejection of native/cultural language proficiency and reduced ties to a country of origin heightens family conflict and lower family attachment (Bostean & Gillespie, 2018).

Prior to birth, discrimination impacts racially marginalized children. A 2020 study found that pregnant individuals from marginalized backgrounds disproportionately encounter "chronic stress in the form of discrimination, historical trauma and acculturation" (Conradt et al., 2020, p. 208). The increased levels of chronic stress impact healthy fetal physical and mental development (Conradt et al., 2020.; Luecken et al., 2017, 2019). A 2019 study found that police violence was a leading cause of death for Black men (Edwards et al., 2019). The impact of racial/ethnic discrimination has detrimental effects on the safety, wellbeing, and overall health of marginalized individuals. Experiences of everyday racism and discrimination can exacerbate internalizing and externalizing mental health symptoms.

Racial discrimination at various levels within the ecological systems can lead to anger, depression, helplessness, disrupted psychosocial development, lower self-esteem, hypervigilance, shame/guilt, and suicidality (R. E. Anderson et al., 2021; Argabright et al., 2022; Benner et al., 2018; Breland-Noble et al., 2016; Brody et al., 2006; Priest et al., 2013b; Walker et al., 2017; Xiao & Lu, 2021). Specifically, for suicidality, perceived racism directly impacted and mediated the relationship between suicidal ideation and depression in African American youth (Walker et al., 2017). African American and Latinx youth experiencing microaggressions and overt forms of discrimination are at risk of increased suicidal ideation (Madubata et al., 2022a). For African American youth, this finding held true even after accounting for the impact of depressive symptoms (Madubata et al., 2022a). Joiner's model of suicidality identified three components necessary for a suicide attempt, thwarted belongingness, perceived burdensomeness and the acquired capability to overcome the inherent fear of death (Joiner & Jr, 2005). For Black individuals perceived racial discrimination served as a significant enough painful experience that increased the capability for suicide (Brooks et al., 2020a). Experiencing racial discrimination directly impacts suicidality among marginalized youth.

Youth who have experienced racial/ethnic discrimination are at an increased risk of substance use, conduct disordered behaviors, health-harming behaviors, and engagement in sexual risk behaviors (R. E. Anderson et al., 2020; Benner et al., 2018; Cave et al., 2020; Neblett Jr. et al., 2010; Weeks & Sullivan, 2019; Xie et al., 2020). Mendez et al. (2022) found that racial discrimination predicted later risk-taking and delinquent behavior among racially/ethnically marginalized trauma exposed youth. Experiencing racial discrimination predicted later aggressive and delinquent behavior in African American and Indigenous youth (Chambers & Erausquin, 2018; Hautala & Sittner, 2019). For Asian youth, perceived discrimination

significantly predicted internalizing and externalizing behaviors and alcohol use (Joo et al., 2022; Latzman et al., 2013). Interpersonal ethnic/racial discrimination increased the risk for internalizing (e.g., anxiety, depression, somatic complaints) and externalizing (e.g., aggressive/oppositional behavior, risk-taking, substance use) behaviors among Black youth in the juvenile justice system (Loyd et al., 2019). Traumatic stress and emotion dysregulation indirectly impacted elevated internalizing and externalizing behaviors and discrimination among Black boys and girls (Loyd et al., 2019).

Intersectionality

Marginalized youth disproportionally receive placements in transracial/transethnic foster homes. Placement in foster homes with families from different cultural backgrounds can often compound the negative effects experienced by maltreated youth with intersecting marginalized identities (Grooms, 2020). Foster parents from different cultural backgrounds may fail to socialize youth adequately with peers of similar backgrounds. The disconnect from important cultural communities may impact healthy identity development among marginalized youth (Pinderhughes et al., 2019).

Racial, gender and sexual marginalized (GSM) youth are at heightened risk of experiencing discrimination compared to their White LGBTQ peers (Whitfield et al., 2014). Further, youth with intersecting marginalized identities are at heightened risk for suicide (Standley & Foster-Fishman, 2021; Wiglesworth et al., 2022). For Black GBT youth, the impact of structural racism and anti-LGBTQ policies significantly increases their risk of substance use, depression, self-harm, previous suicide attempt, feelings of burdensomeness and thwarted belongingness compared to their White GBT peers (English et al., 2022). These findings suggest

future research should examine the intersectional approach in understanding the impact of multiple marginalized identities on an individual's mental health.

Summary and Limitations

Marginalized maltreated youth can experience elevated negative mental health symptoms, suicidality, and additional trauma and victimization due to identity rejection. Future researchers should examine the impact of identity rejection on marginalized maltreated youth's mental health and behaviors, as this may provide insight into disparities experienced within the child welfare system. Furthermore, future researchers should examine how identity rejection encompassing discrimination, racism, and lack of social/familial acceptance coincide with maltreatment to inform potential mechanisms for youth behavior and symptom presentation. Despite racially/ethnically and SGM youth being overrepresented within the child welfare system, there is a significant gap in the literature examining the experiences of these individuals. Research examining the unique experience of marginalized maltreated youth will help support the development of more culturally informed reunification practices, foster home placements, and targeted and effective mental health services for these youth. The following sections covers the effect of child maltreatment on behavior among maltreated youth with marginalized identities.

Effects of Child Maltreatment on Behavior

Youth with attachment-based traumas and early experiences of parental rejection are at an increased risk of engaging in risky sexual behaviors, substance use, and aggression during adolescence and early adulthood (Hentges et al., 2018; Kobak et al., 2004; Puffer et al., 2012). Furthermore, individuals with a history of child maltreatment endorsed heighten negative affect and impulsivity (Arens et al., 2012; Pérez-Balaguer et al., 2022; Xiang et al., 2021). Specifically,

maltreated youth experiencing negative urgency ("a tendency to act rashly when distressed" (Settles et al., 2012, p. 1) are more likely than non-maltreated peers to endorse deliberate self-injurious behaviors as an adult (Arens et al., 2012). Additionally, maltreated youth may engage in self-injurious behaviors, substance use, impulsive or aggressive acts, or high-risk behaviors to cope with the aftereffects of a traumatic event (Center for Substance Abuse (US), 2014; P. K. Kerig, 2019; Koçtürk, 2022; Liu et al., 2018). However, these high-risk behaviors are often overlooked. The subsequent sections review the literature on the effects of trauma on decision-making and behavior among marginalized maltreated youth. These themes form the central thesis of the next several sections.

Decision-Making

Maltreated youth are more likely than non-maltreated peers to choose risker options more quickly and are willing to take more risk to avoid negative consequences even if the potential consequence is greater as a result (Weller et al., 2015). Furthermore, maltreated youth are less likely to reference contextual clues to aid in decision-making, leading to riskier choices (Warmingham et al., 2021; Weller et al., 2015; Weller & Fisher, 2013). Maltreated youth display a heightened insensitivity to punishment, leading to greater risk taking and an inability to make expected value judgments (Weller & Fisher, 2013). Insensitivity to potential punishment may explain why maltreated youth are at heightened risk for negative outcomes and a willingness to engage in unsafe behaviors (e.g. teenage pregnancy, substance use disorders, homelessness, arrest, sexually transmitted infections (STI), school dropout) (Weller & Fisher, 2013).

Youth who have experienced multiple traumatic events display more deficits in executive functioning than youth who have experienced a single trauma (op den Kelder et al., 2017). Executive functioning is responsible for inhibitory control, attention and working memory.

Deficits in executive functioning in maltreated youth may explain impaired decision-making abilities (Aupperle et al., 2012; De Bellis et al., 2013; Polak et al., 2012).

Trauma-related cognitions, particularly negative cognitions about the world and self-blame, predict development and maintenance of PTSD in marginalized maltreated youth (Kaur & Kearney, 2015; Ross & Kearney, 2015; Wiseman et al., 2021). Racially/ethnically marginalized maltreated youth often receive a misdiagnosis of an externalizing disorder despite not having any difference in PTSD symptom presentation (Burke & Kearney, 2022). Experiences of trauma may motivate a youth's decision to engage in risky or self-destructive behavior, which may lead to a misinterpretation of symptoms relating to conduct disorder or other externalizing disorders. Misdiagnosis is particularly harmful and may lead to interaction with the juvenile justice system or police as opposed to effective mental health treatment (P. Kerig, 2017; P. K. Kerig, 2019). High-risk behavior may lead to additional traumatic experiences for maltreated youth, further perpetuating a cycle of harm that contributes to worsened mental health, long-term outcomes, and poor quality of life (Kim et al., 2009). A national community study of adolescents revealed youth who experienced sexual abuse displayed early onset substance abuse, which further predicted exposure to subsequent traumatic experiences (Kingston & Raghavan, 2009). Additionally, individuals with a history of child maltreatment are more likely than non-maltreated peers to experience higher rates of impulsivity paired with a sense of urgency, which increases risk for utilizing deliberately harmful behaviors as coping strategies (Arens et al., 2012).

Maladaptive Coping

Following exposure to trauma, youth may use non-suicidal self-injurious behavior to help regulate their emotions (Silverman et al., 2018). These maladaptive coping strategies may appear

as disordered eating, risky sexual behaviors, delinquent behaviors, substance use, self-injurious behavior, running away, or placing oneself in dangerous situations (Briere & Runtz, 2002; Chaplo et al., 2015). The use of self-harming behaviors may lead to feeling invalidated or betrayed when others view these maladaptive coping strategies as defiant, ultimately leading to ineffective treatment or social isolation (P. Kerig, 2017).

Difficulties with emotion regulation and a lack of positive coping strategies place maltreated youth at higher risk for engaging in risky behaviors (Gruhn & Compas, 2020; P. K. Kerig, 2019; Peh et al., 2017; Titelius et al., 2018). Rajabi Khamesi et al. (2021) found that child maltreatment had a direct effect on suicidal ideation. Moreover, cognitive emotion regulation strategies, unacceptable obsessional thoughts, and responsibility for harm mediated the effects of child maltreatment on suicidal ideation. Maladaptive coping strategies for emotion regulation likely influence engagement in high-risk and self-destructive behaviors (P. K. Kerig, 2019). Maltreated youth may engage in risky behaviors as "a desperate attempt to redress injustice and regain control" (Ford et al., 2006, p. 17). Clinicians and researchers could benefit from reframing the way they view maltreated youth's maladaptive behaviors. By conceptualizing risky behaviors as a survival method of coping as opposed to defiant and careless behavior, clinicians and researchers can utilize a more validating, accurate reflection of risky behaviors. The following section reviews the literature of the behavioral effects of child maltreatment on LGBT+ and racially/ethnically marginalized youth.

Behavioral Effects of Child Maltreatment on Marginalized Youth

Sexual Orientation and Gender Identity

LGBTQ and gender nonconforming youth experience higher rates of sexual maltreatment, emotional maltreatment, and neglect than cisgender populations (Baams, 2018;

Belknap et al., 2012; Friedman et al., 2011; Mallon et al., 2022; Schnarrs et al., 2019). Gay, Lesbian and Bisexual youth are 3.8 times more likely to have a history of sexual abuse, 2.4 times more likely to miss school, 1.7 times more likely to be assaulted by a peer, and 1.2 times more likely to be physically abused by a parent compared to heterosexual peers (Friedman et al., 2011). Sexual and gender marginalized youth are also at an increased risk of suicide, engaging in high risk indirect and direct self-injurious behaviors, victimization, bullying, and social isolation (Barnett et al., 2019; Blashill et al., 2021; Clements-Nolle et al., 2018; Plöderl & Tremblay, 2015; Price-Feeney et al., 2020; Rasberry et al., 2018; Scannapieco et al., 2018; Wilson & Cariola, 2020). Sexual abuse mediated the relationship between lesbian and bisexual girls and self-harm compared to heterosexual girls (Belknap et al., 2012). Furthermore, girls from a sexual marginalized background are more likely to have a history of sexual abuse by an immediate family member than heterosexual girls (Belknap et al., 2012).

Friedman et al. (2011) suggested that higher rates of maltreatment and trauma experienced by LGBTQ youth may be the underlying mechanism for higher rates of mental health problems and high-risk activities compared to heterosexual peers. Additionally, sexually marginalized youth display increase deficits in emotion regulation. The deficits in emotion regulation mediated the relationship between depression and anxiety compared to heterosexual peers (Hatzenbuehler et al., 2008). Taliaferro et al. (2019) also found that over half of transgender and gender non-conforming (GNC) youth endorsed a history of NSSI. Furthermore, transgender and GNC youth with a history of NSSI and a previous suicide attempt reportedly endorsed higher rates of physical and sexual abuse, relationship violence, victimization, poor academic achievement, and running away compared to transgender and GNC youth with NSSI only (Taliaferro et al., 2019).

Race/ethnicity

Child maltreatment is highest among youth from racially/ethnically marginalized backgrounds (L. H. Lee et al., 2017; Roberts et al., 2012; Statista Research Department, 2020; Yi et al., 2020). Further, racially/ethnically marginalized youth who have experienced multiple maltreatment incidents are at a heightened risk of engaging in delinquent behavior (e.g., truancy, substance use, running away, traffic offenses, violating probation or parole) (Cho et al., 2019). Lee et al. (2017) found that, compared to White youth, Black maltreated youth maintained significantly higher risks for heavy drinking and violence during young adulthood.

Maltreated youth of color are vulnerable to the effects of trauma through emotional, psychological, and behavioral deficits compared to peers (Santacrose et al., 2021). African American youth are at heightened risk of witnessing and experiencing violence compared to White youth (Antunes & Ahlin, 2015; Wamser-Nanney et al., 2021). Latinx youth with heighted exposure to trauma displayed poor mental health outcomes (Santacrose et al., 2021). Black and Hispanic maltreated youth are more likely to run away compared to their White peers (Wulczyn, 2020). Black maltreated youth are more likely to be arrested and use alcohol and marijuana compared to White peers (Fagan & Novak, 2018). Black and Hispanic girls who have experienced sexual abuse and/or emotional neglect are at heightened risk for engaging in sexually risky behaviors (Niu et al., 2021).

Intersectionality

Hightow-Weidman et al. (2011) found that racially/ethnically marginalized gay and bisexual boys who experience sexuality-related bullying are at increased risk for depression, previous suicide attempts, and abuse from parents. LGBTQ youth of color with higher rates of suicidal thoughts may be impacted particularly by stigma-related stressors (Hatchel et al., 2021).

Additionally, LGBTQ youth of color are overrepresented within the child welfare system (Pinderhughes et al., 2019). This overrepresentation leads to heightened risk of homelessness, discrimination, and victimization (Grooms, 2020; Morton et al., 2018; Page, 2017).

Summary and Limitations

Suicide is one of the leading causes of death among youth (Clayton et al., 2021; Kann et al., 2018; D. Wasserman et al., 2005). Previous suicide attempts (SA) and NSSI are the largest predictors of future suicide attempts (Coley et al., 2021). Current models of death by suicide fail to identify at risk racially/ethnically marginalized groups accurately (Breland-Noble et al., 2016; Coley et al., 2021), suggesting that suicide prediction models disproportionately benefit White individuals. Current suicide risk prediction models require urgent attention and improvements to diminish existing mental health disparities. Reliance on existing models that do not accurately predict suicidality for marginalized people further discriminates and exacerbates existing mental health disparities and barriers to care.

Very few studies investigate whether certain life, social, behavioral, or cultural factors can affect a youth's decision to actively place themselves in danger. Further, during a youth's time in the child welfare system, resources focus more heavily on predictors that impacts successful reunification or stable placement. Although a stable home life is paramount to predicting higher rates of engagement in treatment and quality of life, this leaves youths' mental well-being in the background.

Direct self-injurious behavior is causing direct harm to the body through cutting, burning, or suicide attempts (Horváth et al., 2018). Indirect methods capture behaviors that may not have immediate harmful impact on the body but can lead to long-term harm such as substance use, disordered eating, reckless behaviors, or abusive relationships (Hooley & St. Germain, 2014).

These methods might bring attention to a deepening of emotional pain these individuals experience. Furthermore, these methods might relate to youths' beliefs that they deserve potentially harmful and negative situations due to past traumatic experiences. Additionally, the inclusion of V-codes for previous suicide attempts and NSSI within the DSM-5-TR warrant further study to provide clarity on case conceptualization and treatment of these most vulnerable populations.

Sparse research exists for predictive factors of youth engaging in risk-taking behaviors. Even fewer studies examine whether certain life, social, behavioral, or cultural factors can affect a youth's decision to place themselves in danger. Gaps in the literature exist in how trauma-related cognitions about oneself or the world influence youths' willingness to engage in direct or indirect self-injurious behaviors to cope with maltreatment. Lastly, limited research exists that seeks to identify the unique impact of trauma and identity rejection of maltreated youth with intersecting marginalized identities. The various forms of identity rejection (e.g., racism, sexism, homophobia, transphobia) may amplify current trauma symptoms and worsen existing mental health symptoms (Pinderhughes et al., 2019). These gaps in the literature lead to vulnerable youth continuing to receive culturally incompetent care and ineffective placements, and further perpetuate racist systems of privilege. By increasing the attention placed on identity rejection and intersectionality among marginalized maltreated youth, research can aim to reduce vulnerabilities, stressors, and future victimization.

Purpose of the Study

The current study aimed to examine possible mechanisms for direct self-injurious behaviors and risky behaviors among marginalized maltreated youth. The study aimed to provide a trauma-informed definition of the underlying maintenance of externalizing behaviors by re-

defining the motives to better inform overall treatment. Marginalized maltreated youth's behavioral presentation may be misunderstood as manipulative, purposely destructive, or defiant instead of as a misguided means of coping with trauma. Clinicians and researchers may benefit from reexamining the way they view externalizing behaviors within a maltreated population. Marginalized maltreated youth are not afforded the opportunity to become dysregulated compared to their White peers due to heightened risk of police involvement or more punitive measures (suspension, expulsion). Additionally, youth from marginalized groups may have had fewer opportunities to learn therapeutic coping strategies to manage emotional dysregulation, leading to the use of externalizing behaviors to cope.

The current study examined maltreated youth through an intersectional lens to better understand the impact of trauma-related cognitions, cultural factors, and sexual identity among those with marginalized backgrounds in the child welfare system. Stern et al. (2021)'s update to Bronfenbrenner's ecological systems of child development influenced the study design. The updated model references an anti-racist perspective to acknowledge how systematic barriers have impacted and shaped the way marginalized groups develop and interact with the world. In utilizing this model, the present study highlighted how specific contextual factors like discrimination within the youth's ecological systems impact healthy development and contribute to longstanding inequalities. This study provided insight into the link between trauma-related cognitions, cultural factors, and sexual identity rejection as underlying motivators for engagement in direct self-injurious behavior and risky behavior. By identifying which trauma-related cognitions, cultural factors, and sexual identity rejections predict direct self-injurious behavior and risky behavior, clinicians and researchers may better assist adolescents who

struggle with the insight and self-awareness to understand the reasoning and motivations for their behaviors.

Hypotheses

This present study aimed to develop a novel approach in identifying predictors of direct and risky behaviors among marginalized youth removed from their homes due to substantiated reports of maltreatment. The long-term goal is to inform culturally responsive assessment and treatment practices for high-risk behaviors in marginalized maltreated youth. Researchers must recognize that the identities of marginalized groups are not risk factors themselves, but rather that the current systems of oppression and discrimination embedded in the various levels of the ecological systems, policies, and institutions create barriers and elevate risk for these youth.

The present study had two hypotheses supported by previous research on the impact of trauma-related cognitions and sexual and cultural identity discrimination on marginalized maltreated youth. Hypothesis 1 was that specific trauma-related cognitions and sexual identity and cultural factors would predict direct self-injurious behavior (previous suicide attempt(s) and NSSI) among marginalized maltreated youth. Negative cognitions of self (NCS), negative cognitions of the world (NCW), and self-blame (SB), youth with multiple marginalized identities and higher rates of sexual and cultural identity discrimination across multiple identities was expected to be most closely associated with direct self-injurious behavior. Hypothesis 2 was that specific trauma-related cognitions and sexual identity and cultural factors would predict risky behavior (recklessness, intentional misbehavior, delinquent behavior, problematic sexual behavior, substance use and running away) among marginalized maltreated youth. NCS, NCW, and SB, youth with multiple marginalized identities and higher rates of sexual and cultural

identity discrimination across multiple identities was expected to be most closely associated with indirect self-injurious behavior.

CHAPTER 3

METHODS

Participants

Participants included 133 youth aged 11–17 years who were in Department of Family Services (DFS) custody following removal from their home after a child maltreatment report. Youth had a mean age of 14.04 (*SD* = 1.82) years. Most (48.1%) identified as cisgender female, 46.6% identified as cisgender male, 3.0% as non-binary, 1.5% as transgender male and 0.8% as transgender female. Youth identified as Black (35.3%), Hispanic/Latinx (26.3%), White (17.3%), Multiracial (14.3%), Other (Hawaiian and Romanian; 3.8%), Asian (2.3%), and Indigenous (0.8%). Youth in the current sample predominately identified as heterosexual (57.9%), questioning (18.0%), bisexual (12.0%), pansexual (6.8%), lesbian (2.3%), and asexual (2.3%) and gay (0.7%). Lastly, the majority of youth in the sample identified as having at least two marginalized identities (34.6%), one marginalized identity (32.3%), three marginalized identities (25.6%) and no marginalized identity (7.5%).

Measures

Demographic/Information Sheet

A demographic/information sheet was used to obtain information on participant's gender, age, race/ethnicity, country of origin, biological parent marital status, biological parent employment and high school level of attainment, religion, and language fluency.

Posttraumatic Cognitions Inventory (PTCI)

The PTCI is a 33-item self-report measure with 3 subscales to evaluate trauma-related cognitions (Foa et al., 1999). The first subscale assesses negative cognitions about the self (21 questions) that represent self-schema that one is incompetent. The second subscale assesses

negative cognitions about the world (7 questions) that represent a world-schema that the world is dangerous. The third subscale assesses self-blame (5 questions) that represents the core belief that the traumatic event was one's fault (Foa et al., 1999). Individual items on the PTCI are rated using a 7-point Likert scale ranging from 1 (totally disagree) to 7 (totally agree).

The PTCI demonstrated excellent internal consistency, test-retest reliability, and validity. Foa et al. (1999) reported excellent to good internal consistency for the overall measure (.97) and 3 subscales, negative cognitions about self (.97), negative cognitions about the world (.88) and self-blame (.86). Test-retest reliability was good at 1 week for overall and the subscales (.74-.89) and 3 weeks (.80-.86) intervals. Foa et al. (1999) also evaluated the PTCI for convergent and discriminant validity using the subscales of the Personal Beliefs and Reactions Scale (PBRS) and World Assumptions Scale (WAS). The PTCI displayed adequate positive correlations across total and subscale scores, demonstrating good convergent validity. The PTCI total and subscale scores significantly differed from individuals with PTSD and individuals without PTSD, thus demonstrating good discriminant validity. The factor structure of the PTCI demonstrates good predictor of reexperiencing and avoidance PTSD symptoms among diverse maltreated youth populations in DFS care (Howard et al., 2022). Cronbach alphas for the PTCI subscales in the present study were calculated for: negative cognitions of self (0.95), negative cognitions of world (0.88), and self-blame (0.76).

The Nevada Child and Adolescents Needs and Strengths (NV-CANS)

The NV-CANS (Lyons et al., 1999; State of Nevada Division of Child & Family Services, 2018) is an information integration tool developed to identify the strengths and needs of youth to support decision-making, service planning and outcome monitoring. Various versions of the CANS are utilized across all 50 states for youth aged 0-21 years within child welfare,

mental health, juvenile justice, and early intervention settings. The NV-CANS utilizes a 4-level rating system of “0” to “3” that corresponds with the level of action required and a recognized need or strength (Table 1). Ratings for youth are based on youth’s presentation regarding the past 30 days and raters are required to consider youths’ culture and development.

Table 1: NV-CANS Rating System

Needs

Rating	Level of Need	Appropriate Action
0	No evidence of need	No action needed
1	Significant history or possible need that is not interfering with functioning	Action/intervention required
2	Need interferes with functioning	Action/intervention required
3	Need is dangerous or disabling	Immediate action/intensive action required

Strengths

Rating	Level of Strength	Appropriate Action
0	Centerpiece strength	Central to planning
1	Strength present	Useful in planning
2	Identified strength	Build or develop strength
3	No strength identified	Strength creation or identification may be indicated

Note: Adapted from Freeman, M. (2018). *Nevada—Child and Adolescent Needs and Strengths NV-CANS 2.0 Ages 0-21 2018 Reference Guide*. 128.

The NV-CANS has 7 primary domains (potentially traumatic/ adverse childhood experiences, behavioral/emotional needs, life functioning, strengths, cultural factors, risk behaviors, and caregiver resources and needs), 2 age-specific domains (transition to adulthood and early childhood) and 11 sub-domains (trafficked, substance use, developmental/intellectual, sexual development, school, danger to others, sexual aggression, problematic sexual behavior, runaway, delinquent behavior, and victimization/exploitation). For an assessor to receive qualification to administer the NV-CANS, they must hold a bachelor's degree, receive annual training, and pass a training and certification test with a reliability of at least .70 (Lyons et al., 1999). The CANS demonstrated average to excellent reliability with vignettes (.78), case records (.84) and live case examples (.90) (Lyons, 2009). The CANS demonstrated excellent validity in relation to level of care decisions and similar measures of symptom, risk behavior, and level of functioning among diverse youth in community and state agencies (R. L. Anderson & Estle, 2001; C. C. Brown et al., 2022; Chor et al., 2012, 2015; Cordell et al., 2016; Israel et al., 2015; Lardner, 2015).

Procedures

Study procedures were in accordance with the University of Nevada, Las Vegas (UNLV) and Department of Family Services (DFS) policies regarding research with human participants, including IRB approval and an interlocal contract. Participants for the present study were randomly selected from a provided list of youth at an emergency shelter in Las Vegas that houses maltreated youths following removal from their home. All measures were part of DFS's standard mental health evaluation, completed by a clinician or graduate student, and associated with a summary report detailing diagnostic findings, clinical impressions, and further assessment/treatment recommendations for each participant.

Assessments, including the PTCI, were completed using an adolescent self-report and a review of records. Trained graduate students and research assistants under the supervision of graduate students conducted the 60-90-minute assessments. Assessments were administered individually in a private office space on-site at the emergency shelter. NV-CANS administered by certified DFS clinical staff were obtained from the participants DFS files. If a NV-CANS was not available at the time of assessment, a certified graduate student completed the assessment from youth self-report and review of available DFS records. All administrators of the NV-CANS had passed the required annual certification to ensure reliability of scores. Exclusionary criteria for youth included youth below age 11 years, due to available norms among assessments. Participant data was de-identified and replaced with a code of letters and numbers prior to data entry and analysis to maintain anonymity. De-identified data was stored on a secure server and paper files were stored in locked filing cabinets in a secure university lab space. Participants received explanations for the purpose of the study, encouraged to ask questions, advised that they need not answer questions that cause them discomfort, and that they were free to withdraw from the study at any time with no repercussions. Mental health providers (i.e., doctoral students, DFS employed clinical staff) were available on-site to support youth participants that expressed emotional distress or discomfort during the assessment. If participants disclosed intent to harm themselves or others, then appropriate action was taken for safety purposes. Youth were routinely referred to therapy services following the assessment process.

Data Analysis

Data analysis for the present study utilized IMB SPSS Statistics (Version 28) decision tree package, classification and regression tree (CART) analyses to determine which trauma-related cognitions from the PTCI (NCS, NCW or SB) and experiences of sexual and cultural

identity discrimination broadly defined from the NV-CANS (sexual identity and cultural factors modules) were predictive of direct self-injurious behavior (previous suicide attempt(s) and NSSI) and/or risky behavior (recklessness, intentional misbehavior, delinquent behavior, problematic sexual behavior, substance use and running away) in marginalized (e.g. race/ethnicity, sexuality and/or gender identity) maltreated youth. The NV-CANS is scored using a 4-level rating system with respect to urgency of response, so items were coded to indicate if they were present or not present. Individual item scores of "1", "2" or "3" were recoded as "P" for present and items scored with "0" were coded with a "N" for not present. Missing items were recoded with a "U".

Previous research demonstrated the benefits of utilizing CART analyses to examine intersectionality theory with respects to overall agreement, sensitivity and specificity (Bauer et al., 2021; Cairney et al., 2014; Dandolo et al., 2022; Greene et al., 2019; Mena & Bolte, 2020; Mortelmans et al., 2016). The advantages of utilizing CART analyses to further examine intersectionality theory and mental health outcomes lies in its ability to not make assumptions about variable distributions or relationships and CART's ability to identify complex and unsuspecting interactions compared to linear or single level regression analyses (Cairney et al., 2014; Greene et al., 2019).

The CANS was utilized in previous research within child welfare systems to develop clinical decision-making models to inform youth placement and service planning (Chor et al., 2012, 2015; Chow et al., 2014; Cordell et al., 2016). However, these models utilized mean total actionable item scores and not individual items as predictors. The present study differed in that individual items were analyzed as possible predictors of potential high risk self-injurious behaviors. Individual item analyses allowed for a more sensitive and specific identification of

actionable predictor items that leave youth at heightened risk for direct and indirect self-injurious behavior to inform service planning.

CHAPTER 4

RESULTS

Hypothesis 1

Hypothesis 1 was evaluated via CART procedures to identify specific trauma-related cognitions and sexual identity and cultural factors that would predict direct self-injurious behavior (previous suicide attempt(s) and NSSI) among marginalized maltreated youth. Trauma-related cognitions (i.e., negative cognitions of self (NCS), negative cognitions of the world (NCW), and self-blame (SB)), youths with multiple marginalized identities, and higher rates of sexual and cultural identity discrimination across multiple marginalized identities were expected to be most closely associated with direct self-injurious behavior. Hypothesis 1 was partially supported. The final models identified several predictors that best determined previous suicide attempt(s) and/or NSSI: (1) NCS, (2) sexual orientation, (3) NCW, (4) race/ethnicity, and (5) SB (Figures 2 and 3).

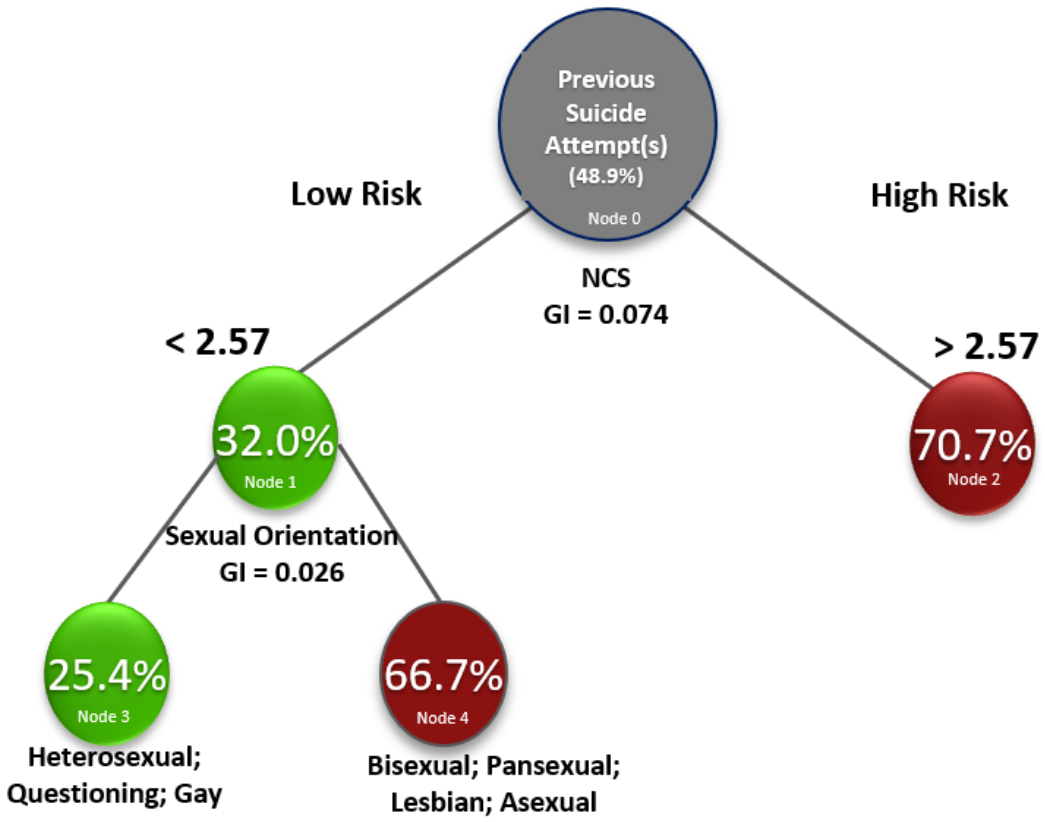
Previous Suicide Attempt(s)

The previous suicide attempt(s) model classified 72.2% of youth correctly (Table 2), with NCS and sexual orientation identified as prominent predictors. The model accurately classified 75.4% of youth who had previous suicide attempt(s) (n = 49) and accurately classified 69.1% of youth who did not (n = 47). The cross-validation risk estimate for previous suicide attempt(s) was adequate (r = 0.28, SE = 0.04).

Table 2: Classification Table for the Final Model of Previous Suicide Attempt(s)

1+ Previous Suicide Attempt(s)	Predicted		
	Yes	No	Percent Correct
Yes	49	16	75.4%
No	21	47	69.1%
Overall Percentage	52.6%	47.4%	72.2%

Figure 2. Previous Suicide Attempt(s) for Maltreated Youth



Interpretive note: 48.9% of participants had previous suicide attempt(s); 32.0% of youth with NCS scores <2.57 reported previous suicide attempt(s); 70.7% of youth with NCS scores >2.57 reported previous suicide attempt(s) and represented the highest-risk pathway. GI: Gini improvement.

The first split differentiated youth with or without previous suicide attempt(s) (Node 0; Parent) by a NCS score of 2.57 (Gini improvement = 0.074). Of youth with a NCS score <2.57, 32.0% endorsed previous suicide attempt(s) (Node 1). Of youth with a NCS score >2.57, 70.7% endorsed previous suicide attempt(s) (Node 2). The second split divided youth in Node 1 (NCS score <2.57) by sexual orientation (Gini improvement = 0.026), which created two terminal nodes (Nodes 3 and 4). Of youth with a NCS score <2.57 and self-identified as heterosexual, questioning, or gay, 25.4% endorsed previous suicide attempt(s) (Node 3). Of youth with a NCS score <2.57 and self-identified as bisexual, pansexual, lesbian, or asexual, 66.7% endorsed previous suicide attempt(s) (Node 4). The IF-THEN rules for youth probability of previous suicide attempt(s) are in Table 3.

Table 3: IF-THEN Rules for the Probability of 1+ Previous Suicide Attempt(s) by Risk Probability

	IF	THEN
Node 3	Heterosexual, Questioning or Gay AND NCS <2.57	25.4% probability
Node 1	NCS <2.57	32.0% probability
Node 4	Bisexual, Pansexual, Lesbian or Asexual AND NCS <2.57	66.7% probability
Node 2	NCS >2.57	70.7% probability

NSSI

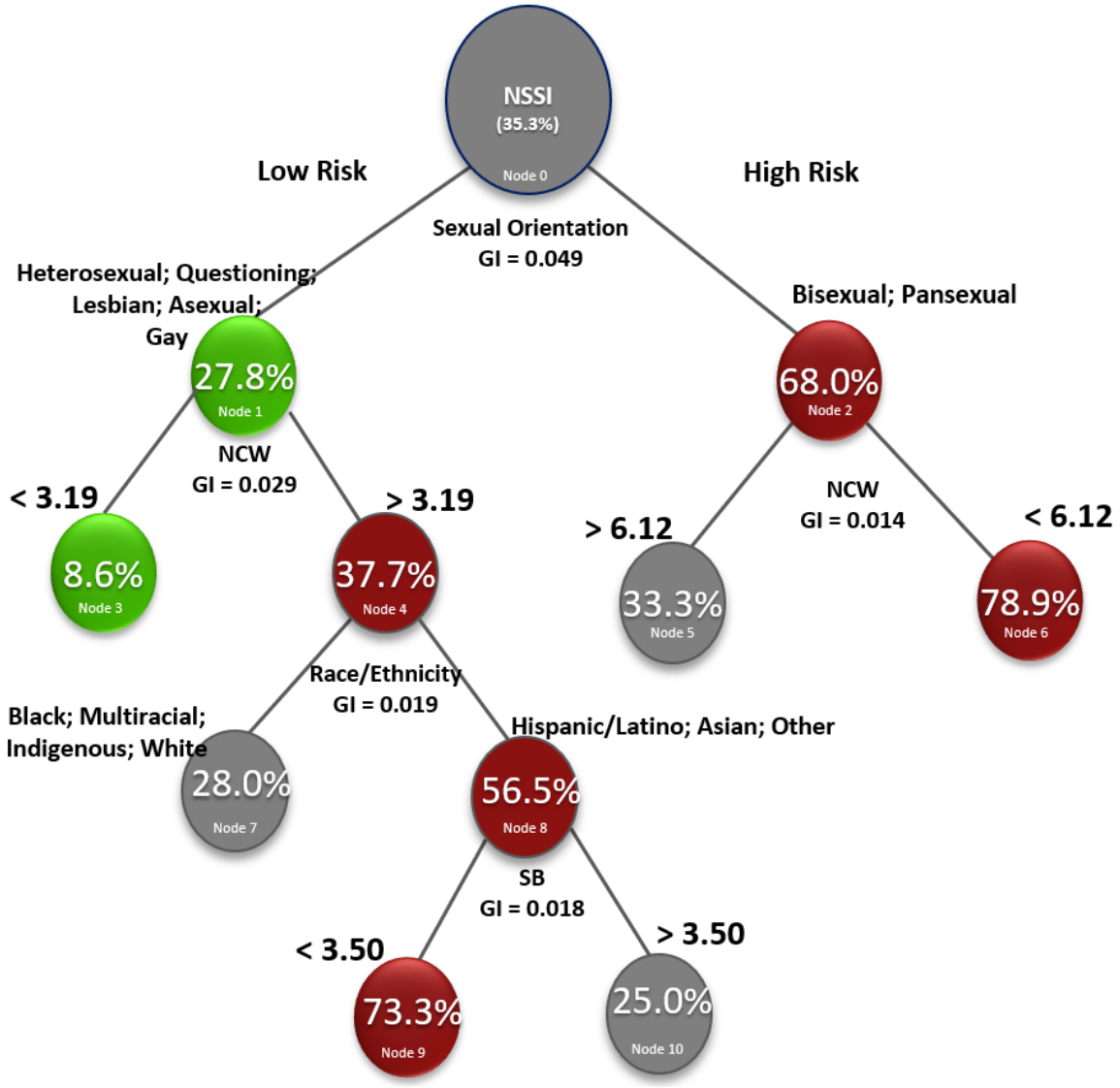
The NSSI model classified 78.2% youth correctly (Table 4), with sexual orientation, NCW, race/ethnicity and SB identified as prominent predictors. The model accurately classified

55.3% of youth who engaged in NSSI (n = 26) and accurately classified 90.7% of youth who did not (n = 78). The cross-validation risk estimate for NSSI was adequate (r = 0.22, SE = 0.04).

Table 4: Classification Table for the Final Model of NSSI

1+ NSSI	Predicted		
	Yes	No	Percent Correct
Yes	26	21	55.3%
No	8	78	90.7%
Overall Percentage	25.6%	74.4%	78.2%

Figure 3. NSSI for Maltreated Youth



Interpretive note: 35.3% of participants engaged in NSSI; 27.8% of heterosexual, questioning, lesbian, asexual or gay youth engaged in NSSI; 68.0% of bisexual or pansexual youth engaged in NSSI; Bisexual or pansexual youth with NCW score <6.12 represented the highest-risk pathway. GI: Gini improvement.

The first split differentiated youth who engaged in NSSI from youth who did not (Node 0; Parent) by sexual orientation (Gini improvement = 0.049). Of youth who identified as heterosexual, questioning, lesbian, asexual or gay, 27.8% engaged in NSSI (Node 1). Of youth

who identified as bisexual or pansexual, 68.0% engaged in NSSI (Node 2). The second split divided youth in Node 1 (sexual orientation; heterosexual, questioning, lesbian, asexual or gay) based on NCW scores (Gini improvement = 0.029), which created two terminal nodes (Nodes 3 and 4). Only 8.6% of youth who self-identified as heterosexual, questioning, lesbian, asexual or gay and had a NCW score <3.19 engaged in NSSI (Node 3). Of youth who self-identified as heterosexual, questioning, lesbian, asexual, or gay and had a NCW score >3.19, 37.7% engaged in NSSI (Node 4).

Youth in Node 2 (sexual orientation; bisexual or pansexual) were split by NCW scores (Gini improvement = 0.014), which created two terminal nodes (Nodes 5 and 6). Of youth who self-identified as bisexual or pansexual and had a NCW score <6.12, 78.9% engaged in NSSI (Node 6). Alternatively, 33.3% of youth who self-identified as bisexual or pansexual and had a NCW score >6.12 engaged in NSSI (Node 5).

The fourth split partitioned youth into two terminal nodes (Nodes 7 and 8) based on race/ethnicity (Gini improvement = 0.019). Of youth who identified as Black, Multiracial, Indigenous or White, had a NCW score >3.19, and self-identified as heterosexual, questioning, lesbian, asexual, or gay, 28.0% engaged in NSSI (Node 7). More than half of the youth (56.5%) who identified as Hispanic/Latino, Asian or Other, had a NCW score >3.19, and self-identified as heterosexual, questioning, lesbian, asexual, or gay, engaged in NSSI (Node 8).

The final partition split youth into terminal nodes (9 and 10) by SB scores (Gini improvement = 0.018). Of youth who had a SB score <3.50, identified as Hispanic/Latino, Asian or Other, had a NCW score >3.19, and self-identified as heterosexual, questioning, lesbian, asexual, or gay, 73.3% engaged in NSSI (Node 9). Only 25.0% of youth who engaged in NSSI had a SB score >3.50, identified as Hispanic/Latino, Asian or Other, had a NCW score >3.19,

and self-identified as heterosexual, questioning, lesbian, asexual, or gay (Node 10). The IF-THEN rules for youth probability of NSSI are in Table 5.

Table 5: IF-THEN Rules for the Probability of +1 NSSI by Risk Probability

	IF	THEN
Node 3	Heterosexual, Questioning, Lesbian, Gay or Asexual AND NCW <3.19	8.6% probability
Node 10	SB >3.50 AND Hispanic/Latino, Asian or Other identity AND NCW >3.19 AND Heterosexual, Questioning, Lesbian, Gay or Asexual	25.0% probability
Node 1	Heterosexual, Questioning, Lesbian, Gay or Asexual	27.8% probability
Node 7	Black, Multiracial, Indigenous, or White identity AND NCW >3.19 AND Heterosexual, Questioning, Lesbian, Gay or Asexual	28.0% probability
Node 5	Bisexual or Pansexual AND NCW >6.12	33.3% probability
Node 4	Heterosexual, Questioning, Lesbian, Gay or Asexual AND NCW >3.19	37.0% probability
Node 8	Hispanic/Latino, Asian or Other identity AND NCW >3.19 AND Heterosexual, Questioning, Lesbian, Gay or Asexual	56.5% probability
Node 2	Bisexual or Pansexual	68.0% probability
Node 9	SB <3.50 AND Hispanic/Latino, Asian or Other identity AND NCW >3.19 AND Heterosexual, Questioning, Lesbian, Gay or Asexual	73.3% probability
Node 6	Bisexual or Pansexual AND NCW < 6.12	78.9% probability

Hypothesis 2

Hypothesis 2 was evaluated via CART procedures to identify specific trauma-related cognitions and sexual identity and cultural factors regarding indirect self-injurious behavior (recklessness, intentional misbehavior, delinquent behavior, problematic sexual behavior, substance use, and running away) among marginalized maltreated youth. Trauma-related cognitions (NCS, NCW and SB), youth with multiple marginalized identities, and higher rates of sexual and cultural identity discrimination across multiple marginalized identities were expected to be most closely associated with indirect self-injurious behavior. Hypothesis 2 was partially supported. The final models identified several predictors that best determined one or more forms of indirect self-injurious behavior: (1) sexual orientation, (2) NCS, (3) race/ethnicity, (4) SB, (5) experience cultural identity discrimination, (6) age, and (7) gender identity (Figures 4-8).

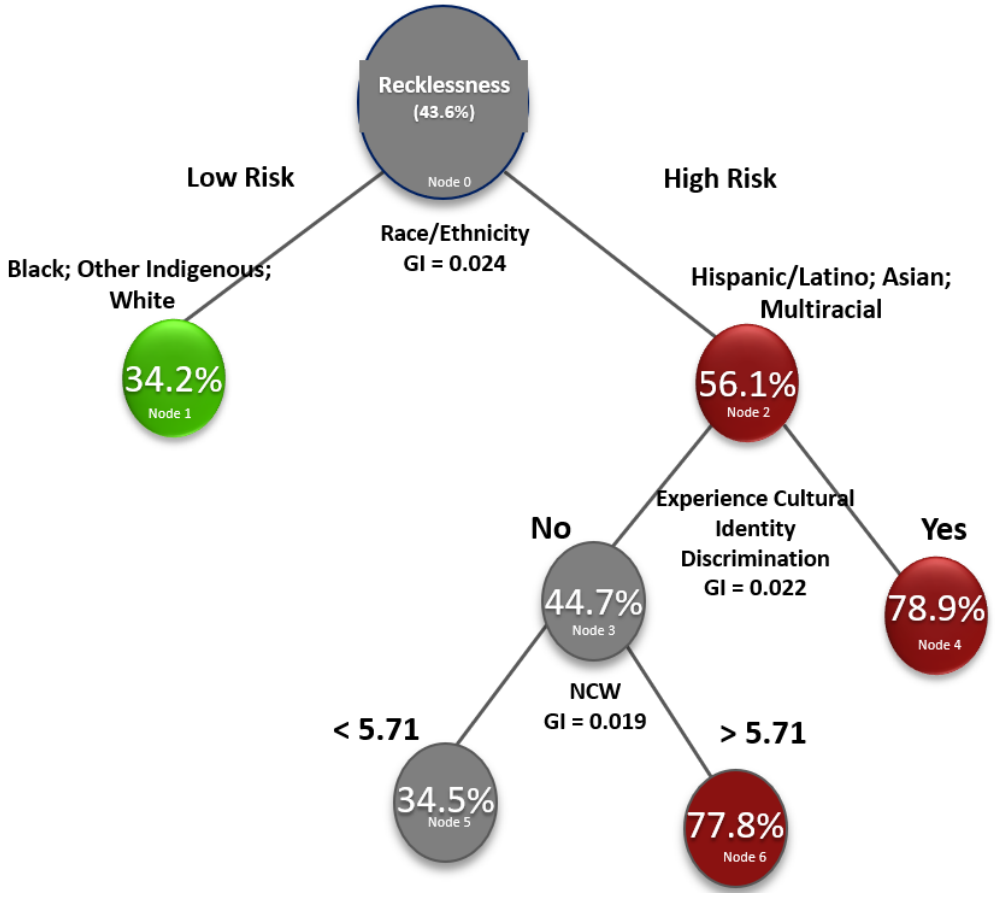
Recklessness

The recklessness model classified 68.4% youth correctly (Table 6), with race/ethnicity, experienced cultural identity discrimination, and NCW identified as prominent predictors. The model accurately classified 37.9% of youth who engaged in reckless behavior (n = 22) and accurately classified 92.0% of youth who did not (n = 69). The cross-validation risk estimate for recklessness was adequate (r = 0.32, SE = 0.04).

Table 6: Classification Table for the Final Model of Recklessness

1+ Recklessness	Predicted		
	Yes	No	Percent Correct
Yes	22	36	37.9%
No	22	69	92.0%
Overall Percentage	21.1%	78.9%	68.4%

Figure 4. Recklessness for Maltreated Youth



Interpretive note: 43.6% of participants engaged in reckless behavior; 34.2% of Black, Other, Indigenous or White youth engaged in reckless behavior; 56.1% of Hispanic/Latino, Asian or Multiracial youth engaged in reckless behavior; Hispanic/Latino, Asian or Multiracial youth that experienced cultural identity discrimination represented the highest-risk pathway. GI: Gini improvement.

The first split differentiated youth who engaged in reckless behaviors from youth who did not (Node 0; Parent) by race/ethnicity (Gini improvement = 0.024). Of youth who identified as Black, Other, Indigenous, or White, 34.2% engaged in reckless behavior (Node 1). More than half of youth who (56.1%) identified as Hispanic/Latino, Asian or Multiracial engaged in reckless behavior (Node 2). The second split divided youth in Node 2 (race; Hispanic/Latino,

Asian or Multiracial) by experiences of cultural identity discrimination (Gini improvement = 0.022), which created two terminal nodes (Nodes 3 and 4). Of youth who identified as Hispanic/Latino, Asian or Multiracial and denied experiences of cultural identity discrimination, 44.7% engaged in reckless behavior (Node 3). Alternatively, 78.9% of youth who identified as Hispanic/Latino, Asian or Multiracial and endorsed experiences of cultural identity discrimination engaged in reckless behavior (Node 4).

Youth in Node 3 (no experience of cultural identity discrimination) were split based on NCW scores (Gini improvement = 0.019), which created two terminal nodes (Nodes 5 and 6). Of youth who denied experiencing cultural identity discrimination and had a NCW score <5.72, 34.5% engaged in reckless behavior (Node 5). Most youth (77.8%) who endorsed experiencing cultural identity discrimination and had a NCW score >5.72 engaged in reckless behavior (Node 6). The IF-THEN rules for youth probability of recklessness are in Table 7.

Table 7: IF-THEN Rules for the Probability of +1 Recklessness by Risk Probability

	IF	THEN
Node 1	Black, Other, Indigenous or White Identity	34.2% probability
Node 5	NCW <5.71 AND Experience Cultural Identity Discrimination is No AND Hispanic/Latino, Asian or Other	34.5% probability
Node 3	Experience Cultural Identity Discrimination is No AND Hispanic/Latino, Asian or Multiracial Identity	44.7% probability
Node 2	Hispanic/Latino, Asian or Multiracial Identity	56.1% probability
Node 6	NCW >5.71 AND Experience Cultural Identity Discrimination is No AND Hispanic/Latino, Asian or Multiracial Identity	77.8% probability
Node 4	Experience Cultural Identity Discrimination is No AND Hispanic/Latino, Asian or Multiracial Identity	78.9% probability

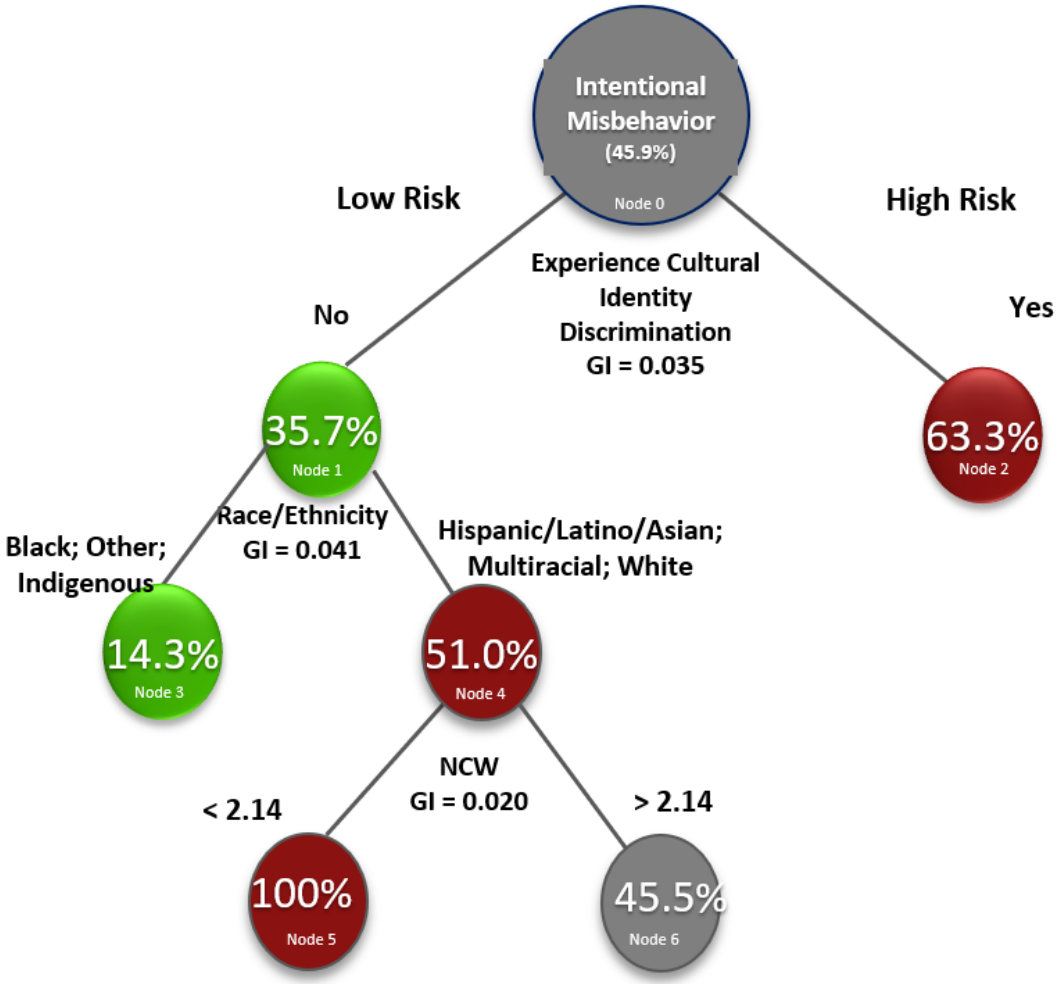
Intentional Misbehavior

The intentional misbehavior model classified 71.4% youth correctly (Table 8), with experience of cultural identity discrimination, race/ethnicity, and NCW identified as prominent predictors. The model accurately classified 67.2% of youth who engaged in intentional misbehavior (n = 41) and accurately classified 75.0% of youth who did not (n = 54). The cross-validation risk estimate for intentional misbehavior was adequate (r =0.29, SE = 0.04).

Table 8: Classification Table for the Final Model of Intentional Misbehavior

1+ Intentional Misbehavior	Predicted		
	Yes	No	Percent Correct
Yes	41	20	67.2%
No	18	54	75.0%
Overall Percentage	44.4%	55.6%	71.4%

Figure 5. Intentional Misbehavior for Maltreated Youth



Interpretive note: 45.9% of participants engaged in intentional behavior; 35.7% of youth denied experiencing cultural identity discrimination. 63.3% of youth that experienced cultural identity discrimination and represented the highest-risk pathway. GI: Gini improvement.

The first split differentiated youth who engaged in intentional misbehavior from youth who did not (Node 0; Parent) by experiences of cultural identity discrimination (Gini improvement = 0.035). Of youth who reported not experiencing cultural identity discrimination,

35.7% engaged in intentional misbehavior (Node 1). Many youth (63.3%) who endorsed experiences of cultural identity discrimination engaged in intentional misbehavior (Node 2).

The second split divided youth in Node 1 (denied experiencing cultural identity discrimination) by race/ethnicity (Gini improvement = 0.041), which created two terminal nodes (Nodes 3 and 4). Of youth who denied experiencing cultural identity discrimination and identified as Black, Other or Indigenous, 14.3% engaged in intentional misbehavior (Node 3). Alternatively, of youth who endorsed experiencing cultural identity discrimination and identified as Hispanic/Latino, Asian, Multiracial or White, 51.0% engaged in intentional misbehavior (Node 4).

The third partition split youth in Node 4 based on NCW scores (Gini improvement = 0.020), which created two terminal nodes (Nodes 5 and 6). All youth who identified as Hispanic/Latino, Asian, Multiracial or White, denied experiencing cultural identity discrimination, and had a NCW score <2.14 engaged in intentional misbehavior (Node 5). Of youth who identified as Hispanic/Latino, Asian, Multiracial or White, denied experiencing cultural identity discrimination, and had a NCW score >2.14, 45.5% engaged in intentional misbehavior (Node 6). The IF-THEN rules for youth probability of intentional misbehavior are in Table 9.

Table 9: IF-THEN Rules for the Probability of +1 Intentional Misbehavior by Risk Probability

	IF	THEN
Node 3	Black, Other, Indigenous AND Experience Cultural Identity Discrimination is No	14.3% probability
Node 1	Experience Cultural Identity Discrimination is No	35.7% probability
Node 6	NCW >2.14 AND Hispanic/Latino, Asian, Multiracial or White Identity AND Experience Cultural Identity Discrimination is No	45.5% probability
Node 4	Hispanic/Latino, Asian, Multiracial or White Identity AND Experience Cultural Identity Discrimination is No	51.0% probability
Node 2	Experience Cultural Identity Discrimination is Yes	63.3% probability
Node 5	NCW <2.14 AND Hispanic/Latino, Asian, Multiracial or White Identity AND Experience Cultural Identity Discrimination is No	100.0% probability

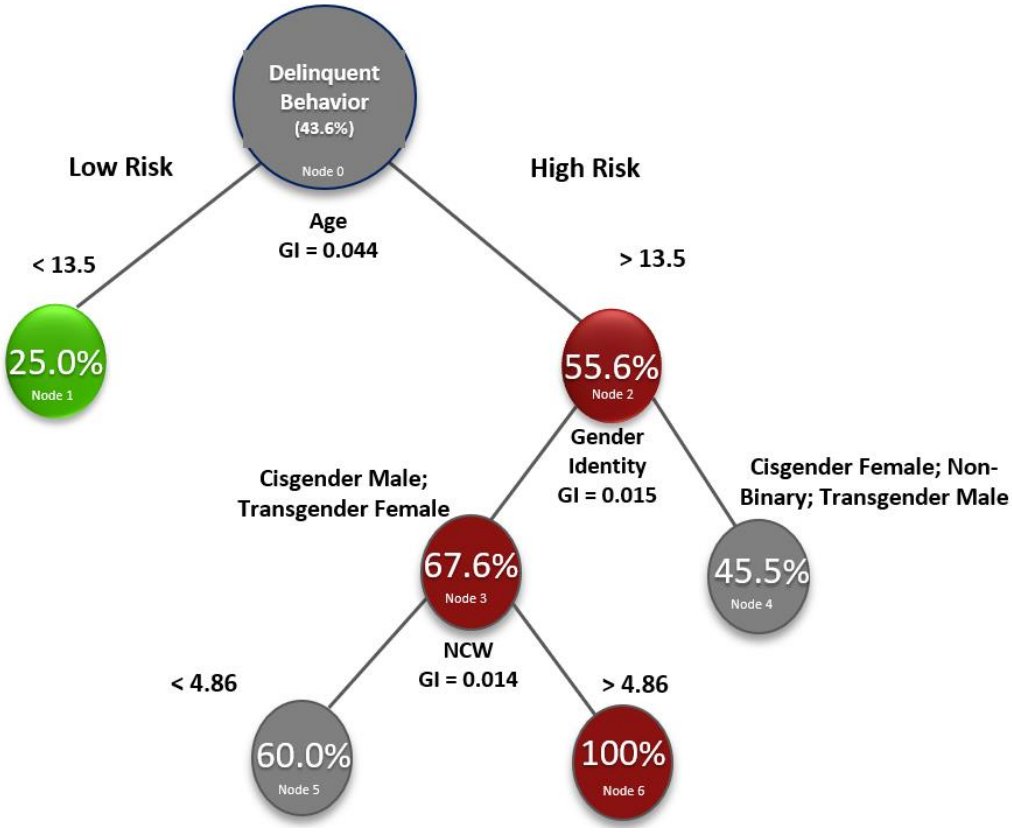
Delinquent Behavior

The delinquent behavior model classified 69.9% youth correctly (Table 10), with age, gender identity, and NCW identified as prominent predictors. The model accurately classified 36.2% of youth who engaged in delinquent behavior (n = 21) and accurately classified 96.0% of youth who did not (n = 72). The cross-validation risk estimate for delinquent behavior was adequate (r =0.30, SE = 0.04).

Table 10: Classification Table for the Final Model of Delinquent Behavior

1+ Delinquent Behavior	Predicted		
	Yes	No	Percent Correct
Yes	21	37	36.2%
No	3	72	96.0%
Overall Percentage	18.0%	82.0%	69.9%

Figure 6. Delinquent Behavior for Maltreated Youth



Interpretive note: 43.6% of participants engaged in delinquent behavior; 25.0% of youth aged <13.5 years engaged in delinquent behavior; 55.6% of youth aged >13.5 years engaged in delinquent behavior; Youth with NCW scores >4.86 identified as cisgender male or transgender female and were aged >13.5 years represented the highest-risk pathway. GI: Gini improvement.

The first split differentiated youth who engaged in delinquent behavior from youth who did not (Node 0; Parent) by age (Gini improvement = 0.044). Of youth aged <13.5 years, 25.0% engaged in delinquent behavior (Node 1). Of youth aged >13.5 years, 55.6% engaged in delinquent behavior (Node 2). The second split divided youth in Node 2 (age >13.5 years) by gender identity (Gini improvement = 0.015), which created two terminal nodes (Nodes 3 and 4). Of youth aged >13.5 years and identified as Cisgender Male or Transgender Female, 67.6% engaged in delinquent behavior (Node 3). Additionally, 45.5% of youth aged >13.5 years and identified as Cisgender Female, Non-Binary, or Transgender Male engaged in delinquent behavior (Node 4).

The third partition split youth in Node 3 based on NCW scores (Gini improvement = 0.014), which created two terminal nodes (Nodes 5 and 6). Most youth (60.0%) aged >13.5 years, identified as Cisgender Male or Transgender Female, and who had a NCW score <4.86 engaged in delinquent behavior (Node 5). All youth aged >13.5 years, identified as Cisgender Male or Transgender Female, and who had a NCW score >4.86 engaged in delinquent behavior (Node 6). The IF-THEN rules for youth probability of delinquent behavior are in Table11.

Table 11: IF-THEN Rules for the Probability of +1 Delinquent Behavior by Risk Probability

	IF	THEN
Node 1	Age <13.5 years	25.0% probability
Node 4	Cisgender Female, Non-Binary or Transgender Male AND Age >13.5 years	45.5% probability
Node 2	Age >13.5 years	55.6% probability
Node 5	NCW <4.86 AND Cisgender Male or Transgender Female AND Age >13.5 years	60.0% probability
Node 3	Cisgender Male or Transgender Female AND Age >13.5years	67.6% probability
Node 6	NCW >4.86 AND Cisgender Male or Transgender Female AND Age >13.5 years	100.0% probability

Problematic Sexual Behavior

The problematic sexual behavior model yielded no identified predictors.

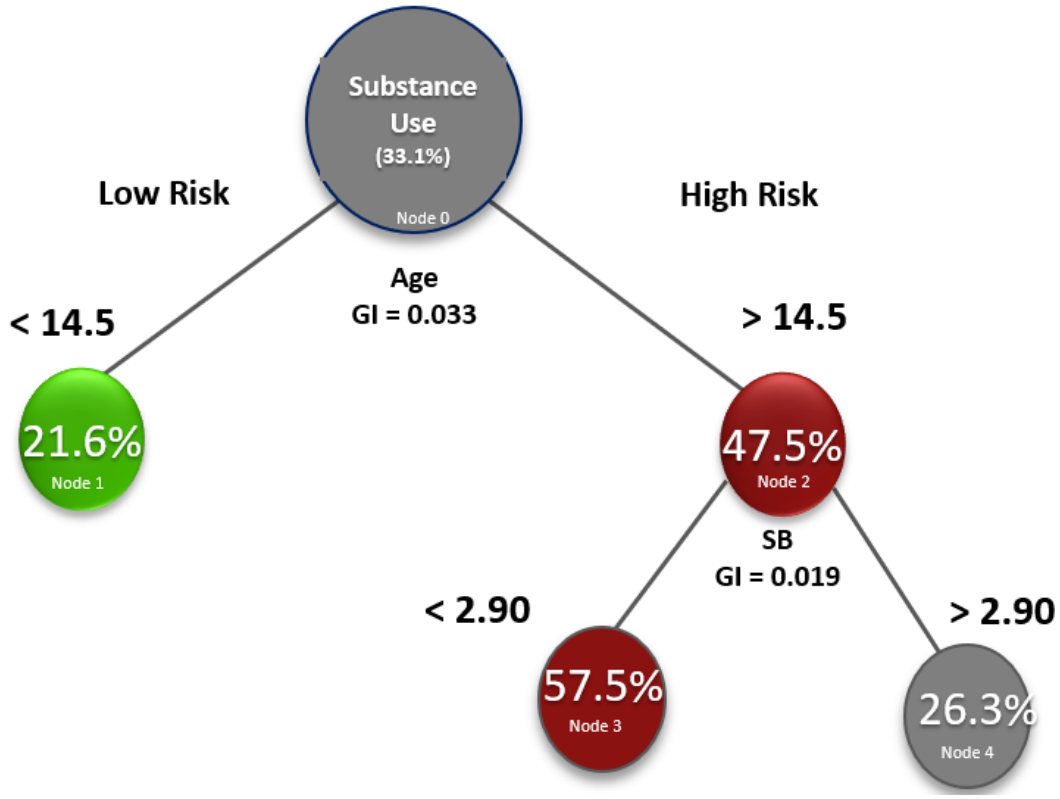
Substance Use

The substance use model classified 71.4% youth correctly (Table 12), with age and SB identified as prominent predictors. The model accurately classified 52.3% of youth who engaged in substance use (n = 23) and accurately classified 80.9% of youth who did not (n = 72). The cross-validation risk estimate for substance use was adequate (r = 0.29, SE = 0.04).

Table 12: Classification Table for the Final Model of Substance Use

1+ Substance Use	Predicted		
	Yes	No	Percent Correct
Yes	23	21	52.3%
No	17	72	80.9%
Overall Percentage	30.1%	69.9%	71.4%

Figure 7. Substance Use for Maltreated Youth



Interpretive note: 33.1% of participants engaged in substance use; 21.6% of youth aged <14.5 years engaged in substance use; 47.5% of youth aged >14.5 years engaged in substance use; Youth with SB scores <2.90 and were aged >14.5 years represented the highest-risk pathway. GI: Gini improvement.

The first split differentiated youth who engaged in substance use from youth who did not (Node 0; Parent) by age (Gini improvement = 0.033). Some youth (21.6%) aged <14.5 years engaged in substance use (Node 1). Alternatively, 47.5% of youth aged >14.5 years engaged in substance use (Node 2). The second split divided youth in Node 2 (age >14.5 years) by SB scores (Gini improvement = 0.019), which created two terminal nodes (Nodes 3 and 4). Many youth (57.5%) aged >14.5 years with SB scores of <2.90 engaged in substance use (Node 3). Alternatively, 26.3% of youth aged >14.5 years with SB scores of >2.90 engaged in substance use (Node 4). The IF-THEN rules for youth probability of substance use are in Table 13.

Table 13: IF-THEN Rules for the Probability of +1 Substance Use by Risk Probability

	IF	THEN
Node 1	Age <14.5 years	21.6% probability
Node 4	SB >2.90 AND Age >14.5 years	26.3% probability
Node 2	Age >14.5 years	47.5% probability
Node 3	SB <2.90 AND Age >14.5 years	57.5% probability

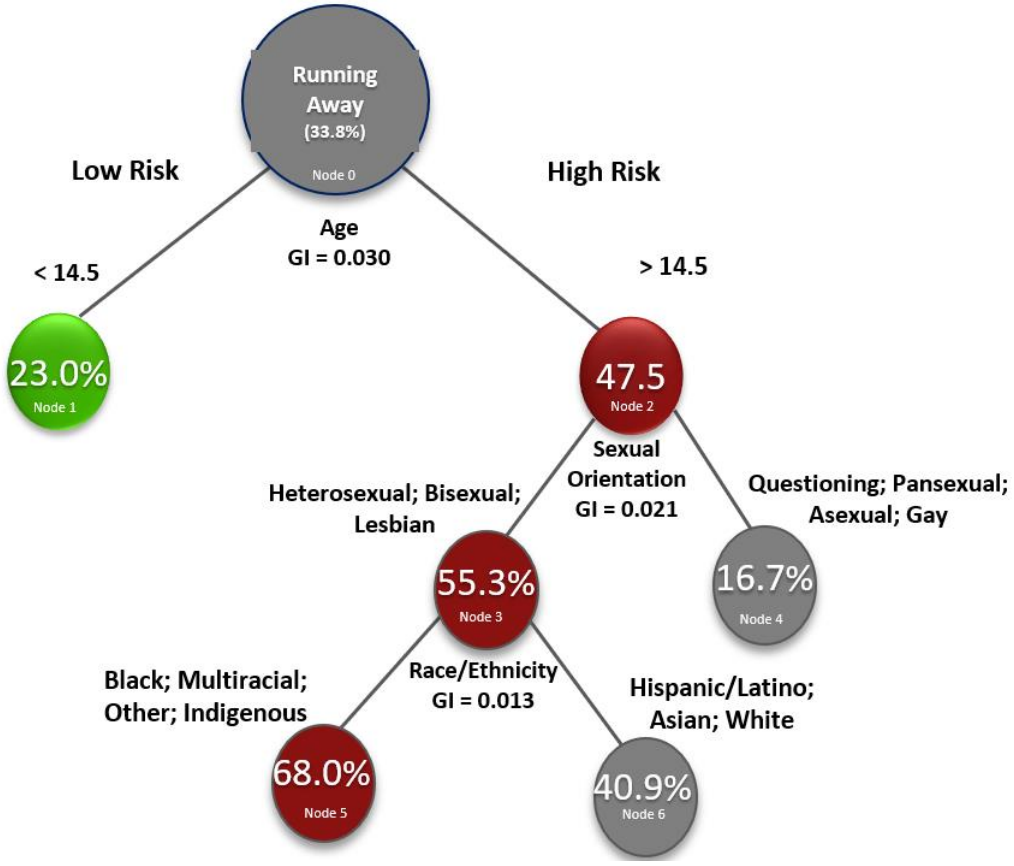
Running Away

The running away model classified 72.9% youth correctly (Table 14), with age, sexual orientation and race/ethnicity identified as prominent predictors. The model accurately classified 37.8% of youth who ran away (n = 17) and accurately classified 90.9% of youth who did not (n = 80). The cross-validation risk estimate for running away was adequate (r = 0.27, SE = 0.04).

Table 14: Classification Table for the Final Model of Running Away

1+ Running Away	Predicted		
	Yes	No	Percent Correct
Yes	17	28	37.8%
No	8	80	90.9%
Overall Percentage	18.8%	81.2%	72.9%

Figure 8. Running Away for Maltreated Youth



Interpretive note: 33.8% of participants ran away; 23.0% of youth aged <14.5 years ran away; 47.5% of youth aged >14.5 years ran away; Black, Multiracial, Other or Indigenous youth who identified as heterosexual, bisexual or lesbian and were aged >14.5 years represented the highest-risk pathway. GI: Gini improvement.

The first split differentiated youth who ran away from youth who did not (Node 0; Parent) by age (Gini improvement = 0.030). Some youth (23.0%) aged <14.5 years ran away (Node 1). Alternatively, 47.5% of youth aged >14.5 years ran away (Node 2). The second split divided youth in Node 2 (age >14.5 years) by sexual orientation (Gini improvement = 0.021), which created two terminal nodes (Nodes 3 and 4). Most youth (55.3%) aged >14.5 years and

identified as heterosexual, bisexual or lesbian ran away (Node 3). Alternatively, 16.7% of youth aged >14.5 years and identified as questioning, pansexual, asexual or gay ran away (Node 4).

The third partition split youth in Node 3 based on race/ethnicity (Gini improvement = 0.013), which created two terminal nodes (Nodes 5 and 6). Many youth (68.0%) aged >14.5 years, identified as heterosexual, bisexual or lesbian, and identified as Black, Multiracial, or Other or Indigenous ran away (Node 5). Alternatively, 40.9% of youth aged >14.5 years, identified as heterosexual, bisexual or lesbian, and identified as Hispanic/Latino, Asian, or White ran away (Node 6). The IF-THEN rules for youth probability of running away are in Table 15.

Table 15: IF-THEN Rules for the Probability of +1 Running Away by Risk Probability

	IF	THEN
Node 4	Questioning, Pansexual, Asexual or Gay AND Age >14.5 years	16.7% probability
Node 1	Age <14.5 years	23.0% probability
Node 6	Hispanic/Latino, Asian or White Identity AND Heterosexual, Bisexual or Lesbian AND Age >14.5 years	40.9% probability
Node 2	Age >14.5 years	47.5% probability
Node 3	Heterosexual, Bisexual or Lesbian AND Age >14.5 years	55.3% probability
Node 5	Black, Multiracial, Other or Indigenous AND Heterosexual, Bisexual or Lesbian AND Age >14.5 years	68.0% probability

Summary

Across seven CART models, overall accuracy ranged from 68.4-78.2%. Risk estimates ranged from 0.22-0.32 with standard errors of 0.04. PTCI subscales and NV-CANS cultural factors module predictors varied between direct and indirect self-injurious behaviors. Race/Ethnicity emerged most frequently as the best predictor of NSSI, recklessness, intentional misbehavior and running away. NCW was the best predictor of NSSI, recklessness, intentional misbehavior and delinquent behavior. Age was the best predictor of delinquent behavior, substance use and running away. Sexual Orientation was the best predictor of previous suicide attempt(s), NSSI and running away. Experience of cultural identity discrimination was the best

predictor of recklessness and intentional misbehavior. SB was the best predictor of NSSI and substance use. NCS was the best predictor of previous suicide attempt(s). Lastly, gender identity was the best predictor of delinquent behavior. NV-CANS sexual identity module did not appear to yield any predictor items for direct or indirect self-injurious behavior.

CHAPTER 5

DISCUSSION, IMPLICATIONS, AND FUTURE DIRECTIONS

The broad aim of the present study was to support clinicians and researchers to better understand and assess the impact of trauma and discrimination among marginalized maltreated youth to reduce mental health disparities and long delays to care and to improve long-term outcomes. The study sought to develop a culturally sensitive trauma-informed prediction model of direct and indirect self-injurious behaviors for marginalized youth removed from their homes due to substantiated reports of maltreatment. The study had two main hypotheses: (1) specific trauma-related cognitions and identity discrimination would predict direct self-injurious behavior (previous suicide attempt(s) and NSSI) among marginalized maltreated youth, and (2) specific trauma-related cognitions and identity discrimination would predict indirect self-injurious behaviors (recklessness, intentional misbehavior, delinquent behavior, problematic sexual behavior, substance use and running away) among marginalized maltreated youth. The CART analyses yielded significant risk and protective factors for youth engaging in direct and indirect self-injurious behaviors. Results are discussed in more detail in the following sections.

Hypothesis 1

Hypothesis 1 was that specific trauma-related cognitions such as NCS, NCW, and SB would increase engagement in direct self-injurious behavior for marginalized maltreated youth. Additionally, youth with multiple marginalized identities who experienced sexual and cultural identity discrimination were expected to have increased engagement in direct self-injurious behaviors. Hypothesis 1 was partially supported. The final models identified several predictors that best determined previous suicide attempt(s) and/or NSSI: (1) NCS, (2) sexual orientation,

(3) NCW, (4) race/ethnicity, and (5) SB. The following sections describe the significant predictors of the present study in the context of the existing literature.

Previous Suicide Attempt(s)

NCS include thoughts such as "Nothing good can happen to me anymore," "I feel dead inside," and "I have permanently changed for the worst" (Foa et al., 1999). The present study found that frequent NCS were a significant predictor of previous suicide attempt(s). The findings for previous suicide attempt(s) are consistent with prior research that reductions in negative cognitions improved psychopathology and suicidality (Alpert et al., 2023; Harned et al., 2018). Negative views of self may strengthen negative thoughts of self and feelings of hopelessness, increasing suicide risk (Rogers et al., 2019; Wolff et al., 2013). Conversely, some literature identifies a link between increased negative cognitions and increased psychopathology and suicidality (Doorn et al., 2020; Horwitz et al., 2018). This link is partially explained by increased rumination and repetitive negative thinking (Law & Tucker, 2018; Luca, 2019; Sorgi-Wilson et al., 2023).

Youth who self-identified as bisexual, pansexual, lesbian, and asexual were more likely to have had previous suicide attempt(s). This is consistent with findings from Standley (2022) who found sexual identity to be significantly correlated with suicidality. The stressors experienced by sexually marginalized youth through peer rejection, homophobia, or harassment increased their risk of suicidality (Fulginiti et al., 2021). In the present study, youth with less NCS and who self-identified as heterosexual, questioning, or gay had lower risk for previous suicide attempt(s). One study found that youth with greater conformity to heterosexual norms displayed reduced suicidal ideation (King et al., 2020). Youth may fear experiencing family or peer rejection if they deviate from societal norms, so they conform to heterosexual norms as a

protective strategy (King et al., 2020). Heterosexual, questioning and gay youth in the present study may increase their conformity to heterosexual norms to protect themselves from experiences of family and peer rejection.

NSSI

NCW encompass thoughts such as “People can’t be trusted,” “The world is a dangerous place,” and “I have to be especially careful because you never know what can happen next” (Foa et al., 1999). Within the present study, frequent NCW were a significant predictor of NSSI. These findings are consistent with research indicating that NCW are common among youth with a history of NSSI (Wolff et al., 2013). This may be attributed to decreased perceived social supports, particularly if a youth feels their needs are not met (De Luca et al., 2022; Prinstein et al., 2009; Zhu et al., 2020).

For NSSI, Hispanic/Latino, Asian and Other race/ethnicity maltreated youth in the present study were found to be at higher risk than Black, Multiracial, Indigenous and White youth. This is consistent with research that Hispanic/Latino and Asian youth are at an increased risk of suicidal behaviors (M. Davis et al., 2022; Eagle et al., 2022; Ramchand et al., 2021). This could likely be influenced by acculturation stress, intergenerational conflict, and discrimination, making it difficult for marginalized youth to navigate new cultural environments (Polanco-Roman et al., 2023).

SB encompasses thoughts such as “The event [trauma] happened because of the way I acted,” “Somebody else would have stopped the event from happening,” and “There is something about me that made this event happen” (Foa et al., 1999). Within the present study, maltreated youth with lower-than-average SB scores were more likely to engage in NSSI. This finding is contradictory to existing research that self-blame often increases engagement in NSSI

(Hauber et al., 2019; Kruzan et al., 2022). One justification for the present finding is that some maltreated youth may engage in more externalizing than internalizing blame (Guimei et al., 2022; Schoenleber et al., 2021)**.** The feeling of shame or self-blame may promote feelings of retribution towards others rather than aggression towards self or NSSI (Michelle et al., 2021). The experiences of self-blame may feel intolerable and increasingly distressing for some youth, leading them to attribute the trauma to external factors and engage in less NSSI and more aggressive acts toward others to cope (Michelle et al., 2021).

With respect to engagement in NSSI in the present study, bisexual and pansexual youth were at heightened risk in the present study. This finding is consistent with research examining NSSI among sexually marginalized youth (Berona et al., 2020; Liu et al., 2019; Taliaferro & Muehlenkamp, 2017). Youth with less endorsed NCW and self-identified as heterosexual, questioning, lesbian, asexual and gay youth at lower risk of engaging in NSSI. Youth who identify as heterosexual and engage in heterosexual normed behaviors have reduced risk for victimization and bullying, decreasing their risk for engaging in NSSI (King et al., 2020; Peters et al., 2020). Lesbian youth may engage in more help-seeking behaviors and receive more school based support, decreasing their engagement in NSSI, compared to their bisexual peers (Kuhlemeier et al., 2023; Zaki et al., 2017).

Hypothesis 2

Hypothesis 2 was that specific trauma-related cognitions such as NCS, NCW, and SB would increase engagement in indirect self-injurious behavior for marginalized maltreated youth. Additionally, youth with multiple marginalized identities and who experienced sexual and cultural identity discrimination were expected to have increased engagement in indirect self-injurious behaviors. Hypothesis 2 was partially supported. The final models identified several

predictors that best determined one or more indirect self-injurious behaviors (recklessness, intentional misbehavior, delinquent behavior, substance use and running away): (1) sexual orientation, (2) NCW, (3) race/ethnicity, (4) SB, (5) experience cultural identity discrimination, (6) age and (7) gender identity. The following sections describe the significant predictors of the present study in the context of extant literature.

Recklessness

Recklessness in the present study was predicted by race/ethnicity, experience cultural identity discrimination, and NCW. Hispanic/Latino, Asian and multiracial youth were more likely to engage in reckless behaviors. Additionally, marginalized youth in the present study who experienced cultural identity discrimination and endorsed heightened NCW were more likely to engage in reckless behaviors. These findings are consistent with previous literature that experiencing racial discrimination increases engagement in reckless behavior for marginalized youth (Benner et al., 2018; Talley et al., 2021; Yang et al., 2019). Youth who have experienced betrayal trauma may endorse an increase in NCW, leading to engagement in reckless behaviors (Armour et al., 2020; Gobin & Freyd, 2014; Zurbriggen & Freyd, 2004). Betrayal trauma may increase youth emotion dysregulation and heighten arousal, resulting in a willingness to engage in reckless behaviors to cope with distress. Maltreated youth may also engage in reckless behaviors to mirror similar levels of arousal experienced during the initial trauma (Armour et al., 2020). Further, betrayal trauma may lead to an inability to make sound judgments due to negative beliefs about the trustworthiness of others and their intentions (Gobin & Freyd, 2014).

Black, Other, Indigenous and White youth in the present study were at lower risk of engaging in reckless behaviors. One explanation for marginalized youth in the present study being at lower risk for engaging in reckless behavior may be attributed to ethnic identity. A

strong sense of ethnic identity may protect some marginalized youth from engaging in reckless behaviors to cope with their experienced trauma (Brittian Loyd & Williams, 2017; Zapolski et al., 2017). Youth with a strong sense of ethnic identity often have a supportive network of prosocial peers and adults that encourage positive behaviors and display disapproval of deviant behaviors, reducing overall recklessness (Zapolski et al., 2017). The impact of ethnic identity in the present study requires further examination.

Intentional Misbehavior

Youth in the present study who experienced cultural identity discrimination and who identified as Hispanic/Latino, Asian, multiracial and White were more likely to engage in intentional misbehavior. Marginalized maltreated youth experiencing discrimination have an increased risk of intentional misbehavior. This may be due to the level of justified anger and distress resulting from any type of cultural identity discrimination (Mendez et al., 2022). Also, youth within the present study who did not experience elevated NCW were more likely to engage in intentional misbehavior. This contradicts the existing literature. One justification for this finding may be that youth who believe the world to be a dangerous place are less likely to engage in behaviors that can lead them to getting into trouble or becoming injured.

Within the present study, fewer experiences of cultural identity discrimination and being Black, Other or Indigenous lowers maltreated youths' risk of engaging in intentional misbehaviors. This finding is consistent with existing research that marginalized youth of color who experience less discrimination and increased peer acceptance are at reduced risk of negative outcomes (Malone et al., 2022; Wu et al., 2019). One explanation for this is that peer acceptance may promote youth self-compassion and self-esteem, reducing emotion dysregulation and the use of maladaptive coping skills (Wu et al., 2019).

Delinquent Behavior

Youth in the present study who were older than age 13.5 years, identified as Cisgender Male or Transgender Female, and who endorsed heightened NCW were more likely to engage in delinquent behaviors. These findings are consistent with existing literature that examined the relationship between maltreatment, self-esteem, and delinquent behavior (Gauthier-Duchesne et al., 2022). For cisgender boys, exposure to sexual abuse lowered self-esteem, which increased their risk of engaging in delinquent behaviors. NCW may promote hopelessness in youth that increases risk for engagement in delinquent behavior (Burnside & Gaylord-Harden, 2019).

Youth in the present study who were younger than age 13.5 years were at lower risk of engaging in delinquent behavior. This may be due to age and access to means to engage in delinquent behaviors or less exposure to antisocial peers (Lansford et al., 2020). Younger youth are more likely to have adult oversight of their behaviors, reducing their risk of engaging in aggressive or delinquent acts (Lansford et al., 2020).

Substance Use

Youth in the present study older than age 14.5 years and who experienced less SB were at heightened risk for substance use. Older youth display higher levels of impulsivity and sensation seeking behaviors, increasing their risk of substance use (A. M. Wasserman et al., 2020). However, the decreased reports of SB are contradictory to existing research (Kearns et al., 2021). However, a recent study revealed that acute substance use was associated with an initial decrease in the severity of PTSD symptoms (Gong et al., 2019). This was likely a result of substance use reducing the stress response and impairing the development of memories, resulting in individuals perceiving the trauma as less stressful (Gilpin & Weiner, 2017; Gong et al., 2019; Nomura & Matsuki, 2008). Nevertheless, chronic substance use increases the severity of PTSD symptoms

and increases vulnerability to additional traumatic events (J. P. Davis et al., 2019; Gong et al., 2019; María-Ríos & Morrow, 2020). Youth younger than age 14.5 years were at lower risk of substance use. The lower risk of substance use may result from heighten levels of supervision due to age, and reduced access to drugs and deviant peers (Winters et al., 2021).

Running Away

In the present study, youth older than age 14.5 years who identified as heterosexual, bisexual or lesbian, and who were Black, Multiracial, Other or Indigenous were at increased risk of running away. These findings are consistent with existing literature that youth with intersecting marginalized identities are at heightened risk for running away due to lack of acceptance, family ejection, or disparities within the child welfare system (Augustyn & Jackson, 2020; Grooms, 2020; Kaasbøll et al., 2022). Youth younger than age 14.5 years were at a lower risk of running away. The lower risk of running away may result from heightened levels of supervision due to age, parental involvement, and access to prosocial peers (Farmer et al., 2021; Kelly, 2020; Lightfoot et al., 2011).

Clinical Implications

The present study highlights the need for a more culturally sensitive understanding of the impact of trauma and discrimination on direct and indirect self-injurious behaviors, particularly for maltreated youth. The study provided several models to help clinicians further their conceptualization of the behavioral response to maltreatment among marginalized maltreated youth. One consistent finding of the study was that marginalized maltreated youth often utilize maladaptive coping strategies to cope with trauma. Marginalized maltreated youth would benefit from an interdisciplinary approach to treatment and care coordination. Further, maltreated youth would benefit from collaborate care due to their frequent interactions across multiple systems

Schools in particular should be an area of interest, as school engagement has shown to decrease substance use for adolescents (H. Lee & Henry, 2022). Black students are 35% more likely to experience suicidal ideation and attempts when they experience a lack of school belongingness (Boyd et al., 2023). By working with schools, clinicians can aim to improve clinical outcomes for marginalized youth.

The importance of a supportive home environment whether that is with fictive kin, guardians/caregivers or foster home placements, is paramount for maltreated youth. A solid network of support from family, peers and the surrounding community can significantly reduce suicide risk and mental wellbeing for youth with intersecting marginalized identities (Dorri et al., 2023; Metzger et al., 2023; Standley & Foster-Fishman, 2021). Additionally, access to supportive nonparental adults (e.g. teacher, friend's parents, coaches) across varying levels within a youth's ecological systems can have positive benefits on well-being (Hagler & Poon, 2023). For maltreated youth, access to sources of support can contribute to better mental health and social outcomes following long-term placement (D. Li et al., 2019).

Clinicians should also integrate cultural and social factors in treatment and assessment to help build the therapeutic alliance and improve patient outcomes. Marginalized youth and families are at heightened risk for encountering the child welfare system due to policies influenced by racism and higher incidence of family rejection (Cénat et al., 2021; Grooms, 2020; McCormick, Schmidt, et al., 2017; Pinderhughes et al., 2019; Scannapieco et al., 2018). The integration of cultural and social factors is crucial to reduce further inequities to this already vulnerable population. One way to address cultural and social factors during initial intakes is by asking youth their chosen name and pronouns, keeping in mind not to force identity disclosure. The use of chosen names and pronouns for gender marginalized youth has consistently shown to

reduce negative mental health outcomes (C. Brown et al., 2020; Russell et al., 2018). Additionally, clinicians should inquire about youths' experiences with discrimination across multiple systems, especially if they hold multiple marginalized identities, because discrimination can further worsen therapeutic alliance and mental health outcomes (Alessi et al., 2019; Chang & Yoon, 2011; Fripp & Adams, 2022; Maharaj et al., 2021; J. Williams et al., 2022).

Limitations

Several limitations of the present study should be noted. First, the study relied on youth disclosure of suicidality and high-risk behaviors. However, only approximately 45% of people disclose suicidal ideation or intent (Hallford et al., 2023). The data utilized for the present study may be an underreporting of suicidal ideation and behavior. Second, the age of participants may have impacted identity development and disclosure of identities. Many sexual and gender marginalized youth realize their gender identity sometime during birth and adolescence, but the overwhelming majority wait until late adolescence or young adulthood to disclose to others (Grafsky, 2018; Hall et al., 2021; Rothman et al., 2012; Turban et al., 2023). Third, the population of the present study may limit generalizability. The study examined the direct and indirect self-injurious behaviors of youth with substantiated maltreatment requiring removal from their home. Researchers and clinicians should be mindful when applying the findings to maltreated youth not removed from their home as their experiences and behaviors may differ.

Fourth, although the PTCI is widely used to assess individuals from a range of backgrounds, less research has examined how experiences of discrimination may elevate scores. The NCW subscale may not reflect cognitive distortions of marginalized maltreated youth and viewing them as distortions only elevates racial/ethnic and sexual/gendered biases. Fifth, information on behaviors and experienced discrimination was largely obtained through the NV-

CANS. The CANS is a widely used measure in child welfare centers but utilizing a single tool to measure multiple constructs may impact validity (Raykov et al., 2016). Additionally, the scoring of the NV-CANS and endorsement of certain risky behavior items on the NV-CANS may be viewed through a lens of bias. As racial disparities in punishment for defiant behavior exist, marginalized youth may have increased the scoring of indirect self-injurious or delinquent behavior compared to non-marginalized maltreated youth (Del Toro & Wang, 2023; Lehmann & Meldrum, 2021). Further, clinicians may not fully assess for experiences of discrimination, leading to underreporting of the marginalized experiences within the child welfare system (Cénat et al., 2021; McCormick, Schmidt, et al., 2017). The following section discusses treatment, assessment, and research recommendations for future research.

Recommendations for Future Research

Assessment

Clinicians should seek to differentiate the presentation of cultural mistrust from clinical paranoia during assessment to reduce biases that contribute to disparities in diagnosis (Dixon et al., 2023). Marginalized youth are vulnerable to bullying and discrimination based on their identities, which increases their risk for negative mental health outcomes (Busby et al., 2020; Fox et al., 2020; Galán et al., 2021). When administering assessments, clinicians and researchers should consider including specific measures that capture discrimination and experienced stigmatization of marginalized youth. A study by Braddock et al. (2021) identified 12 youth-specific measures that assess discrimination or acculturation related stress as contributors to health disparities among marginalized youth.

Current risk assessments fail to adequately capture the experiences of marginalized individuals, furthering diagnostic disparities (Ali et al., 2022; El-Qawaqzeh et al., 2023; Green et

al., 2022; Molock et al., 2023; Pellicane & Ciesla, 2022). Suicide risk assessment should consider how other cultures may engage in suicidal behaviors through other high risk or self-destructive behaviors (Talley et al., 2021). Moreover, assessment of risk should consider including measures of discrimination to address this gap and further the understanding of suicidality among marginalized groups (Brooks et al., 2020b; Madubata et al., 2022b; Polanco-Roman et al., 2019). One potential assessment measure is the short version of the Culturally Assessment of Risk for Suicide (CARS) that incorporates specific questions regarding acculturation and minoritized stress, acceptability of suicide in one's culture, and cultural idioms of suicidal distress (Chu et al., 2018).

Treatment

The present study confirms previous findings that trauma impacts youth decision-making and engagement in risky behavior. Furthermore, the present study contributes evidence that specific trauma-related cognitions and experiences of discrimination have a significant impact on marginalized maltreated youths' behaviors. The present study makes several noteworthy contributions. This study provides clinicians and researchers with an enhanced understanding of the underlying mechanisms of direct and indirect self-injurious behaviors. Such understanding may also reduce diagnostic disparities (Burke & Kearney, 2023).

The present study provides clinicians with a trauma-informed culturally responsive prediction tool for understanding maltreated youths' suicidality and behavioral risk. When diagnosing marginalized maltreated youth, clinicians may consider utilizing a more culturally responsive approach to assessing for suicide that examines risk factors of discrimination, acculturation stress, racial socialization, and environmental stressors (Molock et al., 2023). Clinicians in child welfare agencies are encouraged to reference the cultural and risk items on the

CANS to provide support when making case conceptualization and treatment recommendations for marginalized maltreated youth.

Researchers should continue examining the impact of intersecting marginalized identities on youth psychopathology and provide more culturally responsive methods of suicide prevention (Polanco-Roman et al., 2023). Furthermore, researchers should examine the way mental imagery can impact suicidality (Lawrence et al., 2023). The visualization of engaging in NSSI or suicidal behaviors vastly increases psychological distress and NSSI. Future researchers should examine how mental imagery related to negative cognitions of self or world, or visual reminders in social media of discriminatory events, may exacerbate suicidal behaviors and maladaptive coping (Lawrence et al., 2023).

Clinicians should adopt models designed specifically for marginalized youth. One recommendation is transitioning to a developmental psychopathology framework to prevent suicidality and maladaptive coping for youth (Oppenheimer et al., 2022). The developmental framework allows researchers and clinicians to better understand the trajectory of suicidality in developing youth and intervene prior to the transition from suicidal ideation to suicide attempt or self-harm. Further, the developmental framework can help clinicians develop interventions that are better targeted for the developmental age and understanding of younger suicidal youth (D. Wasserman et al., 2021). Many suicide prevention protocols for youth are adapted from adult models, making it difficult for youth to be properly assessed (Doulas & Lurigio, 2010; Robinson et al., 2018; Witt et al., 2021). Moreover, youth may actively engage in low lethally or indirect self-injurious behavior but fail to articulate their suicidal intent because of developmental age (Ayer et al., 2020; Ben-Yehuda et al., 2012; Liu et al., 2022). This is especially true as youth develop and obtain a better understanding of death (Cuddy-Casey & Orvaschel, 1997; Ridge

Anderson et al., 2016). Clinician efforts to understanding indirect behaviors of self-harm and suicidality like running away, substance use, delinquent behaviors, and recklessness, may contribute to the prevention of future engagements in indirect forms of self-injurious behaviors.

Another model of care is the Family as Host model, which was developed for Black and African youth to promote improvements in mental health. Families are seen as experts or primary initiators of treatment, while the therapist acts as a guest (Ofonedu et al., 2023). This change in psychotherapy structure empowers Black families to navigate treatment in a way that centers them as experts of their own life and experiences. Clinicians could also consider a strength-based model that incorporates intersectionality and empowerment theory to address the impact of discrimination on marginalized groups (Opara et al., 2023).

Most evidence-based interventions fail to address the mental health concerns and experiences of marginalized youth (Arora, Parr, et al., 2021). Further, implementing interventions without utilizing cultural adaptions can negatively impact outcomes and therapeutic alliance (Iwamasa, 2021; Rathod et al., 2005, 2019, 2020). Therefore, providers must review their treatment planning and make cultural adaptions as appropriate rather than relying on "gold standard" status to address all concerns (Huey et al., 2023). For example, the underlying principles of cognitive behavioral therapy may conflict with certain cultures' values and belief (Rathod et al., 2019). Some gold standard interventions focus on individualistic over collectivistic ideals, conflicting with Non-Western cultures (Naeem et al., 2023; Rathod et al., 2019).

Research

Future researchers should expand hypotheses and participation pools to include and address the experiences of marginalized individuals. Marginalized populations are often

excluded, understudied, and underrepresented in research (Etti et al., 2021; Ghorbanian et al., 2022; Huey et al., 2023; Shah & Kandula, 2020). The lack of representation in research furthers inequities in care, increases vulnerabilities and victimizations, and contributes to mental health disparities and treatment barriers. Inclusive research is especially salient in child protective service agencies that have an overrepresentation of marginalized youth. The persistent racial/ethnic disparities leads to further traumatization through forcible separation (Dettlaff & Boyd, 2020).

Future researchers should examine common trauma-related cognitions like "negative thoughts of the world" among maltreated marginalized populations who may experience discriminatory events that negatively impact their world view, prior to an experienced trauma. Experiences of racism and discrimination have been found to increase trauma symptoms, especially if an individual has multiple marginalized identities (M. Williams et al., 2023). Maltreated youth are particularly vulnerable to racism and discrimination within the child welfare system due to structural racism and discrimination (Barth et al., 2020; Cénat et al., 2021; Dettlaff et al., 2020; Kastanis, 2018; Merritt, 2021). Further, race-based trauma contributes to increased emotional dysregulation (Roach et al., 2023). Future researchers should continue examining how experiences of discrimination impact emotion regulation among marginalized maltreated youth and how these experiences may contribute to poor decision-making and maladaptive coping. Additionally, researchers should examine the impact of dissociation on direct and indirect self-injurious behaviors (Fereidooni et al., 2023). Maltreated youth with cumulative and severe trauma are more likely to develop dissociation than non-maltreated trauma-exposed youth (Burton et al., 2018; Hulette et al., 2011; Kisiel et al., 2009). Levels of dissociation may increase marginalized maltreated youths' engagement in high risk or self-

destructive behaviors due to detachment from self (Berardelli et al., 2022; Choi et al., 2019; Ford & Gómez, 2015; Kisiel et al., 2009, 2009).

Lastly, future researchers should always consider how the laws enacted (e.g., restrictions on providing gender-affirming care, anti-abortions legislation) in their state may impact the lives of marginalized populations by exacerbating symptom presentations and worsening mental health outcomes and engagement (Elze, 2019; McCauley et al., 2023; McKinnish et al., 2019; Turban et al., 2021). Furthermore, researchers should consider how to maintain participate safety within these settings in terms of data recruitment and collection.

APPENDIX A: SEXUAL IDENTITY MODULE

[4] SEXUAL IDENTITY MODULE

This module is to be completed when Life Functioning Domain, Sexual Development is rated '1', '2' or '3'.

Rate the highest level from the past 30 days based on relevant information from all sources.

For the **Sexual Identity Module**, use the following categories and action levels:

0	No current need; no need for action or intervention.
1	History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.
2	Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.
3	Problems are dangerous or disabling; requires immediate and/or intensive action.

SI1. SEXUAL ORIENTATION

This item rates the youth's identification as lesbian, gay, bisexual, transgender, questioning (LGBTQ), or straight.

Questions to Consider

- Does the youth identify as lesbian, gay, bisexual, transgender, questioning, or straight?
- Has the youth ever been at risk for hurting themselves due to confusion or stress regarding sexual orientation?

Ratings and Descriptions

0	Youth has a clear and consistent sexual orientation and is connected to others who support youth's orientation.
1	Youth is experiencing some confusion or is struggling with issues related to youth's sexual orientation.
2	Youth has significant struggles with their sexual orientation. Youth may have identified as LGBTQ, however they are not connected with others who support them.
3	Youth is experiencing significant problems due to conflict regarding their sexual orientation that are preventing functioning in at least one life domain (i.e., school, family/home, etc.). This conflict may be internal and/or may be attributed to, or exacerbated by, external factors within the community, home, or school environment.

SI2. GENDER IDENTITY

This item rates a youth's self-perception of gender.

"Biological sex refers to a person's physical anatomy and is used to assign gender at birth. Gender identity refers to a person's deeply felt sense of being male, female, both, or neither. An individual's gender identity may or may not be congruent with that person's biological sex." http://cssr.berkeley.edu/cwscmsreports/documents/Information%20Guidelines%20P4.pdf

Questions to Consider

- How does the youth identify with their physical gender?
- Is the youth confused or distressed about their gender?

Ratings and Descriptions

0	Youth has a clear and developmentally appropriate gender identity. A youth who is comfortable with their self-perceived gender would be rated here.
1	Youth is experiencing some concerns about gender identity.
2	Youth is experiencing confusion and distress about gender identity.
3	Youth is experiencing significant confusion about their gender identity that is placing youth in significant personal or interpersonal conflict. Youth is at considerable risk of harm (from self or others) because of confusion or the confusion is disabling the youth in a least one life domain (i.e., school, family/home, etc.).

SI3. CAREGIVER ACCEPTANCE

This item rates the degree of caregiver support and acceptance of the youth's sexual orientation and/or gender identity.

Questions to Consider

- Is the youth's primary caregiver supportive or accepting of the youth's sexual orientation and/or gender identity?

Ratings and Descriptions

0	Primary caregiver(s) are fully supportive of the youth and accepting of the youth's sexual orientation and/or gender identity.
1	Primary caregiver(s) are generally (but not fully) supportive of the youth and accepting of the youth's sexual orientation and/or gender identity. Caregiver may be accepting but not supportive.
2	Primary caregiver(s) are not supportive or accepting of the youth's sexual orientation or the primary caregiver(s) has no knowledge of the youth's sexual orientation and/or gender identity.
3	Primary caregiver(s) is rejecting of the youth's sexual orientation and/or gender identity.

SI4. OTHER ADULT SUPPORTS

This item rates the degree of support that a youth has from significant adults (excluding primary caregivers) who are accepting of their sexual orientation and/or gender identity.

Questions to Consider

- Does the youth have any adults who accept their sexual orientation and/or gender identity and support them?

Ratings and Descriptions

0	Youth has multiple significant adult supports who are accepting of the youth's sexual orientation and/or gender identity.
1	Youth has at least one significant adult support who is accepting of the youth's sexual orientation and/or gender identity.
2	Youth has no current significant adult supports, however, they have generally positive relationships with adults some of whom are supportive and accepting of the youth's sexual orientation and/or gender identity.
3	Youth has no adult relationships that are supportive and/or accepting of the youth's sexual orientation and/or gender identity.

SI5. PEER CONNECTIONS

This item rates the degree of stable and long-standing connections that a youth has from peers who share their sexual orientation and/or gender identity.

Questions to Consider

- Does the youth know of others who share youth's sexual orientation and/or gender identity?
- How strong are the youth's connections with others?

Ratings and Descriptions

0	Youth has significant (stable and long-standing) multiple peer connections who share the youth's sexual orientation and/or gender identity.
1	Youth has at least one stable and long standing peer connection who shares the youth's sexual orientation and/or gender identity.
2	Youth knows others who share the youth's sexual orientation and/or gender identity but does not have any stable or long-standing relationships.
3	Youth is isolated from others who share the youth's sexual orientation and/or gender identity.

SI6. OPPORTUNITIES FOR OPENNESS

Perceived stigma—the expectation that one will be rejected and discriminated against—leads to a state of continuous vigilance and concealment of one's sexual orientation identity and/or gender identity that can affect one's health. This item rates the degree to which a youth can be open in all aspects of life.

Questions to Consider	Ratings and Descriptions	
✦ How open is the youth able to be about their sexual orientation and/or gender identity? ✦ What impact does stigma regarding their sexual orientation and/or gender identity have on the youth?	0	Youth is generally able to be open in all aspect of life.
	1	Youth has significant opportunities to be open and can be most of the time
	2	Youth has limited opportunities for openness.
	3	Youth feels dramatically restricted and feels unable to be open.

SI7. TARGETED FOR SEXUAL ORIENTATION/GENDER IDENTITY

LGBTQ youth report experiencing elevated levels of harassment, victimization, and violence. School-based victimization due to known or perceived identity has been documented. This item rates the degree to which the individual has been targeted for physical or emotional abuse due to their sexual orientation and/or gender identity.

Questions to Consider	Ratings and Descriptions	
✦ Does the youth note having difficulties at school or with peers due to their sexual orientation identity and/or gender identity? ✦ What is the impact of physical and/or emotional abuse to the youth due to their sexual orientation and/or gender identity?	0	Youth has never been targeted for physical or emotional abuse due to sexual orientation identity and/or gender identity.
	1	History or suspicion that the youth has been targeted for physical or emotional abuse in the past due to sexual orientation identity and/or gender identity, but not recently.
	2	Youth is being targeted for physical or emotional abuse due to sexual orientation and/or gender identity.
	3	Youth is being targeted with an extreme and dangerous level of physical or emotional abuse due to sexual orientation and/or gender identity.

CULTURAL FACTORS DOMAIN

These items identify linguistic or cultural issues for which service providers need to make accommodations (e.g., provide interpreter, finding therapist who speaks family's primary language, and/or ensure that a child/youth in placement has the opportunity to participate in cultural rituals associated with their cultural identity). Items in the Cultural Factors Domain describe difficulties that children and youth may experience or encounter as a result of their membership in any cultural group, and/or because of the relationship between members of that group and members of the dominant society.

Health care disparities are differences in health care quality, affordability, access, utilization and outcomes between groups. Culture in this domain is described broadly to include cultural groups that are racial, ethnic or religious, or are based on age, sexual orientation, gender identity, socio-economic status and/or geography. Literature exploring issues of health care disparity states that race and/or ethnic group membership may be a primary influence on health outcomes.

The cultural issues in this domain should be considered in relation to the impact they are having on the life of the individual when rating these items and creating a treatment or service plan.

Question to Consider for this Domain: How does the child/youth's membership in a particular cultural group impact their stress and wellbeing?

Rate the highest level from the past 30 days based on relevant information from all sources.

For the **Cultural Factors Domain**, use the following categories and action levels:

0	No current need; no need for action or intervention.
1	History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.
2	Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.
3	Problems are dangerous or disabling; requires immediate and/or intensive action.

54. LANGUAGE

This item looks at whether the child/youth and family need help with communication to obtain the necessary resources, supports and accommodations (e.g., interpreter). This item includes spoken, written, and sign language, as well as issues of literacy.

Questions to Consider

- What language does the family speak at home?
- Is there a child/youth interpreting for the family in situations that may compromise the child/youth or family's care?
- Does the child/youth or significant family members have any special needs related to communication (e.g., ESL, ASL, Braille, or assisted technology)?

Ratings and Descriptions

0	No current need; no need for action or intervention. No evidence that there is a need or preference for an interpreter and/or the child/youth and family speak and read the primary language where the child/youth or family lives.
1	Identified need requires monitoring, watchful waiting, or preventive activities. Child/youth and/or family speak or read the primary language where the child/youth or family lives, but potential communication problems exist because of limited vocabulary or comprehension of the nuances of the language.
2	Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning. Child/youth and/or significant family members do not speak the primary language where the child/youth or family lives. Translator or family's native language speaker is needed for successful intervention; a qualified individual(s) can be identified within natural supports.
3	Problems are dangerous or disabling; requires immediate and/or intensive action. Child/youth and/or significant family members do not speak the primary language where the child/youth or family lives. Translator or family's native language speaker is needed for successful intervention; no such individual is available from among natural supports.

55. TRADITIONS AND RITUALS

This item rates the child/youth and family's access to and participation in cultural traditions, rituals and practices, including the celebration of culturally specific holidays such as Kwanza, Dia de los Muertos, Yom Kippur, Quinceanera, etc. This also may include daily activities that are culturally specific (e.g., wearing a hijab, praying toward Mecca at specific times, eating a specific diet, access to media), and traditions and activities to include newer cultural identities.

Questions to Consider

- What holidays does the child/youth celebrate?
- What traditions are important to the child/ youth?
- Does the child/youth fear discrimination for practicing the child/ youth's traditions and rituals?

Ratings and Descriptions

0	No current need; no need for action or intervention. Child/youth and/or family consistently practice their chosen traditions and rituals consistent with their cultural identity.
1	Identified need requires monitoring, watchful waiting, or preventive activities. Child/youth and/or family generally practice their chosen traditions and rituals consistent with their cultural identity; however, they sometimes experience some obstacles to the performance of these practices.
2	Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning. Child/youth and/or family experience significant barriers and are sometimes prevented from practicing their chosen traditions and rituals consistent with their cultural identity.
3	Problems are dangerous or disabling; requires immediate and/or intensive action. Child/youth and/or family are unable to practice their chosen traditions and rituals consistent with their cultural identity.

56. FAMILY CULTURAL STRESS

All individuals are members of multiple identifiable cultural groups. This item describes possible problems that children, youth, or the family may experience with the relationship between their cultural membership and the predominant culture in which they live. This can include but should not be limited to concerns with language, ritual, discrimination, identity, and group membership.

Questions to Consider

- What does the family believe is their reality of discrimination? How do they describe discrimination or oppression?
- Does this impact their functioning as both individuals and as a family?
- How does the caregiver support the child/youth's identity and experiences if different from their own?

Ratings and Descriptions

0	No evidence of stress for the family or individuals within the family that results from cultural identity and the communities in which they function.
1	Some evidence of mild or occasional stress resulting from friction between the family's, or individuals within the family's, cultural identity and the communities in which they function.
2	The family is experiencing cultural stress from friction between the family's, or individuals within the family's, cultural identity and current communities, and that is causing some problems with functioning.
3	The family is experiencing a high level of cultural stress between the family's, or individuals within the family's, cultural identity and communities in which they function that is making functioning very difficult under the present circumstances.

57. CULTURAL STRESS

This item identifies circumstances in which the child/youth's cultural identity is met with hostility or other problems within the child/youth's environment due to differences in attitudes, behavior, or beliefs of others (this includes cultural differences that are causing stress between the child/youth and their family). Racism, negativity toward sexual orientation, gender identity and expression (SOGIE) and other forms of discrimination would be rated here.

Questions to Consider	Ratings and Descriptions	
✦ What does the family believe is their reality of discrimination? How do they describe discrimination or oppression? ✦ Does this impact their functioning as both individuals and as a family? ✦ How does the caregiver support the child/youth's identity and experiences if different from the caregiver's own?	0	No current need; no need for action or intervention. No evidence of stress between the child/youth's cultural identity and current environment or living situation.
	1	Identified need requires monitoring, watchful waiting, or preventive activities. Some mild or occasional stress resulting from friction between the child/youth's cultural identity and current environment or living situation.
	2	Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning. Child/youth is experiencing cultural stress that is causing problems of functioning in at least one life domain. Child/youth needs support to learn how to manage culture stress.
	3	Problems are dangerous or disabling; requires immediate and/or intensive action. Child/youth is experiencing a high level of cultural stress that is making functioning in any life domain difficult under the present circumstances. Child/youth needs immediate plan to reduce culture stress.

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Zurbriggen, E. L., & Freyd, J. J. (2004). The link between child sexual abuse and risky sexual behavior: The role of dissociative tendencies, information-processing effects, and consensual sex decision mechanisms. In *From child sexual abuse to adult sexual risk: Trauma, revictimization, and intervention* (pp. 135–157). American Psychological Association. https://doi.org/10.1037/10785-007

CURRICULUM VITAE

Shadie Burke
Email: burkes188@gmail.com

Education

Ph.D. Clinical Psychology, University of Nevada-Las Vegas, Las Vegas, NV (APA-Accredited)
Expected June 2024
Dissertation: Trauma-Related Cognitions, and Discrimination as Predictors of Maladaptive Coping Among Marginalized Maltreated Youth
Advisor: Christopher Kearney, Ph.D.
Pre-Doctoral Clinical Internship: Harvard Medical School/Boston Children's Hospital 2023-2024

M.A. Clinical Psychology, University of Nevada-Las Vegas, Las Vegas, NV
December 2021
Master's Thesis: Racial/Ethnic Differences in Mental Health Diagnosis of Maltreated Youth
Advisor: Christopher Kearney, Ph.D.

B.A. Psychology, Southern Connecticut State University, New Haven, CT
August 2016, With Honors
Concentration: Mental Health
Honors Thesis: A Study Examining How Prior Sexual Education, Parenting Styles, and Parental Behaviors Related to Self-Reported Sexual Risky Behaviors in College Aged Students
Advisor: Deborah Kraemer, Ph.D.

Clinical Training

Harvard Medical School/Boston Children's Hospital
Boston, MA
Pre-Doctoral Psychology Intern
Training Director: Erica Lee, Ph.D.
July 2023-June 2024

Year-Long Experience

Outpatient Psychiatry Service
Supervisors: Keneisha Sinclair-McBride, Ph.D., Michelle Codner, Psy.D. and Eugene D'Angelo, Ph.D.
Performed intake assessments, individual psychotherapy, and parent support for diverse patients ranging in age from 6-18 with and without medical diagnoses.

Implemented evidence-based treatment for a range of presenting problems, with a focus on delivering patient and family-centered care with appropriate adaptations as needed. Completed case presentations, coordinated care with medical teams, and consulted with school staff.

Six Month Specialty Rotation

Psychiatrist Consultation Service (PCS)
Supervisor: Kevin K. Tsang, Psy.D.
Will provide evaluations and psychotherapeutic intervention to patients, consultations to hospital medical staff and participate in treatment planning for youth and their families on multidisciplinary pediatric inpatient units. Common presenting problems include acute and/or chronic medical or surgical conditions, somatic symptoms and/or related concerns and life-threatening diagnoses.

Emergency Department
Supervisors: Asha Kiirikki, LCSW and Laruen Corell, LCSW
Conducts clinical evaluations, promotes healthy coping strategies, and develops assessment and recommendation plans for patients and their families in acute psychiatric distress presenting to the emergency department. Coordinates with a multidisciplinary treatment team of physicians, psychiatrists, and social works to plan patient disposition. Attends weekly ED case conference.

Atopic Dermatitis Center (ADC)
Supervisor: Jennifer LeBovidge, Ph.D.
Provides brief assessment and evidence-based interventions for patients and their families with severe atopic dermatitis, food allergies, and other allergic conditions. Implements interventions focused on adherence to medical regimen, symptom managements and psychosocial adjustment to a chronic medical condition. Coordinate with a multidisciplinary treatment team of physicians, psychologists, nurses, and dieticians to provide comprehensive interdisciplinary care to patients and families with atopic dermatitis and food allergies.

Neuropsychology Clinic
Supervisors: Celiane Rey-Casserly, Ph.D., ABPP and Sydney Jacobs, Ph.D.
Provides evidence-based assessment to youth and families affected by brain and central nervous system disorders, injuries, and diseases. Reviews medical and school records, complete clinical interviews, observe behaviors, administer and score tests for children with medical and neurological disorders, write integrative reports, and provide feedback to families on recommendations and treatments. Active participant in weekly seminars and journal club focused on diversity and advocacy in psychology and neuropsychology.

*Gender Multispecialty Service (GeMS)**
Supervisor: Kerry McGregor, Ph.D.
Will provide gender-affirmative consultations, psychological assessments and resource referrals to transgender and gender diverse youth in the gender in which they identify in an outpatient clinic. *Three-month rotation.

Cure 4 the Kids Foundation
Las Vegas, NV
Doctoral Practicum Student
Supervisor: Danielle T. Bello, Ph.D.
July 2022- December 2022

Conduct comprehensive neuropsychological assessments and write integrated reports in a pediatric hospital setting to youth referred from oncology, hematology, rheumatology, and genetic disorder clinics. Common psychological diagnoses included cognitive disabilities, neurodevelopmental disorders, learning disorders, anxiety disorders, depressive disorders, and Attention-deficit/hyperactivity Disorder (ADHD. Provide consultation/liaison services and brief interventions utilizing a cognitive-behavioral orientation to target anxiety and depressive symptoms, behavior management, medical adherence, and increase positive parenting practices. Coordinate with a multidisciplinary treatment team of physicians, psychologists, social workers, nurses and educational specialists in weekly grand rounds, sickle cell anemia clinic, and long-term follow-up clinic.

UNLV PRACTICE: A Community Mental Health Clinic
Las Vegas, NV
Supervisor in Training
Supervisors: Sarah Ramos, Ph.D. & Michelle Paul, Ph.D.
May 2022 – August 2022

Provided weekly individual supervision to a first-year practicum student from an integrative and interpersonal recall framework with oversight and guidance from a licensed clinical supervisor. Assigned related reading and didactics related to patient's presenting concerns, reviewed session tapes and provided feedback and guidance on clinical notes and treatment plans. Attended weekly individual supervision of supervision. Participated in biweekly interdisciplinary case rounds.

Desert Willow Treatment Center
Las Vegas, NV
Doctoral Practicum Student
Supervisors: Caron Evans, Ph.D. and Richard Humes, Psy.D.
August 2021- May 2022

Implemented trauma-informed, culturally responsive, evidence-based crisis intervention, via individual, family and group psychotherapy to a diverse population of youth 11-17 years old at a pediatric psychiatric hospital. Addressed presenting concerns included neurodevelopmental, mood, anxiety, obsessive-compulsive, trauma, psychotic, and disruptive behavior disorders. Modalities used included Cognitive Behavioral Therapy, Acceptance and Commitment Therapy, Dialectical Behavioral Therapy, Family Systems Therapies and Psychodynamic Therapy. Administered and interpreted comprehensive psychological assessments to inform treatment and discharge planning. Presented cases during multidisciplinary case conferences. Participated in weekly consultation calls with a wide range of health professionals in efforts to facilitate the best treatment and support to patients.

The UNLV Child School Refusal and Anxiety Disorder Clinic
Las Vegas, NV
Doctoral Practicum Student
Supervisor: Christopher A. Kearney, Ph.D.
August 2021- May 2022

Implemented evidence-based individual and family therapy to a diverse population of children and adolescents, 4-17 years old in a specialty outpatient setting. Youth presented with a range of behavioral, neurodevelopmental and emotional concerns related to school attendance problems including depressive, anxiety, autism spectrum disorder, obsessive-compulsive and related disorders, trauma and stressor related disorders impulse-control and conduct disorders. Administered comprehensive intakes utilizing semi-structured interviews, behavior rating scales, and symptom inventories in addition to implementing cognitive-behavioral treatment protocols (i.e., CBT for school refusal, Coping Cat and Habit Reversal Training). Collaborated with a wide range of school professionals in efforts to facilitate efficacious treatment and support to patients. Provided frequent consultation to school personnel regarding diagnostic impressions and recommendations to inform IEP and 504 plans.

Children's Heart Center of Nevada
Las Vegas, NV
Doctoral Practicum Student
Supervisor: Beth Creel, Ph.D.
September 2020- June 2021

Implemented evidence-based interventions to a diverse population of children and adolescent in-person and via tele-health. Provided brief, solution focused interventions to children, adolescents, young adults and expecting parents presenting to specialty care for a range of complex heart conditions (e.g., congestive heart failure, heart transplant, tetralogy of fallot, and pacemaker). Modalities used included Cognitive Behavioral Therapy, Acceptance and Commitment Therapy, family systems therapies, psychodynamic therapy and grief counseling. Collaborated with a wide range of health professionals on a multidisciplinary team.

Department of Child and Family Services- Child Haven Campus
Las Vegas, NV
Doctoral Practicum Student
Supervisor: Lisa Linning, Ph.D.
August 2020- June 2021

Implemented evidence-based crisis intervention and distress tolerance skills to maltreated youth at an emergency shelter. Facilitated a range of psychotherapy groups for teenage boys (ages 12-17), including DBT skills and culture and identity development. Developed and facilitated a group on emotional intelligence, empathy and prosocial behaviors for diverse maltreated children (ages 2-7). Co-facilitated a group for non-offending parents in sexual abuse cases.

University of Nevada, Las Vegas (UNLV) PRACTICE a Community Mental Health Clinic
Las Vegas, NV
Doctoral Practicum Student
Supervisors: Carolina Meza Perez, Psy.D (Postdoctoral Fellow) & Michelle Paul, Ph.D.
August 2019- August 2020

Provided evidence-based and trauma-informed therapeutic services to children and adolescents at a department-sponsored community mental health clinic. Implemented individual and family psychotherapy in tele-health and in person settings. Youth aged 5-17 presented with a range of behavioral and emotional concerns including neurodevelopmental disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, trauma and stressor related disorders, and disruptive, impulse-control, and conduct disorders. Modalities used included Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Acceptance and Commitment Therapy and family systems therapies. Conducted intakes for children, adolescents, and adults. Provided neuropsychological assessment services for children ages 5-17 utilizing cognitive, achievement, and executive functioning assessments as well as behavior rating scales and symptom inventories. Comprehensive assessments focused on differential diagnosis, developing treatment plans (interventions and accommodations), and providing applicable referrals. Co-facilitated a stress management workshop for health professional students at Roseman University.

Adolescent and Child Trauma (ACT) Lab
Las Vegas, NV
Graduate Research Assistant
Supervisor: Christopher Kearney, PhD
August 2018-May 2023

Administrated psychodiagnostics assessments to diverse population of maltreated youth. Scored and wrote comprehensive evaluations used in the determination of services and care provided to children and adolescents under the care of child welfare.

The UNLV Child School Refusal and Anxiety Disorder Clinic
Las Vegas, NV
Selective Mutism Group Co-Facilitator
Supervisor: Christopher Kearney, PhD
February 2018- May 2019

Co-facilitated group therapy for children ages 5-8 with Selective Mutism for an outcome study. Utilized an exposure-based cognitive-behavioral framework with separate group sessions for children and parents.

The STEP Clinic at the Yale School of Medicine
New Haven, CT
Research Assistant 1
Supervisor: Vinod Srihari, MD
2016-2018

Served as a research assistant in a first episode psychosis clinic treating youth and young adults 15-35 years old. Administered and scored assessments to patients presenting with psychotic symptoms including the Structured Interview for Psychosis-Risk Syndromes

(SIPS), Positive and Negative Symptoms Scale (PANSS), Columbia Suicide Severity Rating Scale, Global Assessment of Functioning/Social/Role (GAF) and Pathways to Care. Participated in an NIH funded campaign to help educate the community about mental health stigma and psychosis. Aided in the collection of blood samples and the interpretation of lab results for an immune marker study. Managed and analyzed data for a multi-site study. Assisted in the preparation and submission of a National Institute of Health (NIH) P50 grant.

The ARC of Ulster County
Kingston, NY
Residential Specialist
Supervisor: Jacob Vosper
2015-2016

Served as a Residential Specialist at a day program for adults with developmental disabilities. Implemented behavior plans. Encouraged goal setting activities and social interactions between clients.

Clifford Beers Clinic
New Haven, CT
Undergraduate Intern
Supervisor: Jessica Bigelsen, MA
January 2015- May 2015

Served as an Undergraduate intern at a community health partner treating diverse youth and families from 0 to 19 years old with a range of presenting concerns. Administered an array of assessments (including Global Appraisal of Individual Needs-Short Screener, Ohio Mental Health Consumer Outcomes System [both Parent and Youth], Hopes and Goals of Treatment Forms, and The Child Behavior Checklist for Ages 1 ½ - 5), coordinated and co-facilitated group therapy with children under the age of five with exposure to domestic violence. Maintained and recorded therapy outcome data.

Research Experience

The UNLV Child School Refusal and Anxiety Disorders Clinic
Las Vegas, NV
Graduate Student
Child and Adolescent Research in Selective Mutism, Anxiety, and Absenteeism (CHARISMA) Lab
Supervisor: Christopher Kearney, PhD
August 2018-May 2023

Trained and supervised undergraduate research assistants in lab tasks. Analyzed data and prepared for publications, posters, and oral presentations utilizing SPSS. Created and managed a Redcap database for multiple IRB approved research studies.

The PRIME Clinic
New Haven, CT
Undergraduate Intern
Supervisor: Barbara Walsh, PhD
August 2015 - December 2015

Organized, retrieved, and compiled client data files. Performed descriptive analysis utilizing Redcap software. Observed clinical evaluations and assessments in youth presenting with prodromal symptoms. Collaborated with community members increase awareness of prodromal symptoms in youth and young adults.

The Speech, Reading, and Cognition Lab, Southern Connecticut State University
New Haven, CT
Undergraduate Research Assistant
Supervisor: Larry Brancazio, PhD, and Dina Moore, PhD
January 2014- May 2014

Scheduled and organized participants for a two-day research study. Administered assessments (including Woodcock Johnson Tests of Achievement, Test of Word Reading Efficiency, Comprehensive Test of Phonological Processing, Matrix Reasoning, Speech-In-Noise, Stroop Test, McGurk HowSure, and Spatial Working Memory), and provided a safe and positive environment during stressful, challenging assessment situations.

Invited Talks, Oral Presentations and Symposia

Burke, S. *Suicide Risk Assessment in Pediatric Setting.* (2022, December). Interdisciplinary Inservice Presentation presented at Cure 4 the Kids Foundation, Las Vegas, NV.

Burke, S. *Understanding racial/ethnic differences in mental health symptom presentation.* (2021, October). Inservice Presentation presented at Desert Willow Treatment Center, Las Vegas, NV.

Clement, N. D.*, Rivens, A.*, Yu, H. S.*, **Burke, S*.** *Improving equity for marginalized students in clinical psychology through an open-access resource.* (2021, August). Symposium presented at 2021 APA Virtual Convention.

Howard, A. N., **Burke, S**., Mraz, A., Ellis, K., Kearney C.A. (2021, June). *Assessment of PTSD and related symptoms for maltreated adolescents: Protocol and empirical findings.* Workshop presentation presented at the Nevada Child Abuse Prevention and Safety (NCAPS) Virtual Conference.

Association for Psychological Science (APS) Student and Early Career Webinar Series "*Marginalized Graduate Student Survival Kit*." Invited Speaker. April 13th, 2021.
Society for Research in Child Development (SRCD) Black Caucus. *"Virtual Graduate School Application,*" Clinical Psychology Doctoral Student Panelist. September 25th, 2020.

Srihari, V., Ferrara, M., Li, F., **Burke, S**., Kline, E., Pollard, J., Cahill, J., Guloksuz, S., McDermott, G., Woods, S., Seidman, L., Keshavan, K. (2018, October). *Mindmap- A*

quasi-experimental test of early detection of psychosis in the U.S. Symposium presented at the 11th International Conference on Early Intervention in Mental Health, Boston, MA.

Mathis, W., Ferrara, M., **Burke, S.,** Li, F., Cahill, J., Lin, I., Pollard, J., Woods, S., Srihari, V. (2018, October). *Filters or barriers? Quantitative analysis of pathways to care and durations of untreated psychosis for a population based first-episode service.* Oral presentation presented at the 11th International Conference on Early Intervention in Mental Health, Boston, MA

**denotes co-first authorship*

Campus and Department Talks

University of Nevada, Las Vegas Outreach Undergraduate Mentoring Program (OUMP) "First-Generation Graduate Student Panel," Clinical Psychology Doctoral Student Panelist. November 10th, 2022.

Burke, S. *Racial/ethnic disparities in mental health diagnosis of maltreated youth.* (2021, October). The Rebel Grad Slam presented at University of Nevada, Las Vegas. Las Vegas, NV.

Burke, S. Guest Speaker. (2021, July 1) "Episode 3 – Talking Anxiety and PTSD". Okay, But Seriously. KUNV Radio. https://okbutseriously.transistor.fm/3

University of Nevada, Las Vegas Outreach Undergraduate Mentoring Program (OUMP) "Applying to Graduate School Panel," Clinical Psychology Doctoral Student Panelist. March 26th, 2021.

Publications

Burke, S., & Kearney, C. A. (2022). Diagnostic disparities among maltreated youth in a child protective services agency. *Journal of Public Child Welfare.* https://doi.org/10.1080/15548732.2022.2162654

Mathis, W. S., Ferrara, M., **Burke, S.,** Hyun, E., Li, F., Zhou, B., … Srihari, V. (2022). Granular analysis of pathways to care and durations of untreated psychosis: A marginal delay model. *PLoS ONE 17*(12). https://doi.org/10.1371/journal.pone.0270234

Kearney, C. A., Childs, J., & **Burke, S.** (2022). Social forces, social justice, and school attendance problems in youth. *Contemporary School Psychology*, 1-16. https://doi.org/10.1007/s40688-022-00425-5

Srihari, V., Ferrara, M., Kline, E., Li, F., **Burke, S.,** Cahill, J., ... & Keshavan, M. (2020). O1. 2. Reducing the duration of untreated psychosis in a US catchment: The mindmap campaign. *Schizophrenia Bulletin*, *46*(Suppl 1), S1. https://doi.org/10.1093/schbul/sbaa028.001

Ferrara, M., Guloksuz, S., Li, F., **Burke, S.,** Tek, C., Friis, S., … & Simonsen, E. (2019). Parsing the impact of early detection on duration of untreated psychosis (DUP): Applying quantile regression to data from the Scandinavian TIPS study. *Schizophrenia Research.* https://doi.org/10.1016/j.schres.2019.05.035

Ferrara, M., Guloksuz, S., **Burke, S**., Li, F., Friis, S., Hegelstad, W. ten V., Joa, I., Johannessen, J., Melle, I., Simonsen, E., Srihari, V. (2018). F136. Parsing DUP to refine early detection: Quantile regression of results from the Scandinavian tips study. *Schizophrenia Bulletin*, *44*(Suppl 1), S272–S273. http://doi.org/10.1093/schbul/sby017.667

Ferrara, M., Guloksuz, S., **Burke, S**., Baccari, F., Miselli, M., Saponaro, A., Ferri, M., Srihari, V., Starace, F. Gruppo Regionale Esordi Psicotici. (2018). S254. Implementation of a program for early intervention in psychosis onset: The experience of Regione Emilia Romagna, northern Italy. *Schizophrenia Bulletin*, *44*(Suppl 1), S426–S427. https://doi.org/10.1093/schbul/sby018.1041

Manuscripts In Preparation

Yu, H.S., Clement, N. D., Rivens, A., **Burke, S.,** Nachabe, J**.** *Promoting inclusion, wellbeing, and empowerment of racial/ethnic marginalized scholars: An evaluation tool to inform graduate program selection.* Manuscript in preparation.

Book Chapters

Kearney, C. A., **Burke, S**., Constantine, M., & Rede, M. (2019). Trouble de stress post-traumatique chez l'enfant et harcèlement. In L. Mathis (Ed.), *Harcèlement scolaire: de la destruction à la reconstruction* (pp. 91-94). Paris: Editions Josette Lyons.

Presentations

Arcaina, V. J. V., **Burke, S**., & Kearney, C. A. (2023). *Emotional Reactivity Predicts Posttraumatic Cognitions in Maltreated Youth*. Poster to be presented at the Association for Behavioral and Cognitive Therapies, 57th Annual Convention, Seattle, WA.

Ellis, K., **Burke, S.,** Arcaina, V.J., Fensken, M., Kearney, C.A. (2022). *Negative posttraumatic cognitions and expressive suppression in maltreated youth.* Poster presented at the Western Psychological Association Convention (WPA), Portland, OR, United States.

Burke, S., Constantine, M., Mraz, A., Ellis, K., Howard, A., Kearney, C.A. (2021). *Do trauma-related cognitions predict indirect self-injurious behaviors in maltreated youth?* Poster presented virtually at the Association for Behavioral and Cognitive Therapies (ABCT) Virtual Conference.

Mraz, A., **Burke, S.,** Constantine, M., Ellis, K., Howard, A., Kearney, C.A. (2021). *Diminished emotional and social resilience predicts dissociation in maltreated youth.* Poster accepted

at the American Psychological Association (APA) 55th Annual Convention, Virtual Conference.

Mraz, A., Constantine, M., **Burke, S.,** Ellis, K., Howard, A., Kearney, C.A. (2021, May). *Obsessive-compulsive disorder predicts traumatic dissociation in maltreated youth.* Poster presented at the Association for Psychological Science (APS) Virtual Conference.

Ellis, K., **Burke, S.,** Mraz, A., Kearney, C.A. (2021, May). *Expressive suppression of positive emotion predicts severity of ptsd symptoms in maltreated youth.* Poster presented at the Association for Psychological Science (APS) Virtual Conference.

Burke, S., Constantine, M., Rede, M., Howard, A., Mraz, A., Kearney, C.A. (2020). *Suicidal ideation, suicide attempts, and non-suicidal self-injury associated with lower rates of resilience in maltreated youth.* Poster accepted at the Association for Psychological Science (APS), Chicago, IL, United States.

Rede, M., **Burke, S.,** Romero, A., Bacon, V., Diliberto, R., Kearney, C.A. (2019, October). *Gender Differences in selective mutism symptom severity*. Poster presented at the Selective Mutism Association (SMA) National Conference, Las Vegas, NV.

Fornander, M.J., Bacon, V., Rede, M., Constantine, M., **Burke, S.,** Howard, A., Gerthoffer, A., Diliberto, R., Kearney, C.A. (2019, October). *Selective mutism presentation in US versus non-US children*. Poster presented at the Selective Mutism Association (SMA) National Conference, Las Vegas, NV.

Howard, A.N., Fornander, M.J., Bacon, V., Rede, M., **Burke, S**., Constantine, M., Gerthoffer, A., Diliberto, R., Kearney, C.A. (2019, October). *Somatic symptoms and internalizing problems as moderators of selective mutism severity*. Poster presented at the Selective Mutism Association (SMA) National Conference, Las Vegas, NV.

Bacon, V. R, Fornander, M. J., Rede, M., Constantine, M., **Burke, S**., Howard, A., Gerthoffer, A., Kearney, C. A. (2019, May). *Bullying as a risk factor for school absenteeism*. Poster presented at the Association for Psychological Science (APS), Washington, D.C.

Ferrara, M., Guloksuz, S., **Burke, S**., Li, F., Friis, S., Hegelstad, W. V., Joa, I., Johannessen, J., Melle, I., Simonsen, E., Srihari, V. (2018, April). *Parsing DUP to refine early detection: Quantile regression of results from the Scandinavian TIPS study*. Poster presented at the 6th Biennial Schizophrenia International Research Society Conference, Florence, Italy.

Ferrara, M., Guloksuz, S., **Burke, S**., Baccari, F., Miselli, M., Srihari, V., Starace, F. (2018, April). *Implementation of a program for early intervention in psychosis onset: The experience of Regione Emilia Romagna, northern Italy*. Poster presented at the 6th Biennial Schizophrenia International Research Society Conference, Florence, Italy.

Ferrara, M., Li, F., Baccari, F., Guloksuz, S., **Burke, S**., Miselli, M., Saponaro, A., Ferri, M., Srihari, V., Starace, F. (2018, October). *Clinical remission in first episode of psychosis:*

Results from cohort in northern Italy. Poster presented at the11th International Conference on Early Intervention in Mental Health, Boston, MA.

Ferrara, M., Li, F., Guloksuz, S., **Burke, S**., Cahill, J., Lin, H., Mathis, W., Pollard, J., Walsh, B., Woods, S., Srihari, V. (2018, October). *Before the storm: Attenuated positive symptom psychosis-risk syndrome (APS) as an opportunity for early detection*. Poster presented at the11th International Conference on Early Intervention in Mental Health, Boston, MA.

Burke, S. (2016, April). *A study examining how prior sexual education, parenting-styles and parental behaviors relate to self-reported risky sexual behaviors in college aged students*. Poster presented at Southern Connecticut State University's 2nd Annual Undergraduate Research and Creativity Conference, New Haven, CT.

Brancazio, L. & Moore, D. L., Tyska, K. L.; Cosgrove, D. R.; **Burke, S. M**.; Demartino, K. E., Irwin, J. (2015, May). *McGurk-like effects of subtle audiovisual mismatch in speech perception.* Poster presented at the 27th Annual Meeting of the Association for Psychological Science, New York, NY.

Teaching Experience

Graduate Student Instructor
Cognitive Psychology; Abnormal Psychology; Introduction to Psychology
University of Nevada, Las Vegas
August 2020 – December 2022

Taught multiple sections of undergraduate Cognitive Psychology, Abnormal Psychology and Introduction to Psychology each semester in in-person, remote-based, and online formats. Classroom size was approximately 35 students per section. Created and graded unit exams and assignments for an undergraduate psychology course. Developed a lesson plan and prepared teaching material focused on fostering personal growth and developing scientific values and skills. Incorporated issues of diversity and inclusions for historically excluded groups within psychology. Increased accessibility to all students through the use of captions, removal of time limits and availability of recorded lectures.

Co-Instructor
Introduction to Psychology
University of Nevada, Las Vegas
June 2019 and July 2021

Created and graded unit exams for Psychology 101 course. Developed a lesson plan and prepared teaching material for sections on Human Development, Social Psychology, Stress, Health and Coping and Psychological Disorders.

Graduate Teaching Assistant
Research Methods; Cognitive Psychology; Abnormal Psychology; Psychology of Learning, Psychology of Aging, Capstone in Psychology
University of Nevada Las Vegas
August 2018-May 2020

Assisted undergraduate students in developing a well-formed research study and graded undergraduate assignments and final papers.

Leadership and Professional Service

Interprofessional Education and Practice (IPEP) Club at UNLV
August 2021- May 2023
Position: Founder and President

A student-led group encouraging the collaboration and dissemination of education, research and training to a wide range of allied health care professions at UNLV.

Psychology Students for Inclusion Diversity and Equality (PSIDE)
September 2020- Present
Position: Graduate Student Member

Served on the Psychology Students for Inclusion, Diversity and Equity (PSIDE), a grassroots organization of psychology graduate students. PSIDE aims to provide a platform for connection across pillars of learning, advocacy, and peer support. Our goal for learning and education is to deepen both self-knowledge and a broader, intersectional understanding of DEI related issues. We aim to organize concrete efforts to promote sustainable DEI initiatives across university departments. We also aim to provide a space for students to connect at a national level to share strategies and initiatives to enrich DEI efforts in their own institutions.

Dismantling Systemic Shortcomings in Education and Clinical Training (DiSSECT)
September 2020- Present
Position: Graduate Student Member; Marginalized Survival Guide Sub-Committee

Served on DiSSECT, a national organization led by graduate students striving to advance antiracist initiatives in clinical psychology and related graduate training programs by increasing access to resources and highlighting BIPOC (Black, Indigenous, and people of color) perspectives. Notable projects include the co-creation of the Helping Give Away Psychological Science/Marginalized Survival Kit: Navigating Academia as a Marginalized Student - Wikiversity and **DISSECT Evaluation Tool for Students Applying to Graduate School.**

American Psychological Association (APA) Division 53
August 2020- March 2022
Position: Graduate Student Mentor

Served as a graduate student mentor to facilitate meaningful mentoring relationships among Division 53 aspiring psychology doctoral program applicants.

Diversity and Inclusion Student Committee (DISC)
September 2019- May 2023
Position: Clinical Psychology Graduate Student Member

Severed on DISC, a social justice group composed of psychology graduate students, with aims to advance social justice and authentic community within the UNLV Department of Psychology.

Nevada Psychological Association Diversity Committee
Position: Graduate Student Member
August 2019- December 2020

Served on the Diversity Committee for the non-profit professional association representing psychologists and others affiliated with the delivery of psychological services in the state of Nevada. Subcommittees take part in creating and disseminating initiatives throughout the state of Nevada. Notable projects include advocating for the inclusion of DEI CE credits, co-created a draft of NPA DEI mission statement, contributed to the DEI strategic planning for the year.

UNLV Psychology Clinical Student Committee (CSC)
August 2018-May 2023
Positions: Co- Chair, Social Media Committee Co-chair, Secretary, IDEAS (Inclusion, Diversity, Equity, Access and Solutions) Liaison, and Cohort Representative

Served on the CSC, the voice of Clinical PhD students to department faculty, university organizations, and other relevant committees. Duties included advocating for student needs, increasing student engagement, increasing student and faculty recognition, planning social events, improving department cohesion, and addressing the diversity needs of students. To best advocate for student needs, a yearly student department review survey was developed to address financial, research, diversity, clinical, and personal functioning of students. Findings of the survey are gathered each year and presented to psychology faculty with suggested areas of improvement. Notable projects include co-creating and dissemination psychology/mental health-based content for the UNLV psychology social media pages and advocated for the creation of mental health providers for graduate students.

IDEAS (Inclusion, Diversity, Equity, Access and Solutions) Committee
September 2018- May 2023
Position: Clinical Psychology Graduate Student Member and CSC Liaison

Served on the Psychology Department diversity committee which includes graduate students and faculty from clinical psychology and psychological brain science. Discusses and advocates for diversity, equity and inclusion efforts in the department. Notable projects include co-creating a gender inclusive dress code policy, subcommittee member for redesigning the department website's diversity page, and contributed to IDEAS committees' statements and actionable items around denouncing, racism, police brutality and anti-Asian hate.

Outreach Undergraduate Mentoring Program (OUMP)
September 2018-May 2022
Position: Graduate Student Mentor

Provided mentorship to UNLV undergraduate psychology students from under-represented backgrounds to increase student retention and graduate school applications. Duties included one-on-one mentoring, linking students to resources (e.g., faculty, contacts, research experience, etc.), providing CV development, editing application materials, guiding career planning, and attending mentoring training.

Select Certifications and Training

Structured Interview for Psychosis-Risk Syndromes (SIPS)
Positive and Negative Symptoms Scale (PANSS)
Columbia Suicide Severity Rating Scale
Global Assessment of Functioning/Social/Role (GAF)
Nevada Child and Adolescent Needs and Strengths (NV-CANS) 0-21 2.0
Children's Uniform Mental Health Assessment (CUMHA)
Child and Adolescent Services Intensity Instrument (CASII)
Pathways to Care
Introduction to Biostatistics in Clinical Investigation
Trauma Focused Cognitive Behavioral Therapy Certification Training and Consultation
Dialectical Behavioral Therapy (DBT) Part 1 and Part 2
UCLA Child/Adolescent PTSD Reaction Index for DSM-5 (PTSDRI)

Professional Memberships

2020 Association for Psychological Science (APS)
2020 Society for Research in Child Development – Black Caucus
2020 APA Division 45- Society for the Psychological Study of Culture, Ethnicity and Race
2020 APA Division 37 - The Society for Child and Family Policy and Practice – Section 1 on Child Maltreatment
2020 APA Division 56 – Trauma Psychology
2020 APA Division 2 – Society for the Teaching of Psychology
2020 APA Division 54- Society of Pediatric Psychology
2019 APA Division 53 - Society for Clinical Child and Adolescent Psychology (SCCAP)
2019 APA Division 9 - The Society for the Psychological Study of Social Issues (SPSSI)
2019 American Psychological Association (APA) Graduate Student Member
2019 Nevada Psychological Association (NPA) Graduate Student Member - Diversity and Inclusion Committee
2019 American Group Psychotherapy Association (AGPA)

Honors and Awards

2023 Patricia Sastaunik Scholarship
2022 Outstanding Thesis Award Nominee
2022 Summer Doctoral Research Fellowship
2021 Outstanding Contribution to Diversity, Equity, and Inclusion, UNLV Psychology Departmental Award, Las, Vegas, NV
2014 Psychology International Honor Society