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Barriers to Mental Health Support and Recommendations for Improvement From the Perspectives of LGBTQ+ Youth

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A B S T R A C T

Purpose: Lesbian, gay, bisexual, transgender, queer, intersex, asexual plus (LGBTQ+) youth face significant barriers to mental health care, ranging from a lack of access to therapists, months-long waitlists, and lack of insurance coverage to receiving incompetent care from non-affirming providers. The current study sought to understand the experiences of LGBTQ+ youth when accessing mental health care.
Methods: The current study utilized a fixed, embedded mixed methods design with 808 LGBTQ+ youth in the United States. Participants reported their experiences with mental health access and use, as well as provided qualitative responses about their experiences.
Results: In this sample, less than half of LGBTQ+ adolescents stated they were able to access mental health care when it was needed. Youth described experiencing unethical therapy practices by clinicians, cited their parents and practical concerns as barriers to accessing care, and concealing their identity from providers out of fear and mistrust. Youth also described feeling both validated and invalidated once they did receive care. Youth provided recommendations around LGBTQ+ competence, respect for youths' identities and autonomy, and making care as accessible as possible.
Discussion: Recommendations for caregivers, providers, organizations and programs, and policymakers are provided based on youth responses and previous literature. For example, guidelines were provided for parents on how to communicate with youth about mental health concerns, for therapists on how to improve cultural competency when working with LGBTQ+ youth, and for policymakers on how to improve access to affirming care through legislation and community engagement.
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IMPLICATIONS AND CONTRIBUTION

LGBTQ+ youth report numerous barriers to mental health care, ranging from a lack of access to therapists to receiving incompetent care from nonaffirming providers. To best support the mental health needs of LGBTQ+ youth, we need to make structural changes and provide training to clinicians.

Conflicts of interest: S.H. is employed full-time by the Trevor Project; however, S.H. engaged in the reported project and manuscript as an independent researcher, and the project was not associated with the Trevor Project. J.L.S. serves on the Scientific Advisory Board for Walden Wise and the Clinical Advisory Board for Koko; receives consulting fees from Kooth, LLC and Woebot Health; is Co-Founder and Co-Director of Single Session Support Solutions; and receives book royalties from New Harbinger, Oxford University Press, and Little Brown Book Group.

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Within the mental health field, there have been increasing calls for youth-centered health care, a framework encouraging clinicians to engage in shared decision-making with youths and center their unique preferences and ideas about treatment [1–3]. Lesbian, gay, bisexual, transgender, queer, intersex, asexual plus (LGBTQ+) youth, in particular, experience identity-based stressors at multiple levels spanning across individual (e.g., internalized cissexism or heterosexism, identity concealment, expectations of rejection [4]), interpersonal (e.g., peer victimization, family rejection [5]), and structural stressors (e.g., anti-equality laws, societal stigma [6,7]). When accessing mental health care, LGBTQ+ youth cite parents as a major barrier, [8] whereas parents are often unaware of youth mental health symptoms [9].

Despite research finding only small to moderate associations between youth and caregiver agreement on mental health symptoms [10], perceived need for treatment [11], and treatment satisfaction [12], youth are often "spoken for" by the adults in their lives and infrequently consulted about their experiences and needs [13,14]. Although multiple perspectives and systems of support can contribute to quality care, the removal of youths from collaborative decision-making contributes to youth disempowerment and may downplay their autonomy, agency, and competency during a particularly formative developmental period in their lives [2].

Due to the unique mental health care challenges faced by LGBTQ+ youth, as well as their relative underrepresentation in the broader literature on youth-centered care, it is crucial to highlight their lived experiences to evaluate and improve existing systems of care.

Barriers to quality mental health care for LGBTQ+ youth

Minority stress theory posits that chronic prejudice and marginalization place LGBTQ+ individuals at an elevated risk for mental health difficulties via heightened emotional dysregulation, social isolation, hopelessness, and pessimism [4,15]. As a result of these stigma-driven pathways, LGBTQ+ youth experience higher rates of depression [16], anxiety [17], substance use [18], and suicide [19] compared to their cisgender and heterosexual peers. Despite experiencing an urgent need for quality and tailored mental health support, many LGBTQ+ youth face barriers to identity-affirming, effective treatment, and report greater unmet mental health needs relative to their cisgender and heterosexual peers [20,21].

In a 2023 national survey of over 28,000 LGBTQ+ youth and young adults from the United States, less than half were able to access mental health care when they wanted it [21]. Among the top reasons for not accessing support were fears of discussing mental health, parental permission requirements, concerns about being taken seriously, and financial barriers [21]. Fear and mistrust surrounding mental health providers is another commonly cited barrier to care for LGBTQ+ individuals [22], due to broader societal stigma and decades of pathologization of LGBTQ+ identities within the mental health care system [23]. As a result, some LGBTQ+ youth also report delaying or forgoing treatment due to concerns about provider knowledge or competency surrounding LGBTQ+ topics [24] and fears of harassment or not being understood by providers [25,26]. Other barriers to care involve privacy and confidentiality concerns [27]. Specifically, LGBTQ+ youth may feel pressured to "come out" to a caregiver to access tailored mental health services [28] or are concerned that their sexual or gender identity will be disclosed to a caregiver during treatment [24,29]. Notably, most research to date has focused on barriers, rather than facilitators, to accessing care among LGBTQ+ youth [26].

Although barriers to accessing care are more commonly studied, a small but burgeoning field of literature is calling attention to the experiences of LGBTQ+ youth who do access and engage in mental healthcare services. In an interview-based study conducted in the United States, transgender youths and their caregivers highlighted therapist expertise surrounding LGBTQ+ issues, gender affirmation, and positive caregiver engagement as crucial determinants of a strong therapeutic alliance and treatment satisfaction [30]. In another focus group and individual interview study, LGBTQ+ youth in the United States with a history of treatment for suicidality emphasized the importance of trust, respect, and confidentiality in treatment [31]. Youth also preferred when providers avoided overemphasizing or underemphasizing the role of LGBTQ+ identities in treatment and had mixed opinions about having a provider with shared identities. Furthermore, in one community-based participatory research study conducted in Canada, LGBTQ+ youth and young adults reported a paucity of mental health services tailored to their needs, a lack of provider knowledge on LGBTQ+ identities, and instances of provider biases [32]. In the same study, LGBTQ+ youth recommended implementing various system-level changes, such as provider training in LGBTQ+ topics and systematic provider competency evaluations to increase quality care [32]. Additional recommendations from an LGBTQ+ youth advisory council in Australia included overt signals of provider support (e.g., visual identification of provider pronouns), transparent discussions surrounding gender-affirming care, and provider self-reflection [33].

Despite a small, emerging literature on LGBTQ+ youth perspectives of mental health care access and experiences, parental consent requirements in research may limit how voices are represented. Among qualitative and mixed-methods studies that include LGBTQ+ youth perspectives, approximately half required parental consent to participate, leading to the exclusion of many LGBTQ+ youth from research who are not "out" to their caregivers or who have unsupportive families [34]. For example, in one sexuality-focused study, 37.6% of LGBTQ+ youths reported that they would not have participated if parental consent was required [35]. Youth who reported that they would have opted out of the study had significantly higher levels of negative effect and lower levels of family support compared to youths who would have participated even if parental support had been required [35].

Similarly, studies exploring the barriers for LGBT+ youth often neglect to include youth from specific geographic regions (e.g., specific sociopolitical climates [36]) or lack representation of racial/ethnically and gender-diverse experiences [37]. Ultimately, youth autonomy and perspectives need to be centered in an effort to identify and overcome barriers to quality care [13]. Highlighting underrepresented LGBTQ+ youth perspectives without requiring parental consent may be especially important in efforts to improve mental health care at the dyadic (e.g., provider-patient), organization, and system levels [38].

The present study

The present study used a mixed methods approach to center LGBTQ+ youth experiences within the US mental health care

system. Specifically, youth were asked questions about mental health care access, barriers, and facilitators to identity-affirming care, and recommendations for improving the mental health care system. A waiver of parental consent was obtained for this study, allowing the research team to maintain youth privacy and autonomy and collect a more representative and diverse array of perspectives. Youth perspectives were recruited from throughout the United States to ensure a diversity of perspectives across LGBTQ+ youth living in different sociopolitical contexts. Results were used to identify youth-centered suggestions to improve care at the dyadic, organization, and system levels, as informed by LGBTQ+ youths' lived experiences, ideas, and preferences.

Method

Positionality statement

The researchers used a pragmatic theoretical approach grounded in an underlying social constructivist epistemology at each stage of the study, or in other words, the authors reflexively considered the influence of each of their identities and positionalities throughout the design and analytical process of the study [39]. The researcher team represents a diverse range of sexual and gender identities (i.e., lesbian, gay, bisexual, queer, asexual, polyromantic, genderqueer, genderfluid, and cisgender). The research team consisted of 3 doctors of clinical psychology, 3 clinical psychology student trainees in advanced training, and one psychology student with a bachelor's degree. In addition, the researchers represented various racial and ethnic groups (i.e., White, Middle Eastern/North African, Latiné, Asian). The authors collectively represented diverse experiences with both receiving and providing mental health support, including access to affirming care, receiving non-affirming care, experiences with lack of access or long waitlists to services, and the provision of affirming care to adults and youths. The researchers' diverse experiences produced varied influences on the study design and interpretation of the results. The ranging identities and experiences of the research team also provided a "checks and balances" system to mitigate bias throughout the design and analytic processes. For example, scoring of qualitative data was performed in small chunks (20–30 responses at a time), after which, a third researcher not involved in the coding procedure would review the coding to make sure that the team was sticking to the developed code book and to address any potentials for bias or drift in the coding procedure.

Study design

We designed the present study using a fixed, embedded mixed-methods approach [40]. The survey included quantitative questions and qualitative questions to elicit subjective responses of participants' mental health support experiences. Following a pragmatic approach by using a social constructivist research paradigm, we asked qualitative questions to enhance our exploration of barriers to mental health support and recommendations to improve care for LGBTQ+ youth, providing a fuller understanding of the research problem. As a result, we achieved triangulation of the mental health support experiences of LGBTQ+ youth by integrating qualitative and quantitative insights on these topics to inform and enhance each other. We followed the Consolidated Criteria for Reporting Qualitative Research guidelines in the report of this study (see our Open Science Framework materials for blinded review: https://osf.io/dya83/). Moreover, the researchers modeled several questions off previous research that examined both mental health care access and sexual and gender identities [41].

Procedure

The institutional review board at Stony Brook University granted ethical approval before study initiation. The study was preregistered on the Open Science Framework (which has been blinded for review; https://osf.io/dya83/). We recruited participants through social media advertisements on Instagram during May 2023, inviting them to participate in a 10–15-minute anonymous survey with a chance to win a $20 Amazon gift card. Inclusion criteria included (1) identifying as LGBTQ+; (2) reporting an age between 13 and 17 years old; (3) reading English proficiently; (4) having reliable internet access within the United States; and (5) identifying as less than 12 feet tall (i.e., our attention/bot detection item). Importantly, we obtained a waiver of parental consent for this study, considering that many LGBTQ+ youth may not feel safe asking parents for participation permission [35]. We offered youth who were ineligible for participation LGBTQ+ mental health resources and directed them to a website where they could find additional research opportunities. If youth were eligible for participation, the researchers asked them to provide informed assent before presenting the survey.

Participants

Our sample captured a diverse range of identities. Participants frequently selected multiple categories and labels for demographic variables (e.g., gender identity, race, ethnicity). Approximately 42.7% (n = 339) of participants selected multiple gender identities and 12.6% (n = 101) selected multiple racial and ethnic identities (Table 1). Due to a clerical error, "select all that apply" did not appear for sexual orientation, but would likely have yielded similar results (i.e., many youths selecting multiple sexual identities). The same number of participants (n = 57) provided open-text responses for gender identity and sexual orientation, indicating that the options provided did not sufficiently capture their intersecting identities. Thus, participant responses highlighted the limiting nature of single labels when describing LGBTQ+ youth identities. Zip code data were also requested to identify the distribution of participants from urban or rural areas.

Measures

Demographic variables

Sexual orientation. Sexual orientation was assessed using the question "How do you identify your sexual orientation?" For response options, see Table 1.

Gender identity. Gender identity was assessed using the question "How do you identify your gender identity? Please check all that apply." For response options, see Table 1.

Disclosure and concealment. To further understand whether youth have disclosed their sexual or gender identity to others, we

Table 1
Participants demographics

Demographics	N = 808[a]
Age	
13–14	150 (18.6%)
15–16	430 (53.2%)
17	228 (28.2%)
Rurality	
Urban	574 (71.0%)
Rural	69 (8.5%)
Sex at birth	
Female	704 (87.1%)
Male	93 (11.5%)
Intersex	3 (0.4%)
Gender identity	
Man/boy	176 (21.8%)
Woman/girl	307 (38.0%)
Transgender	162 (20.0%)
Trans woman/feminine	21 (2.6%)
Trans man/masculine	155 (19.2%)
Genderqueer	130 (16.1%)
Gender expansive	29 (3.6%)
Androgynous	64 (7.9%)
Nonbinary	208 (25.7%)
Agender	48 (5.9%)
Unsure/questioning	95 (11.8%)
Another identity not listed[b]	69 (8.6%)
I do not use a label	35 (4.3%)
Sexual orientation	
Heterosexual	9 (1.1%)
Gay/lesbian	215 (26.6%)
Bisexual	204 (25.2%)
Pansexual	99 (12.3%)
Queer	88 (10.9%)
Asexual	65 (8.0%)
Another identity not listed	57 (7.1%)
Unsure/questioning	34 (4.2%)
I do not use a label	37 (4.6%)
Race and ethnicity	
American Indian or Alaska Native	23 (2.8%)
Asian (including Asian Desi)	100 (12.4%)
Black/African American	84 (10.4%)
Hispanic/Latiné or Mexican American	106 (13.1%)
Native Hawaiian or other Pacific Islander	7 (0.9%)
White/Caucasian (non-Hispanic; includes Middle Eastern)	581 (71.9%)
Another race/ethnicity not listed	11 (1.4%)
Middle Eastern or North African	6 (0.7%)

[a] n (%); Mean (SD).
[b] This category also includes “Third Gender” and “Two-Spirit”.

asked the questions: “Who have you disclosed your sexual orientation to? Select all that apply.” Response options included: friends, parents, siblings, teachers, school administrators, community members, and another person (with a free response option). We also asked “Who have you disclosed your gender identity to?” and "Who do you avoid talking about your [sexual orientation; gender identity] with?" with identical response options.

Sex assigned at birth. Researchers measured sex assigned at birth by asking the question "What sex were you assigned at birth?" Mutually exclusive response options included female, male, intersex, a free response option, and “I prefer not to answer.”

Racial/ethnic identity. Participants were asked to identify their race/ethnicity using the question "How do you identify your race/ethnicity?" Please check all that apply.” For response options, see Table 1.

Age. Participants were asked to select their current age from the following choices: “12–13 years old”, “14–15 years old”, and “16–17 years old”. Age was determined using brackets to preserve youth anonymity.

Subjective social status. Subjective social status was assessed using the MacArthur Scale of Subjective Social Status - Youth Version [42]. Participants were asked to rate their perceived socioeconomic and social status using 2 items. On these items, participants indicated where they see themselves on a ladder with 10 rungs, ranging from 1 to 10, where 1 represented families with the most money, education, and jobs, as well as youth with the highest respect, grades, and social standing; and 10 represented families with the least social status (i.e., low income, low access to social support, food insecurity, etc.). The total score was assessed as a sample demographic.

School information. Participants were asked to indicate their current year in school from 5th to 12th grade. They were asked whether they attended a public school, a private school, or were homeschooled.

Zip code. Participants were asked to provide their local zip code and using the Rural Urban Continuum Codes (RUCC [43]), we assigned participants an RUCC classification number corresponding to their location. The RUCC categorizes areas in the United States based on rurality, with 9 separate categories (e.g., metro >1 million; nonmetro 2,500–19,999 adjacent; nonmetro rural nonadjacent; etc.). For the purposes of this study, we combined all nonmetro areas into a “rural” category and all metro areas into an “urban” category.

Access and barriers variables

Access to mental health care. Participants were asked to consider in the past year, (1) “Have you tried to access mental health care (e.g., visited or made an appointment to meet with a therapist, counselor, social worker, or physician)?” and could respond with “no,” “yes,” or “prefer not to say.” Following, participants were asked (2) “When in need of mental health care, have you been able to access this care (e.g., were you able to schedule an appointment, afford services, or get the care you need)?” and could respond with “no,” “yes,” or “prefer not to say.”.

Barriers to care. All participants were asked the following open-ended question: “What got in the way of accessing mental health care?”

Experiences of validation and invalidation variables

All participants were asked (1) “Have you ever received mental health care by a professional (i.e., therapist, counselor, psychologist, or psychiatrist)?” and could select “no,” “yes,” or “not applicable/prefer not to say”. Participants who selected “yes” were then asked (2) “Did you feel supported or validated in your sexual or gender identity by the mental health professional you received care from? Why or why not?” and could select “yes” or “no” and provide an open-ended response, or they could select “prefer not to respond”.

Recommendations variable

All participants were asked the following open-ended question: "What would make you feel more supported or validated by mental health professionals?"

Analytic plan

Quantitative analyses. For the majority of quantitative analyses, the entire sample was used. For some items, groupings (e.g., demographics-related analyses) were used. Chi-square analyses were run to determine significant differences and all results were significant at least at $p < 0.05$. We used descriptive statistics to report on the major sample characteristics as well as relevant variables. All analyses were performed with R Studio (version 12.1) [44].

Qualitative analyses. The qualitative data were analyzed using inductive codebook thematic analyses through a constructivist epistemology bound in a relativist ontology [45], meaning as researchers, we can only interpret the responses through the lens of our own experiences, biases, and understanding. We also interpreted the responses with the mindset that the participants are experts in their own lives, and thus, their words are seen as truth. A team of 2 researchers trained in thematic coding met to review the data before coding or discussing the data. Once the data were reviewed independently by the team members, the team met to discuss their initial impressions, as well as to develop an initial set of themes for coding.

Team members independently reviewed participants' responses again to determine if identified themes fit the data before meeting to discuss any discrepancies. The codebook underwent 3 iterations before consensus was made on the final themes (i.e., data saturation was assumed [46]). During these iterations, the team members were blind to the data (i.e., the team only saw participants' responses to the open-ended question and no other data). They discussed potential biases in their interpretations of the responses, the appropriateness of the themes, and how to define themes. All iterations, definitions, and notes on these discussions, as well as decision trails, can be found at https://osf.io/dya83/. Coding was performed by the 2 team members after the final themes were determined. The 2 team members reached 100% agreement on their codes. Responses to the open-ended questions ranged from simple sentences to longer blocks, with rich descriptions and elaboration.

Results

Using a convergent parallel mixed-method study design (fixed, embedded mixed-methods approach), we collected and analyzed both quantitative and qualitative data separately, followed by integration for a comprehensive review. We organized our major findings under 3 domains (i.e., barriers and access, experiences of validation and invalidation, and recommendations) with subsequent themes identified following thematic analyses under each domain. We then complemented our qualitative findings with quantitative data (Table 2).

Demographics

Regarding age, 19% of the samples were between 13-14 years old, 53% between 15–16 years old, and 28% was 17 years old. Survey respondents predominantly reported being assigned female at birth (87%), consistent with recent youth mental health research that used social media-based recruitment approaches, and the majority of the participants identified with a gender identity that either did not correspond with their assigned sex at birth or with a gender diverse identity (63%; e.g., transgender or nonbinary). About 28% of the sample identified as youth of color (e.g., non-White), and most participants joined from urban areas of the United States (71.0%), with some youth joining from rural places (8.5%). For a full breakdown of participant demographics, please see Table 1.

Barriers and access

Access. The majority of youth (n = 748) responded to survey questions about mental health care access. Out of all youth (N = 808), most had attempted to access care (62.00%, n = 501), about 27.80% (n = 224) had not attempted to do so, and 2.90% (n = 23) of youth indicated they "prefer not to say." When all youth were asked if they were able to access care when needed, slightly less than half reported that they had accessed care (46.04%, n = 372), approximately 38.00% (n = 307) were unable to access care when needed, and 8.54% (n = 69) responded that they "prefer not to say." About 7.43% (n = 60) did not respond to the prompt. Thematic analyses revealed 6 themes of barriers to care.

Barriers. Out of all participants (N = 808), approximately 36.26% (n = 293) described barriers they encountered when seeking mental health care. Nearly half (48.81%, n = 143) of these 293 youth identified parental involvement as a barrier to care, often explaining that parental consent requirements prevented youth from accessing care because they wanted to avoid involving their parents. One participant explained, "The only way to access [mental health care] is to ask my parents and if I ask my parents they'd either be like 'Oh don't be silly [you're] fine' or want to know why and I can't tell them why." This quote demonstrates how parents may inadvertently invalidate their children's mental health struggles and how youth may fear parent invalidation. In addition, in the case of LGBTQ+ youth, many youths are also hesitant to discuss mental health problems due to their LGBTQ+ identity not being disclosed. The second most commonly reported barrier was practical concerns (47.78%, n = 140). Youth often mentioned "time, money, availability, and location" as barriers to care, in addition to explaining that "there were no available therapists that took our insurance," when describing practical concerns. Although parental involvement and logistical barriers were commonly reported, they were not the only

Table 2
Integration of quantitative and qualitative results in analyses

Section	Subsection	Mixing of results
Access and barriers to care	Access to care	Quantitative only
	Barriers to care	[QUAL + QUAN]
Validation and invalidation	Validating care	[QUAL + QUAN]
	Invalidating care	[QUAL + QUAN]
Recommendations	LGBTQ+ youths' recommendations from an open-response survey question	Qualitative only

QUAL = qualitative; QUAN = quantitative.

hurdles youth described when attempting to access mental health support.

Some participants also reported personal fears (14.33%, n = 42) as a barrier to care, describing their anxieties, worries, and fears associated with accessing care or utilizing therapy. Fears often included, "being scared of going to a mental [institute] or what people would say", "getting over the stigma to talk about my mental health", "I personally fear discrimination", and how "bad experiences in the past sort of put me off of therapy." Youth wariness of unethical therapy practices was another barrier to care (4.44%, n = 13), driven by prior experiences of discrimination or prejudice, therapists' lack of cultural competence related to LGBTQ+ topics, and having therapists disappear without notice. One youth described their concern for "queerphobia by the mental health professionals [and] invalidation of my troubles and previous diagnosis", whereas another youth depicted how "the lady tried to force me to come out to my parents even though I said I'm unsure and they are homophobic." One youth stressed her worry for a "therapist not accepting me because my disabilities make it more 'complicated'," and another participant recounted how one "counselor [canceled] our meeting but never rescheduled." A few participants listed some "other" barriers to care (1.02%, n = 3; i.e., "The list is very long") or did not provide any response at all (1.02%, n = 3). A small number of youth responded to the open-ended question by explaining that they were able to access care (4.44%, n = 13), despite the prompt inquiring about encounters with barriers.

Experiences of validation and invalidation

More than half of the youth in this study (59.28%, n = 479) shared their experiences of being validated and invalidated as an LGBTQ+ person by a mental health professional. When asked if they felt validated in their sexual or gender identity by the mental health professional providing them care, 479 youth provided responses where approximately 51.98% (n = 249) stated "yes," about 22.96% (n = 110) responded "no," and 25.05% (n = 120) selected that they "prefer not to respond." Youths who selected "yes" were asked "Why?" and those who chose "no" were asked "Why not?"

Validation. For respondents who reported feeling validated by the mental health professional providing them care (n = 249), 93.17% (n = 232) explained why. Among responses from these 232 youth, the most common theme was LGBTQ+ youth referencing common therapy skills, which included positive experiences with providers without explicitly feeling supported in their sexual or gender identities (36.21%, n = 84). Youth derived many benefits from passive acts of affirmation by therapists, such as when they are "supportive and kind and don't judge me" and "nice and talks me through everything." Participants also felt validated when "[therapists] guide me through my thoughts and feelings" and when "my mental health professional makes it very clear to me that I am supported by her and others in or outside of her office." Overall, general cues of social safety seemed to signal to LGBTQ+ youth that they are welcomed, supported, and valid. The second most frequently cited experience of validation came from youth feeling respected (21.55%, n = 50), specifically by having their pronouns, names, and autonomy respected. One participant appreciated that "I had told [my therapist] a different name and pronouns I preferred and she just used them no question" because it reaffirmed their autonomy and emphasized the message that "I decide my pronouns." Another youth reported that "one of the first things she told me was that it was normal to be LGBTQ and she respected my desire to not discuss it" and how "we go over preferred names, pronouns, and such often", emphasizing the importance of adhering to youth preferences.

Youth also reported feeling validated by providers with specialized training and knowledge on relevant resources (12.07%, n = 28) and by providers who openly discussed LGBTQ+ topics in therapy (12.07%, n = 28), such as helping youth navigate identity and sexuality development. Youth described how "I felt extremely supported and validated because my therapy provider specialized in the experiences of LGBTQ teens," and how they "told me where to go for more information and for hormone replacement therapy," demonstrating the importance of cultural competence when working with LGBTQ+ individuals. Youths also explained how openly discussing LGBTQ+ topics felt validating by outlining how "they helped me understand my sexuality on a psychological level" and that "they provided me with a space where I could talk to an adult about being queer and genderqueer without any fear or shame." Because of stigma, LGBTQ+ youth are often barred from accessing not only affirmative care, but also general knowledge on resources, culture, and history related to LGBTQ+ communities. Therefore, cultural trainings for providers can enhance care provided to LGBTQ+ youth. Another common experience of feeling validated arose from meeting providers with shared identities (21.55%, n = 19), that is, providers who were members of the LGBTQ+ community themselves, as expressed by youth reporting that "I saw a therapist that really helped me and was also queer" and "one of my therapists is even apart of the community, so it's welcoming talking to her."

Some youth reported feeling partially validated (5.17%, n = 12), where they either felt validated by their providers some of the time, or where they sometimes felt validated and other times they did not. Participants also expressed feeling validated by providers who protected their privacy (3.02%, n = 7), most often by maintaining confidentiality and refraining from sharing sensitive information with the youth's parents. Youth were validated by providers who actively advocated for LGBTQ+ rights (2.16%, n = 5) and providers who presented themselves as allies to the LGBTQ+ community (1.72%, n = 4). Lastly, some youths' responses were coded as not applicable (6.47%, n = 15) when their responses indicated that they refrained from discussing their LGBTQ+ identity with their provider.

Invalidation. From all youth who reported feeling invalidated by the mental health professional (n = 110) providing them with mental health care, 96.36% (n = 106) described why. The most common invalidating experience reported by participants related to providers who youth viewed as lacking the competency to provide affirming care (40.57%, n = 43), even if well-intentioned. Youth described how "while my counselor says she doesn't mind, she still says vaguely homophobic things and extensively questions me about whether I'm sure," and how "another psychologist would not take my sexual orientation seriously because of my age," reiterating the importance and consequences of not respecting youth and their autonomy, regardless of age. One youth described their experience as:

> "*she uses outdated terms and information and it feels like every therapist I go to including her has no idea what a trans person is*

other than the little that they have heard like saying things like you're a boy [in] a girl's body or vice versa *etc etc and it feels like I can't even speak to them about anything regarding transition or dysphoria or anything like that it makes me want to give up*."

These instances illustrate the effects of identity-related invalidation for LGBTQ+ youth, highlighting the need for providers to receive cultural training and respect youth autonomy.

Another common experience of invalidation was identified as concerns about privacy and mistrust of providers (23.58%, n = 25). Youth expressed that "[I] did not tell her about any of it ([because I] was not out to family yet and didn't want her to out me)," "I did not discuss it with them because I did not trust their levels of… secrecy," and "I never mentioned my sexual or gender identity because I feared they would tell my parents." These experiences were further marked by invalidation connected to identity concealment (21.70%, n = 23), where youth described their active efforts and specific reasons for avoiding topics related to their sexual orientation and gender identity when meeting with a provider. One youth reported that "I never felt comfortable enough to discuss anything too in depth" and so "I made myself as straight as I could and wouldn't do anything or say anything considered 'gay'," whereas another youth specified that "I never mentioned my sexual or gender identity because I feared they would tell my parents." LGBTQ+ youth frequently reported concerns about their identity being targeted by the provider or revealed to their parents, underscoring the fear of negative consequences resulting from their LGBTQ+ identity being revealed.

Some youth also reported feeling invalidated by providers who mentioned or discussed religion, most commonly Christianity, while delivering mental health care services (13.21%, n = 14). One youth described how their therapist would "subtly encourage me to seek relationships with men instead of women and told me that being a Christian could help me 'control my undesirable thoughts'." A subgroup of youth indicated that they felt invalidated by providers who engaged in unethical practices (6.60%, n = 7), or instances where youths explicitly described being harmed by a provider violating the American Psychological Association's code of ethics. One youth explained that "my therapist told me how I needed help, but provided me with ways to harm myself and told me how other people hide their self-harm in better ways," emphasizing how providers have the potential to increase risks of negative outcomes following the treatment for LGBTQ+ youth when engaging in invalidating malpractice. Lastly, about 28.30% (n = 30) of responses were categorized as not applicable or unclear when youth explained that their therapy was altogether focused on something unrelated to their LGBTQ+ identity, when the youth was uncertain of their LGBTQ+ identity, or when they refrained from disclosing their identity to their provider.

How can providers best support LGBTQ+ youth mental health?

A majority of participants (71.04%, n = 574) offered recommendations for how mental health care providers can support or validate LGBTQ+ youth. Following thematic analyses, 8 categories of recommendations were outlined.

The most common recommendation endorsed focused on providers receiving training in LGBTQ+ cultural competency (45.30%, n = 260), which should include overviews of LGBTQ+ history, minority stress theory, and common LGBTQ+ experiences, as well as training in knowing when or when not and how to bring up LGBTQ-related topics with youths. One youth specified that it would be beneficial if, "[providers] understand the social difficulties, and the mental difficulties… are up-to-date on current events within the world… that [affect] LGBTQ+ people… [and] also knowing comprehensive LGBTQ+ sexual health, and history." Another youth hoped, "mental health professionals [would be] doing independent research on how queer identities impact mental health," and many youths recommended that providers have "just a better understanding of what it's like," believing they could "[understand] anything about the community and their experiences." Overall, youth expressed a desire for mental health professionals to be educated on the unique struggles faced by LGBTQ+ communities and to learn how to best approach related topics in conversation.

The second most frequently reported recommendation was for providers to respect youth during treatment sessions (16.20%, n = 93). Specifically, providers should respect a youth's pronouns, preferred names, and what they want to discuss in session, whether or not related to their identity. In other words, providers should respect youths by not making assumptions about their identities. Recommendations related to respect focused on moments during therapy, such as youth wishing their providers exhibited "less judgment and more acceptance and understanding" in session. Youth used expressions like "I would love to be respected and welcomed into a mental health prof's office with helpful advice," and requested that providers "support you [and] your identity to begin with and not asking for [your identity] unless it applies to the sort of care you're receiving." Youth recommendations for respect were clear: prioritize youth autonomy.

Youths also suggested that greater accessibility (7.49%, n = 43) to providers would improve their experiences of mental health care. Accessibility recommendations ranged from requests for "getting ways to help your mental health at school and places" to requests for access to diverse providers (e.g., "if mental health professionals who were people of color or LGBTQ were more accessible"). Some youth directly addressed the United States' national shortage of providers, describing how "if mental health professionals were less scarce," then perhaps there would be less of a "mental health crisis in America right now." Beyond general requests for increased accessibility, youth also highlighted the need for accessible gender-affirming care (1.92%, n = 11), especially for youth who are transgender, highlighting the need for care tailored to non-cisgender people.

Two additional recommendations made by youth included requests for increased privacy between providers and youth (5.75%, n = 33), and requests for providers with lived experience of LGBTQ-related experiences (5.75%, n = 33). When recommending that providers offer increased privacy, youths remarked needing "[to be] sure that mental health professionals will not out me," often because youths also explained that "I'm in a situation where I don't want to tell my family about my gender identity or sexual orientation." Youth explicitly stated that they would feel more validated and supported "if there were more professionals that were openly part of the LGBT community," often expressing how "only people that can relate can understand the struggles that come with being LGBTQ+." Youths also recommended that providers be explicit in their advocacy and support for the LGBTQ+ community (4.36%, n = 25). Explicit advocacy would include open displays of affirmation (e.g., pride flags, "showing casual allyship with LGBTQ+ symbols") as well as

engagement in activism supporting LGBTQ+ communities ("They should let the world know that LGBTQ+ should not be stigmatized"). Some youth also recommended that providers cultivate a "safe space" or sense of safety in the environment during care (1.92%, n = 11). These recommendations typically describe youths' desire to feel comfortable and safe while openly talking about their identities and experiences. Finally, about 27.70% (n = 159) of responses were deemed as not applicable if the youth did not provide a clear recommendation and instead only described a personal experience with mental health providers, without detailing practical recommendations for care improvement.

Discussion

In the current study, we used a mixed-methods approach to gather information about mental health care access and barriers, validating and invalidating care experiences, and suggestions to mental health care providers from 808 LGBTQ+ youth aged 13–17 (49 states and territories, including Puerto Rico and Washington D.C.). Most participants reported wanting mental health care but not being able to access it; responses revealed both practical (e.g., financial consideration, transportation, lack of parental permission) and stigma-based (e.g., internalized homophobia/transphobia, concern about non-affirming care) barriers. When they did receive care, some youth reported that care was helpful and identity-affirming, but others reported experiences of rejection, invalidation, and even breaches of confidentiality. Participants' suggestions regarding ways for providers to best support LGBTQ+ youth and their mental health centered around LGBTQ+ competence, respect for youths' identities and autonomy, and making care as accessible as possible. We will discuss results in relation to the existing research literature, and then provide specific recommendations to readers, based on these results, for improving mental health support for LGBTQ+ youth.

Overview of results

In this sample, less than half of LGBTQ+ youths stated they were able to access mental health care when it was needed. This mirrors the broader literature on youth mental health access in the United States, which indicates that the majority of youth with mental health needs go without care [47,48]. When considering the reasons for these low access rates in our sample and the population more broadly, results of the present study highlight diverse and formidable barriers faced by youth attempting to access care. Overall, the themes from this survey are similar to findings from Radez et al's [49] review of qualitative and quantitative studies on child and youth mental health access barriers, in which the most prominent barriers could be organized into individual barriers (e.g., lack of relevant knowledge), social barriers (e.g., mental health stigma), concerns about trust and confidentiality, and structural barriers such as cost or availability of providers. These findings also mirror results from the survey by The Trevor Project [50], in which the most endorsed barriers to care by youth were fear of discussing one's mental health issues with other people/not being taken seriously, concern around parental consent for services, and not being able to afford care. However, the qualitative nature of our data allows for a more nuanced understanding of these barriers, in youths' own words. For instance, regarding family barriers, youth in this study specifically explained that their parents did not believe in mental health problems or treatment, or thought they were "fine" or should "suck it up".

Others linked the invalidation of mental health needs to the invalidation of their identities or felt it would not be possible to explain their mental health needs to their parents without disclosing concealed identities. Parental rejection and invalidation are reported by many LGBTQ+ youth and are associated with a myriad of adverse psychosocial outcomes [51]. Our data underscore the impact that parental rejection can have on LGBTQ+ youth's mental health: youth with unsupportive parents are more likely to have mental health difficulties, and this additional risk factor may simultaneously act as a barrier to much-needed mental health support. Similarly, when referencing financial barriers, youth in this study specifically noted that their family's health insurance did not have adequate coverage for mental health care or include enough providers in their area. In addition, these findings demonstrate that these youth are aware of and concerned about the specific ways in which their family's socioeconomic status and provider shortages complicate access to needed care.

Of youth who received mental health care, slightly more than half reported that they felt validated in their sexual orientation or gender identity by their care provider. This is an encouraging result suggesting that a substantial portion of mental health providers can successfully make LGBTQ+ youth feel supported in care. Some of the qualities that made a difference to participants—such as empathy, warmth, and a nonjudgmental manner—are core counseling skills that contribute to treatment outcomes generally [52,53]. Others, such as knowledge of LGBTQ+ history or sexual health, involve LGBTQ-specific competence, which can be built with training or self-education [54]. Knowledgeability by care providers creates a shared foundation of information in treatment and avoids placing youth in the position of having to educate their care providers about the issues impacting them. It can also serve to communicate allyship to youth by demonstrating that a provider has connections to the LGBTQ+ community and/or has made efforts to educate themselves on issues relevant to LGBTQ+ people. Comments from participants around the impact of provider knowledge of current events and up-to-date terminology make it clear that such self-education must be an ongoing project for providers seeking to effectively validate LGBTQ+ youth. Regarding the use of youth's indicated names and pronouns by care providers in particular, chosen name use in various contexts is associated with better mental health outcomes among transgender and gender-diverse youth [55–57]. Our results emphasize mental health care settings are no exception. Using the correct name and pronouns to refer to a young transgender person in treatment is a clear gesture of affirmation for their identity and may foster positive, meaningful emotional experiences for them (i.e., "gender euphoria" [50,58]). If a provider also uses a youth's chosen name and pronouns when communicating with their caregivers (with the youth's permission), this further supports the youth by modeling affirming behavior to caregivers.

At the same time, around a quarter of participants indicated that their care provider was not validating of their identity. This aligns with the growing literature on the topic of LGBTQ+ youth's experiences with mental health care, in which poor LGBTQ+ competence and microaggressions are a frequent reality for those seeking care [30,59,60]. In addition to the more overt experiences of invalidation or rejection youth mentioned in this

Table 3
Recommendations for caregivers, providers, programs, organizations, and policymakers based on LGBTQ+ youth–reported barriers and recommendations for care

Recommendations	Caregivers	Providers	Programs and organizations	Policymakers
Cultural Competency	- Learn/educate yourself and reflect on the history of the community, issues, terminology, and mental health intersections. - Support youth in accessing culturally competent providers.	- Learn/educate yourself, look at APA guidelines. - Take courses, seek supervision. - Go to available relevant grand rounds. - Consider identity issues and minority stress in assessment and case. conceptualization. - Engage in continuous self-reflection about individual identities, socialization, beliefs, and potential biases.	- Require training of trainees/care providers. - Pay experts to provide education and consultation. - Evaluate the competence of trainees and providers. - Develop and implement valid assessments of competency.	- Require training in this area for licensure. - Clarify regulations around what care can be legally provided. - Expand the availability of educational materials for teens and families. - Fight bans on educational materials.
Respect	- Use correct names, pronouns, and other identity-relevant languages. - Avoid assumptions about youths' gender and sexual orientation. - Support youth autonomy over the content of therapy.	- Use correct names, pronouns, and other identity-relevant language in session and documentation. - Ask about the above. - Allow teens to guide the conversation (e.g., avoid over or under-emphasizing teens' identities in treatment). - Do not assume youth want to discuss identities.	- Use inclusive intake forms. - Implement EHR systems that allow for storage and use of identity-affirmed information. - Emphasize the importance of correct names, pronouns, and other identity-relevant language in organization-wide training.	- Allow the use of correct pronouns and names in schools. - Expand legislation to protect youth from conversion therapy and similar. - Incentivize communication between caregivers and instructors to support youth identity-related mental health.
Accessibility	- Discuss payment options with clinics. - Look into telehealth if transportation is a barrier. - Allow youth to access treatment. - Emphasize to youth that confidentiality between clinicians and youth will be respected. - Normalize mental health struggles in the home or around the youth to encourage help-seeking.	- Get training/competency in telehealth. - Look into partnerships with community organizations to provide treatment in more settings. - Expand payment options. - Expand available hours. - Accumulate and share referrals for other affirming providers and other community-specific resources.	- Look into partnerships with community and research organizations to provide treatment in more settings/formats. - Accumulate and share referrals for other affirming providers. - Offer additional MH services like group offerings, courses and workshops. - Offer community-specific support groups. - Allow youth to maintain anonymity when useful or needed (e.g. when seeking LGBTQ-specific care).	- Lobby for insurance to cover more gender-affirming care. - Improve transportation infrastructure. - Push for broader access in areas w/provider shortages e.g. telehealth, seeing providers across state lines. - Lobby for young people to be able to get mental health care w/o parental consent. - Expand school-based mental health services.
Privacy	- Respect confidentiality between youth and providers. - Clarify with the therapist the limits of confidentiality. - Encouraging open and honest conversations with youth.	- Know about regulations for violating confidentiality. - Be honest and clear with kids and parents about these limits. - Develop and share policy on confidentiality outside these things. - Clarify early and often with youth how to handle names, pronouns, and identity issues with parents. - Honor youth's decision on when and how to disclose to caregivers.	- Clearly outline policies on confidentiality between youth and provider. - Clearly outline policies on confidentiality between caregiver and provider. - Support sharing records in a way that does not violate youth's preferences for privacy.	- Clarify and update state-level recommendations about confidentiality, record-keeping, etc. - Support federal regulations to ensure the safety of teens. - Implement policies related to confidentiality breaches during a crisis and outside of the crisis.
Advocacy	- Consider joining parent support groups or parent advocacy groups to get involved with the LGBTQ community. - Engage in activities in the community or with queer media. - Contact school officials to promote affirmation for LGBTQ youth at school. - Explicitly inform youth that you support the LGBTQ community (whether or not your youth identifies within it).	- Displays of support (e.g., own pronouns, queer paraphernalia). - Ask youth if it would be helpful to be present during identity closure (i.e., "coming out") to mediate. - Facilitate conversations surrounding LGBTQ identity for normalization among caregivers.	- Engage in public events in support of the LGBTQ community. - Make public statements or practices easily accessible to the public on websites or the premises. - Establish networks with local organizations committed to advancing LGBTQ rights. - Promote local advocacy events (i.e., petitions, protests, etc.) among staff and clients served by the clinic or program.	- Implement state-wide policies that protect individuals who report instances of abuse or discrimination in mental healthcare. - Increase access to LGBTQ-related resources (e.g., literature, services, etc.). - Protect the discussion of LGBTQ topics in schools. - Create legislation that protects and increases access to gender-affirming care.

(*continued on next page*)

Table 3
Continued

Recommendations	Caregivers	Providers	Programs and organizations	Policymakers
Safety	- Encourage youth to set boundaries in the youth-caregiver relationship. - Actively prioritize youth autonomy and work to cultivate a sense of independence in youth. - Guide youth in identifying strategies to create safety for themselves in unsafe situations. - Allow youth to express themselves on their terms and at their pace.	- Help youth assess if/when it is safe to come out; develop a safety plan for if others react negatively. - After-hours availability for crises. - Providing youth with community-specific support or crisis lines, if needed (e.g. trans lifeline, Trevor Project). - Establish strategies for creating safety in unsafe situations.	- Offer community-specific support groups. - Have guidelines and safety precautions in place for LGBTQ clients of all ages. - Establish a crisis line to offer after-hours availability for crises. - Facilitate safety-focused workshops to discuss safety risks and strategies for prevention and response to safety emergencies.	- Require safety procedures or guidelines for mental health facilities for LGBTQ clients/patients. - Legislation to protect the health and safety of LGBTQ teens who are homeless or who have been rejected by their families. - Establish anti-discrimination policies to protect LGBTQ individuals from stigma (e.g., violence, harassment).

All recommendations were made by the authors based on the qualitative results of the current study and the current literature.
APA = American Psychological Association; EHR = electronic health record; MH = mental health.

study, several participants reported that mental health care providers tried to be LGBTQ-affirming but did not have the concrete knowledge and competency to do so, leading to an inadvertently invalidating experience. These findings highlight that it is not enough for care providers to have positive intentions and avoid intentional queer and transphobic behavior in the care setting; providers who wish to effectively support and validate LGBTQ+ youth should actively work to educate themselves and increase their knowledge and competency around issues of LGBTQ+ identity and mental health. Many LGBTQ+ youth in this study did not disclose their sexual orientation or gender identity to their care provider out of concern that the provider would share this information with parents against the youth's wishes. This shows clearly the impact on youth of providers' policies around confidentiality of such information, as well as the way they communicate that policy with youth clients.

Recommendations based on results

In the current study, LGBTQ+ youths endorsed several specific barriers and facilitators to validating mental health support. In Table 3, we provide actionable recommendations for caregivers, mental health providers, programs and organizations, and policymakers to address their concerns based on youth recommendations and reports, best practices for mental health professionals, and the current literature. Youth cited specific experiences of discrimination, microaggression, and a lack of cultural and clinical competency among mental health providers. In Table 3 we outline recommendations for lifelong learning and training to encourage respect and validation of youth seeking mental health support.

Accessibility for LGBTQ+ youth to engage with mental health services is integral to their well-being. Table 3 explores several recommendations to improve access to care and overcome youth-reported barriers associated with practical concerns (e.g., transportation, caregiver stigma, consent for care, and family issues). These recommendations are accompanied by sections addressing youth concerns regarding their safety (e.g., fear of hospitalization, retaliation from family or friends, forcing them to conceal their gender identity or orientation) and privacy. Recommendations include providing waivers of parental consent for services, clarity in privacy laws and practices within mental health organizations, and steps to ensure the safety of youth seeking support. Lastly, Table 3 outlines potential avenues for advocacy and ways in which individuals at all levels of youth support can work together to promote the mental health and well-being of LGBTQ+ youth. The recommendations include activism and improving the visibility of current support for LBTQ+ communities.

Strengths, limitations, and future directions

The current study had several notable strengths. First, our methods allowed us to recruit a large sample including youth who would likely be excluded from traditional research. The study enabled remote participation and did not require parental consent to participate, to increase youth participation and honesty. In other research, a substantial portion of LGBTQ+ youths report they would not participate in studies for which parental consent is required; compared to those who say they would participate, youth report lower family support as well as higher internalized homophobia/transphobia, more internalizing symptoms, and less self-reported likelihood to seek help [35]. Requiring parental consent for this study would have significantly biased our sample—and, given the direct relevance of these differences to our research questions, our results. Second, our sample was diverse concerning sexual orientation and gender identity, with 63% of participants identifying as transgender or gender nonbinary. Transgender and nonbinary youth face additional barriers and negative experiences with mental health care, and the inclusion of their perspectives in LGBTQ+ research is vital. Thirdly, this study used a mixed-methods approach, integrating quantitative data for understanding of larger-scale trends with analysis of youth's lived experiences, in their own words. Such an approach positions LGBTQ+ youth experiencing mental health challenges as experts in their own experiences and amplifies their voices in the face of the systemic inequities they face.

This study's results should also be interpreted in the context of its limitations. Findings from our sample may not generalize to US LGBTQ+ youth as a whole. However, the sample did include youths from 49 US states and territories. The characteristics of our sample were generally similar to those of very large samples of LGBTQ+ youth in recent surveys [50,61]. However, like those samples, our study was limited to English-speaking youths with internet access and who responded to recruitment

advertisements. Their experiences may differ from those of non-English speaking youth, and those without internet access or who do not use Instagram or are not interested in participating in such research. Also, relative to these samples and the general youth population of the United States [62], our sample included an overrepresentation of White non-Hispanic youth, as well as youth assigned female at birth. Future research could gather information from a wider variety of youth by making study materials available in languages other than English, combining online with in-person recruitment strategies, and deliberately targeting racial/ethnic minoritized youth for greater inclusion. In addition, we only reported on results from our sample as a whole, rather than examining experiences of youth of specific LGBTQ+ identities or living at intersections of multiple marginalized identities. In the current study, a large majority of the sample identified with multiple gender identities, and no sample was collected on individuals identifying as cisgender" (i.e., only man, woman, etc. Table 1) limiting our ability to fully power analyses comparing the endorsement of each qualitative theme by gender categories. Furthermore, youth reported zip codes in both rural and urban areas of the United States, but both groups were combined due to a lack of sample size needed to power analyses comparing rural versus urban youth. Finally, although the survey-based format of this study allowed us to reach many more participants than an interview study, our data were consequently in the form of brief text responses that coders interpreted without opportunities to follow up or ask for clarification as we would have in an interview.

Implications

The results of this study both align with and expand on prior knowledge about the successes and challenges LGBTQ+ youth face when seeking and receiving mental health care. Along with our findings, we have provided concrete suggestions for how individuals in various roles can better support this vulnerable population of youth by accessing the support they deserve. Still, there is more work to be performed to improve understanding of these issues, and researchers pursuing these questions should continue to leverage the invaluable expertise by experience that LGBTQ+ youth themselves have to share.

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Data Availability Statement

All data are available by request and via the open science framework at https://osf.io/dya83/.

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