

Youth of Color Perceptions of Sexual Orientation and Gender Identity Discrimination in Mental Healthcare Settings

Abstract

Through interviews with youth of color, we explored how sexual orientation or gender identity (SOGI) discrimination affected the youth's experiences with mental healthcare. Youth were recruited between November 2021 and April 2022 in a public safety net hospital during a psychiatric emergency services visit. Data were collected from audio-recorded interviews with six youth and observations of their interactions with clinicians. Inductive coding was used to identify themes. Participants self-identified as: Latinx (4), Black (1), or Asian (1); sexual orientations as bisexual (2), pansexual (1), asexual (2), or gay (1); and gender identities as cisgender (3), nonbinary (2), or transgender (1). Participants described past *bullying*, *hidden identities*, *uncertain expectations of support* and *mitigating harm* in community and healthcare spaces. Youth who publicly expressed their SOGI were victims of discrimination in healthcare settings. Opening up to clinicians to express SOGI and mental health needs was taxing, inhibiting engagement with new providers. LGBTQ+ youth of color experienced SOGI-related discrimination early in their adolescence. Previous experiences of stigma and rejection hindered LGBTQ+ youth of color's trust of clinicians and created challenges during their mental health treatment.

Key words: Youth of color, SOGI, bullying, discrimination, youth, mental health, LGBTQ+

Introduction

Sexual and gender minority adults frequently encounter discrimination in healthcare settings, which leads to delayed or avoided care due to fears of stigma and mistreatment (Ayhan et al., 2020). Sexual and gender minorities are hesitant to disclose their identities to their providers for fear of stigmatization (Whitehead et al., 2016). A national survey of lesbian, gay, bisexual, transgender, and queer (LGBTQ+) adults found that discrimination in healthcare spaces was common, with more than half reporting slurs, microaggressions, sexual harassment, and violence (Casey et al., 2019). Anticipated discrimination led to more than one in six LGBTQ+ adults avoiding healthcare (Casey et al., 2019).

Similarly, adults who identify as Black, Indigenous, and other people of color (BIPOC) experience widespread racial discrimination in healthcare, driven by provider bias and systemic racism (Ayhan et al., 2020; Hall et al., 2015; Paradies et al., 2014; Sim et al., 2021). A systematic review of 15 studies reported that most healthcare providers harbored implicit biases, including positive attitudes towards white patients and negative attitudes towards people of color (Hall et al., 2015). Another review found evidence of racist beliefs, emotions, or practices among healthcare providers towards minority groups in 70% (26 of 37) of included studies (Paradies et al., 2014). A synthesis of 23 qualitative studies found that racial minority patients felt that lack of provider empathy and racial supremacism led to inadequate medical treatment (Sim et al., 2021). Current studies of racial inequities in healthcare find that BIPOC adults avoid care if they have negative experiences with their providers (Zhang et al., 2022).

These forms of discrimination exist in mental healthcare, where LGBTQ+ adults—especially those who are also BIPOC—face compounded barriers to accessing affirming and effective services (Ayhan et al., 2020; Button et al., 2020). A review of 14 qualitative studies found that

LGBTQ+ persons reported their experiences with mental health services reinforced stigma, often due to lack of understanding of LGBTQ+-specific needs among providers and staff (Rees et al., 2021). Discrimination in mental health settings is particularly concerning for people who identify BIPOC and as LGBTQ+ (Cyrus, 2017). Prior research has found significant discrimination against transgender or non-binary Black and Latinx patients with regard to accessing mental healthcare appointments (Button et al., 2020). Further, a recent study indicates that Black, Latinx, and Asian patients who experienced racial discrimination were more likely to delay or forgo medical care (Zhang et al., 2022). A substantial body of literature documents higher rates of depression, anxiety, and suicidal ideation among LGBTQ+ youth (Haas et al., 2011; Newcomb et al., 2020). Evidence also exists that LGBTQ+ youth experience discrimination in mental healthcare spaces, which can lead to delays or avoidance of care seeking (Bohlmann et al., 2021; White & Fontenot, 2019).

When mental healthcare is inaccessible or unwelcoming, BIPOC and LGBTQ+ youth often forgo early intervention, leading to increased reliance on psychiatric emergency services (PES) for crisis care (Kalb et al., 2019). PES includes mental health visits to emergency departments, use of psychiatric urgent care centers, and engagement with mobile crisis teams (Oblath et al., 2023). PES enables those who may be experiencing a severe mental health crisis to access psychiatric clinicians and services at any time (Berona et al., 2020). PES also serves as a gateway to other mental health services as it provides care coordination and referrals (Herrera et al., 2023). Recent studies report that PES visits have doubled for youth who are 17 years or younger, while increasing more than 35% for adolescents and young adults (Kalb et al., 2019; Lo et al., 2020). This trend was largely driven by youth of color (Kalb et al., 2019). Race/ethnicity was found to be associated with higher likelihood of mental health revisits at pediatric

emergency departments, and youth of color were more likely to have multiple PES admissions as compared to white youth (Cushing et al., 2022; Marr et al., 2021).

Intersectionality theory underscores how the convergence of marginalized identities—such as being both BIPOC and LGBTQ+—can contribute to poor mental health outcomes and healthcare discrimination (Crenshaw 1991). LGBTQ+ youth of color are at heightened risk for various mental health concerns due to their multiple marginalized identities. LGBTQ+ youth of color disproportionately experience adverse mental health outcomes, including depression, suicidal ideation, and attempts, when compared to their heterosexual and white LGBTQ+ counterparts (Conron et al., 2015; Eden, 2022). However, existing research frequently treats sexual orientation, gender identity, and racial/ethnic identity as separate, non-overlapping categories, limiting understanding of how these intersections uniquely influence the mental health outcomes of LGBTQ+ youth of color. Mallory and Russell (2021) highlight how the intersection of LGBTQ victimization and racial discrimination may have interactive effects on depression and suicidality, thereby compounding mental health risks among multiply marginalized individuals. Intersectionality foregrounds how overlapping systems of oppression produce distinct experiences that cannot be captured by single-axis analyses (Crenshaw, 1991). Empirical work with transgender and gender-diverse youth of color shows how provider bias, administrative barriers, and structural racism converge across schools, families, and community settings to compound stigma and limit access to care (Malpas et al., 2022; Rhodes et al., 2020), supporting the need for an explicitly intersectional analysis of mental healthcare discrimination in this study. While existing research acknowledges the disparities faced by LGBTQ+ youth of color, less is known about how experiences of discrimination emerge during early identity development and influence patterns of mental healthcare engagement. (Williams et al., 2019) Given that

adolescence is a critical period for identity formation, youth may be particularly sensitive to stigma and discriminatory interactions within healthcare settings. Early encounters marked by perceived discrimination can shape youths' trust in providers and their ongoing willingness to engage with mental health services. Through an in-depth exploration of the lived experiences of LGBTQ+ youth of color, this study seeks to illuminate how perceived sexual orientation or gender identity (SOGI) discrimination affect their experiences with mental health services. By centering youths' perspectives, the study aims to generate nuanced insights to inform more responsive and affirming care for this doubly marginalized population.

Materials and Methods

Recruitment

Youth (ages 13-20) were recruited from the psychiatric emergency services of a safety net hospital after clinicians confirmed youth were stabilized and capable of assent. Prior to recruitment, research team members [initials] identified potential eligible participants by speaking with clinicians and reviewing pediatric emergency room patient boards. The evaluating clinician was asked to confirm the youth had the capacity to currently assent/consent to a research study, taking into account ill severity, age, and developmental stage. Participant youth were only approached for recruitment after the researchers received a clinician's confirmation that the youth's visit fit the study criteria (psychiatric evaluation had already been performed; visit was not for psychosis or substance use disorders; youth was stabilized; and youth was capable of assenting; youth spoke English or Spanish; and youth had least one parent or guardian engaged in care decisions). The research team did not recruit patients when emergency departments or inpatient units were addressing COVID-related patient surges or staffing constraints. The team could not recruit participants while they were on isolation precautions for

COVID. The research team did not recruit participants when a PES clinician was in the room. No youth was recruited without having their parent/guardian also recruited to the study. Youth and their guardians were provided English-language or Spanish-language consent forms (for those over age 18) and assent forms (for those younger than age 18) to review. Consent forms indicated that interviews about their mental health care experiences were for research purposes only, voluntary, would not affect their care plans, and that they could terminate participation at any point. Each participant received a copy of their signed consent form which included information on how to contact the IRB or terminate study participation. Many youth who fit the study criteria were awaiting safe discharge to home, a partial hospitalization program, or an inpatient unit. Participants chose where and when to hold their interviews.

Data Collection

The *Youth in Emergency* project (grant number), launched in 2021, aimed to understand how and why youth of color access psychiatric emergency services (PES) and to examine their prior mental healthcare experiences. Guided by the Candidacy model—a framework used to analyze how individuals engage with healthcare systems and how access is facilitated or obstructed—the study explored patients’ trajectories toward timely and appropriate care. Specifically, the study addressed three research questions: (1) How and why do Youth of Color become candidates for emergency psychological stabilization services? (2) How do racism and parental involvement shape their previous experiences with mental healthcare? and (3) In what ways does their candidacy for PES differ from or mirror earlier interactions with mental health services?

This paper specifically seeks to illuminate how perceived SOGI discrimination affects LGBTQ+ youth of color experiences with mental health services. A semi-structured interview guide was

developed in both English and Spanish (Appendix A). The same interview guide was used for youth and parents.

We conducted in-depth, semi-structured interviews with youth of color (ages 13–20). Interviews elicited accounts from youth about their experiences with psychiatric care prior to a PES visit, the experiences during the PES visit, outcomes from prior PES visits, experiences with healthcare providers, treatment outcomes, and hopes. No youth were recruited without guardian consent for the study. Adults (ages 18+) directly consented to the study; adolescents (ages 13–17) consented with guardian consent. Participants were paid \$30 each after the completion of their interview. Payments were provided through debit cards.

Interviews were performed between November 2021 and August 2022. Research team members [initials] conducted youth interviews face-to-face or via telephone to accommodate participant schedules. Researchers audio recorded the sessions, and interviews averaged 60 minutes.

Data Analysis

Transcription was performed by the research team [initials] following each English-language interview. Spanish-language interviews were transcribed by a third-party, HIPAA-compliant service. English language translations were performed and double checked by the research team. All data were stored on a secure server.

For this paper we focused on interviews from 6 LGBTQ+ youth. Using grounded theory, we conducted iterative, inductive analysis of interview transcripts with youth, using open and axial coding to identify emerging patterns and conceptual categories (Chun Tie et al., 2019). Coding and analysis were conducted in NVivo 1. Four members of the research team (initials) independently reviewed, listened to, and double-coded transcripts to enhance rigor and ensure

analytic depth. Examples of open codes included “lack of connection with provider,” “assumptions about sexual orientation,” “pronouns and medical chart conflicts,” “school harassment,” and “combative/adversarial treatment.” These codes were then grouped into higher-order categories that directly informed the development of the reported themes. The team met weekly to engage in constant comparative analysis, discussing preliminary codes, refining conceptual labels, and exploring relationships between categories as they emerged from the data. Memos were used throughout to document analytic decisions and evolving theoretical insights. Through ongoing discussion and comparison, related codes were clustered into higher-level categories, which were then synthesized into overarching themes that captured shared experiences and core processes. Following completion of axial coding, the team convened to synthesize findings, develop higher-order themes, and identify central phenomena. Final themes were established through collaborative consensus in December 2023. Illustrative quotes were included for each theme, with pseudonyms used when describing participants. Quote selection prioritized representativeness and exemplarity across participants and emergent themes: although not every participant is quoted at length, all six youth of color contributed to the analytic set, and excerpts were chosen to illustrate intersectional patterns rather than to imply exclusivity to any one gender identity.

Positionality Statement

The research team consisted of health services researchers and clinicians with experience in qualitative research. Most research team members identified as female. Two of the research team members identified as LGBTQ+, contributing diverse perspectives shaped by gender and sexual orientation. Additionally, two team members were people of color, bringing important cultural insights and awareness of systemic inequities that may influence both data collection and

interpretation. Four researchers directly engaged in participant observation within the psychiatric emergency services (PES) setting, spending time observing patients, guardians, and clinicians, which enhanced contextual understanding and grounded the analysis in lived experiences.

Recognizing that individual identities inevitably shape researchers' viewpoints, assumptions, and potential biases, the team engaged in ongoing reflexivity practices throughout the study. This included regular reflective discussions to surface and critically examine how their overlapping and non-overlapping social identities—such as gender, race/ethnicity, sexual orientation, and professional roles—might influence interactions with participants and the interpretation of data.

One team member's proficiency in spoken and written Spanish facilitated communication with Spanish-speaking participants, reducing language barriers and improving the depth and accuracy of data collected from this group. To further mitigate potential bias related to language and cultural interpretation, this researcher collaborated closely with others on the research team during transcription and analysis, fostering checks and balances in meaning-making. Together, these diverse perspectives and deliberate reflexive practices strengthened the rigor and credibility of the study by fostering a more nuanced and balanced understanding of the data.

IRB Approval

The study and methods were approved by the [University] (H-40376). Recruitment and consent materials were available in Spanish and English.

Results

Six of the fifteen youth self-identified as LGBTQ+ and were included in this study. Of the six included youth, four were English-speaking Latinx, one was Black, and one was Asian. Two youth identified as bisexual, one as pansexual, two as asexual, and one as gay. Two youth were

nonbinary and one was transgender. Four key themes emerged from their accounts of seeking mental health treatment: *bullying*, *hidden identities*, *uncertain expectation of support* and *mitigating harm*. A table with themes and representative quotes is included in the appendix.

Bullying

In our study, youth described experiences of SOGI-related bullying in their everyday life, and relayed that their fear of bullying affected their mental health. Based off of youth description, we defined bullying as unwanted, aggressive behavior that is repeated or has the possibility to be repeated, and where there is a real or perceived power imbalance between the actor and target.

James, a 17-year-old Latinx, bisexual transgender male, describing how bullying in school affected his mental health “It was in like middle school, that I was just, you know, ... getting bullied, and that kind of is what started my mental health, like, just declining. And I noticed that I was, you know, not wanting to go to school, you know. So, I wanted to stay in bed all day. I don't want to talk to anybody. Um, I kind of feared going to school because I didn't know what was going to happen on one specific day. And I just didn't want like, you know, because every day it was like, same, same thing, just getting bullied. And then yeah, it was just not wanting to go to school, but like still going because you know, I have to.”

Kai, a 14-year-old Black, pansexual non-binary youth, describing other students at their school “Like, if you're gonna be homophobic, at least like don't cover it up. [They say] like, ‘I'm not homophobic, I just don't want people to be gay near me. Just as like, as long as you're not like, doing it in public.’ Then you have [student name] that was like, ‘I don't mind you being gay, but like, just don't like act like it.’”

Bullying continued in mental health treatment settings, particularly for trans and gender expansive youth. Youth described situations in which anti-LGBTQ+ sentiments were overtly expressed to them by other patients or staff making them feel unwelcome when receiving mental health treatment.

James describing a previous inpatient experience with another patient “And yeah, there was just there was a situation where I got hostile and angry. Because this one guy basically tried telling me and another person, that we aren't real men, because we have female parts, and that got me angry. So then I started yelling, I started screaming, and you know, that I had to take a moment outside to calm down..”

Kai, describing an experience with staff “And one of my sits was transphobic. Like we were watching ‘I am Jazz.’ And Jazz was talking about her life and how it’s not going to feel natural. And she (the sitter) was like ‘this is because you’re [Jazz is] not a real woman.’ I spun my head so fast, and I was like, ‘Yeah, she is a real woman.’ And she was arguing with me how she’s not a real woman and how she’s a man...she was like, in her medical charts, it’s going to say that she’s a man...She was like, insisting on telling me.... And it was like, I was nervous. I was shook. I was shook to the core.”

Hidden Identities

Youth described hiding their SOGI in various aspects of their lives which stemmed from their prior experiences with bullying and harassment. The decision to keep some or all aspects hidden was related to the complexity of the dynamics within, and between, their intersectional identities.

Kai explaining their decision to hide their SOGI from their family “So I identify as gender fluid, which is basically like you can, I don’t know how to explain it. But like, it’s, you go by they/them, sometimes. She/her sometimes, then he/him sometimes. And like, you can tell, mainly in my tone or how my act, because it’s a big difference. And like it’s just who I am. And I didn’t know that. And I just found that out in seventh grade, that there’s a word for me. And there’s other people like me, and I’m not completely alone...[but] I never will [tell my family]. They’re not that type of people. I feel like if I told them that they wouldn’t believe that it’s a thing. And they see me as overdramatic because I tried to open up to them. And I was told I’m being dramatic. That I’m acting depressed for attention. Yeah, because everybody wants to feel this way.”

James discussing why he didn’t share his identity with anyone so as to not be seen as overreacting “I didn’t confide in anybody really, I kind of just like kept it to myself. Because, you know, people were like, ‘Oh, they’re not bullying you. It’s not that big of a deal. You don’t have to make it that big of a deal.’ And honestly, I thought that I was just blowing it out of proportion. That’s what I thought I was just, you know, over, over overreacting.”

Youth were also hesitant or fearful of sharing their identities with mental health professionals, either from previous negative experiences or doubts about acceptance. Many described having an emotional barrier to care after previously having, but then losing contact with, a trusted mental health provider who was aware of the youth’s SOGI. Some were unwilling to connect with providers who lacked cultural concordance. Youth felt opening up to a new provider of a different race was emotionally taxing, and therefore many chose to keep their identity hidden in future interactions.

Alex, a 13-year-old Latinx, asexual non-binary youth, discussing losing contact with a therapist and subsequent difficulty opening up to new therapists “It’s hard for me like to connect with therapists, like, the person who I had like at [age] seven. Like, I did like them a lot but then-- they run... When I got like therapy at 11, I wanted to get therapy with them again. But like, they stopped working at that place. So I didn’t get to see them again after that. And at first it was really hard for me to like talk to them, because I don’t like therapy, like I don’t find it useful for me, it doesn’t help me that much. And like I find it hard, like just meeting new people. Like I don’t like new things, and I don’t like changes and I have a hard time interacting with people and with interactions in, in general. So then it was hard for me to like, open up to the person and like by now, like I [finally] opened up to them. But now it’s like it’s gone now. Like when I just started to wanting to talk to them like to open up, it had to end and I had to start talking with a new person.”

Kai discussing lack of connection with mental health clinicians “Yeah. Like Dr. X asked if I’m gay, and I said no. And that’s how, that’s how far the conversation got. I’m not going to open-up. I feel no cosmic connection man, there’s like, they told you like it’s your therapist, you’re supposed to, like, connect to them. Like, I can’t connect with them. They’re like old white people.”

Uncertain expectations toward support

Experiences with bullying and harassment in their daily lives and during mental health treatment reinforced youth’s decision to keep their SOGI hidden. Youth also described home or family dynamics that suggested their SOGI would cause unavoidable conflict, leading them to have uncertain expectations of support with certain family members or guardians.

Alex discussing the complexities of using gender neutral pronouns in Spanish “The thing about Spanish is that, it’s more difficult... There are pronouns that exist that are neutral and things like that. But the thing is – it’s hard to like expect and it’s hard to find the people who will be the ones who will be willing to use those pronouns. Since I know a lot of people won’t like [it] once I use those pronouns. I mean, you’re usually, if like, a person doesn’t want to use [someone else’s] pronouns, I will not talk to them. But like, I know there’s people certain people that I cannot do that with, because maybe it’s family... and I won’t be able to avoid that.”

Conflicts, or anticipated conflicts, with guardians about the youth’s SOGI carried over into their experiences with mental health treatment. Inherent in the mental health treatment of youth is coordination and communication with parents, guardians, or caregivers. Youth had differing

experiences with guardians who were unaware or unsupportive of their SOGI, which led youth to have negative mental health treatment experiences.

Henry, a 20-year-old Latinx gay male, describing his parents placing them in conversion therapy “Yeah, my first therapist was super. It was a conversion therapy kind of thing. Though, not my parents’ proudest decision. Hopefully they regretted it, but I’m not sure. And, yeah, it was not. That was my first thing. So I felt like I have a lot of negative things about therapists [now].”

Alex discussing how clinicians often direct questions to the parent and not the youth “Sometimes it’s hard because like, they ask the questions to my mom and not me, because maybe they think my mom knows me. I mean, I guess she’s supposed to know. But...it’s hard for me to open-up about things that sometimes she doesn’t like, know about. And people ask her and it’s like, that’s a bit, that’s gonna be hard, because she doesn’t know [my SOGI]. But like, there’s a big part of that, that’s left out.”

Mitigating harm

In part due to previous experiences with bullying and uncertain expectations of support, youth recounted situations in which they attempted to disclose their SOGI to family members who would potentially be accepting. However, these situations often involved some component of ignorance, which youth were willing to forgive or ignore in order to return to the status quo.

Kai describing revealing sexual orientation to gauge their sister’s response “I like [tried] one test. In like, the middle of the night. I know, my sister was tired, and she was going to the bathroom. So I knew she probably wouldn’t remember this when she woke up. So I told her, like, hey, I want to start off with the basics first. And I just went with the simple. ‘Hey, I think I’m gay.’ You know, just flat and simple. Not nothing complicated. Even though I’m not gay. I’m pan, but you know, one step at a time. And then she kind of went on a tangent. Too many questions. Questions about myself that I couldn’t really answer. So then I was like, never mind, then went back to bed and never tried ever since.”

Youth responded to anti-LGBTQ+ bias and/or lack of knowledge in mental healthcare settings with strategies previously reported on by racial/ethnic minority adults to deal with racial discrimination. Youth invested time and effort into helping clinicians or patient peers understand LGBTQ+ terminology and perspectives. Youth also minimized the harm or impact these

situations had on their mental health, asserting that it was unintentional, and the effort alone was positive.

Alex discussing if they felt like they were treated differently by providers "And like, in for like, my gender. Like, [being treated differently] in a bad way...I was transgender. Now agender...so they treated me a little bit more carefully to not mess up the gender thing...some people here have used [gendered] pronouns, but like, I mean, I didn't care enough for it to like to affect me. I prefer they/them. And like my therapist, like they used [binary pronouns] until they find out that I was agender."

James describing responses from staff and patients "When it came to like the staff, [they were] very respecting of people's pronouns and stuff, like, the staff was very respecting, and the other patients were very respecting too, you know, and, yeah, honestly, I didn't have a problem with that. Personally. I didn't have a problem with people not using my pronouns."

Discussion

To our knowledge, this project is among the first to explore how SOGI discrimination affected youth of colors' experiences using mental healthcare. Our findings suggest that youth of color strategically conceal their SOGI in mental healthcare spaces. Previous experiences of stigma and rejection inhibit LGBTQ+ youth of colors' mental healthcare utilization even before clinicians are engaged. SOGI discrimination inhibited youth trust of clinicians and guardians which complicated the youth's psychiatric treatment.

Youth access to mental health treatment is conditioned on the support of the adults around them, particularly their guardians. Mixed feelings among guardians about a youth's SOGI may lead parents to pursue inappropriate treatments, and youth may choose to hide their SOGI identities from guardians and clinicians to avoid conflict or mistreatment. Our results indicate that uncertain expectations of support led to negative treatment experiences for youth. When youth were unsure whether a clinician or guardian would be affirming, they often chose to withhold important information about their identity, which limited the clinician's ability to provide

appropriate, affirming care. Youth in our study reported being hesitant to share SOGI with clinicians, especially when those clinicians had different racial or LGBTQ+ identities than the youth. Prior research has found that adults who experience discrimination avoid mental health treatment so as to not be labeled with a second stigmatized identity of mental illness (DuPont-Reyes et al., 2020; Gary, 2005). More than one third of adults avoid disclosure of LGBTQ+ identity to medical providers, while rates of nondisclosure are even higher for younger LGBTQ+ individuals (Durso & Meyer, 2013; Rossman et al., 2017). Prior qualitative research has typically explored reasons for nondisclosure among adult LGBTQ+ people, but a recent study of LGBTQ+ young adults found reasons may include: lack of provider inquiry, desire for discretion, avoiding stigma/labeling, and feeling their SOGI was not relevant to healthcare (Rossman et al., 2017). For youth in our study whose guardians were unaware of their SOGI, there may not have been an opportunity for youth to disclose their SOGI without the guardian present. This dynamic touches on the complexity of intersectional identities, particularly for youth in our study who are grappling with mental health, racial discrimination, SOGI, and the typical stressors of adolescence.

Youth described bullying from patients and harassment from staff related to their SOGI when receiving mental health treatment. SOGI-related training has reduced bullying and harassment in other contexts, specifically for students and teachers in the school setting (Ioverno et al., 2022). Existing school-based interventions range from those which include the entire school population, to those that focus specifically on students, teachers, or staff (Earnshaw et al., 2017). Further, these interventions may include student-focused strategies such as educational instruction, discussion groups, or creative activities, professional development for teachers or staff, or school-level policy interventions (Earnshaw et al., 2017). With regard to healthcare settings, a

recent systematic review assessing training to reduce LGBTQ-related bias among medical, nursing, and dental students and providers found that bias-focused interventions improved knowledge of LGBTQ+ health-related issues, experiential learning interventions increased comfort levels when working with LGBTQ+ patients, and intergroup contact promoted more tolerant attitudes towards LGBTQ+ patients. However, there were no interventions that addressed implicit bias, few with validated outcome measures, and no exploration of outcomes at long-term follow-up (Morris et al., 2019). For pediatric psychological and medical staff – not just clinicians, but sitters and aides who might have sustained contact with youth – SOGI support training may make a difference. However, there is little research on this in the pediatric or adolescent mental health setting.

Within our study, youth described situations in which they experienced SOGI-related bias or discrimination but minimized the severity of these situations. Youth reported having conversations with clinicians or patients to help them understand LGBTQ+ terminology and their own perspectives, a type of coping strategy which has been previously described in the literature for racial/ethnic minority adults. A systematic review detailing coping strategies of Black people dealing with racism included: social support, religion, avoidance, and problem-focused coping (Jacob et al., 2023). Problem-focused coping can include confronting the situation directly to attempt to eliminate, modify, or reduce the stressor, which aligns with youth providing SOGI-related education to others (Jacob et al., 2023; Schoenmakers et al., 2015). Coping through avoidance, such as disengagement, distancing, denial, or self-blame/accepting responsibilities, was also a strategy reported by youth in our study, particularly for those who felt their SOGI may be difficult for others to understand or come to terms with. A recent study exploring experiences of discrimination in healthcare among BIPOC and/or LGBTQ+ adults identified “excusing” as a

common response to discrimination (Apodaca et al., 2022). Excusing included dismissing or denying the provider's discriminatory behavior, or treating discriminatory behavior as a stress response opposed to racial or SOGI-related bias (Apodaca et al., 2022). These situations place an undue burden on BIPOC and LGBTQ+ persons, particularly youth, which may further reduce BIPOC LGBTQ+ self-efficacy and self-worth. Future work should investigate whether mitigating harm reinforces the cycle of delaying or avoid care

Our results have several implications for policy and practice related to mental health experiences for sexual and gender minority youth. While prior research confirms that LGBTQ+ youth are at greater risk for mental health issues, our results indicate that LGBTQ+ youth do not always experience mental health treatment settings as safe and welcoming environments. Some studies have explored ways to signal safety in mental health settings to sexual and gender minority youth. Hadland et al. (2016) describe strategies that can be adopted for individual providers to create a welcoming healthcare environment for LGBTQ+ youth (Hadland et al., 2016). Strategies pertaining to language include signaling inclusivity, such as non-presumptive questions (Are you in a relationship vs Do you have a boyfriend?) and routinely sharing personal pronouns and asking for and using the youth's pronouns (Hadland et al., 2016). It is also important for providers to acknowledge that prior, negative interactions may make youth hesitant to disclose SOGI, and stating upfront that they are an LGBTQ+ friendly provider may ease these concerns (Hadland et al., 2016). Further, youth in our study highlighted their concerns with revealing SOGI to family and friends due to cultural aspects of their communities. For these youth, having clinicians and support staff trained to signal safety may make mental health treatment settings more welcoming and reinforce youth's trust in clinicians. Diversifying the healthcare workforce

to include more racial/ethnic minority and/or LGBTQ+ clinicians can also make youth feel more welcome in all healthcare spaces (Cohen et al., 2002; Mensah & Sommers, 2016).

There are several limitations to our study. First, this study reports data from six participants, who are a subset of those in the wider *Youth in Emergency* project. However, these six participants reflect a population of adolescents and young adults (youth of color and LGBTQ+) who are vastly underrepresented in the literature. Second, recruitment for the *Youth in Emergency* project occurred during the COVID-19 pandemic, and COVID-related precautions limited our ability to recruit more youth who may have been otherwise eligible for inclusion. Third, none of the youth were available for follow-up interviews after discharge from PES, reflecting a known problem with retention of emergency room patients. Fourth, this analysis did not include perspectives of clinicians and/or guardians, as we focused on how youth perceived SOGI-related discrimination affected their use of mental healthcare. Further, we note that four of our six participants identified as gender nonconforming, while two identified as cisgender. This sample composition may have influenced the prominence of gender nonconforming perspectives throughout our findings. Lastly, this analysis draws on a larger project that recruited youth of color and examined race, culture, racism, and prior mental healthcare experiences. The present manuscript addresses a more delimited question: how perceived SOGI-related discrimination shaped mental healthcare experiences among the LGBTQ+ youth-of-color subsample. Although all six youth contributed to the analytic set and participants at times described family, culture, language, and racialized experiences as relevant context, the coding, themes, and quote selection were not designed to systematically examine the interplay among race, culture, and SOGI. This focus reflects the research team's analytic approach and consensus interpretation of the data, but it is a limitation. Accordingly, the study should not be interpreted as a fully intersectional analysis.

Future research should directly examine how race, culture, and SOGI co-constitute mental healthcare experiences among LGBTQ+ youth of color. ~~future intersectional analyses that more closely examine the interplay between race, culture, and SOGI could illuminate how these identities co-constitute mental healthcare experiences among LGBTQ+ youth of color in ways that extend beyond the present study's SOGI-focused findings. We encourage the research community to pursue such work, and we are committed to advancing this intersectional inquiry in future phases of our research.~~

This study sheds light on the complex and deeply rooted ways that SOGI-related discrimination shapes the mental healthcare experiences of LGBTQ+ youth of color—often beginning long before they engage with a clinician. Our findings emphasize that improving access to and quality of mental healthcare for this population requires more than individual-level interventions; it demands structural and cultural changes across the healthcare system. Youth in our study navigated not only intersecting stigmas tied to race, sexual orientation, gender identity, and mental health but also power dynamics with caregivers and providers, often feeling compelled to hide essential parts of themselves. This concealment, combined with previous stigmatizing experiences, may delay care-seeking, diminish trust in providers, and compromise treatment outcomes. Mental healthcare systems must move beyond provider-focused training to develop comprehensive, youth-centered policies that promote safety, inclusion, and trust—especially in acute care settings where youth are most vulnerable. Research is needed to examine how institutional practices (e.g., intake procedures, documentation policies, staff training) can be designed or restructured to better support LGBTQ+ youth of color, and how these interventions impact long-term mental health trajectories. Future studies should also incorporate perspectives from clinicians, caregivers, and peers to build a more holistic understanding of the care

environment. Importantly, youth should be meaningfully engaged as partners in developing and testing solutions. As our healthcare systems strive to become more equitable, centering the lived experiences of LGBTQ+ youth of color must be a core part of that effort—not only to reduce harm, but to build care systems where all young people can safely and fully be themselves.

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