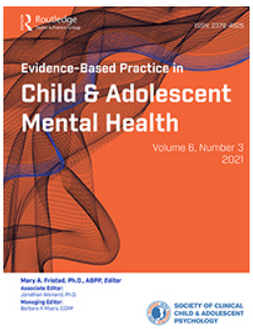

Evidence-Based Practice in Child and Adolescent Mental Health

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/uebh20

Treatment Recommendations and Barriers to Care for Suicidal LGBTQ Youth: A Quality Improvement Study

Lucas Zullo, Ilana Seager van Dyk, Elizabeth Ollen, Natalie Ramos, Joan Asarnow & Jeanne Miranda

To cite this article: Lucas Zullo, Ilana Seager van Dyk, Elizabeth Ollen, Natalie Ramos, Joan Asarnow & Jeanne Miranda (2021) Treatment Recommendations and Barriers to Care for Suicidal LGBTQ Youth: A Quality Improvement Study, Evidence-Based Practice in Child and Adolescent Mental Health, 6:3, 393-409, DOI: 10.1080/23794925.2021.1950079

To link to this article: https://doi.org/10.1080/23794925.2021.1950079

EVIDENCE-BASED PRACTICE IN CHILD AND ADOLESCENT MENTAL HEALTH
2021, VOL. 6, NO. 3, 393–409
https://doi.org/10.1080/23794925.2021.1950079

Routledge
Taylor & Francis Group

Treatment Recommendations and Barriers to Care for Suicidal LGBTQ Youth: A Quality Improvement Study

Lucas Zullo[a], Ilana Seager van Dyk[b], Elizabeth Ollen[a], Natalie Ramos[a], Joan Asarnow[a], and Jeanne Miranda[a]

[a]Department of Psychiatry and Biobehavioral Sciences, University of California, Los Angeles, USA; [b]Department of Social and Behavioral Sciences, Yale School of Public Health, New Haven, USA

ABSTRACT

Lesbian, Gay, Bisexual, Transgender, and Queer or Questioning (LGBTQ) youth are at elevated risk for suicide. Despite this, there is limited information on how to optimize care for suicidal LGBTQ youth. Qualitative interviews were conducted with LGBTQ youth with a history of mental health treatment to identify treatment recommendations and barriers to care for this vulnerable population through the lens of a quality improvement approach. Individual qualitative interviews (n=20) and focus groups (n=21 participants) were conducted. Key findings included the critical role of receiving emotional support from caregivers related to LGBTQ identity, youth's concern about whether it was safe to share LGBTQ identity with a mental health provider due to uncertainty about how this information would be received, the use of self-report measures early in care for self-disclosure, using clear symbols such as the rainbow pride flag indicating support for the LGBTQ community, and the importance of confidentiality in terms of both suicidality and LGBTQ identity. Youth also described being unaware of existing mental health resources designed for LGBTQ youth and emphasized the importance of educating youth directly on the availability of these resources. These findings underscore the importance of attending to the role of the family in supporting suicidal LGBTQ youth and designing clinic spaces where these youth feel comfortable seeking services. This study is one of the first to elicit direct feedback from LGBTQ youth themselves to inform quality improvement of suicide-prevention care for this population.

Introduction

Although there has been increased awareness and acceptance of Lesbian, Gay, Bisexual, Transgender, and Queer or Questioning (LGBTQ) individuals in North America in recent years (Lewis et al., 2017), LGBTQ youth remain at high risk for poor mental health outcomes, including suicide. In fact, there is evidence that LGBTQ youth make suicide attempts four times more often than their straight and cisgender peers (Kann et al., 2018). Indeed, a recent survey of more than 40,000 LGBTQ youth aged 13–24 years in the United States found that 40% of all respondents – and more than half of all transgender and nonbinary youth – seriously considered attempting suicide in the past 12 months (The Trevor Project, 2020).

These statistics indicate a clear public health crisis demonstrating a need to reduce this disparity in mental health outcomes for LGBTQ youth. A variety of risk and protective factors for suicide risk among LGBTQ youth have been identified, leading to several ways to conceptualize potential avenues for intervention (Hatchel et al., 2019). However, an especially prominent barrier to these efforts appears to be one of the access to mental health care. Specifically, in a 2020 report by the Trevor Project, a leading national organization devoted to LGBTQ youth suicide prevention, 46% of LGBTQ youth reported wanting psychological or emotional counseling from a mental health professional but were unable to obtain it in the past 12 months (The Trevor Project, 2020). This large gap in the delivery of mental health services to youth reporting a desire to utilize them indicates a flaw in the current structure of the mental health system and represents an opportunity to benefit from quality improvement initiatives.

The aim of the current study was to collect qualitative data (i.e. semi-structured individual interviews,

CONTACT Lucas Zullo LZullo@mednet.ucla.edu Department of Psychiatry and Biobehavioral Sciences, University of California, 300 Medical Plaza Driveway, Room 3308, Los Angeles, California 90095

Supplemental data for this article can be accessed on the publisher's website.

focus groups) from LGBTQ youth with a history of psychological treatment to better understand how to inform quality improvement efforts on mental health care for suicidal LGBTQ youth. Practical recommendations were then identified for clinicians to implement in their daily practice. The rationale for going to youth as stakeholders is manyfold: to benefit from feedback from those with lived experience, and to obtain perspectives that may be missing during conversations with parents or providers. The emphasis of the study was to treat youth stakeholders as experts in their lived experience of navigating the mental health-care system and to identify ways clinicians could learn from these viewpoints to improve care at the service level for suicidal LGBTQ youth.

Previous qualitative work has focused on better understanding the dynamic interplay between the mental health of LGBTQ youth and the environment/social factors. In a recent systematic review of qualitative studies on mental health services for LGBTQ youth, five themes were identified: (a) isolation, rejection, phobia, and a need for support, (b) marginalization, (c) depression, self-harm, and suicidality, (d) policy and environment, and (e) connectedness. These themes primarily describe the many risk factors present for LGBTQ youth, as well as positive and protective factors (Wilson & Cariola, 2020). Although there is a variety of research on broad environmental interventions such as ways to improve the school setting for LGBTQ youth, there is a clear absence of studies focusing on specific treatment targets for quality improvement of mental health treatment for suicidal LGBTQ youth.

There has been a recent interest in investigating whether adapting existing suicide prevention treatments for LGBTQ populations could help reduce suicide in this group (Mustanski & Espelage, 2020). Additionally, outside of the realm of suicide prevention research, there have already been promising findings for cognitive behavioral interventions for LGBTQ youth (Craig & Austin, 2016; Pachankis et al., 2015). For instance, Craig and Austin (2016) successfully created an intervention in the form of an affirmative cognitive behavioral coping skills group for sexual and gender minority youth that demonstrated reductions in depressive symptoms and the appraisal of stress as a threat while improving reflective coping skills and teaching youth to instead view stress as a challenge. Pachankis et al. (2015) have developed a transdiagnostic cognitive behavioral intervention for young gay and bisexual men with effects on a variety of outcomes, including depressive symptoms, alcohol use problems, and risky sexual behavior.

An exception to the paucity of targeted suicide prevention interventions for LGBTQ youth is Attachment-Based Family Therapy (ABFT) for Lesbian, Gay, and Bisexual (LGB) Youth (Diamond et al., 2013). ABFT has previously been studied with a general population of youth and has shown promise for reducing suicidal ideation (Diamond et al., 2019, 2010). Diamond et al. (2013) adapted this evidence-based treatment for LGB youth to emphasize individual time spent with parents in order to process emotions around youth LGB identity, address the implications and process of acceptance within the family, and heighten parents' awareness of potentially invalidating responses to the youth's identity. This modified version of ABFT was delivered as a 12-week treatment in an open trial with 10 LGB youth. Results indicated a significant decrease in youth self-reported suicidal ideation and depressive symptoms over the course of treatment. Although this trial benefited from an extensive treatment development phase with input from community clinicians who had experience with suicidal LGB youth, there was notably no involvement from youth stakeholders themselves.

One of the explanations for the increased prevalence of mental health concerns among LGBTQ populations, including suicidal thoughts and behaviors, is described through the minority stress framework (Meyer, 2003; Hendricks & Testa, 2012). This framework states that LGBTQ people are at higher risk for mental health concerns by virtue of the additional stress they experience related to their minority status (e.g., discrimination, internalized homophobia) in combination with the general life stress they experience. Further, minority stress theory posits that the deleterious effect of minority stressors on mental health can be buffered through adaptive coping resources, positive social support, and/or positive aspects of one's minority identity (e.g., feeling affirmed and secure in one's identity as a lesbian) ((Russell & Fish, 2016). For example, perceived sexual orientation-related discrimination accounts for elevated suicidal ideation among

young LGBTQ males relative to their non-LGBTQ peers (Almeida et al., 2009). Other studies have shown that support of gender minority youth's chosen name in multiple contexts (e.g., home, school, work, peers) is associated with reduced depression, suicidal ideation, and suicidal behaviors (Russell et al., 2018; The Trevor Project, 2020).

The minority stress framework can also be used to explain patterns of help-seeking among suicidal LGBTQ youth. Only two research studies have directly examined this topic. A recent study of 592 LGBTQ youth found that greater lifetime minority stress was associated with decreased comfort in sharing suicidal thoughts with others, including mental health-care providers (Chang et al., 2020). The other investigation found that while a large proportion of LGBTQ youth did not tell anyone about their suicidal thoughts or behaviors (e.g., 73.1% of gay male respondents), those who did reach out for support were most likely to seek support from a friend (Lytle et al., 2018). However, support from family was associated with fewer suicidal behaviors, underscoring the significance of family support.

The current study seeks to build on the lessons learned from the minority stress framework by incorporating the voices of LGBTQ youth with lived experience to provide treatment recommendations on quality improvement for mental health clinicians. This study is one of the first to directly elicit feedback from youth stakeholders on the topic of improving suicide prevention care specifically for LGBTQ youth, with the overall aim of informing quality improvement for strengthening outcomes in this population characterized by high suicide and suicide attempt risk.

Materials and methods

Participant demographics

Individual interview participants were recruited through study flyers posted throughout UCLA's medical and college campus, outpatient mental health clinics, and distributed through UCLA's LGBTQ student resource center e-mail newsletter. Eligible participants met the following inclusion criteria: 1) endorsement of an LGBTQ identity, 2) history of mental health treatment for past suicidal thoughts and/or behavior, and 3) current age of 12–25 years. Focus group participants were recruited from UCLA's EMPWR clinic, which provides affirming mental health services (psychotherapy and psychopharmacological care) to LGBTQ youth (aged 12–17) and their families. Youth seeking care at this clinic typically present with distress as a function of minority stressors and a desire to obtain care in an environment that is affirming to LGBTQ youth.

Demographic data were collected via administration of a Qualtrics questionnaire, through chart review, and orally during the qualitative interviews. Examples of questions assessing LGBTQ identity include "What is your sexual orientation?," "What is your gender identity?." When answering questions through the Qualtrics questionnaire, participants were given a variety of multiple-choice answers to select, as well as an option for a write-in response for instances when the desired answer was not available.

Youth participating in the individual interviews (n = 20) identified primarily as female (40%), bi/pansexual (75%), and White (40%) with an average age of 20.8 years. Due to the age range of the individual interviews, most youth had or were pursuing an undergraduate degree, with a small subset in the process of obtaining a master's degree (often in psychology or a related field). In contrast, the majority of youth participating in the focus groups (n = 21) identified as male (29%) or transgender male (24%), with a more equal distribution on sexual orientation: lesbian/gay (38%), bi/pansexual (33%), and questioning (29%). The average age among focus group participants was 14.8 and most identified as White (81%). Full participant demographics are displayed in Table 1.

Study procedures

Qualitative data were collected in two ways: individual interviews and focus groups. For the individual qualitative interviews, interested participants contacted the research coordinator through information listed on study flyers to complete an initial study screening to determine whether an individual met study inclusion criteria. A crisis management protocol was in place in the event that a prospective participant expressed current suicidal ideation. Youth recruited through the EMPWR clinic were provided with information on study procedures

Table 1. Participant demographics.

Variables	Individual Interviews (n = 20)	Focus Groups (n = 21)
Age (Mean)	20.8	14.8
Race		
White	8 (40%)	17 (81%)[2]
Asian	5 (25%)	-
Nonwhite, Not Otherwise Specified	1 (5%)	4 (19%)
Missing	6 (30%)[a]	-
Sexual Orientation		
Lesbian/Gay	2 (10%)	8 (38%)
Bi/Pansexual	17 (75%)	7 (33%)
Queer/Questioning	3 (15%)	6 (29%)
Gender Identity		
Male	1 (5%)	6 (29%)
Female	8 (40%)	3 (14%)
Non-binary/Fluid	6 (30%)	4 (19%)
Trans male	4 (20%)	5 (24%)
Trans female	1 (5%)	0
Agender	0	2 (9%)
Unsure	0	1 (5%)

[a]Race data were collected after individual interviews had been conducted; six participants did not respond to requests for this information and were thus coded as "Missing." [2] Focus group participants were identified as either White or nonwhite; no additional categories were collected.

and given the opportunity to speak with study staff about participation in qualitative focus groups. Informed consent and assent were obtained from all study participants and/or parents/caregivers. All youth participating in the individual interviews were over the age of 18 and able to provide informed consent without parental involvement. Youth were given a 25 USD gift card as reimbursement for participation in the study. This study received approval from UCLA's Institutional Review Board.

Youth participating in the individual qualitative interviews were asked questions from a semi-structured interview. Individual interviews emphasized quality improvement of suicide prevention-specific care for LGBTQ youth. Questions sought to elicit suggestions on how to improve mental health care for suicidal LGBTQ youth, feedback on past experiences with clinical care, and suggestions on specific components of treatment such as family involvement and ways to provide a safe therapy space for LGBTQ youth. Individual qualitative interviews lasted approximately 45 minutes in duration.

Focus groups lasted approximately 25 minutes in duration and consisted of an average of five youth with four focus groups total. Focus groups emphasized components of mental healthcare related to LGBTQ topics. Questions in focus groups targeted what was and was not helpful about the group treatment received at the EMPWR program, including potential barriers to care, and suggestions on improvements for the intervention that was received.

Data analysis

The audio of all interviews and focus groups was recorded and transcribed verbatim. Prior to coding, the study team deductively created a codebook highlighting the core themes of interest. During the coding process, additional codes were inductively added as they arose (Crabtree & Miller, 1999). Researchers used an iterative process to continuously refine and revise these codes (Cohen & Crabtree, 2008). Two researchers (LZ and ISvD) coded each of the transcribed interviews. To calibrate scores, the first three transcriptions were coded together and discussed in detail. The remaining transcriptions were then coded separately by each of these raters who later met to reconcile any discrepancies and reach consensus (Cope, 2014). The software NVivo 10.0 (QSR International Pty Ltd, 2014) was utilized to organize and analyze these qualitative data.

The final codebook can be found in Table 2 and consists of 13 distinct codes with two additional options to denote a particularly powerful quote ("Nugget") or information that may necessitate the creation of an additional code ("Bucket"). The 13 codes included (a) Helpful about treatment received, (b) Not helpful about treatment received, (c) How to bring up LGBTQ identity, (d) Important clinician factors, (e) Impact of LGBTQ identity on care, (f) Youth suggestions, (g) Suicide risk reduction, (h) Link to LGBTQ identity, (i) Ways youth found provider, (j) Parent/Caregiver involvement, (k) Treatment barriers, (l) Non-therapy factors impacting wellbeing, and (m) Unique challenges. During the coding process, both raters determined that thematic saturation had been met due to a lack of emergence of new codes or themes (Saunders et al., 2018). Discussion of findings with the entire study team confirmed this conclusion and the decision was made to discontinue recruitment of study participants.

Results

Given the richness of the data, results have been organized into four overarching sections. First,

Table 2. Codebook.

Code	Description
Helpful about treatment received	Factors identified about what is helpful in treatment
Not helpful about treatment received	Factors identified about what is not helpful in treatment
How to bring up LGBTQ identity	Insight on ways to appropriately bring up LGBTQ identity in care
Important clinician factors	Factors specific to therapist that are helpful in care
Treatment barriers	Factors that get in the way of obtaining treatment
Impact of LGBTQ identity on care	Ways LGBTQ identity of youth may impact care received
Youth suggestions	Treatment suggestions made by youth
Parent involvement	Suggestions made for effective parent involvement
Suicide risk reduction	Helpful strategies for suicide risk reduction
Link to LGBTQ identity	Ways youth feel LGBTQ identity is linked to mental health
Unique challenges	Unique challenges that may contribute to mental health issues for LGBTQ youth
Ways youth found provider	Manner in which youth found mental health care provider
Non-therapy factors impacting wellbeing	Non-therapy factors that impact LGBTQ-specific wellbeing (e.g., moving to California)

results will detail participants' specific reflections on accessing and receiving evidence-based care (see "Therapy"). Next, results are presented that are pertinent to three key domains of youth functioning, specifically: functioning in the home (see "Home"); school setting (see "School"); and with peers (see "Peers"). See Table 3 for a depiction of how study codes loaded onto each domain. In the following sections, considerations are illustrated that may be helpful for clinicians to keep in mind when providing care for suicidal LGBTQ youth. See Table 4 for a distribution of codes across sources (i.e. individual interviews and focus groups).

As each of the sources used in the study had nuanced strengths in the information gathered (i.e. individual interviews emphasizing suicide-specific considerations and focus groups highlighting minority stress factors), results were synthesized to showcase the unique perspectives gathered from each sample of stakeholders in a manner readily transferable to quality improvement recommendations. Similarly, it should be noted that due to the diversity of the sample in regard to demographic factors such as LGBTQ identity, age, and race, as well as history and type of past mental health treatment, some study results and related recommendations may be especially relevant to certain subgroups of youth while not being as salient to others. Due to this, it is essential to avoid viewing findings in a strict "one-size-fits-all" approach during the application to clinical practice, and to instead consider which themes appear to be the most helpful when working with an individual youth.

Therapy

Finding an affirming provider

In order to receive evidence-based care, youth and their families must first locate a provider, ideally one who is affirming to LGBTQ youth (e.g., viewing LGBTQ identity as part of normative process and providing a safe therapy space). When asked about how youth initially found their clinicians, many described searching online. One participant reported, "I desperately wanted some sort of help and so

Table 3. Relationship of codes to themes.

Heading	Themes	Codes Contributing to Theme
Therapy	Finding an affirming provider	Ways youth found provider; Important clinician factors; Youth suggestions; Unique challenges
	Important clinician factors	Important clinician factors; Helpful about treatment received; Not helpful about treatment received
	Creating a safe therapy space	Impact of LGBTQ identity on care; Helpful about treatment received; Important clinician factors; Suicide risk reduction
	Confidentiality of LGBTQ identity and suicidality	Impact of LGBTQ identity on care; Not helpful about treatment received; Parent involvement; Suicide risk reduction
	How to initiate discussion of LGBTQ identity	Impact of LGBTQ identity on care; Not helpful about treatment received; Parent involvement; Suicide risk reduction
	Link between suicidality and LGBTQ identity	Link to LGBTQ identity; Helpful about treatment received; Important therapist factors; Not helpful about treatment received
Home	Barriers to accessing mental health care	Treatment barriers; Parent involvement; Unique challenges
	Parent/caregiver involvement	Parent involvement; Helpful about treatment received; Suicide risk reduction
School	Clinician as advocate	Youth suggestions; Unique challenges
	Role of school staff	Treatment barriers; Non-therapy factors impacting wellbeing
Peers	Connecting LGBTQ youth to peers	Youth suggestions; Helpful about treatment received; Unique challenges
	Role of online communities	Non-therapy factors impacting wellbeing; Suicide risk reduction; Unique challenges

Table 4. Distribution of codes across sources.

	Code												
Source	Helpful about treatment received	How to bring up LGBTQ identity	Impact of LGBT identity on care	Important clinician factors	Link to LGBTQ identity	Non-therapy factors impacting wellbeing	Not helpful about treatment received	Parent Involvement	Suicide Risk Reduction	Youth Suggestions	Treatment barriers	Unique challenges	Ways youth found provider
Interview 1	X	X	X	X	X	X	X			X	X		
Interview 2	X	X	X	X			X	X	X	X	X		
Interview 3	X	X	X	X		X	X	X	X	X	X		
Interview 4	X	X	X	X	X	X	X	X	X	X	X	X	
Interview 5	X	X		X	X		X	X	X	X	X	X	X
Interview 6	X	X	X	X		X	X	X	X	X	X	X	
Interview 7	X	X	X	X	X	X	X	X		X	X	X	X
Interview 8	X	X		X			X	X	X	X	X	X	
Interview 9	X	X	X	X		X	X	X		X	X		X
Interview 10	X	X	X	X	X		X		X		X		X
Interview 11	X	X		X	X		X	X	X	X		X	X
Interview 12	X	X	X	X	X	X	X	X	X	X	X	X	X
Interview 13	X	X		X	X	X	X	X	X	X	X	X	X
Interview 14	X	X		X	X	X	X	X	X	X	X	X	
Interview 15	X	X		X	X	X	X	X	X	X	X	X	
Interview 16	X	X	X	X			X	X		X	X	X	
Interview 17	X	X	X	X	X	X	X	X	X	X	X		X
Interview 18	X	X	X	X		X	X	X		X	X	X	X
Interview 19	X	X	X	X	X	X	X	X	X	X	X		X
Interview 20	X	X	X	X		X	X	X	X	X	X		X
Focus group 1	X						X	X		X			
Focus group 2	X						X			X			
Focus group 3	X							X		X			
Focus group 4	X		X				X	X	X	X	X		
% of sources	100.00%	83.33%	62.50%	79.17%	54.17%	58.33%	95.83%	87.50%	66.67%	95.83%	83.33%	50.00%	45.83%

I turned to the internet." Several youth indicated that they felt more comfortable contacting clinicians who listed having experience with LGBTQ populations on their website. "I tried to go on people's websites and look at their bios to see if they listed LGBTQ issues as something they could handle," one participant said.

However, not all youth had the flexibility of selecting a preferred clinician online. Instead, many were limited to the mental health professionals who were available through school services. One youth indicated, "The only help I could potentially get as a minor without my parents knowing was going to my school counselor." Another young person, who waited until college to seek care, shared, "I just went to the university counseling center and got paired with the graduate counselor."

Youth's decision-making processes with regard to finding a clinician were often heavily influenced by their level of independence in healthcare decisions. Some youth reported that their only option was to see a provider selected by their parents due to their lack of autonomy. One participant shared, "My mom found me a therapist that she wanted me to see and unfortunately, I didn't really feel like I had a choice." Another noted that although they had a choice about whether or not to attend therapy, they often had no choice about the specific clinician they would see. One participant described, "The initial want to start therapy was mine, but then the ultimate decision on which therapist was my mom's." While caregivers making healthcare decisions for their children is arguably the norm, it is important to consider the unique challenges this practice places on LGBTQ youth. As one youth later learned about his clinician, "I found out that my mom chose her with an intention in mind of asking her to do conversion therapy on me."

Important clinician factors

When asked what was most helpful in terms of clinician qualities, the majority of participants emphasized the importance of a clinician who is able to quickly build rapport. Two youth noted that "I think the one thing you need with a therapist is mutual trust and respect," and "I feel like [I can be comfortable] as long as a professional has an accepting, open environment." While these are undoubtedly qualities that are essential in any therapeutic setting, they appear to be even more important for youth who may have experienced discrimination related to their LGBTQ identity. Because of this sensitivity, many youth reported a preference for working with younger clinicians due to the belief that these providers may be more accepting. One youth stated, "I was concerned about sexuality issues, and I just had this assumption that if they were younger, they're probably gonna be more understanding and more open about that."

Youth were more divided about whether they preferred their clinician to share their LGBTQ identity. Many believed that in order to work successfully with LGBTQ youth, a provider must also have a LGBTQ identity. For example, one youth noted that "If a therapist is heterosexual, they wouldn't be able to respond appropriately to a young adult seeking help in that field, because they haven't struggled with it themselves, there isn't really much to say," while another stated, "If you're a therapist and you don't go through the experience, I don't understand how you could be an [effective] therapist." One youth shared that for her, the importance of having a clinician with a LGBTQ identity was helpful to build hope for the future. She noted, "Just seeing that there's a queer person who is living her life and having a great time being a therapist made me feel a lot better."

In contrast, several participants did not identify LGBTQ identity as a necessary quality for an effective and affirming clinician. As one youth pointed out, "Being LGBT doesn't predicate you being knowledgeable about LGBT issues," and "Just because someone is straight does not mean they will not be a better fit." Instead, an emphasis was placed on training providers have received and their ability to utilize this knowledge in session without placing the burden of education on the clients themselves. One youth reported, "I don't go to therapy so I can go educate somebody. With my current therapist I'll be like I'm nonbinary, trans-masculine and I don't have to explain what that means." Another participant said, "Providers who make a serious effort to get pronouns right and names right and things like that I feel much more comfortable with."

Many youth also expressed a strong preference for BIPOC (Black, Indigenous, People of Color)

clinicians. Similar to the reasoning outlined for LGBTQ clinicians, there was the belief that BIPOC clinicians might be able to better understand the challenges LGBTQ youth were experiencing. As one youth noted, "If you already have a marginalized identity, you would be more likely to be able to understand the experience of another marginalized identity." In addition, youth brought up the critical need for a clinician to be educated about specific cultural beliefs/practices in regards to gender and sexual identities. One participant reported that "Cultural differences and the stigma with Mexican parents and people in the LGBTQ community are very specific," while another noted

> That's where the cultural competency came in, because my experience is that people who are not very well versed in this got stuck around issues on sexual orientation and gender identity, but never brought in the cultural context of it, which just makes us go in circles.

Creating a safe therapy space

Several youth described how they were initially unsure if their clinicians would be affirming their LGBTQ identity. Youth reported examining the clinician's environment for signs of support. Indicators pertaining to LGBTQ support significantly influenced their comfort around disclosing personal information during therapy sessions. Participants suggested the use of various items that would indicate a clinician's support of and experience with LGBTQ people. For example,

> If you have a lanyard or something you could wear, something connected to the LGBTQ community, whether it be a rainbow flag or something … it's a clear message to other LGBT people that they can come to you and trust you about who they are.

One youth recalled the strong impact that these small gestures can have on their trust of clinicians, noting, "I remember a therapist, they had these little stickers of the pride flag on their wall, just knowing that they deliberately put them up there was helpful."

Confidentiality of LGBTQ identity and suicidality

One of the main concerns identified by youth was the notion of confidentiality related to both suicidal thoughts and LGBTQ identity. Youth shared that they felt a double threat of sorts, noting that "There's suicidal thoughts and then another barrier of being queer, it's kind of like a double wall that you have to break in order to get what you need." Youth emphasized the importance of a thorough explanation of confidentiality as one of the first pieces of information to be conveyed during an initial session. One participant stated that "it helped that she made sure I was super clear on her role as a mandatory reporter. At what point she would be required to say something, and at what point it would be confidential." Youth expressed often being extremely concerned that sensitive session content would be shared with parents when confidentiality was unclear. As a result, youth reported sometimes not disclosing information during sessions, which significantly limited utility of therapy; for example, one youth reported,

> I was very careful to not make what I was feeling sound too serious because I didn't know if they had mandates for telling people or parents or professionals if they assumed the kid was actually in danger. Even though I definitely was very suicidal, I tried to definitely tone it down.

Although LGBTQ identity is not information that would require a clinician to break confidentiality according to the APA Ethics Code, this was an unexpectedly common misconception among youth interviewed. Indeed, one youth stated, "I was worried that it was gonna get back to my parents, or something bad was gonna happen and I was gonna get sent away." Several youth indicated that this fear prevented them from feeling comfortable in therapy and sharing their LGBTQ identity during the initial sessions.

How to initiate discussion of LGBTQ identity

In order to implement the recommendations outlined in this article, it is first necessary to identify LGBTQ youth in a clinical setting. Some youth emphasized the importance of broaching this topic early in treatment due to the message of acceptance it sends to patients. One youth reported that "The fact that they never brought it up made me feel like 'this is still something to hide, this is still something that shouldn't be talked about.'" Despite many youth wanting clinicians to ask about this topic, they also acknowledged that it

can be challenging to do so depending on the youth's comfort level with LGBTQ identity. One participant stated that "Some people are more comfortable talking about it than others, and it's hard to gauge how someone is going to respond to that, especially if they are not out or they're not comfortable talking or just confused in general." Another participant agreed, noting that "It's a very sensitive topic. When I was 14, I was just figuring it out, if someone asked me that I would have said no, like it doesn't matter who it was."

Because of potential difficulties in navigating this conversation, youth suggested the use of a survey to ask about LGBTQ identity. A participant said, "I really liked the form at the university counseling center because it's a lot easier to disclose your problems on a non-personal form before facing someone." One youth highlighted the benefits of a written survey option:

> You don't have to disclose anything if you don't want to come out, or if you do want to come out but you don't want to come out through talking about it … it's not putting you on the spot right there in an in-person intake.

Other suggestions from youth included clinicians asking about romantic relationships in the context of getting to know a youth better during the beginning of therapy or asking about which of their identities (e.g., racial, cultural, sexual orientation, role as student/sibling, etc.) are most important to a youth.

Link between suicidality and LGBTQ identity

Several youth highlighted the importance of clinicians understanding the link between LGBTQ identity and suicidality. Youth often brought up interactions with past mental health-care providers who incorrectly believed that a youth's suicidal thoughts were entirely a result of their LGBTQ identity. Observations shared by participants indicate that not only is this assumption factually incorrect, but this belief then limits the effectiveness of treatment due to an inaccurate case conceptualization. Participants often spontaneously clarified this distinction during interviews, with one participant noting "I have had suicidal tendency and I'm LGBT, but I have not had suicidal tendency because I am LGBT." Another youth highlighted that "It's part of my identity and yes it might have something to do with how I feel but I am my own person and I shouldn't be dictated by my sexual orientation or gender identity." At the same time, youth also emphasized the harmful effects of environmental stressors due to their LGBTQ identity. One youth shared that "Being LGBTQ and just how society looks at you and things like that, it does amplify your mental health obviously or mental health issues," while another stated that "If I was with my girlfriend and I wanted to hold hands with her, it was kind of like … just all these eyes on me, it's like compounded stress. You would just feel like 'I don't wanna exist.'" As a result of these factors, youth urged clinicians to be aware of striking the balance of how much to incorporate the role of LGBTQ identity into treatment. As one youth emphasized, "Understanding how the two interact, because there was definitely a point where being queer interacted with being mentally ill. It wasn't the cause of it or anything, but especially stress around going out with partners and things like that."

Home

Barriers to accessing mental health care

The fact that youth under the age of 18 rely on caregiver support to obtain mental health care was identified as a primary barrier to care. Youth with parents who were unsupportive of therapy or of their LGBTQ identity described frequently feeling hopeless about accessing care. One youth described, "I was completely barred from actually getting adequate help because there was just no way I could talk to my parents about it." Youth also brought up structural barriers like finances and transportation, both of which are often difficult to navigate without assistance from caregivers. Another youth explained, "There was literally no way I could have left the house on my own and go to see this particular therapist without my parents knowing and then I also wouldn't have had any way to pay for it."

Parent/caregiver involvement

When asked about the role of parents in therapy, youth often highlighted the significant impact that

their families of origin had on their mental health. As one participant described, "People who have family support come out of really dark places. If I didn't have that family support, I don't know where I'd be today, so I think that is a huge aspect of it." Youth showed empathy for their parents, noting that it is not always easy to know how to best support suicidal LGBTQ youth. "For parents who are straight, having a gay kid could be confusing," one participant stated. They highlighted the importance of clinicians normalizing this experience and providing parents with education about LGBTQ topics and suicidality. One participant noted that "My mom really needed to know that it is not something that you can change and it is not something that you can hide and pretend that it's not going to affect you when you hide it." Another said, "[Clinicians can] help parents understand how to talk to kids about things like self-harm or suicidality." Youth described finding it helpful for the clinician to function as an advocate in therapy sessions by assisting the youth in navigating challenging conversations or providing psychoeducation on LGBTQ topics and suicide prevention.

Some youth reported feeling stressed by the idea of educating their parents and instead preferred for the clinician to take on this role. As one participant described, "I don't want to be the person to teach you, I shouldn't be required to explain why I'm, trans or bi, or how it feels, and all this information." Several youth preferred for the clinician to meet with their parents alone so that parents could have the opportunity to learn how to respond appropriately without the youth present. Other youth found it helpful when the clinician facilitated these conversations with the youth part of the session:

> [My clinician] acted as an advocate for me. I think she knew that I wouldn't wanna say a lot under that kind of pressure, so she took on a lot of the talking for me. But she didn't try to put words in my mouth, so like asking my opinions.

Although youth were understanding of parents needing resources and additional education around mental health and LGBTQ identity, youth also expressed the need for clinicians to send a clear message around the importance of acceptance. One participant expressed that "Outreaching, normalizing the concept of mental health, having resources for the parents that the youth can send to their parents, in their native language would be great," while another highlighted the need for clinicians to send the message that "You may not agree with it, but this is your kid's reality. Your child is experiencing this every day, and it's not about whether you agree with it, it's about the fact that they are going through it."

School

Clinician as advocate

When asked about ways clinicians can support LGBTQ youth's adaptive functioning in the school setting, youth overwhelmingly identified a need for greater visibility around mental health resources, in both high school and college environments. As one participant described, "When I was in high school a lot of people were struggling with mental health issues but they didn't know where to go, because it's stigmatized in that way, it's this issue that no one wants to address." Youth expressed a desire for mental health providers to directly target this issue by contacting schools to provide resources, "I think they should be the educator for society . . . being able to give out flyers to schools, so they can put them up or getting on social media and showing the real aspects of mental health and what's going on." Additional suggestions included providing workshops on LGBTQ and mental health topics on college campuses that are accessible to both school staff as well as students. One youth suggested, "Maybe having more workshops on campus that are centered around these topics to push people that are struggling with similar things to come together, discuss, and connect to one another."

Youth emphasized the importance of improving accessibility of information around mental health for LGBTQ youth. One participant noted in the college setting, "I don't feel like I've seen any flyers or listings for getting mental health help for LGBTQ youth . . . even adding them to newsletters can be helpful. If students are subscribed to groups that send these emails, that would be helpful." In addition, some youth made a clear link between suicidal thoughts and the absence of LGBTQ topics in the high school curriculum. As one youth noted, "In sexual education in general, the lack of LGBT content is harmful," while another said, "I feel like

if they would have gone into more depth with that, even if it doesn't apply to the whole class, the one or two people it applies to . . . it would drastically help them, it might even save them."

Role of school staff

Youth also discussed the role of empowering high school staff to better support LGBTQ youth who might be at risk for suicide because, unlike clinicians, they are accessible during the school day. Youth emphasized "Better equipping people who might be the first person they turn to, even like teachers." In particular, participants described how even small comments made by school staff indicating support of the LGBTQ community could be immensely helpful. One youth said, "If you are struggling with identity, if you are struggling in that way, there was no one that ever said anything that would have really been nice and helpful." The overarching theme of suggestions from youth was that while changing the culture of an entire school is by no means feasible for a single mental health provider, it may be possible to support a youth in connecting to one school employee who can provide some level of validation.

Peers

Connecting LGBTQ youth to peers

Many youth cited feeling isolated due to their LGBTQ identity and often not knowing others who identified as queer. Several youth identified social connection to other LGBTQ youth as creating a significant improvement in their suicidal thoughts and suggested that clinicians help encourage this link to peers. One participant noted that "For a gay person to feel seen, heard, and connected to other gay people you start to not be so insecure about that aspect of your identity," while another described

> Now I'm in a LGBT club and I volunteer at the LGBT center, but that was me doing work and me meeting people that I could identify with and it would have been helpful if my therapist had suggested that I do these things because I sought it out on my own.

Because of this suggestion, youth reported it may be helpful for clinicians to familiarize themselves with local LGBTQ organizations that are appropriate for youth in order to help improve youth's social functioning with peers. One participant stated,

> If there is any kind of local queer event or support group or anything for young people to go, that are queer, that would be very useful and helpful. Growing up in an area where any sort of gay or queer stuff was really frowned upon, in general not accepted growing up, being older and being able to be around queer people would be very helpful.

Role of online communities

As discussed in the section on the importance of confidentiality, many youth had significant misconceptions about confidentiality. Indeed, some youth expressed their distrust of adults in a pointed manner: "It's generally a rule that if you know a friend who self-harms, you do not tell anyone . . . it's definitely a thing among people who are mentally ill that going to adults is a big 'no-no.'" Instead, youth reported that they suggest the use of online communities to their LGBTQ peers who are in distress. One participant noted,

> It becomes a thing where they will rather seek out support online, online groups or friends rather than resort to going to adults because they don't want to be forced to do something against their will. Which, in the end, it might actually trigger them into actually harming themselves, so in the end it may be, it might just do more bad than good.

Several youth suggested that if clinicians were to distribute information on mental health in the form of fliers or other media in educational settings, it might be worthwhile to also mention the option of online communities for those who may be especially uncomfortable with the idea of going to an adult for help.

Youth wanted to be clear with interviewers that they were not encouraging their peers to go to online friends for mental health treatment, especially for suicidal thoughts. Instead, youth primarily described online communities as a way to gain increased exposure to other LGBTQ people who are thriving, both mentally and in other aspects of their lives:

> Having the online community support and just kind of seeing that you can be, Trans and happy, you can be, Trans and pursue your transition and you know making friendships and seeing my friends living their lives and

being happy and seeing their struggles and stuff was really helpful for me and having that representation.

Discussion & treatment recommendations

The rich interview data provided by LGBTQ youth highlight various quality improvement considerations that clinicians should be aware of when working with these youth. To facilitate the connection between the responses obtained from the qualitative interviews and the practical clinical recommendations gleaned from them, the discussion and recommendations have been organized under the same headings as those presented earlier. As previously mentioned, recommendations are meant to be considered in the context of relevant clinical factors for each youth prior to application, as study findings represent a multitude of viewpoints drawn from many different LGBTQ youth. Recommendations for quality improvement presented below are informed directly by study results.

Therapy

Finding an affirming provider

Given that identifying an affirming provider was often cited as a prominent concern, it is highly recommended for clinicians to help youth feel comfortable when reaching out to a mental health provider for the first time. They are likely unsure about a clinician's feelings around the LGBTQ community. To assist youth in recognizing a clinician as LGBTQ affirming (e.g., willing to provide a safe therapy space for LGBTQ youth, knowledgeable about LGBTQ specific stressors), it is recommended to customize websites or flyers containing clinic information to include indicators such as relevant trainings that have been completed on LGBTQ topics, listing LGBTQ issues as an area of specialization, or clearly stating support for the LGBTQ community.

Important clinician factors

In order to provide a therapy environment that is perceived as warm and accepting by youth, it is recommend to become educated about LGBTQ topics and vocabulary while also staying informed about current events impacting LGBTQ patients. These recommendations may be especially important for clinicians who are not LGBTQ and/or not familiar with LGBTQ-related stressors. Similarly, because many youth indicated a preference for younger, BIPOC clinicians due to their personal experiences of marginalization, older, non-BIPOC clinicians may want to intentionally educate themselves about these topics. It would be important for these clinicians to specifically learn about how cultural factors may intersect with LGBTQ identities in causing stress that precipitates suicidality in LGBTQ youth and to be aware of assumptions that youth may make around their level of acceptance.

Creating a safe therapy space

Youth indicted that clear indicators of LGBTQ allyship within the clinic can help set the tone of the therapy setting and increase comfort with the clinician even prior to the start of a session. To ensure that a physical therapy space conveys a message of a safe, affirming environment for LGBTQ youth, it is recommended to have readily visible indicators of this commitment to acceptance that are easily displayed in the clinic setting. Examples of these items include wearing a lanyard, pin, or another accessory that has features such as a rainbow flag or preferred pronouns. In the clinic waiting room or therapy rooms (including telehealth backgrounds), pride flags or certificates of completion for trainings that a clinician/clinic has done on providing LGBTQ affirming care can be displayed.

Confidentiality of LGBTQ identity and suicidality

There was a clear message from participants regarding confusion around limits of confidentiality as it relates to suicidal thoughts as well as LGBTQ identity. While many clinicians review the general limits of confidentiality for youth prior to providing treatment, it is especially important to give examples of limits around suicidality. Some youth may find it reassuring to understand what types of statements would lead to a recommendation for a higher level of care. In addition, while it may be common to list exceptions to confidentiality at the outset of therapy, it might be helpful to also provide examples of potentially sensitive topics for youth that would not require a break in confidentiality (e.g., questioning sexuality and gender identity, negative thoughts about parents, not doing well in school). These discussions could potentially help clinicians build

rapport with the youth, which may lead to increased comfort in disclosing personal information during sessions.

How to initiate discussion of LGBTQ identity

Since youth indicated that it may take some time for them to feel comfortable sharing their sexual and gender identity with a clinician, it is recommended to give patients multiple opportunities to disclose this information in a variety of ways. Options include written demographic forms during intake and through ongoing discussions of peers, romantic interests, and support systems. Clinicians should be careful to intentionally not use gendered language when asking about romantic relationships (e.g., have you had/do you have a boyfriend?) to avoid making any assumptions about sexual orientation. It would also be beneficial to identify one's own pronouns during the introductory session and to invite a youth to do the same in order to demonstrate a clear appreciation of the value of using a youth's preferred pronouns at the outset of treatment. However, it is important to not ask these questions when caregivers are in the room and to instead make this a private conversation between the clinician and youth so that the patient does not feel pressured to share information with family members.

It is recommended that clinicians make an effort to normalize LGBTQ identities by discussing them in fashion similar to other factors potentially relevant to therapy such as race, ethnicity, culture, and religion. For example, a clinician might make the following statement: "Just so I can get to know you better, can you tell me a little bit more about what's important to you? Some people feel certain identities are especially important to them. Can you help me to better understand how you identify? For example, for some people, gender, race, or sexual orientation are important ways they identify." This approach is in line with the Cultural Formulation Interview from the DSM-V, specifically the section on the role of cultural identity (Aggarwal & Lewis-Fernández, 2015). For additional questions like these and to learn more on ways to ask about a patient's current distress in a culturally inclusive manner, it is recommended that clinicians familiarize themselves with this clinical resource which can be used effectively with LGBTQ youth.

Link between suicidality and LGBTQ identity

Feedback from participants indicated that it is critical for providers to understand that LGBTQ identity does not cause suicidality. Youth experience stressors in their social environments related to LGBTQ identity that cause distress. Additionally, reported stressors may be just one factor contributing to a youth's suicidality. As such, it is important for clinicians to not make assumptions about ways a youth's identity is connected to suicidal thoughts and to instead discuss with the youth the role these factors play in their current presentation. If caution is not taken to avoid generalizations when first learning about a youth's LGBTQ identity, a clinician risks potentially alienating a patient at the outset of treatment.

Home

Barriers to accessing mental health care

Due to the many financial and transportation barriers raised by participants due to unsupportive caregivers, it is important to consider ways the standard clinic procedures could be modified to accommodate these needs. For instance, a clinician might consider offering sessions via telehealth and having flexible scheduling options in the afternoons and evenings for youth attending school who do not have access to transportation. It might also be worthwhile to investigate programs in the local community that may provide low-cost transportation for youth when telehealth is not a viable option. For clinicians who feel comfortable going above and beyond standard practice, there may be interest in offering need-based low-or-no cost services to youth with limited financial resources (in line with the APA Ethics Code, Principle of Fidelity and Responsibility, American Psychological Association, 2017). Similarly, clinicians should be knowledgeable on state policies relevant to whether certain youth can obtain clinical services without parental consent.

In the event that a lack of parental consent is a significant barrier for a youth seeking care, it may be helpful to include alternatives to therapy on a clinic website for youth who may be searching online for a provider. Examples are further discussed under the Peers heading where options such as online LGBTQ communities appropriate for youth are covered (such as Trevor Space), in

addition to in person/virtual support groups. While these recommendations are later discussed as being helpful to provide in the context of therapy, they can be equally important to list as options that youth may pursue on their own when therapy is not an option. Additional resources that may be helpful to list on a clinic website include suicide prevention hotlines such as the National Suicide Prevention Hotline (800–273-8255) and the Trevor Project Lifeline (suicide prevention hotline specifically for LGBTQ youth, 1–866-488-7386) where it is free to talk to a crisis counselor and parental consent is not required.

Parent/caregiver involvement

Participants described a significant variability in support from caregivers around LGBTQ identity. Providers should engage youth in deciding if and to what degree to involve caregivers in treatment. It is recommended that decisions about the extent of the parents' role be made in collaboration with the youth so that the patient feels their needs are valued. During potentially challenging family sessions where LGBTQ identity or suicidality is the topic of conversation, it can be helpful for a clinician to actively advocate for the youth if there are concerns about lack of support. When caregivers have a clear need for education on LGBTQ topics or suicide prevention, it may be appropriate for the clinician to meet with parents alone to provide psychoeducation so that this responsibility does not fall to the youth. In these sessions with caregivers, clinicians can normalize LGBTQ identities and provide parents with opportunities to express feelings about their child in an open and genuine way so that they can feel heard and validated by the clinician. This opportunity might also be used to discuss concerns about suicidality in language that is easy for parents to understand.

School

Clinician as advocate and role of school staff

Many participants described a hope for clinicians to act as advocates and educators to some degree in both the high school and college settings. When working with caregivers who are supportive of their children, providers might explore their interest in becoming more active in the youth's high school organizations (such as in Parent Teacher Association meetings) so that they can encourage representation of marginalized communities such as LGBTQ people in school curricula and services. Clinicians can also collaborate with schools directly to provide workshops or open forums for school staff, parents, and youth with the goal of sharing information on mental health topics and the LGBTQ community. Additionally, collaborating with schools could be an opportunity to highlight clinician's services so that youth learn more about potential options for care. For interested high school and college staff, clinicians could provide resources on supporting the mental health needs of students in the school setting and suggest trainings that may be applicable for educators.

Peers

Connecting LGBTQ youth to peers and online communities

Participants described powerful positive effects of having supportive LGBTQ peers on mental health and suicidal thoughts. Due to this, to the degree that it aligns with a youth's treatment goals, clinicians can convey the importance of social connection to other LGBTQ youth and encourage contact with supportive peers. Clinicians can take time to research resources for LGBTQ youth in the local community (e.g., support groups, LGBTQ youth drop-in centers) and share these resources with patients during the course of therapy. It may also be helpful to assess a youth's use of online communities and their engagement in safe internet practices (e.g., disclosing personal, identifiable information). Moreover, clinicians might discuss healthy and appropriate use of online communities and distinguish between making new LGBTQ friends and seeking crisis support from peers.

Diversity considerations

When considering these study findings, it is essential to note the diverse identities and experiences of LGBTQ youth. For example, one youth stated,

> There are going to be gay teens who are totally accepted by their family and they have social support, especially now when it's becoming more and more accepted in society versus maybe a, trans teen who is closeted and is coming from a family of immigrants. It's like totally different, right?

Therefore, one of the most important considerations when working with LGBTQ youth is to conduct a thorough assessment of the factors that may play a relevant role in the manifestation of suicidality when creating a case conceptualization.

Due to the vast number of identity intersections that can be present when working with suicidal LGBTQ youth, participants advised for clinicians to take a humble approach, which would likely be met with empathy from youth. One youth stated, "Sometimes therapists have an idea like, 'I went to school and I got my PhD, and that means I know.' But you don't always know, and it's not even anyone's fault, it's just that you can't live all identities."

Limitations

The primary limitation of the study is that posed by the issue of intersectionality within the LGBTQ community and the relatively small sample size. It is essential to recognize that for example, the experiences of a black lesbian cisgender girl would be drastically different than a white gay transgender boy. Due to the great diversity within LGBTQ communities, combined with factors such as race, ethnicity, and culture, there will undoubtedly be limitations in the generalizability of study findings during the translation to clinical application. Unfortunately, this is further pronounced by the fact that data on race were missing for a subset of participants. It also must be noted that the sample was drawn from a large urban university and an associated clinic in the state of California, which traditionally has more affirming views in regard to LGBTQ rights. Additionally, the viewpoints of the participants from the focus groups are unique in that they are from youth already at the stage of seeking out affirming care, which likely reflects perspectives of those who have given thought to factors such as minority stress (representing a subset of LGBTQ youth presenting for mental health treatment). Future research would benefit from a much larger and more diverse sample, drawing from different parts of the country and ensuring representation from individuals with varying identities within the LGBTQ community.

Conclusion

Whether a clinician is new to working with suicidal LGBTQ youth or has worked with this population for some time, it can be helpful to remember the words of one participant, "I just remember feeling very lost, like I was the only person in the whole world who thought this way, and everything I was feeling was wrong, and there was something wrong with me." The potential positive impact of receiving affirming care is enormous for suicidal LGBTQ youth and clinicians who take the time to consider the unique needs of this population are one step closer to making a meaningful difference in the lives of these youth.

Printer-friendly handouts summarizing quality improvement recommendations are available at the end of this article. For clinicians interested in learning more, additional resources specific to trauma-informed care for LGBTQ youth can be found through the National Child Traumatic Stress Network (https://www.nctsn.org/what-is-child-trauma/populations-at-risk/lgbtq-youth/nctsn-resources). While the focus of the present study was quality improvement on care for suicidal LGBTQ youth, mental health providers looking for information on youth suicide prevention more generally are encouraged to explore the UCLA-Duke ASAP Center's website (asapnctsn.org).

Acknowledgments

We would like to thank all of the youth who participated in the study interviews for their time and insight. We would also like to thank Kathryn Piper for her assistance in transcribing the audio recordings of the qualitative interviews.

Disclosure statement

The authors do not report any conflicts of interest.

Funding

This work was supported by the National Institute for Mental Health under Grant [R01MH112147-02S1] and by a National Institute for Mental Health Diversity Supplement (3R01MH112147-04S1).

ORCID

Lucas Zullo http://orcid.org/0000-0001-5363-5227
Ilana Seager van Dyk http://orcid.org/0000-0002-3369-1317
Joan Asarnow http://orcid.org/0000-0002-1610-044X

References

Aggarwal, N. K., & Lewis-Fernández, R. (2015). An introduction to the cultural formulation interview. *Focus*, *13*(4), 426–431. https://doi.org/10.1176/appi.focus.20150016

Almeida, J., Johnson, R. M., Corliss, H. L., Molnar, B. E., & Azrael, D. (2009). Emotional distress among LGBT youth: The influence of perceived discrimination based on sexual orientation. *Journal of Youth and Adolescence*, *38*(7), 1001–1014. https://doi.org/10.1007/s10964-009-9397-9

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct*. Retrieved October 29, 2020, from https://www.apa.org/ethics/code/

Chang, C. J., Kellerman, J., Feinstein, B. A., Selby, E. A., & Goldbach, J. T. (2020). Greater minority stress is associated with lower intentions to disclose suicidal thoughts among LGBTQ + youth. *Archives of Suicide Research*, 1–15. https://doi.org/10.1080/13811118.2020.1818656

Cohen, D. J., & Crabtree, B. F. (2008). Evaluative criteria for qualitative research in health care: Controversies and recommendations. *The Annals of Family Medicine*, *6*(4), 331–339. https://doi.org/10.1370/afm.818

Cope, D. G. (2014). Methods and meanings: Credibility and trustworthiness of qualitative research. *Oncology Nursing Forum*, *41*(1), 89–91. https://doi.org/10.1188/14.ONF.89-91

Crabtree, B., & Miller, W. (1999). A template approach to text analysis: Developing and using codebooks. In B. Crabtree & W. Miller (Eds.), *Doing qualitative research in primary care: Multiple strategies* (pp. 93–109). Sage Publications.

Craig, S. L., & Austin, A. (2016). The AFFIRM open pilot feasibility study: A brief affirmative cognitive behavioral coping skills group intervention for sexual and gender minority youth. *Children and Youth Services Review*, *64*, 136–144. https://doi.org/10.1016/j.childyouth.2016.02.022

Diamond, G. M., Diamond, G. S., Levy, S., Closs, C., Ladipo, T., & Siqueland, L. (2013). Attachment-based family therapy for suicidal lesbian, gay, and bisexual adolescents: A treatment development study and open trial with preliminary findings. *Psychology of Sexual Orientation and Gender Diversity*, *1*(S), 91–100. https://doi.org/10.1037/2329-0382.1.S.91

Diamond, G. S., Kobak, R. R., Ewing, E. S. K., Levy, S. A., Herres, J. L., Russon, J. M., & Gallop, R. J. (2019). A randomized controlled trial: Attachment-based family and nondirective supportive treatments for youth who are suicidal. *Journal of the American Academy of Child & Adolescent Psychiatry*, *58*(7), 721–731. https://doi.org/10.1016/j.jaac.2018.10.006

Diamond, G. S., Wintersteen, M. B., Brown, G. K., Diamond, G. M., Gallop, R., Shelef, K., & Levy, S. (2010). Attachment-based family therapy for adolescents with suicidal ideation: A randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, *49*(2), 122–131. https://doi.org/10.1016/j.jaac.2009.11.002

Hatchel, T., Polanin, J. R., & Espelage, D. L. (2019). Suicidal thoughts and behaviors among LGBTQ youth: Meta-analyses and a systematic review. *Archives of Suicide Research, 25*(1), 1–37. https://doi.org/10.1080/13811118.2019.1663329

Hendricks, M. L., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the minority stress model. *Professional Psychology: Research and Practice*, *43*(5), 460–467. https://doi.org/10.1037/a0029597

Kann, L., McManus, T., Harris, W. A., Shanklin, S. L., Flint, K. H., Queen, B., Lowry, R., Chyen, D., Whittle, L., Thornton, J., Lim, C., Bradford, D., Yamakawa, Y., Leon, M., Brener, N., & Ethier, K. A. (2018). Youth risk behavior surveillance—United States, 2017. *MMWR. Surveillance Summaries*, *67*(8), 1–114. https://doi.org/10.15585/mmwr.ss6708a1

Lewis, D. C., Flores, A. R., Haider-Markel, D. P., Miller, P. R., Tadlock, B. L., & Taylor, J. K. (2017). Degrees of acceptance: Variation in public attitudes toward segments of the LGBT community. *Political Research Quarterly*, *70*(4), 861–875. https://doi.org/10.1177/1065912917717352

Lytle, M. C., Silenzio, V. M. B., Homan, C. M., Schneider, P., & Caine, E. D. (2018). Suicidal and help-seeking behaviors among youth in an online lesbian, gay, bisexual, transgender, queer, and questioning social network. *Journal of Homosexuality*, *65*(13), 1916–1933. https://doi.org/10.1080/00918369.2017.1391552

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674

Mustanski, B., & Espelage, D. L. (2020). Why are we not closing the gap in suicide disparities for sexual minority youth? *Pediatrics*, *145*(3), e20194002. https://doi.org/10.1542/peds.2019-4002

Pachankis, J. E., Hatzenbuehler, M. L., Rendina, H. J., Safren, S. A., & Parsons, J. T. (2015). LGB-affirmative cognitive-behavioral therapy for young adult gay and bisexual men: A randomized controlled trial of a transdiagnostic minority stress approach. *Journal of Consulting and Clinical Psychology*, *83*(5), 875. https://doi.org/10.1037/ccp0000037

QSR International Pty Ltd. (2014). *NVivo (Version 10) [Computer software]*. https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home

Russell, S. T., & Fish, J. N. (2016). Mental health in Lesbian, Gay, Bisexual, And Transgender (LGBT) youth. *Annual Review of Clinical Psychology*, *12*(1), 465–487. https://doi.org/10.1146/annurev-clinpsy-021815-093153

Russell, S. T., Pollitt, A. M., Li, G., & Grossman, A. H. (2018). Chosen name use is linked to reduced depressive symptoms, suicidal ideation, and suicidal behavior among transgender

youth. *Journal of Adolescent Health*, *63*(4), 503–505. https://doi.org/10.1016/j.jadohealth.2018.02.003

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., … & Jinks, C. (2018). Saturation in qualitative research: exploring its conceptualization and operationalization. *Quality & Quantity*,*52*(4), 1893–1907.

The Trevor Project. (2020). *2020 national survey on LGBTQ youth mental health*. https://www.thetrevorproject.org/survey-2020

Wilson, C., & Cariola, L. A. (2020). LGBTQI+ youth and mental health: A systematic review of qualitative research. *Adolescent Research Review*, *5*(2), 187–211. https://doi.org/10.1007/s40894-019-00118-w