Division 44 Committee on Racial and Ethnic Diversity (CoRED)
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Proposal Submission Form

Title of Presentation	An Intersectional Examination of Identity-Based Disparities in the Mental Health Symptomatology of Clinically Referred Youth
Authors	Nathan Hollinsaid, Maggi Price, Ph.D., & John Weisz, Ph.D.
Summary of Presentation (500-1000 words)	**Purpose:** Gender minority youth ("GMY"; i.e., children and adolescents whose gender identity or expression differs from societal expectations for their birth-assigned sex) report elevated rates of anxiety (Reisner et al., 2015), depression (Roberts et al., 2013), self-harm (Veale et al., 2017), suicidality (Toomey et al., 2018), and other mental health disorders (Becerra-Culqui et al., 2018). Stigma-related stressors, including disproportionate exposure to violence (e.g., physical/sexual assault; Johns et al., 2019), interpersonal victimization (e.g., bullying; Day et al., 2018), discrimination (Kosciw et al., 2018), and trauma (e.g., child abuse; Roberts et al., 2012), contribute to GMY's psychological distress (Hatzenbuehler & Pachankis, 2016). Little is known, however, about mental health disparities facing gender minority youth of Color (GMYoC), particularly during childhood and early adolescence. Gender minority people of Color experience multiple forms of stigmatization (e.g., transprejudice, racism) related to their intersecting identities (Garofalo et al., 2006), which, in late adolescence and emerging adulthood, are associated with greater risk for mental and physical health problems, including anxiety, depression, PTSD, suicidal ideation, substance abuse, and HIV (Garofalo et al., 2006; Wilson et al., 2015; Swann et al., 2019). GMYoC may be particularly vulnerable to mental health difficulties, as they encounter disparate rates of victimization (e.g., school-bullying, verbal/physical harassment) compared to their White classmates (Hatchel & Marx, 2018). Though recent studies have examined the mental health of school-age GMY (Becerra-Culqui et al., 2018), none has explored variations in symptomatology across race/ethnicity. **Research Aims:** To address this gap in the literature, the present study assessed group differences in the mental health of clinically referred school-age youth. First, we compared symptomatology between cisgender youth and GMY. Consistent with the extant literature, we expected to find greater internalizing and externalizing problems for GMY. Next, we examined potential mental health disparities across (non-Latinx) White GMY and GMYoC. Given the frequency with which GMYoC are victimized in school-based settings (Hatchel & Marx, 2018), we anticipated that they too would have more internalizing and externalizing difficulties relative to White GMY.

	Methods: Participants were pooled across three randomized controlled trials (RCTs) of MATCH (the *Modular Approach to Therapy for Children*) in community outpatient clinics (Weisz et al., 2019; Chorpita et al., 2013; Weisz et al., 2018). The sample included N = 817 youth (age range: 7-15; M = 10.6, SD = 1.6) diverse with respect to birth-assigned sex (43.6% girls, 56.4% boys) and race/ethnicity (53.5% White, 12.6% Black, 11.0% Latinx, 1.7% Asian, 19.1% multiracial, 2.1% "other"). Pretreatment youth- and caregiver-reported mental health symptomatology was assessed via broad- (i.e., internalizing, externalizing) and narrow-band (i.e., DSM-oriented) scales of the *Youth Self-Report* (YSR) and *Child Behavior Checklist* (CBCL). As the RCTs did not collect gender identity data, gender minority status was identified from YSR Item 110 ("I wish I were of the opposite sex"), the utility of which is well supported across studies (e.g., van der Miesen et al., 2018). To begin, gender identity-based differences in symptomatology were examined between n = 755 cisgender youth and n = 62 GMY; subsamples did not differ in age, $t(815) = 1.2$, $p = .23$, or race/ethnicity, $\chi^2(5, N = 817) = 9.3$, $p = .1$. Subsequently, the GMY subsample was divided into groups of n = 24 (non-Latinx) White GMY and n = 38 GMYoC in order to explore mental health disparities across race/ethnicity. As in previous studies and national surveys of sexual and gender minority populations, Latinx youth were included in the GMYoC subsample (James & Salcedo, 2017; Toomey et al., 2017). **Results:** To account for uneven subsample sizes and unequal variance (Delacre, Lakens, & Leys, 2017), Welch's t-tests were employed, when indicated, to examine potential heterogeneity in symptomatology between cisgender youth and GMY on the YSR and CBCL. No significant group differences emerged in caregiver-reported problems across CBCL broad- and narrow-band scales. However, on the YSR, GMY endorsed more internalizing (M = 63.7, SD = 8.0) and externalizing (M = 57.1, SD = 10.6) difficulties relative to their cisgender peers (M = 54.2, SD = 11.6; M = 51.1, SD = 11.1), $t(83.6) = 8.6$, $p < .001$ and $t(72.4) = 4.3$, $p < .001$, respectively. These findings were ubiquitous across all YSR DSM-oriented scales (affective, anxiety, somatic, ADHD, and conduct problems, ps < .01), excluding oppositionality. Welch's t-tests were also utilized to explore racial/ethnic variation in mental health symptomatology within the GMY subsample. On the CBCL, White GMY had marginally higher internalizing problems (M = 65.9, SD = 7.9) compared to GMYoC (M = 60.8, SD = 10.9), $t(58.7)$, $p = .04$. Specifically, these youth had greater caregiver-reported DSM-oriented anxiety problems, $t(45.7) = 2.2$, $p = .03$. No other significant differences were found between White GMY and GMYoC on either the CBCL or YSR.

Discussion: In partial support of our first hypothesis, relative to cisgender youth, GMY had higher self-reported internalizing (i.e., affective, anxiety, somatic problems) and externalizing symptoms (i.e., ADHD, conduct problems). Interestingly, these findings were not reflected by their caregivers. Given that GMY often conceal their identities to avoid familial rejection (Aparicio-García et al., 2019), they may also withhold related mental health concerns. No support was found for our second hypothesis, as GMYoC were no more likely to report mental health problems than their White counterparts. Though multiply marginalized, GMYoC often draw on their intersectional identities as sources of resiliency (Singh, 2013), potentially moderating the compounding effects of stigmatization on well-being by embracing one identity in order to accept and empower of the other (i.e., positive intersectionality; Ghabrial et al., 2017).

Because the sample was limited to clinically referred youth, study findings may not generalize to GMY without access to or not in need of mental health treatment. Moreover, some GMY may be underrepresented, as YSR Item 110 provides an exclusively binary measure of gender and does not explicitly ask about gender identity (Olson-Kennedy et al., 2016). Nonetheless, by elucidating the mental health concerns unique to GMY, the present study highlights the importance of developing interventions targeted to this at-risk population. Existing evidence-based practices might be adapted to address the specific stigma-related stressors encountered by GMY and to facilitate the protective role of resiliency for GMYoC.

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