Emergency Care for Youth Who Experience Suicidality and Identify as Lesbian Gay Bisexual Transgender Queer/Questioning (LGBTQ+): An Interpretive Phenomenology

Theresa Schultz

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EMERGENCY CARE FOR YOUTH WHO EXPERIENCE SUICIDALITY AND IDENTIFY AS LESBIAN GAY BISEXUAL TRANSGENDER QUEER/QUESTIONING (LGBTQ+): AN INTERPRETIVE PHENOMENOLOGY

A Dissertation
Submitted to the School of Nursing

Duquesne University

In partial fulfillment of the requirements for the degree of Doctor of Philosophy

By
Theresa Ryan Schultz

August 2022
EMERGENCY CARE FOR YOUTH WHO EXPERIENCE SUICIDALITY AND IDENTIFY AS LESBIAN GAY BISEXUAL TRANSGENDER QUEER/QUESTIONING (LGBTQ+): AN INTERPRETIVE PHENOMENOLOGY

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Approved June 30, 2022
ABSTRACT

EMERGENCY CARE FOR YOUTH WHO EXPERIENCE SUICIDALITY AND IDENTIFY AS LESBIAN GAY BISEXUAL TRANSGENDER QUEER/QUESTIONING (LGBTQ+): AN INTERPRETIVE PHENOMENOLOGY

By
Theresa Ryan Schultz
August 2022

Dissertation supervised by Dr. Rick Zoucha

Purpose: Suicide is a leading cause of death in children; youth who identify as LGBTQ+ are at an exponentially higher risk of suicide. The purpose of this study was to explore the lived experiences of young adults who identify as LGBTQ+ and sought emergency care for suicidality when they were adolescents.

Methods: Heideggerian hermeneutics phenomenology is the research method used in this study. Youth, ages 18-25 years, who identify as LGBTQ+ and sought emergency treatment for suicidality when they were adolescents (13-17 years) were recruited to participate; fifteen youth enrolled. Individuals ranged in age from 20 to 25 years. Participants described their ethnicity as: African American/Black, Hispanic/Latino, Pacific Islander and Hispanic, and Other. Individuals described their gender identity as male, female, non-binary, transgender female, and their sexual
orientation as: female, demisexual, bisexual, gay, homosexual, lesbian, queer, asexual, and transgender.

**Results:** This study establishes that youth who identify as LGBTQ+ seeking emergency care for suicidality value these shared meanings: 1) coping and control, 2) acceptance from others and self, 3) communicating with me about me, and 4) moving beyond danger and distress. Lack of psychological safety—from the emic perspective of individuals—emerged as a critical finding.

**Conclusion:** The outcome of this research has strong implications for clinical practice, policy, and research. Future research must seek to understand ways in which psychological safety is assessed in the healthcare setting if we are to more deeply understand and effectively address the impact on health equity and health disparities.

**Keywords:** adolescents, LGBTQ+, suicidality, emergency care, psychological safety
DEDICATION

I am grateful for the blessing of many incredible mentors in my life. I must make special mention of my first and most influential mentors who guided, counseled, advised, listened, and pushed back. They offered a clear framework and role modeled the way; they are my parents. And my children, who have endured their mother’s journey as a life long learner; they support and encourage me every step of the way and have developed the strong ability of holding each other up—which anchors me.
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Dissertation Proposal

Specific Aims

Suicide is the second leading cause of death for youth ages 12-18 years (Hedegaard et al., 2020; WISQARS, 2020). Among Medicaid-enrolled youth who committed suicide (ages 10-18 years), 75.5% of them had connected with mental health services in the 6 months prior to their death; a significant proportion of these youth had a mental health diagnosis when compared with index cases (Fontanella et al., 2020). Adolescents who identify as lesbian, gay, bisexual, transgender, queer/questioning, intersex (LGBTQ+) are greater than three times more likely to attempt suicide when compared with their peers (Raifman et al., 2020).

Emergency Department (ED) encounters for suicidal ideation and suicide attempts at children’s hospitals increased by 292% between 2008 and 2015 (Plemmons et al., 2018a). Findings from an unpublished mini-study—conducted by this researcher—seeking to understand the lived experience of youth who identify as LGBTQ+ and sought emergency care for suicidality as an adolescent, included concerns for: acceptance, accomplishment, control, and safety (Schultz & Zoucha, 2020). This highlights a knowledge gap; we do not know how individuals who identify as LGBTQ+ experience emergency care for suicidality, nor do we understand the impact of such care.

The proposed study will more fully explore the values, beliefs, and lived experiences of young adults, identifying as LGBTQ+ who sought emergency treatment for suicidality as adolescents by building on the data previously collected in the mini-study. The research question is: What are the lived experiences of young adults (aged 18-25 years) who identify as LGBTQ+ and received emergency care for suicidality as an adolescent (13-17 years)? The specific aims are: 1) identify and understand the values, beliefs, and experiences of youth who identify as
LGBTQ+ and received emergency care for suicidality from the emic perspective, 2) determine the retrospective needs of adolescents who identify as LGBTQ+ and seek emergency care for suicidality based on their unique cultural care experience, and 3) explore the needs of adolescents who identify as LGBTQ+ to inform evidence-based future care delivery for such needs.

The significance of the problem and the social constructs which perpetuate barriers to healthcare access for individuals who identify as LGBTQ+ beckons a comprehensive full-scale investigation imperative. This research aligns with NIH priorities to advance culturally congruent care of vulnerable populations. Culturally congruent care within a therapeutic care environment—inform ed by the population served—will align with the values and beliefs of youth who identify as LGBTQ+ receiving emergency care for suicidality. In turn, pediatric psychiatric emergency health care may improve as a result. The findings may inform pediatric practice and policy.
Significance

Suicide in Youth

Suicide is the second leading cause of death for youth ages 12-18 years (Hedegaard et al., 2020; WISQARS, 2020). National data affirms that there is an average of 3,041 suicide attempts among youth (grades 9-12) each day (Foundation, 2017). Adolescent suicide increased by 32% between 2000 and 2017 (Frazee, 2019). Most young adults and adolescents who attempt suicide have significant mental health concerns, such as depression (The American Academy of Child and Adolescent Psychiatry, 2019).

Suicide Prevalence in Youth who Identify as LGBTQ+

Adolescents who identify as LGBTQ+ are greater than three times more likely to attempt suicide when compared with their peers (Raifman et al., 2020). The highest rate of suicide in youth who identify as LGBTQ+ were in children ages 12-14 years old (Ream, 2019). These alarming research statistics and the staggering increase in demographic adolescent death by suicide create a burning platform for this public health crisis.

Indicating increased acuity, from 2015 to 2016, the pediatric EDs in Washington, D. C. experienced a dramatic increase in the number of formal psychiatric evaluations and a 240% rise in the number of psychiatric boarders (patients who meet inpatient criteria and remain in the ED due to lack of placement options). This coincided with an increase in patient elopement and the use of violent restraints, with 8% of patients presenting for mental health evaluation requiring violent restraint use in June 2016 (Wavra, 2019). These trends continue -- when comparing FY’16 to FY’18, psychiatric boarding increased 83% (FY’16 = 111 and FY’18 = 641).
In accordance with the Joint Commission sentinel event alert 56: Detecting and treating suicidal ideation in all settings (JCAHO, 2019), the pediatric EDs in Washington, D. C. screen all behavioral management patients six years and older. Between July 2019 and December 2020, 62% of these children were at risk for suicide—78% of them were between ages 12 and 17 years, and 37% at risk children were assessed as high risk for suicide (Chan-Salcedo, 2020).

Adolescents who identify as LGBTQ are greater than three times more likely to attempt suicide when compared with their peers (Raifman et al., 2020). Thus, adolescents who identify as LGBTQ+ are a particularly vulnerable population with respect to suicide.

Risk Factors

Research has identified numerous risk factors for suicide among youth who identify as LGBTQ+. In community, regional, and national quantitative longitudinal, cross-sectional, descriptive, mixed methods, and secondary data analysis studies of 572 and 246 sexual and gender minority youth, it was reported that youth who identify as LGBTQ+ have higher prevalence of mental health disorders when compared to national samples (Fulginiti et al., 2020; Mustanski et al., 2010). Additional risk for youth who identify as lesbian, gay, or bisexual includes disproportionate homelessness and increased experiences with acts of violence when compared with their peers (Johns et al., 2020; Keuroghlian et al., 2014). A study examining the impact of victimization on suicide risk in 2,154 students in grades 9-12 across 15 San Francisco high schools, found that those who identify as lesbian, gay, or bisexual have significantly higher odds for forming suicide plans (3.9) and making suicide attempts (3.6) in the prior 12 months (Shields et al., 2012). When specifically looking at youth seeking psychiatric emergency services in 285 youth (41.8% sexual minority and 2.5% gender minority) ages 13-25 years, predictors of suicidal behavior in adolescents who identified as lesbian, gay, bisexual, transgender are: prior
ED visits and hospitalizations, more severe lifetime history of non-suicidal self-injurious behavior, and frequency of suicidal ideation in the prior week (Berona et al., 2020).

**Healthcare Access Barriers**

Researchers have demonstrated that those within the LGBTQ+ community report healthcare avoidance, trans-specific negative experiences, and non-affirmative healthcare encounters (Baams, 2018; Bauer et al., 2014; Delaney & McCann, 2020). Obstacles for youth who identify as LGBTQ+ accessing mental health exist at the individual, sociocultural, and mental health system level (Higgins et al., 2020). Health system failures are illustrated in a case report of a 14-year-old birth assigned female transitioning to male, who sought emergency care for suicidality. This adolescent experienced emotional distress and demonstrated behavioral outbursts when addressed with female pronouns (she/her) instead of identified pronouns (he/him) (Day et al., 2019).

Barriers to healthcare access for suicidality align with reports of growing numbers of psychiatric ED presentations and inpatient admissions (Bauer et al., 2014; Plemmons et al., 2018a). Research findings suggest a critical need for additional community resources and ED provider preparedness (Burstein et al., 2019; Plemmons et al., 2018b). National data report on the enormity of these challenges, estimating 7.3 million pediatric ED visits for suicidal ideation and suicide attempts between 2007 and 2015 (Burstein et al., 2019). This constellation perfectly positions ED staff to develop risk reduction initiatives to decrease the burden of suicide among our most at risk children and youth.

**State of the Science**
A synthesis of the literature was conducted and included 13 peer reviewed publications between 2011 and 2020. Sources were published in the English language in peer review journals between 2000-2020 and included LGBTQ+ youth with emergency care needs for suicidality. This selected search timeline reflects published research after Vermont became the first state to legalize civil union between same-sex couples in 2000 (Cox, 2000). Of the 13 qualitative, quantitative, and mixed methods studies, 62% were published in 2018 and 2020. Studies included individuals between the age of 5 and 26 years old. Youth who identify as LGBTQ+ have higher prevalence of mental health disorders, homelessness, and victimization. In addition, they experience rejection, stigma, and social bias, which has been linked with increased psychological distress and homelessness (Janeway & Coli, 2020). Associated stress is directly and indirectly linked with suicidality and mental health conditions such as depression and post-traumatic stress disorder (Fulginiti et al., 2020).

Healthcare access hurdles coupled with one’s receptiveness to engage impact care delivery. Individuals’ willingness to accept crisis services is influenced by the service setting, structure, and flexibility of the crisis intervention system. For example, a study of 1,520 Ontarian youth ages 17-25 reports that a structure which accepts “walk in” appointments, and incorporates texting options is favorable (Wang et al., 2020). It was also reported that youth who identify as LGBTQ+ assert the need for acceptance in a malleable health system which acknowledges individual strengths, approaches individuals with the emic perspective of the patient, and avoids introduction of psychological distress. Therefore, in order to provide youth who identify as LGBTQ+ with the accessible, therapeutic and culturally congruent mental health services for suicidality, a comprehensive understanding of their experiences is needed.

*Emergency Care for Suicidality in Youth who Identify as LGBTQ+ Remains a Gap*
The reported research has identified significant prevalence, health disparities, risk factors, and barriers to healthcare access for individuals who identify as LGBTQ+. The literature has not addressed the emic perspective of individuals who identify as LGBTQ+ and need emergency treatment for suicidality beyond limited structured surveys and case reviews. The proposed research will address the gaps by learning from the population such that their experience be more deeply understood and translated into new knowledge intended to inform the future.

Psychological distress, which is linked with social bias, stigma, rejection, depression, and post-traumatic stress disorder, has been described. However, the etic impact of an emergency care visit for suicidality on such conditions has not been explored. Furthermore, the seasonal health seeking patterns for the growing number of psychiatric ED and inpatient admissions is associated with the academic calendar (Plemmons et al., 2018a). This rationale and relationship surmise such and does not account for the complex internal and external factors associated with suicidality in youth who identify as LGBTQ+. Confirmation bias—interpreting new data as confirmation of one’s existing beliefs—may be present when it is deduced for example, that existing barriers at the mental health system level are primarily inadequate community resources. It is possible that the barriers exist within the individuals who make such deductions.

To our knowledge, there has been no research conducted in the U. S., which is aimed to examine the intersection between adolescents who identify as LGBTQ+ and emergency care for suicidality. There is one published study which begins to touch on the identified need; investigators in Ireland examined mental health service seeking behaviors in 1,064 LGBTQ+ youth ages 14-25 (Higgins et al., 2020). They propose that future studies include a semi-structured interview method to provide more contextualized data than the qualitative written survey method used in their study (Higgins et al., 2020).
The fullness of the identified phenomenon has not been sufficiently explored. We do not know how youth who identify as LGBTQ+ experience emergency care for suicidality. The proposed research study and approach to inquiry—using open-ended interview questions—may result in deep descriptive data emanating from each individuals’ social, cultural, and historical perspective.

**Implications of the proposed work**

**Nursing Practice**

Nurses are ill prepared to most effectively respond to the growing number of youth seeking emergency care for suicidality as evidenced based standards—beyond suicide screening—do not exist (Ballard et al., 2017). Culturally congruent care based on the unique needs of this population is not possible when there is a void of information about what these needs are. Synthesis of the literature and results of the mini-study suggest that a strength-based approach to patient care should encourage the opportunity for these youth to identify their personal gifts and goals for the near term and future time period (Schultz et al., 2021). Findings from the proposed full-scale study may further close the identified gap and better prepare nurses to provide culturally congruent care in the future.

Every day, nurses are caring for youth seeking emergency care for suicidality. Most often, nurses are the first person the patient encounters at registration/patient triage where they are presumed as male or female. The literature suggests that this type of encounter could be distressful to a patient who identifies as LGBTQ+. Investigators in medicine, psychiatry, and social work have conducted research informing emergency care seeking patterns, practices, and predictors with youth who are suicidal and identify as LGBTQ+; there is no evidence of nursing
involvement (Schultz et al., 2021). This nurse-led study offers the first step toward understanding the emic perspective of such care and the reciprocal impact of the encounter on the individual. This research aligns with The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity, which advances the imperative to address social needs in clinical settings (Hassmiller, 2021). The roadmap outlined in this report highlights the need to educate nurses with a focus on population health, health equity, diversity, and social determinants of health (Hassmiller, 2021, p. 190).

Creating a care environment which is affirmative—signifying acceptance—should be included in all elements of care. Culturally congruent care—quality care which reflects not only how care is offered but also, how care is received based upon the values, beliefs, perspective, and experiences of the patient (Marion et al., 2016)—may reduce psychological distress and improve the healing milieu. All youth should be addressed with openness and understanding that transition from adolescence to adulthood is complex; understanding one’s sexual orientation and gender identity evolves over time. When family support is not present in their lives, youth are at risk for adversity such as homelessness, poor socioeconomic status, and barriers to achieve educational goals (Cutuli et al., 2013; Edidin et al., 2012; McConnell et al., 2015). Caution should be taken when interacting with youth who may not have disclosed their gender identity or sexual orientation with their parents. The proposed research may inform future nursing practice by advancing personalized care which is informed by the knowledge, beliefs, and experiences of youth who identify as LGBTQ+ and require emergency care for suicidality. Hence, there is an imperative to move forward and complete the full-scale study as the next step in the research process to holistically understand the emic perspective of youth who identify as LGBTQ+ and
need emergency care for suicidality. Data previously collected in the mini-study will be used as a starting point for the proposed study.

**Healthcare Policy**

The Centers for Medicare and Medicaid Services 1986 Emergency Medical Treatment and Labor Act (EMTALA) laws require that we care for individuals regardless of healthcare insurance coverage. Policies which drive decisions about access to healthcare for the LGBTQ+ community have far reaching implications. Lack of mental healthcare coverage may alter health seeking patterns and practices by further increasing ED utilization for such psychiatric emergencies; EMTALA laws prevail under these circumstances (Plemmons et al., 2018a). Critical updates to healthcare policy, informed by the results of this proposed research, may impact barriers to emergency health services for suicidality for youth who identify as LGBTQ+.

Healthcare policy influences healthcare access and experience. In June 2020 the Office for Civil Rights of the Department of Health and Human Services issued a final ruling which erases civil rights of transgender individuals in relation to the Affordable Care Act (ACA) (Simmons-Duffin, 2020). The decision removes health care and health insurance protections for individuals who identify as LGBTQ+. Lack of such protections reduces healthcare opportunities and may force individuals to seek care in EDs for emergency care which may have been addressed in preventive ways. Non-ACA related Supreme Court rulings may or may not influence upcoming Supreme Court hearings as they have or have not in the past.

State level policy which contradicts emerging central concerns for youth who identify as LGBTQ+: acceptance (affirmation), accomplishment (strengths), control (approach/interventions), and safety (reduced psychological distress) is evident in the Arizona
State House Senate Bill 1456, passed in April, 2021. This legislation removes inclusion of sexuality, gender identity, gender expression, and sexual orientation materials in the classroom; (Ronan, 2021). Active engagement with Government Affairs to influence this type of regulation with research findings is imperative and underway through hospital system connections and advocacy oversight agencies. The proposed study could demonstrate the harm which can come from such Supreme Court and House Senate decisions and influence healthcare policy accordingly.

Given the significance of the problem, the civil rights concerns, and the social constructs which perpetuate barriers to healthcare access for individuals who identify as LGBTQ+, a comprehensive full-scale investigation is imperative. Evaluating existing and pending healthcare policy with the lens which is informed by the lived experiences of all populations—inclusive of those who identify as LGBTQ+—may impact health outcomes in the future.
Innovation

Culturally Congruent Evaluation and Care

Commonly, emergency care for children who are suicidal aims to create safety from the perspective of providers (etic) by providing close or constant observation in an environment which is free from sharp objects and ligature risk. In contrast, this study aims to understand the lived experiences of youth who identify as LGBTQ+ and had emergency care needs for suicidality from the perspective of the youth seeking such care (emic) in order to promote safety and reduce health disparities. By completing the full-scale qualitative study as a next step in the research process, and examining the extremely at-risk population—youth who identify as LGBTQ+ and sought emergency care for suicidality (aged 18-25 years)—we can begin to learn more deeply how life experiences have shaped their reality. The importance of this approach accounts for the current state, where children who present for mental health emergencies are not routinely asked about their sexual orientation or gender identity. Working with youth (aged 18-25 years) who experienced suicidality in their recent past to offset this challenge posits a breakthrough imperative.

LGBTQ+ Community Lens

Discovering the values, beliefs, and lived experiences of youth who identify as LGBTQ+ more deeply, using a qualitative phenomenological method of inquiry has not been reported and may inform the development of culturally tailored healthcare interventions. This approach offers the unique possibility that science, based on the population’s perspective, will inform the future in ways which have advantages over prior research efforts and practices. The research method proposed for this study will focus on each participant’s recollection of their emergency care experience as an adolescent. Community LGBTQ+ leaders from the only bilingual LGBTQ+
homeless shelter in Washington, D. C. have committed to aid in the identification of 18-25-year-old eligible individuals. This connection supports the feasibility to conduct research with this vulnerable population.

**Advancing Symptom Science**

The National Institute of Nursing Research highlights the importance of symptom science in both research and in practice. Physically and verbally expressed symptoms can be associated with multiple different diseases or conditions. Symptom science focuses on the biological and behavioral mechanisms of symptoms which are expressed in symptom *experiences* and contribute to wellness and/or illness. The paradigm shift from suicidal presentation symptoms to prior life experiences and possible determinants/symptoms, could be a pivotal juncture in suicide symptom science. Such advances in suicide science may transform the way we think about suicide symptoms, patient evaluation, and healthcare management. The developments which result from the pioneering body of knowledge may lead us to evidenced-based practice guidelines envisioned to improve healthcare outcomes for this population.
Approach

Previous Work

Research has demonstrated that those within the LGBTQ+ community report healthcare avoidance, trans-specific negative experiences, and non-affirmative healthcare encounters (Baams, 2018; Bauer et al., 2014; Delaney & McCann, 2020). Youth who identify as LGBTQ+ face barriers to accessing mental health at the individual, sociocultural, and system level (Higgins et al., 2020). Findings from an unpublished mini-study (3 participants) seeking to understand the lived experience of youth who identify as LGBTQ+ (ages 18-22 years) and sought emergency care for suicidality as an adolescent, included concerns for: 1) acceptance, 2) accomplishment, 3) control, and 4) safety (Schultz & Zoucha, 2020). Principal researcher field notes reflect participant comfortability, openness, and willingness to share their adolescent life experiences of emergency care for suicidality in a setting which was familiar to them (Schultz & Zoucha, 2020).

Given all that we know about the health risks associated with the LGBTQ+ community, the urgency exists to explore the identified gaps in knowledge by gathering contextualized data to inform nurses how to most effectively care for this population. By listening to, learning from and being open to young adults who and sought emergency care for suicidal ideation as adolescents and identify as LGBTQ+, we may begin to understand their unique lived experience. As a result, we may decipher which elements of care are most therapeutic and avoid experiences which may be considered non-therapeutic-or even, distressful.

Heideggerian Hermeneutic interpretive phenomenology (Allen et al., 1986; Heidegger, 1962, 1975)—a qualitative research methodology aimed to elucidate the meaning of a
phenomenon in order to appreciate the human experience—will be used for this study (Crist & Tanner, 2003, p. 202). The notion that human beings and the environment are inseparable is key to understanding why this method is best suited for this research (Horrigan-Kelly et al., 2016). Because Heideggerian hermeneutic phenomenology is about understanding the way we are from an emic perspective, not the way we know the world—etic perspective, the research method and design used in this study will focus on each participant’s recollection of their unique emergency experience as an adolescent (Laverty, 2003).

**Setting and Participants**

In qualitative research the study setting and participant sample epitomize the phenomenon of focus within the study aims (Sargeant, 2012). The Casa Ruby and Empowerment Justice Center (EJC) partnership, established in February 2019, is specifically aimed to support mental health and social service needs of individuals who identify as LGBTQ+. Services available include preventive health, social services, Latino and immigration services, support services for victims of violence, and housing services. One specifically stated goal of Casa Ruby and EJC is to improve the health of the LGBTQ+ community and reduce rates of suicide through their collaborative efforts.

Study participants will meet inclusion criteria which are: ≥ 18 and ≤ 25 years of age, identify as LGBTQ+, received emergency care for suicidal ideation or suicide attempt between 13 and 17 years of age, can read, and understand, and speak English. Access to a smart phone, a computer, and internet are required if participating via Zoom interviews. Interested individuals will be excluded if they are actively suicidal (defined as expressed thoughts of suicide during the interview(s) and/or sought treatment for suicidal thoughts, plans, or attempts in the prior 3
months), or are actively psychotic (defined as expressed psychotic symptoms at the time of the interview(s) and/or sought treatment for hallucinations and/or delusions in the prior 3 months). In person interviews and Zoom sessions will take place in the EJC consultation office—which is familiar to individuals who utilize Casa Ruby and EJC services. On site counselors will be available before, during and after each interview—in person and Zoom, to provide support as needed.

Individuals who participate in social services available at Casa Ruby and EJC will be invited to represent the population of interest and decide if they meet criteria to be included in the study. In keeping with Hermeneutic phenomenology, there are no explicit assumptions or influences contributing to the process of sample selection (Laverty, 2003). Demographic data collection will include open-ended questions, offering each individual the opportunity to describe versus choose pre-identified categories regarding how they represent the population of interest. The established partnerships and committed counseling resources from Casa Ruby and EJC uniquely position this research with a vulnerable population to advance in the most culturally congruent supportive environment.

**Recruitment**

A brief summary of the study, with inclusion and exclusion criteria, will be posted in common areas at Casa Ruby and EJC to advertise the research study. Participants for this study will receive, in person or electronically, a $50 Walmart gift card in appreciation for their time after completion of each requested interview (Appendix A). The flyers will be made available at Casa Ruby and interested individuals will contact the researcher directly by telephone, text, or email. When individuals express interest to gatekeepers at Casa Ruby; they will be guided to contact this researcher directly. The snowball method will be employed to recruit additional
participants. The snowball method is a common form of recruitment via word of mouth. The researcher will recruit between 15-20 participants or until saturation of data occurs. For the purposes of clarification and confirmation of data, participants may be asked to engage in a second interview. At no time will medical records be accessed for the purpose of participant recruitment. A summary of de-identified study findings will be available upon request at no cost to all participants.

**Interview Conditions**

The Covid-19 pandemic may create challenges for this qualitative study. As such, in-person interview plans will occur only when the Centers for Disease Control (CDC) guidance permits or changes. On occasions where an in-person interview is possible, strict hand washing, mask wearing, and safe distance procedures will be in place. When this is not possible, or at the request of the individual, video conferencing via Zoom will be conducted. Individuals who express interest in participating in the study—by contacting the researcher directly—will be offered a Zoom or an in-person interview. During this point of contact the researcher will: 1) summarize what can be expected by consenting to participate in the research process, 2) confirm that inclusion criteria are met and exclusion criteria are not present, 3) address questions, 4) explain that talking about their experience, seeking emergency care for suicidality as an adolescent, may be difficult for them before, during, and after participant interviews for this study, 5) offer each interested individual the National Suicide Prevention Lifeline number (1-800-273-8255) and an assigned counselor from EJC, who will be on site and available for counseling if indicated, and 6) offer the interested individual the opportunity to read the consent form or have the consent form read to them.

**Study Procedures**
Study procedures will be explained to all interested and enrolled participants. Details about how the researcher and participants will proceed will be explained and the option to complete the interview during this point of contact or at a future date will be offered. During this initial encounter, the researcher will explicitly review study withdraw conditions and procedures. They will be reminded that they are under no obligation to start or continue the study; they can withdraw at any time without penalty or consequence by informing the researcher that they no longer wish to participate. Additionally, it will be explained that they can withdraw from the study should they become visibly upset by the research process; this type of withdraw would initiate referral for services at the on-site EJC. In order to support the research efforts of this specific study, Casa Ruby and EJC leaders have agreed and committed to assigning a therapist/counselor (social worker licensed counselor, or Psychology PhD intern) to this study. The assigned therapist/counselor will be on site and available as needed before, during, and after all interviews.

The investigator has completed CITI training for the Human Participant Protection Education Research certification prior to conducting any research activities. Consent and interviews will be conducted in person or via Zoom as indicated by CDC guidelines or participant preference. When in person consent is obtained, two copies of the consent form will be presented to the participant for initials and signature, the researcher will witness the signature (Appendix B). One copy will be given to the participant and one copy will remain on file. When Zoom consent is obtained, the consent form (as well as any other participant completed documents) will be reviewed on Qualtrics prior to obtaining electronic signatures. When the Zoom interview option is selected, a password protected link with instructions for access and use will be shared with the participant. All study notes, audiotapes, and video recordings will be
stored and locked in the researcher’s office and these materials will be destroyed 3 years after completion of the study. Permission to conduct this study will be obtained from the Duquesne University Institutional Review Board.

One to one, open-ended interviews will be scheduled and conducted in person or via Zoom. Questions asked aim to elicit insights into how adolescents with suicidal ideation experience emergency care, based on their current recollection of prior experiences (Appendix C). Consistent with hermeneutic interpretive phenomenology, the research questions will guide the interview and observation process. Open-ended interview questions and procedures will focus on illuminating each individual’s social, cultural, and historical perspective from where they were situated. Follow-up questions will be informed by the participant response and initiated only as they relate to the guidance of the participant; data collection and analysis will occur concurrently. The interviews will be conducted by this investigator; field notes reflecting participant responses and investigator observations will be manually recorded, and either audiotaped or video recorded (Zoom). Interview questions will include supplemental demographic data as well (Appendix D).

**Analytic Plan**

Data collection and analysis will be conducted concurrently using the circular hermeneutics process. Narratives are examined simultaneously with the emerging interpretation, never straying from the participant’s particular story and context (Crist & Tanner, 2003). The process of hermeneutic interpretive phenomenology expects that the research questions and the participants evolve during the interview and observation process. The involved procedures often overlap throughout the five phases described: 1) early focus and lines of inquiry; 2) central
concerns, exemplars and paradigm cases; 3) shared meanings; 4) final interpretations; and 5) dissemination (Crist & Tanner, 2003).

Qualitative data collection and analysis is an iterative process resulting in themes which yield new knowledge about the study phenomenon (Sargeant, 2012). The data collection method will include an interview process which will be audiotaped and transcribed verbatim for analysis. The researcher will take notes on observations and participants’ responses to open-ended questions. Concurrent data collection and analysis will occur; participants will be encouraged to raise any questions they have before, during and after the interview(s). Discussions will take place in a private space to safeguard participant comfort and confidentiality. As hermeneutic interpretive phenomenology posits, space will be created to allow for the research questions and the participants to evolve during the interview and observation process. NVivo12 software will be used to transcribe the audiotaped data. The researcher will perform a manual review of each audiotaped session against the NVivo12 transcribed data and update the transcribed text for accuracy when gaps or errors are found. NVivo12 software will also be used to manage, organize and assist with the systematic coding of study findings, count concepts, establish categories, analyze relationships and observe for emerging patterns and themes.

The data from each interview will be analyzed to determine the historical meaning and cumulative effect of participants’ shared values, beliefs, and experiences specific to emergency care for suicidality as an adolescent. Observations and verbal/nonverbal communications will guide the interpretative process—using language and text to determine the retrospective needs of participants when seeking emergency care for suicidality—based on their unique cultural care needs. The researcher will document their experience and reflective insights regarding perceptions and bias during the investigations. Researcher reflections and assumptions will not
be bracketed, but rather noted for their likely contribution to the research process (Laverty, 2003). Through the ongoing and iterative analysis—which includes context of written text, as well as the researcher, the participant, and their context—shared meanings and final interpretations will result (Laverty, 2003). The process of co-creation between the participant and the researcher will result in unique new meaning and shared understanding about the experience of adolescents who identify as LGBTQ+ and seek emergency care for suicidality in the future.

Data accuracy and authenticity will be evaluated throughout all stages of data analysis. Cycles of data deconstruction, interpretation, and reconstruction will concentrate on addressing the specific study aims to: 1) identify and understand the values, beliefs, and experiences of youth who identify as LGBTQ+ and needed emergency care for suicidality, 2) determine the retrospective needs of adolescents who identify as LGBTQ+ and seek emergency care for suicidality based on their unique cultural care preferences, and 3) explore the needs of adolescents who identify as LGBTQ+ and require emergency care for suicidality in the future based on their unique experiences. More specifically, exactly how each aim will be addressed and evaluated is contingent on the direction offered by participants’ responses in context with the researcher, written text and related context. Analysis and the interpretive process will continue until the researcher appreciates reasonable meanings of the experience—without inner contradictions—understanding that new meanings remain tentative in the hermeneutic process (Caputo, 1987; Kvale, 1994).

**Study Limitations**

Participant accessibility is a possible limitation of this study. Individuals who use services at Casa Ruby and EJC are often transient. This poses a potential limitation to this study where participant data and findings may include a follow-up interview. This can be problematic if participants are no longer available or reachable. This study includes English speaking
individuals and as such, the limitation is that we will not have the contribution of non-English speakers.

**Possible Problems with Proposed Procedures and Potential Strategies to Mitigate**

Study participants will be asked to talk about a vulnerable time in their life which may be challenging for them to share. Ethical considerations related to data collection will include procedures that honor the privacy, feelings, and dignity of all participants, and minimize any risks from the research process. The participants in this study will have the right and freedom to withdraw from the study at any time; this is one of several strategies to mitigate stated vulnerabilities. Additionally, private space for the individual interviews will be prioritized to aid in the protection of each individual’s privacy. All participants will be asked prior to, during, and after the interview if they have any questions or concerns in order to mitigate such special considerations by engaging the assigned counselor. Special attention will be paid to each participant, specifically observing for demeanor, body language, tone, facial expressions, and level of engagement.

Due to the Covid 19 pandemic, research procedures have been forced to change for the protection of both researcher and participants. Therefore, flexibility around data collection must be employed to include in person or Zoom options. In addition to the logistical challenges which have come with the current pandemic, increased resistance to participating in research efforts due to lack of community trust may exist and be amplified as a result of the health disparities which emerged with the Covid 19 pandemic. This researcher will respectfully elicit confidence from participants by listening to proposed concerns, providing education about the research, and assuring confidentiality.
References


Chan-Salcedo, C. (2020). *CNH Suicide Screening and Assessment Data.*


https://doi.org/10.1542/peds.2017-2426


Schultz, T. R., & Zoucha, R. (2020). Exploring the Lived Experience of Lesbian Gay Bisexual Transgender Queer (LGBTQ) Young Adults Who Received Emergency Care for Suicidal Ideation as an Adolescent: An Interpretive Phenomenology 2020 Research, Education, and Innovation Week, Children’s National Hospital, Washington, D. C.


Appendix A

Flyer

DUQUESNE UNIVERSITY
600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

You are invited to participate in a research study aimed to understand the lived experience of adolescents who identify as LGBTQ who received emergency care for suicidal ideation. By working with young adults who identify as LGBTQ and sought emergency care for suicidal ideation as adolescents, we seek to understand what might improve such care in the future. The research process will include up to two interviews which will take no more than one hour to complete. A $50 Walmart gift certificate will be offered for each completed interview in appreciation for your time should you complete.

If you are between the ages of 18 and 25, identify as LGBTQ, and received emergency care for suicidal ideation (suicidal thoughts, plans or attempts) between 13 and 25 years of age and are interested to know more about this research study please contact Theresa Ryan Schultz at schultzt1@duq.edu or 267-809-1951. Please sign up in the EJC office for access to make contact.

Thank you for your consideration; I look forward to talking with you about this research.

Theresa Ryan Schultz
CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: Emergency Care for Youth Who Experience Suicidality and Identify as Lesbian Gay Bisexual Transgender Queer (LGBTQ): An Interpretive Phenomenology

INVESTIGATOR: Theresa Ryan Schultz, MBA, MSN, RN, NEA-BC PhD in Nursing Student
Duquesne University School of Nursing
(267) 809-1951
schultzt1@duq.edu

ADVISOR: Rick Zoucha, PhD, PMHCNS-BC, CTN-A, FAAN
Duquesne University School of Nursing
zoucha@duq.edu
(412) 396-6545

SOURCE OF SUPPORT: This study is being performed as partial fulfillment of the requirements for the course GPNG 915 Grant Writing and the requirements for the PhD in Nursing at Duquesne University.

STUDY OVERVIEW: The following health risks associated with the LGBTQ community: rates of mental health disorders, psychological distress, suicidality, and the growing number of children presenting locally for emergency psychiatric care, is a compelling reason to further explore how best to care for these patients. By learning from young adults who identify as LGBTQ who sought emergency care for suicidal ideation as adolescents, we may begin to understand their lived experience and decipher which elements of care are most therapeutic, and avoid experiences which may be considered non-therapeutic-or even, distressful. Eligible participants will have the benefit of contributing to this research study focused on understanding the lived experience of adolescents who identify as LGBTQ who received emergency care for suicidal ideation, and inform how others might experience care in the future. Fifteen to twenty, 18-25 years of age, will be asked to share...
their adolescent experience (13-17 years of age) when receiving emergency care for suicidal ideation.

PURPOSE:
You are being asked to participate in a research project that is investigating the lived experiences of youth who identify as LGBTQ and received emergency care for suicidal ideation as teenagers.

In order to participate you must be:
- ≥18 and ≤ 25 years of age
- identify as LGBTQ
- have received emergency care for suicidal ideation between the ages of 13 and 17 years of age
- able to read, understand, and speak English

PARTICIPANT PROCEDURES:
If you provide your consent to participate, you will be asked to share your adolescent experiences when seeking emergency care for suicidal ideation. In addition to learning about your experiences, you will also be asked to answer demographic questions which include: age, gender identity, sexual orientation, level of education, employment status, and ethnicity.

This research process may require more than one interview to be conducted. The open-ended questions should be answered based on how you experienced emergency services; and your answers to initial questions will guide follow-up questions. The interviews will be conducted at Casa Ruby in person or via Zoom. During these interviews, field notes reflecting participant responses and investigator observations will be manually recorded and audiotaped. The demographic section of the research study can be completed independently or in a question and answer format, with read-back confirmation and documentation by the researcher.

RISKS AND BENEFITS:
There are minimal risks to participating in this research, but no greater than those encountered in everyday life. Should your participation in this research, aimed to understand the lived experiences of young adults who identify as LGBTQ and received emergency care for suicidal ideation as an adolescent, cause any distress for you the interview will be terminated immediately and healthcare resources will be offered for support.

A potential benefit of your participation in this study is that the interpretations of what you and other participants describe will help to create understanding which can ultimately be used in ways which can improve experiences of adolescents who identify as
LBGTQ and seek emergency care for suicidal ideation in the future. Additionally, upon your request, a summary of the results of this study will be provided to you at no cost.

**COMPENSATION:** In appreciation for your time and participation in this study, you will be compensated with a $50.00 Walmart gift card. This will be distributed at the completion of each interview; no partial payments will be made if you choose not to complete the study. There is no cost to you for your participation in this study.

**CONFIDENTIALITY:** Your participation in this study, and any identifiable personal information you provide, will be kept confidential to every extent possible, and will be destroyed 3 years after data collection, data analysis and findings dissemination is completed. You will be identified only by study identification number; your name will never appear on any survey or research instrument. All written and electronic forms and study materials will be kept secure in a locked cabinet in the researcher’s office. All video and audio recordings will be destroyed 3 years after the completion of the study. In addition, any publications or presentations about this research will only use data that is combined together with all subjects without using any names; therefore, no one will be able to determine how you responded.

**RIGHT TO WITHDRAW:** You are under no obligation to start or continue this study. You can withdraw at any time without penalty or consequence by informing the researcher that you no longer wish to participate. Should you choose to withdraw after data collection has begun, these data will be destroyed.

**SUMMARY OF RESULTS:** A summary of the results of this study will be provided to you at no cost. You may request this summary by contacting the researchers and requesting it. The information provided to you will not be your individual responses, but rather a summary of what was discovered during the research project as a whole.

**VOLUNTARY CONSENT:** I have read this informed consent form or the informed consent form has been read to me, and I understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw at any time, for any reason without any consequences. Based on this, I certify I am willing to participate in this research project.

I understand that if I have any questions about my participation in this study, I may contact Theresa Ryan Schultz by telephone (267-809-1951) or email (schultztl@duq.edu) or Dr. Rick Zoucha by telephone (412-396-6545) or email (zoucha@duq.edu). If I have any questions
regarding my rights and protections as a subject in this study, I can contact Dr. David Delmonico, Chair of the Duquesne University Institutional Review Board for the Protection of Human Subjects at 412.396.1886 or at irb@duq.edu.

___________________________________  __________________
Participant’s Signature  Date

___________________________________  __________________
Researcher’s Signature  Date
Appendix C

Interview Guide

- I am interested to know more about you; can you tell me about you?

- Can you describe for me what your life is like right now?

- Can you tell me about where you live? What it is like?

- Who do you consider your community? Can you tell me about that?

- Do you have people you consider family? Can you tell me about your family?

- I would like you to think back to when you were a teenager and you went to the ER because you were suicidal. What was that experience like for you? Can you describe?

- If you can think back, what was your life like for you at that time?

- Follow-up questions will be informed by the participant response and initiated only as they relate to the guidance of the participant.

- Thank you so much for your time; this has been very helpful in you sharing your experiences. We talked about many things; is there anything that you may have forgotten but remember now? Or are there things you would like to add?

- Do you have any questions for me?
Appendix D

Demographic Data

- Study participant identification number:______________________________________
- What is your age? __________________________________________________________
- How would you describe your ethnicity? _______________________________________
- What gender do you identify with? ____________________________________________
- How would you describe your sexual orientation? ______________________________
- How much schooling have you completed at this time? ________________________
- What is your employment status? ____________________________________________
- Do you have any religious affiliation? If yes, please describe: __________________
Appendix E

Study Timeline

| Spring 2021 | • Prepare research proposal  
|            | • Incorporate faculty, external reviewer, committee, and chair feedback  
|            | • Submit application for funding opportunity |
| Summer 2021 | • Defend dissertation proposal, receive IRB approval and grant funding award  
|            | • Recruit, enroll, and begin participant interviews |
| Fall 2021  | • Begin analysis as continuous ongoing and iterative process  
|            | • Continue to recruit, enroll, and interview study participants until data saturation occurs |
| Spring 2022| • Overlapping process of interviews, observations, and analysis results in 1) early focus and lines of inquiry, 2) central concerns, exemplars, and paradigm cases, 3) shared meanings, 4) final interpretations, and 5) dissemination |
| Summer 2022| • Defend dissertation  
|            | • Prepare findings manuscript to submit for publication |
The intersection between youth who identify as LGBTQ+ and emergency care for suicidality: an integrative review

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ABSTRACT

Problem: Suicide is a leading cause of death in children. Sexual minority youth are greater than three times more likely to attempt suicide than their cisgender heterosexual peers. Eligibility criteria: Empirical and theoretical literature were evaluated through the integrative review process using the Whittenmore-Stoddard integrative review model (2005). Studies were included when they addressed LGBTQ+ youth seeking emergency care for suicidality.

Sample: The final sample included a mix of qualitative, quantitative, and mixed methods studies published in peer-review journals between 2011 and 2020. These articles were located in journals found through a database search, including Medline EBMCO, Health Source/Nursing Academic Education, SportDiscus, ERIC EBSCO, Academic Search Elite, Social Services Abstracts, Sociological Abstracts, APA Psych Info, Embase, and CINAHL.

Results: Thirteen studies included individuals 5 to 26 years of age; ten studies included individuals > 11 years old. The analysis and synthesis of coded and grouped data resulted in four themes: 1) affirmation/acceptance, 2) strength, 3) approach/intervention, and 4) safety/psychological distress.

Conclusions: Research study methods, design, setting, and quality varied. This integrative review has established that youth who identify as LGBTQ+ and are seeking emergency care for suicidality, value: acceptance, safety, strength, and approach/intervention.

Implications: There are strong implications for research, healthcare policy, and pediatric nursing practice. Future research is needed to explore the unique values, beliefs, and experiences of youth who identify as LGBTQ+ seeking emergency/crisis care for suicidality.

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Suicide is the second leading cause of death for youth ages 12–18 years according to the 2020 Center for Disease Control’s Web-based Injury Statistics Query and Reporting System (WISQARS, 2020). More teenagers die from suicide than from cancer, heart disease, AIDS, congenital disabilities, stroke, pneumonia, influenza, and chronic lung disease combined. From 1999 through 2014, the age-adjusted suicide rate in the United States increased 24%, from 10.5 to 13.0 per 100,000 population, with the pace of increase greater after 2006 (Curin et al., 2016). As national data affirms, there is an average of 3041 suicide attempts among youth (grades 9–12) each day (Foundation, 2017). Adolescent suicide increased by 32% between 2000 and 2017 (Frazee and Patty, 2019). Psychological autopsy—qualitative data elicited from individuals a decedent has experienced—indicate that 90% of those who committed suicide suffered from mental health conditions (Isometsä, 2001). Most young adults and adolescents who attempt suicide have significant mental health concerns such as anxiety and depression (The American Academy of Child and Adolescent Psychiatry, 2019).

Sexual minority adolescents are greater than three times more likely to attempt suicide when compared with their heterosexual peers (Raffman et al., 2020). As a result of the impact of victimization, lesbian, gay, and bisexual youth are at statistically significant higher odds for making suicidal plans (3.9) and suicide attempts (3.6) in the prior 12 months (Shields et al., 2012). The highest rate of lesbian, gay, bisexual, and transgender youth who committed suicide were ages 12–14 years old (Ream, 2019). Some barriers to transgender and nonconforming adolescent care include a lack of focus in medical school education, cost-prohibitive gender-affirming surgical care options, and discriminatory experiences with health care systems. Researchers have focused on the phenomenon of Emergency Department (ED) avoidance, use, and experience and identified 52% of transgender Ontarians (Canada)

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recounted trans-specific negative ED experiences when they presented in their identified gender (Bauer et al., 2014).

Research with individuals who identify as lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ+), which is the most current acronym used in this population, focuses on diverse individuals within the LGBTQ+ community. The plus indicates the inclusion of subsets of the of the community such as ally, pansexual, androgynous, etc., as more and more subsets are identified. Because the acronym has grown over recent years as new subsets are identified, for purposes of this article, the acronym as it was identified at the time of each publication will be described: LGBTQ+ experience isolation/rejection, depression/suicidality, and marginalization (Wilson & Carvajal, 2020). Youth who identify as LGBTQ+ experience higher prevalence of victimization, mental health conditions such as depression, psychological distress, and related suicidality (Mustanski et al., 2010). Healthcare avoidance as it relates to increased health care needs for victimization, depression, and suicidality, raises concerns (Baums, 2018). The fracture between mental health needs and the disproportionate access to such services is illustrated in a study of four transgender people ages 20, 25, 29, and 45, whereby mental health service encounters resulted in non-affirmative interactions and lack of understanding, which led to erosion of clinician-patient relationships, and denial from return to these essential services (Delaney & McCann, 2020).

Based on the approach to synthesis using the Whittemore and Knafle synthesis model and the diverse literature reviewed, the following evidence emerged: suicide is a leading cause of death in youth; LGBTQ+ youth are exposed to more adversity and victimization; LGBTQ+ youth have a higher prevalence of mental health disorders, and psychological distress; and LGBTQ+ youth are more likely to attempt suicide. Transgender individuals report ED avoidance due to trans-specific negative experiences (Bauer et al., 2014). Non-affirmative healthcare experiences, which contribute to poor clinician-patient relationships with transgender populations, impact subsequent mental health service-seeking behaviors. A methodical examination of the evidence through the integrative review process is indicated.

Purpose and specific aim

Adolescent presentation patterns for evaluation and treatment of suicidal thoughts, plans, and attempts are not well understood in the literature. The purpose of this integrative review is to explore the values, beliefs, and lived experiences of youth, identifying as LGBTQ+ who sought emergency care for suicidality. The synthesis of the literature examines LGBTQ+ youth emergency psychiatric health care experiences and identifies areas for future research. The research question guiding this integrative review of the literature: What are the health care-seeking values, beliefs, and experiences of LGBTQ+ youth needing emergency care for suicidality?

Methods

Design

Empirical and theoretical literature were evaluated through the integrative review process using the Whittemore-Knafle integrative review model (2005). This model was chosen because it is the broadest method for conducting a literature review and accommodates diverse findings from qualitative, quantitative, and mixed methods studies. This model included a clear problem identification, extensive and reproducible literature search, data evaluation with selected critical appraisal tool, and data analysis to include ordering, coding, categorizing, comparing, synthesizing primary source data, and presentation.

Literature search

The literature searches were carefully modeled in partnership with an experienced health sciences librarian. Critical keywords and concepts were used to construct each database search: LGBTQ+, youth, suicide, adolescence, emergency/crisis care, mental health services, child mental health services, teenage suicide, suicidal behavior, and young adults.

The literature search included thirteen databases; three databases were subsequently eliminated due to irrelevant findings. Due to the diverse nature of this review, medical, cultural, social services, psychiatry, and health science databases were included: Medline EBSCO, Health Source Nursing Academic Education, SportDiscus, ERIC EBSCO, Academic Search Elite, Social Services Abstracts, Sociological Abstracts, APA Psych Info, EMBASE, and CINAHL. The PRISMA method was utilized to transparently illustrate the process and describe decisions regarding identification, screening, eligibility, and final inclusion (Moher, Liberati, Tetzlaff, Altman, & The P. G. C., 2009). Confidence software was used for collaboration and to electronically manage the literature review and selection process.

Sources were included when they were published in the English language in peer review journals between 2000 and 2020 and included the LGBTQ+ youth population with emergency care needs for suicidality. This selected timeline reflects published research after Vermont became the first state to legalize civil union between same-sex couples in 2000 (Cox, 2000). This significant legislation expedited prior policies aimed to oppress sexual minorities, historically advancing the civil rights movement, and notably shaping what the future would bring. Sources from newspaper articles, non-scientific journals, gray literature, and websites were excluded. All search decisions were carefully systematized and documented with supporting rationale. Explicitly stated criteria were used and consistently applied; studies were excluded, for example, when the population was mainly comprised of adults (mean age 36 years). Youth was expanded to include young adults in their late 20’s, consistent with science on adolescence, social, physical, intellectual, and hormonal development (Arain et al., 2013).

Fig. 1 illustrates the PRISMA process used to aid the integrative review method (Moher, Liberati, Tetzlaff, Altman, and The P. G. C., 2009). Database searches resulted in 250 articles, 58 duplicates were removed, 192 articles were screened, and 121 were eliminated. Seventy-one full-text articles were assessed for eligibility, 58 articles were excluded for the following reasons: 38 did not report on emergency/crisis care, 13 did not include the population of interest, five focused on the adult population, and two reported on emergency care for something other than suicidality. The final sample included 13 studies: nine quantitative, two qualitative, and two mixed methods studies. Ancestry and progeny searches were conducted after the final sample was determined and yielded no additional results.

Data evaluation

The Quality Assessment Tool for Studies with Diverse Designs (QATSSD) aligns with this integrative review of the literature. This appraisal tool has been used widely; researchers have documented the strong reliability and validity for the purpose of standardizing a rigorous assessment of qualitative and quantitative works (Struyf et al., 2012). For qualitative and quantitative research, the QATSSD is designed to score 14 or 16 distinct criteria with a zero through four rating: zero, not addressed at all; one, addressed very slightly; two, addressed moderately; or three, addressed completely. Mixed methods studies are appraised with all 16 items using the same zero through four scoring described here. To test the tool for fit and inter-rater reliability, two individuals independently reviewed and appraised a randomly selected article from the final sample selection. They separately arrived at 31 of 42 points allocated, assigning a 74% quality rating to the article. Subsequently, each article from the final sample was appraised using the
QATSDD and resulted in quality scores ranging between 14% and 90%. As indicated in the last column of the matrix table (Table 1): nine quantitative studies assessed between 52% and 90% quality score, two qualitative studies resulted in 14% and 24% quality score, and two mixed methods studies resulted in quality scores of 25% and 81%. The wide range in critical appraisal scores was accepted as this reflects the scarce research available on this topic. Case reviews, for example, offer important insights about the intersection between youth who identify as LGBTQ+, suicidality, and emergency psychiatric health care.

Data analysis

A matrix table was created to capture and organize key findings from the study sample. Each study within the sample was examined against the study question. Table 1 outlines the matrix developed to capture the important elements of each study: purpose/research question, design, sample setting, defined key terms, methodology, instruments, procedures and analysis used, study findings, results, strengths, limitations, recommendations for future research and results of the critical appraisal described herein. Data extracted to populate the matrix were reviewed and accounted for through an iterative process. After the research question (previously mentioned) for this integrative review of the literature was applied to each study within the sample, individual results were associated and grouped for further analysis according to the study question's focus: values, beliefs, and experiences. Subsequently, data were systematically extracted from each primary source. Extracted data were methodically coded, synthesized, and clustered for continuous line by line compare and contrast using quantititve and qualititve analysis (Cooper, 1998; Sandelowski, 2000; Whittemore & Knaff, 2005).

Results

Sample description

The final sample studies were published between 2011 and 2020; the majority of the sample studies (62%) in 2018 (4) and 2020 (4). Included research was published in various peer-review journals: *Journal of Gay & Lesbian Mental Health* (2), *Child & Adolescent Social Work*...
Table 1: Summary of Findings Related to EMergency Care of Youth Who Identify as LGTBQ+ for Suicide.

<table>
<thead>
<tr>
<th>Author</th>
<th>Purpose</th>
<th>Sample/Design</th>
<th>Results</th>
<th>Critique/Future Direction</th>
<th>QATSDD score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steinfield et al. (2013)</td>
<td>Determine the mental health experiences of emerging adult YMMY in NYC.</td>
<td>Quantitative longitudinal cohort study of adolescent YMMY in New York City; ages 18–19 were identified as exclusively homosexual, 59.4% not exclusive.</td>
<td>Clear association between socioeconomic status (SES) and multiple mental health problems. Unhealthy identified YMMY, as well as those not enrolled in school, are at greater risk for depression, PTSD, and suicide attempts. Black and Asian youth were less likely than White YMMY to have ever been in counseling or psychotherapy, and that higher SES was a predictor of having received a mental health diagnosis. Recent suicide attempts were the strongest predictor of mental health hospitalization and current counseling or psychotherapy services.</td>
<td>Suicide cannot be inferred. Data were self-reported and subject to social desirability bias. Unhealthy identified youth may have symptoms, or sensitive behaviors such as suicide attempts, due to perceived stigma of concerns about mandated reporting in possible. Non-random sampling may limit generalizability. YMMY of color are least likely to receive mental health services as they often lack the resources to do so. Facilitating access to quality mental health care by reducing barriers and increasing uptake may help reduce resistance and provide a buffer for the stressors that YMMY face.</td>
<td>69</td>
</tr>
<tr>
<td>Wolfe (2015)</td>
<td>Review the factors associated with sexual and gender minority adolescents.</td>
<td>Case Review Qualitative determination of the impact of school and mental health staff.</td>
<td>On the micro-level, it is imperative that school mental health staff are able to create good enough learning environments for their sexual minority and gender non-conforming clients. An important part of developing the therapeutic alliance was sharing my gender pronouns (she) and asking for their gender pronoun (he) at the outset of our work together, once we were in a private space. Ensuring that questions and comments were inclusive—without assumptions about gender. Micro-level school. Unlike other historically oppressed and disenfranchised groups (social, ethnic, religious minorities), sexual and gender minority adolescents do not share their sexual orientation/gender identity status with their family members. Otherwise, as a result, they are not a part of families and/or communities with which they can serve as a buffer of support and protection from the micro- and macro-aggressions of the outside world (Matthews &amp; Adams, 2009). More than one quarter (25%) of respondents reported that they would not have contacted another helper if this particular crisis service provider did not exist, and another 46% were unsure if they would have contacted another service. The most commonly mentioned reason for contacting this crisis service agency rather than another service was because this agency was LGTBQ-affirming. This theme was described by 68% of respondents.</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Goldbach et al. (2015)</td>
<td>The overarching goal was to understand sociodemographic subgroup differences that may have service implications.</td>
<td>Mixed Methods (Quant and Qual): Drawing on data from 657 LGTBQ+ identified youth aged 12–25 who sought crisis services from an LGTBQ-focused national provider in the USA during an 18-month period (2015–2017).</td>
<td>Strength in enrollment procedures to assess confidentiality. Fewer than 5% of youth contacted could not remember or were unsure about the name of their agency. Individuals who could not correctly cite the agency’s name were told they could not participate and were thanked for their time.</td>
<td>81</td>
<td></td>
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</table>
## Table 1 (continued)

<table>
<thead>
<tr>
<th>Author</th>
<th>Purpose</th>
<th>Sample/Design</th>
<th>Results</th>
<th>Critique/Future Direction</th>
<th>QATIPO score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kidd et al. (2012)</td>
<td>Evaluate MHS use among SM and heterosexual girls in public high schools in Boston, Mass. Compare prevalence of suicidality and self-injury among SM and heterosexual girls. Compare the rate of MHS use among SM and heterosexual adolescent girls. Examine how the rate of MHS use among heterosexual and SM girls varies in relation to suicidality and self-injury.</td>
<td>Quantitative. 32 eligible public schools within the Boston Public Schools system were invited to participate. 22 agreed. Of the 2735 students selected for participation, 1438 completed a questionnaire.</td>
<td>This study establishes that SM girls, particularly those experiencing suicidality, are more likely to have sought help from a mental health professional in the prior 12 months.亦然。1438 of SM girls reported a suicide attempt in the past year.</td>
<td>Explanations for use of instruments and questions were offered on specific evidence of reliability and validity testing. Respondents also provided low-income youth of color as evidenced by the fact that 72% of youth in the EPS-D district are eligible for free- or reduced-price meals in school. The utility of these findings may limit generalizability. Limitations: asked about visiting counselors, therapists, or psychologists; did not reference other types of providers; therefore, MHS contacts may be underestimated.</td>
<td>74</td>
</tr>
<tr>
<td>Day et al. (2015)</td>
<td>Describes the unique case of an adolescent with gender dysphoria, severe body dissatisfaction, and suicidal ideation who presented for emergency psychiatric evaluation.</td>
<td>Case presentation. A 14-year-old birth-assigned female teenager who presented to the emergency psychiatric department (ED) with complaint of suicidal ideation.</td>
<td>The repeated expressions of extreme dissatisfaction with appearance were noted. It has been found that among transgender youth, a significantly greater proportion of those who had attempted suicide expressed weight-related body dissatisfaction than those who had not. A collaborative, multidisciplinary approach can help care for this vulnerable population and avoid tragic outcomes.</td>
<td>This case highlights the importance of assessing the degree and characteristics of body dissatisfaction as they may contribute to suicidal risk. Gender-affirming therapy also seems to be associated with improved self-esteem, self-efficacy, and socialization.</td>
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<td>Mannen and et al. (2018)</td>
<td>Examine trends in Emergency departments (EDs) and acute care hospitals on the critical safety net for youth experiencing S1 and/or S4A.</td>
<td>Quantitative. PHIS database used to identify ED encounters, observation stays, and inpatient hospitalizations for children and adolescents 5 to 17 years of age between 2006 and 2015 using current_providential terminology codes. During the study period, 11,561,856 encounters for S1 and S4A were examined, representing 1.21% of the 9,674,229 total encounters across 31 hospitals.</td>
<td>More than half of S1 and S4A encounters resulted in an inpatient hospitalization at a children’s hospital (n = 6,758,896; 56.3%) of these, 4,907,132 (35.9%) required intensive care. Half of encounters were adolescents 15 to 17 years old (n = 56,386; 50,336; 41,664; 12 to 14 years (37.3%), and 14,625 were 5 to 11 years (13.8%). Percentage of total annual encounters per year, more than doubled over the study period, increasing from 0.66% in 2006 to 1.42% in 2015. Total annual encounters for S1 and S4A increased from 8,682 to 25,085 encounters (an increase of 203.7%); encounters were seen in both ED and inpatient settings, with slightly higher increases noted in ED encounters, compared with inpatient encounters. These findings have important implications for exploring age- and sex-specific approaches to suicide screening and prevention interventions.</td>
<td>Cultural and economic barriers to seeking mental health care were not explored. No observed significant trends between quarters of median household income or changes in payment were seen during the study period. Marked seasonal variation in percentage of total S1 and S4A encounters were observed throughout the study period. Limitations discussed. The algorithm used to identify S1 and S4A encounters previously reported a high positive predictive value (66.6%), but authors acknowledge it was derived from youth enrolled in Medicaid from a single state; thus, it may not be generalizable to youth in other states or those with other insurance coverage. The PHIS database is limited to fee-for-service children’s hospitals; thus, findings are only applicable to these hospitals. No consideration for gender identity or sexual orientation.</td>
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Table 1: Continued

<table>
<thead>
<tr>
<th>Objective</th>
<th>Methodology</th>
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<td>Understand the characteristics of qualitative frameworks and their potential to elucidate and explain health inequalities and social determinants of health in the context of mental health.</td>
<td>Case-study approach, in-depth interviews with key informants, and document analysis.</td>
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<td>Investigate the role of community-based organizations in promoting mental health in low-income communities.</td>
<td>Focus groups with community leaders and members, participatory observation, and surveys.</td>
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<td>Explore the impact of urban planning on mental health outcomes.</td>
<td>Mixed-methods design, including questionnaire surveys, focus groups, and health impact assessments.</td>
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**References**


**Appendix**

Institutional Review Board Approval: All procedures were conducted in accordance with the ethical standards of the institutional research committees and the World Medical Association Declaration of Helsinki (2013).
Table 1 (continued)

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<tr>
<th>Author</th>
<th>Purpose</th>
<th>Sample/Design</th>
<th>Results</th>
<th>Critique/Failed Direction</th>
<th>QATDDO score, %</th>
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<td>Wata et al.</td>
<td>Determines the development and design of a Youth Wellness Centre (YWC), which aims to address the gaps in mental health services for transition-aged youth. Demographic characteristics, clinical needs, and service use of youth engaged in services at YWC were evaluated.</td>
<td>Quantitative</td>
<td>Top five primary presenting problems at the time of referral included: problems with mood (25.6%), anxiety (24.5%), difficulties coping (15.8%), substance use (9.8%), and suicidality. Model COKAS score indicated some difficulty in social, occupational, or school functioning. Mean BERS score at orientation indicated very high emotional dysregulation and psychological distress. Strikingly, 80.8% of youth at the YWC reported lifetime S. YWC is meeting its mandate to reach youth with elevated mental health concerns. The large proportion of clients who self-referral highlights the importance of self-referral as a pathway for accessing services. No significant differences based on age, race/ethnicity, poverty status, or type of child welfare involvement. No significant differences were found between the groups in the six months leading up to intake or being bullied or cyberbullied and experiencing a physical assault. LGBT youth experienced significantly higher levels of being a victim of a sexual assault and experiencing a physical illness than the non-LGBTQ youth. At intake into CMRS OC services (counselling for gender), LGBT youth had significantly higher levels of internalizing problems, anxiety, p = .66, and depression, compared to non-LGBTQ youth. No significant differences were found between the groups in externalizing problems, social problems, substance use, substance use, functioning, and personal strengths. All youth in the study experienced significant improvement, further supporting the effectiveness of systems of care approaches. These findings suggest that while SMA had higher rates of abuse and peer victimization than their heterosexual peers, the association between SMA status and SI and NSSI variables were not attributable to shared variance with abuse history and peer victimization. Acknowledging that this is surprising and different from other published works, also acknowledged that the present study is underpowered.</td>
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<td>Scardapi et al.</td>
<td>This study had two purposes: first to examine mental health disparities among LGBTQ youth and their heterosexual peers who are involved in the child-welfare system, and second to observe the effectiveness of systems of care with youth in child-welfare and non-differential youth between LGBTQ youth and heterosexual youth.</td>
<td>Quantitative</td>
<td>This study was a secondary analysis of data that comes from a larger dataset collected for the CAMH SOC national evaluation. N = 557. Ages 11-21. The LGBTQ group had a significantly higher number of females compared to males and younger age than non-LGBTQ youth; therefore, gender was controlled for in the analyses.</td>
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<td>Peters et al.</td>
<td>The study hypothesized that although the sample would demonstrate elevated symptoms and rates of NSSI and suicidal behavior, SMA would demonstrate higher levels of NSSI, suicidal ideation, and suicidal behavior, as well as greater psychopathology and interpersonal victimization, than their heterosexual counterparts. Authors examined the forms and functions of NSSI for SMA, as this is limitations reviewed, e.g., sample size, representativeness, missing data, non-randomized, reliance on memory, caregiver versus youth, may be foster parent who does not know the child that well, etc. This study demonstrated clearly that LGBTQ youth in the child welfare system entered CMRS OC services with higher levels of suicidal ideation, suicide attempts, depression, and gender identity related problems compared to heterosexual youth in child welfare. If LGBTQ youth are not identified, their challenges and strengths may be overlooked and not properly addressed, possibly leading to a mental health crisis or worse. The child welfare system would better address the safety and well-being of LGBT youth if they were asked about their sexual orientation and gender identity and expression.</td>
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T.K. Schultz, K. Zozolla and L.K. Selulo

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<th>Author</th>
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<th>Critique/Future Direction</th>
<th>QATIADO score, %</th>
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<td>perinatal to prevention and intervention efforts.</td>
<td>Participants were between the ages of 12–18. Frequency of thoughts over preceding month. These findings converged with SI severity ratings on the C-SSRS. In that interview, SAs reported experiencing higher levels of SI than the heterosexual group in the week prior to hospitalization, but the group difference on lifetime SI severity was nonsignificant. While all of the inpatient youth report similar lifetime histories of SI, SAs are reporting more intense acute SI at hospitalization, perhaps reflecting a more severe state of crisis. This could be driven by greater experiences of adverse and stigma-specific events precipitating hospitalization. These results are also consistent with prior findings demonstrating that suicide risk differences between SAs and heterosexual adolescents may persist even when differences in depression are accounted for.</td>
<td>mediation or moderation analyses. Future work is needed here. While all of the inpatient youth report similar lifetime histories of SI, SAs are reporting more intense acute SI at hospitalization, perhaps reflecting a more severe state of crisis. This could be driven by greater experiences of adverse and stigma-specific events precipitating hospitalization. A tendency not to ask for help or discuss SI until more severe, and/or other factors not assessed in the study. Further investigation is needed to better understand implications of these differences in acute SI prior to hospitalization. This work suggests that SAs may be at higher risk of engaging in self-harming behavior to manage their distress. The greater number of methods of NSSI utilized by the SAs may also reflect elevated risk for suicide attempts. Future work should examine these associations longitudinally in high-risk youth to understand whether NSSI may contribute to the elevated suicide rates found in SAs over time. Clinically, careful assessment of interpersonal victimization and stressors may be particularly important for SAs to determine whether these factors may be present and contributing to distress. Future larger studies should examine additional constructs as potential factors in elevated self-harm and SI, such as those that have been found to promote resilience in community SAs samples, including family support and connectedness. Primarily, sexual identity identified groups, so these findings may not generalize to youth of other sexual minority identities or genders; further research is needed with broader samples.</td>
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*Jeneway and Colle (2020)* Pediatric Emergency Medicine Practice describes the current evidence surrounding best practices for caring for TGD children and adolescents in the ED. Mixed Methods Several case scenarios and critical appraisal of the literature. TGD youth have increased internalizing and externalizing behavioral and emotional problems. It has been shown that these comorbidities are a response to external factors such as stigma, rejection, and societal bias rather than something intrinsic to a youth’s gender identity. The patient is the expert in their own identity, and all efforts should be made to use terms that are consistent with the individual patient’s identity and the diverse ways they define themselves. A large-scale population study of 47,568 TGD adolescents in Minnesota showed that just over 60% of TGD youth reported suicidal ideation, 2.1 times greater than that of their cisgender classmates, and 3.2% reported a suicide attempt in comparison to 2% of cisgender adolescents. If any patient is expressing suicidal ideation, ask about the patient’s gender identity and sexual orientation, as LGBTQI individuals have an additional risk factor that may alter disposition and treatment planning. | 25 |
Buenas et al. (2020)  The aims were two-fold: First, to characterize STIs among LGBT youth. Second, to examine which STIs (sexually transmitted infections) were associated with suicidal behavior within one year of discharge. Quantitative Longitudinal The purposive sampling implemented in this study allowed for the observation of suicidal behavior in a sizable number of participants. The purposive sample of LGBT youth receiving psychiatric ED services at a large Midwest university hospital between June 2014 and January 2015. Participants were 283 adolescents and young adults ages 13–25. Results suggest the importance of assessing both lifetime and recent factors (i.e., past week and month), particularly for LGBT youth. Key findings include overrepresentation of LGBT youth, differences in severity of NSSI history, and time frame of suicides of suicidal behavior. LGBT youth committed 4.8% of this sample of adolescents and young adults receiving psychiatric emergency services, likely an underestimate of the number of LGBT adolescents receiving psychiatric emergency services (by parental presence). This proportion is 3 times higher than other ED studies, likely due to measurement of NSSI status. No significant differences found in histories of suicidal behavior; however, sexual orientation is related to measurement of NSSI status. Although LGBT youth presented with more severe histories of NSSI and other suicide-risk factors, only recent ED-based interventions were significantly associated with future suicidal behavior.

Emergency clinicians must recognize that gender identity is complex. For children expressing gender incongruent features or gender dysphoria, an appropriate referral should be made to a professional with experience with TGD youth.

This study had several methodological strengths. The longitudinal design and use of a large high-risk sample increased the likelihood of observing post-discharge outcomes, enhancing statistical power to study outcomes and explore within-group risk factors. The combination of closed- and open-ended measures of LGBT status added in identifying several high-risk subgroups of youth, including bisexual, mostly heterosexual, and trans/gender nonconforming youth. Future research should replicate these findings in larger samples to explore whether there are unique risk factors that can aid in predicting and preventing suicide among LGBT youth. Interventions are efficacious in targeting these risk factors among LGBT youth. Future studies should examine the extent to which existing brief ED-based interventions are efficacious in targeting these risk factors among LGBT youth.

The analysis and synthesis of coded and grouped data resulted in four themes: 1) affirmation/acceptance, 2) strengths, 3) approach/interventions, and 4) safety/psychological distress.

Affirmation/acceptance

Sexual minority and gender non-conforming youth experience rejection, stigma, and social bias, which has been linked with increased psychological distress and homelessness (Janeway & Coli, 2020). Suicidality among these youth is exponentially increased compared with their cogenital heterosexual peers (Janeway & Coli, 2020). Goldbach and colleagues report transgender and gender nonbinary youth seeking mental health crisis services most commonly commented that they chose this service over others because the service was LGBT affirming (Goldbach et al., 2019). Janeway and Coli posit each person is the expert in their own identity and, as such, should be asked what pronouns they use (2020, p. 5).

Strength

The Behavioral and Emotional Rating Scale, Second Edition (BERS-2-Y), aimed to examine interpersonal, intrapersonal, and affective strengths (capacity to endure)—along with family involvement and school functioning—was included in a secondary analysis study focused on mental health and substance abuse outcomes and outcomes comparing LGBTQ+ and heterosexual youth in the child welfare system (Scaampio, 2018, p. 42). These authors compared youth who identify as LGBTQ+ to non-LGBTQ+ youth and found youth who identify as LGBTQ+ experienced significantly heightened levels of suicidal ideation in the six months prior to Children’s Mental Health Initiative.
(CMHR) Systems of Care (SOC) services intake, as well as even in their life (\textsuperscript{2}Scannapieco et al., 2018). In addition, the researchers identified significant improvement from intake to six and twelve-month follow-ups in the following areas: internalizing, externalizing and total problems, anxiety, depression, personal strengths, and functional impairment in LGBTQ+ and non-LGBTQ+ youth (\textsuperscript{2}Scannapieco et al., 2018).

Storholm and colleagues explain strengths could be found due to improved access to quality mental health care aimed to cultivate resilience and offer a buffer for the stresses, which young men who have sex with men (YMSM) face (2013). Importantly, the criticality of identifying and improving strengths, in youth who identify as LGBTQ+ and are at higher risk for mental health crisis and suicidality, is emphasized.

**Approach/Intervention**

In a study focused on LGBTQ+–centered crisis services, clients described the importance of timely responsiveness to expressed needs, noting that someone was always available—they never had to wait (\textsuperscript{3}Goldbach et al., 2019). In a case review of a 14-year-old birth-assigned female transitioning to male, who sought emergency care for suicidality, the only reported emotional outburst occurred when female pronouns were used to reference/address the patient (Day et al., 2019).

Kidd and colleagues examined mental health service use in public high schools in Boston and reported sexual minority girls, particularly those who experienced suicidality, were more likely to have sought mental health services in the prior 18 months than their heterosexual counterparts (2012). This study did not collect data on gender identity, which could account for the differences found with other studies that report "despite higher rates of mental health service use, significantly more sexual minority youth (51.2%) than peers (36.7%) had unmet mental health needs" (\textsuperscript{4}Williams & Chapman, 2011, p. 201). Researchers who studied differences between sexual minority adolescents and their heterosexual peers during a psychiatric inpatient admission found no difference in the lifetime history of suicidal ideation between groups (\textsuperscript{5}Peterson et al., 2020). In this study, the intensity of suicidal ideation was higher in the sexual minority adolescent group (\textsuperscript{5}Peterson et al., 2020).

Wang and colleagues established a Youth Wellness Center (YWC) in Ontario, Canada, with a specific aim to address the identified gap in mental health needs for at-risk emerging young adults aged 17 to 25 (2020). These authors report 80.6% of youth reported lifetime suicidal ideation, 6% of this population were transgender, and 29.5% identified as LGBTQ+. These health service options included self-referrals and drop-in counseling, which further substantiates the importance of timely intervention.

These data offer direction to the approach/intervention theme, which has emerged and validates that how, when, and where we approach youth who identify as LGBTQ+—who need emergency/crisis care for suicidality makes a difference. The pattern of access for emergency services and psychiatric admissions should be considered. Researchers highlight the striking seasonal variation in the percentage of total encounters for suicidal ideation and suicide attempts (\textsuperscript{6}Plemmons et al., 2018).

**Safety/psychological distress**

Gender identity incongruence introduces psychological distress; those transgender and gender diverse youth who reported a lack of support from their families have a higher propensity for health conditions, psychological distress, suicide attempts, homelessness, and financial struggles (\textsuperscript{7}Jayne & Coi, 2020, p. 6). Moreover, in a study seeking to explain the socioeconomic factors contributing to mental health disparities and access services among young men who have sex with men in New York City, Black and Latino men indicated the highest prevalence of arrest history, and Black men indicated the highest rate of unstable housing (\textsuperscript{8}Storholm et al., 2013). These researchers further elucidate those without stable housing and those who were not enrolled in school were at higher risk for PTSD, depression and suicide attempts (\textsuperscript{9}Storholm et al., 2013).

Youth who identify as LGBTQ+ experience higher rates of victimization and physical abuse than their cisgender heterosexual counterparts (\textsuperscript{10}Scannapieco et al., 2018). Peters and colleagues' research with psychiatric inpatient adolescents who were admitted for suicidality concerns reported sexual minority adolescents experienced higher levels of peer victimization than heterosexual adolescents (2020). Wolford's review indicates that, in addition to the emotional pain resulting from family rejection, internalized homophobia may be present (2017).

There is a significant relationship between homelessness and suicidality in LGBTQ+ youth seeking 24/7 crisis services; youth who experienced homelessness were more likely to report a suicide attempt than youth who had never experienced homelessness (\textsuperscript{11}Rhoades et al., 2018). Bivariate regression analysis used in this study demonstrated staggering results; youth who identified as LGBTQ+ "had a 75% increased odds of homelessness if they had experienced parental rejection, 56% if they had disclosed their LGBTQ+ identity to their parents, and youth with lifetime experiences of homelessness had more than three times the odds of reporting a lifetime suicide attempt or a likely future suicide attempt" (\textsuperscript{11}Rhoades et al., 2018, p. 64).

**Discussion**

Suicide is a leading cause of death worldwide, the second leading cause of death for youth ages 12–18 years, according to the 2020 Center for Disease Control's Web-based Injury Statistics Query and Reporting System (WISQARS, 2020). High rates of individuals who die by suicide presented in an ED during the prior year (\textsuperscript{12}Cenni et al., 2016). Youth who identify as LGBTQ+ are at higher risk for victimization and suicidality (\textsuperscript{13}Baum, 2018; Russell & Joyner, 2001). Little is known about the emergency health seeking practices and patterns for suicidal youth who identify as LGBTQ+.

The integrative review of the literature, which resulted in four themes: 1) affiliation/acceptance, 2) strengths, 3) approach/interventions, and 4) safety/psychological distress, aligns closely with the results of the unpublished phenomenological mini-study conducted by this researcher and referenced herein, where second level analysis resulted in four central concerns: 1) acceptance (affiliation), 2) accomplishment (strengths), 3) control (approach/interventions), and 4) safety (psychological distress).

Based on the synthesis of the literature, this appears to be the first nursing research study to establish important links between internalizing and externalizing problems, victimization, homelessness, and suicidality. The emerging themes within these research results beckon a holistic approach to care such that the values, beliefs, and experiences of LGBTQ+ youth needing emergency care for suicidality—acceptance/affirmation, strengths/accomplishment, approach/interventions (control), and safety (psychological distress avoidance)—be incorporated into nursing care assessments and plans of care.

Emergency Department visits, observation stays, and hospitalizations for children and adolescents experiencing suicidal ideation and suicide attempts doubled between 2008 and 2015 (\textsuperscript{14}Plemmons et al., 2018). Among these ED visits, observation stays, and hospitalizations at children’s hospitals, encounters for suicidal ideation and suicide attempts increased by 28% during the study period, with EDs experiencing higher increases than inpatient encounters (\textsuperscript{15}Plemmons et al., 2018, p. 3). Lack of evidence to guide health care practices for youth who identify as LGBTQ+ experiencing suicidality remains a significant gap.

**Strengths**

Strengths of this integrative review are the extensive database searches resulting in strong evidence, which substantiates the gap in the literature. Ancestry and progeny searches validated such with no finding for additional sample inclusion. The progeny search...
also resulted in two additional recently published articles, which outlined the stated purpose of this integrative review as an identified gap in their future research section, further validating the direction of this research. Specifically, Higgins and colleagues recently published work, which begins to look at mental health seeking behaviors in youth who identify as LGBTQ+ in Ireland, reports qualitative findings which align with the results of this integrative review and add that a semi-structured interview method may provide more contextualized data than the qualitative written survey method used in this study (Higgins et al., 2020).

Limitations

The QATSDL is a useful tool for reviews which include diverse studies. A limitation of this review is QATSDL results can be artificially inflated because scores for mixed methods studies are appraised with two additional indicators than quantitative or qualitative studies (Frenos et al., 2015). This review incorporated research where self-reporting, guardian reporting, and secondary analysis of databases were included. Under-reporting can be a limitation for youth who identify as LGBTQ+—struggling with acceptance regarding their gender identity and sexual orientation. Guardian reporting can be limited when youth are in temporary placement, and the guardian does not have in-depth knowledge about the youth. Lack of acceptance regarding sexual orientation and gender identity could lead guardians to reflect their own beliefs rather than those of the youth. In at least one study, lack of parental consent for adolescents to participate in the study was a limitation (Kidd et al., 2012). This offers an example of how research with minors may contribute to underreported findings regarding adolescent mental health service needs for suicidality and self-harm.

The integrative review is limited by search terms, selected databases, and applied search strategy methods. Within the final study sample, research that included secondary analysis of databases can be limited when there is missing information or insufficient information to answer the specific study question. The qualitative studies included, which were appraised as low quality, may be a limitation of this integrative review as well.

In some research included in this review, study instruments were well described with strong indications of instrument reliability and validity; in others, instruments were not well defined. Due to the diverse description of the population in each of the studies included, for example, a sexual minority who did not elicit gender identity, gender non-conforming or gender diverse definitions, generalizability of findings may be limited.

Conclusions

This integrative review establishes what youth who identify as LGBTQ+—seeking emergency care for suicidality value: affirmation, acceptance, safety (reduced psychological distress), strengths, and approach/interventions. Nursing care practices may benefit from developing personalized care, which is congruent with these identified values and beliefs. In doing so, the therapeutic patient care experience may improve healthcare outcomes for youth who identify as LGBTQ+ receiving care for suicidal ideation and suicide attempts. Nursing research should add to the body of new knowledge, which will create the evidence needed to advance future nursing practice.

Implications for research, healthcare policy, and pediatric nursing practice

Little research has been done to understand the values, beliefs, and experiences of youth who identify as LGBTQ+—seeking emergency/crisis care for suicidality. The outcome of this integrative review substantiates the need for research with little to no evidence-based practices to guide the intersection of the growing healthcare problem of suicidality for youth who identify as LGBTQ+—with an understanding that how they experience such services impacts their future health outcomes. Beross and colleagues suggest future research should examine how effective ED-based interventions address LGBTQ+ youth risk factors (2020, p. 68).

In June 2020, the Office for Civil Rights of the Department of Health and Human Services issued a final ruling which erases the civil rights of transgender individuals as it relates to the Affordable Care Act (ACA) (Simmons-Duffin, 2020). The decision removes health care and health insurance protections for individuals who identify as LGBTQ+. Non-ACA-related Supreme Court rulings may or may not influence upcoming Supreme Court hearings as they have or have not in the past. Arizona State House Senate Bill 1445, passed in April 2021, removes inclusion of sexuality, gender identity, gender expression, and sexual orientation materials in the classroom; this is an example of policy which contradicts emerging central concerns for youth who identify as LGBTQ+—acceptance (affirmation), accomplishment (strengths), control (approach/interventions), and safety (reduced psychological distress) (Ronan, 2021). Active engagement with Government Affairs to influence such legislation with research findings is imperative and underway through hospital system connections and advocacy oversight agencies.

The Centers for Medicare and Medicaid Services Emergency Medical Treatment and Labor Act (EMTALA) laws require that we care for individuals regardless of healthcare insurance coverage. Policies that drive decisions about access to healthcare for the LGBTQ+ community have far-reaching implications. Lack of mental healthcare coverage may alter health-seeking patterns and practices by further increasing ED utilization for such psychiatric emergencies; EMTALA laws prevent under such circumstances (Wenham et al., 2016). Critical updates to healthcare policy may increase or reduce LGBTQ+ youth barriers to emergency health services for suicidality; evaluating existing and pending policy with the lens which includes affirmation, strengths-based care, approach, and psychological safety will impact health outcomes.

The Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity advances the imperative to address social needs in clinical settings (Hassmiller, 2021). The roadmap outlined in this report highlights the need to educate nurses with a focus on population health, health equity, diversity, and social determinants of health (Hassmiller, 2021, p. 190). As such, nursing practice can benefit from understanding LGBTQ+ youth emergency/crisis care-seeking patterns and practices. This work suggests a strengths-based approach to patient care should assure that youth who identify as LGBTQ+—seeking crisis care for suicidality be given the opportunity to identify their personal gifts and goals for the near term and future time period.

From the health system perspective, institutional policy has been influenced by this unpublished work. For example, an ED safety check policy for patients who present for psychiatric care incorporates a double wandling process using hand-held high-level metal detection devices before and after patients change into a hospital gown and have their undergarments inspected. An early draft of this policy included removal of bras and binders to reduce the risk of contraband and self-harm. Evaluating the proposed policy with the lens which includes affirmation, strength-based care, approach, and psychological safety, influenced the ability to advance the safety imperative—reduce the risk of contraband and self-harm—in a way which reflects emerging knowledge. As a result of this work, future policy may be influenced such that registration demographics for example, include more than male or female.

Creating a caring environment, which is affirmative—signifying acceptance—should be included in all elements of care. Culturally congruent care will likely reduce psychological distress and improve the healing milieu. All youth should be addressed with openness and understanding that transition from adolescence to adulthood is complex;
understanding one's sexual orientation and gender identity evolves over time (Janeway & Coll, 2020). When family support is not present, youth are at risk for adversity such as homelessness, low socioeconomic status, and barriers to achieve educational goals (Catullo et al., 2013; Feldman et al., 2012; McConnell et al., 2015). Caution should be taken when interacting with youth who may not have disclosed their gender identity or sexual orientation with their parents. As a result of this integrative review's findings, future nursing care models and personalized care should include affirmative, strength-based, and psychologically safe approaches and interventions.

Credit authorship contribution statement
Theresa Ryan Schultz: original draft conceptualization, methodology, investigation, analysis, and writing. Richard Zeinstra: writing review and editing, consulting, editing, and mentoring. L. Kathleen Sekula: writing review and editing.

Declaration of competing interest
None.

Acknowledgments

References
Research Findings

Emergency care for youth who experience suicidality and identify as Lesbian Gay Bisexual Transgender Queer/Questioning (LGBTQ+): An interpretive phenomenology

Suicide is a leading cause of death for youth; adolescents who identify as LGBTQ+ are greater than three times more likely to attempt suicide (WISQARS, 2020). Risks include increased mental health disorders, homelessness, and acts of violence for youth who identify as LGBTQ+ (Fulginiti et al., 2020; Johns et al., 2020; Keuroghlian et al., 2014). Predictors of suicidal behavior in adolescents who identify as LGBTQ+ include prior ED visits and hospitalizations and these individuals report healthcare avoidance, trans-specific negative experiences, and non-affirmative healthcare encounters (Baams, 2018; Bauer et al., 2014; Berona et al., 2020; Delaney & McCann, 2020). Health system failures—as illustrated in a case report of a 14 year transgender male, who sought emergency care for suicidality and experienced behavioral outbursts when addressed with female pronouns—are not well understood (Day et al., 2019).

Purpose and Research Question

The purpose of this study was to explore the lived experiences of youth who identify as LGBTQ+ and sought emergency care for suicidality when they were teenagers. The research question is; what are the lived experiences of young adults (aged 18-25 years) who identify as LGBTQ+ and received emergency care for suicidality as an adolescent (13-17 years)?

Methods

Heideggerian hermeneutics phenomenology (Allen, Benner, & Diekelmann, 1986; Heidegger, 1962; 1975), methodology was used in this study which aimed to understand human experience (Crist & Tanner, 2003). To reduce vulnerabilities, the research design and procedures
focused on learning from LGBTQ+ young adults who sought emergency treatment for suicidality when they were adolescents. The research procedures focused on each participant’s recollection of their experience (Laverty, 2003). Open-ended interview questions sought to illuminate each individual’s social, cultural, and historical perspective. Follow-up questions were initiated relative to participant guidance; data collection and analysis occurred concurrently. In person and virtual interviews were conducted using video and/or audio recording and were transcribed verbatim. During the Covid 19 pandemic, in person interview procedures followed CDC guidelines for social distancing, hand washing, and mask wearing.

**Data Analysis**

Data collection and analysis were conducted concurrently using the circular hermeneutics process. Narratives were examined simultaneously with the emerging interpretation, never straying from the participant’s particular story and context (Crist & Tanner, 2003). The involved procedures overlapped; the narratives and observations between the researcher and the participants evolved throughout five phases of analysis: 1) early focus and lines of inquiry; 2) central concerns, exemplars and paradigm cases; 3) shared meanings; 4) final interpretations; and 5) dissemination (Crist & Tanner, 2003).

As hermeneutic interpretive phenomenology posits, space was created to allow for the research questions and the participants to evolve during the interview and observation process. NVivo1.5.1 software was used to transcribe recorded data, manage, organize, and assist with the systematic coding of study findings, concepts, categories, relationships and meaning. The researcher performed manual audits and updated all transcriptions for accuracy. Researcher reflections, perceptions, bias and assumptions were noted for their likely contribution to the research process (Laverty, 2003). Data accuracy and authenticity were evaluated throughout all
stages of data analysis. Cycles of data deconstruction, interpretation, and reconstruction concentrated on addressing the specific study aims to: 1) identify and understand the values, beliefs, and experiences of youth who identify as LGBTQ+ and needed emergency care for suicidality, 2) determine the retrospective needs of adolescents who identify as LGBTQ+ and seek emergency care for suicidality based on their unique cultural care preferences, and 3) explore the health needs of adolescents who identify as LGBTQ+ and require emergency care for suicidality in the future based on their unique experiences. Analysis and the interpretive process continued until the researcher appreciated reasonable meanings. Additional first interviews and second interviews served to address pending lines of inquiry and validate findings. Final interpretations are reported in the dissemination phase; new meanings remain tentative in the hermeneutic process (Caputo, 1987; Kvale, 1994).

**Results**

**Description of Participants**

Detailed participant characteristics are presented in Table 1. Fifteen youth who identify as LGBTQ+ and sought emergency care for suicidality when they were adolescents participated in this study. Enrolled eligible individuals ranged in age from 20 to 25 years. Participants described their ethnicity as: African American/Black, Hispanic/Latino, Pacific Isander and Hispanic, and Other. Individuals described their gender identity as male, female, and non-binary, and their sexual orientation as: demisexual, bisexual, gay, homosexual, lesbian, queer, asexual, and transgender.

**Lived Experience**

Four shared meanings were identified and interpreted across and from ten central concerns: 1) achievement emerges with openness, 2) authentic inquiry yields understanding, 3)
conflict needs a voice, 4) control and coping are connected, 5) lack of acceptance injures, 6) presence or absence of culturally congruent care is associated with impact of care, 7) resource insecurity is related to knowledge gaps, 8) respectful communication generates healing, 9) safety threats are internal and external, and 10) trust engenders candor. Participant narratives were merged with the researcher’s interpretation of narrator interactions and resulted in the following four shared meanings.

**Shared Meaning One: Coping and control are connected and lack of either or both can lead to feelings of hopelessness**

All participants shared being in hopeless situations, believing that the only escape from the lonely despair which comes with compounded traumatic events was to end their own life. Participant-narratives and their interpretation consistently led to lack of autonomy and feelings of hopelessness: 1) needing to have a voice, 2) having no control, 3) having a sense of loneliness/not belonging.

Individuals reported finding their voice in the form of verbal or written speech, for example singing, artwork, or writing—for example, notes to the clinical team. The abuse which results from speaking up oftentimes compounds feelings of hopelessness and causes adolescents to escape. When adolescents attempt to gain control, they sometimes exhibit hostility; controls which are then placed on them have the opposite effect—they escalate further. In these situations, that which underlies behaviors are not addressed. One participant reflected:

“They put me in the ambulance the one they strapped me to the bed. However, when we got up there before I could get in they put me in handcuffs—I don’t know why if you already have officers around you. And the thing is I wasn’t showing any violent signs at all. And prior to being in there it was just that I was being treated like I could attempt to
do anything at any moment. And the feeling of, that the thought of, that it didn’t make me feel any better. So, it was like well, if you’re going to treat me like that.”

When adults release extensive controls and engage with adolescents in respectful ways, adolescents gain healthy controls and both individuals learn to cope. Pride results from caregiver faith; trust that the adolescent can manage behaviors becomes a form of coping. Adolescents then grow confidence, feelings of hopelessness abate and they are inspired to set goals.

Reflections shared from one participant:

“This is your decision; I don’t want to stop your dreams. And I’m just gonna support you, and then I, if anything I can-so if you want to stay, you’re gonna stay (narrator’s dad)...I have more confidence with him right now. But before, mhm mhm (shaking head no).”

Shared Meaning Two: Acceptance from others and self can create a space of safety and be life saving

By participant report, important ingredients to achieve psychological safety are lacking:

1) self-acceptance and love come first, 2) feeling cared for, 3) care which is congruent with their culture (LGBTQ+), 4) sense of support, and 5) needing courage. Rejection from self and others contributes to suffering and pain. When individuals welcome their authentic self—which requires a reliance on beliefs they hold dear (belief in self, others, God)—they make clearer decisions. One participant reflects his father’s words: “God will never take your glory.”

Participants who are not accepted by others were bullied, jumped, abandoned, and assaulted. Youth oftentimes work on achieving acceptance from those they consider to be key individuals. When these efforts do not yield fruitful results, youth conceptually bury the idea of such reality, and acknowledge a persistent level of internal distress. Conversely, when individuals feel they belong, they feel happy—even when living in scarcity. Adolescents
describe important individuals—accepting relationships—as lifesaving, the reason why they did not ultimately commit suicide. Some may not accept themselves to avoid betrayal:

“I’m still trying to be comfortable with myself...I really do want to be a female the whole time...I wanted to get the whole.....but at the same time, I was like, I’m not going to do that...It will just forever be a fantasy. I’m not going to do that, my mom had a son. That’s all I’m gonna be, I’m gonna be a male.”

Lack of acceptance can be subtle for example, being stared at or looked through. “Like when I told my mom I look, I have a boyfriend, she’s like for real, what’s his name. But when I tell you I have a girlfriend like, you kind of skip over the question like, we don’t care.” In some cultures where being LGBTQ+ is largely unaccepted, overt demonstration causes individuals to be targeted in focused ways—for example, gang related activity.” Because of the harm done within families due to lack of acceptance, youth who identify as LGBTQ+ embrace what they call their chosen family, which is culturally accepting.

Absence of culturally congruent care—care which is inclusive of an individual’s cultural values, and beliefs—results in distress which can elicit aggressive behaviors. Care teams then focus on keeping everyone physically safe by administering sedatives or placing the adolescent in physical holds or violent restraints. Consequently, during interventions aimed to address physical safety, psychological safety deteriorates. When treated in ways which are aligned with an individual’s needs, they feel respected which aids one’s ability to find value in themselves and the care they receive.

Culturally congruent care to LGBTQ+ youth can minimize “othering”. Space where individuals can be their authentic self has been described as a sacred space.

“Most adolescents who are trans have suicidal ideation of some kind, and it’s because they just feel like invisible, because no one sees them as a person, so it can, when you use
the right pronouns for someone, you're just like I'm using a basic level of respect for that person, like the very minimum, bare minimum of like respect for that person.”

**Shared Meaning Three: The value of communicating with me is central to understanding me and my care**

Participants stressed the association between meaningful communication and feeling valued by: 1) closing the loop, 2) feeling respected “for who I am”, 3) “tell me why”, 4) inclusive decision making, and 5) “challenge me constructively”. Even while reflecting on prior hardships, participants referenced the research process as supportive. The following reflections further elucidate the importance of therapeutic communication for individuals to feel valued:

“The conversation has been quite engaging. I feel like I've been able to open up much. I feel like the conversation has been some of... I feel tired, I feel exhausted”.
“You know... She actually challenged me—sat me down, looked in my eyes, like you're doing right now—with a challenge”.

Participant-interpreted narratives illuminate the importance of communicating **with me about me**. Individuals echo a resounding lack of interest and understanding from caregivers who were portrayed as impersonal and mechanical. Engaged caregivers are disconnected as well. They ask: *Do you feel sad? How many times a week do you cry?* however, one participant shared that no one ever asked, “*Why do you feel like that? Where does this pain come from?*”.

Receiving emergency care for suicidality is scary and confusing; interactions between adolescents and caregivers are dependent on inclusion and engagement.

“So they actually do like... how do you feel now? I’m okay, ain’t nothing wrong but I’m obviously not going to talk while she’s (stepmother) in the room.”

“After a while I told them that I didn’t really feel comfortable talking to him (psychiatrist), so they let me talk with one of his interns or team members instead.”

Adolescents brought to emergency care do not always know why; as a result, they rebel. Restrictive patient procedures—for example, personal items removal and holding in secure
placement—can lead to aggression, self or staff harm, property destruction, which perpetuates the behavior triggered by the treatment itself. Culturally congruent care may be effectively achieved when individual comfort measures are known—for example, listening to music or taking hot showers. “Nobody ever asks me why did I do something, they just assume they know.”

Inevitably, multiple versions of an adolescent experience are available. Accounts which come from someone who has knowledge of the adolescent’s experience is shared in context with their own individual values, beliefs, experiences, and sometimes motives, which are sometimes different than those of the adolescent. Mutual understanding between the care team and the adolescent is critical to achieve culturally congruent care. When interactions are met with perceived disinterest—for example, communication without eye contact, individuals do not feel heard. Authentic inquiry of self and others is critical; one participant’s exposure to trans individuals, triggered exploration of self. This individual acknowledged the desire to be trans and decided that they would stay true to their deceased mother, who gave birth to a boy. This made the researcher wonder how this might have gone if they could talk with their mother about it.

**Shared Meaning Four: Being vulnerable and living in a constant state of danger**

Within the fabric of each conversation, energy was observed as participants talked about living in danger—being persistently vulnerable. Priority focus was paid to 1) facing financial instability, 2) feeling abandoned, neglected, and abused, and 3) moving beyond distress and destruction. Resource insecurity is related to knowledge gaps. For individuals to function, basic fundamentals are required, neglect leaves them ill prepared. Participants describe abuse and rejection from which they learn to interact using their fists, harsh words, and betrayal. Lack of resources needed to understand oneself and navigate the world leads to self-doubt and associated
unworthiness. One participant shared: “Sadly, I tell them upfront, I don’t know how to do it however, I’m willing to learn. Just don’t leave me in the dust.”

Participants highlight that youth confront lack of comfortability from others who encounter LGBTQ+ individuals, perhaps due to resource insecurity (lack of cognizance). “Looking at you in these ways as related to being gay and so you don’t like talk to people, because you don’t want that reaction.” Vital information to combat resource insecurity is sometimes street knowledge. For example, some don’t know how to take public transportation. When resources are introduced and accepted, individuals can learn and grow and find opportunities to become secure in their future. These opportunities are described as blessings—once again, signaling beliefs which individuals value.

When individuals don’t know what to do, they find themselves in trouble which leads to perpetuating insecurity and harm. Lack of understanding about their rights to resources such as labor laws; resulted in employee maltreatment for some. Attempts to gain a resource secure state can be damaging, due to lack of knowledge of how, for example sex work would take a toll. Moving beyond distress and destruction is possible. “And I’m blessed and happy that Ruby gave me training…she gave me a full-time job which is a blessing. Everything just fell into place but at first, I just feel like the pieces was falling apart.”

Discussion

This study establishes that youth who identify as LGBTQ+ seeking emergency care for suicidality value: 1) coping and control, 2) acceptance 3) communicating with me about me, and 4) moving beyond danger and distress. These findings are consistent with published results from an integrative review of the literature, and further validate that clinical care practices must
include care, which is congruent with these values (Schultz et al., 2021). Adolescents may not experience essential safe spaces which promote acceptance and authentic communication. Increased ED volume, acuity, identified positive risk of suicide, elopement, and use of violent restraints for adolescents presenting for mental health evaluation suggests that clinical practice guidance which incorporate these findings may improve the adolescent’s experience and associated health outcome (Chan-Salcedo, 2020; Latif et al., 2020; Wavra, 2019).

The transition from adolescence to adulthood is complex; gender identity and sexual orientation evolve over time (Janeway & Coli, 2020). The findings of this study substantiate a basic health imperative to address individuals with proper pronouns. Systems changes are essential; electronic, instead of verbal exchange of personal information may be preferrable and thus, improve electronic health record data accuracy. Parental rejection predicts psychological difficulties in youth who identify as LGBTQ+ (D’Amico & Julien, 2012). This study deepens our understanding; when relating to youth who identify as LGBTQ+, parental values and beliefs may overshadow that of youth which intensifies psychological distress for those seeking emergency care for suicidality.

Maslow’s theory reflects an order of human needs; each level must be met in order to ascend to the next level (Kaur, 2013). Psychological needs are not met when equilibrium, as a state of mind, is not present. Literature is dense with findings related to Maslow’s theory and psychological safety needs to maintain healthy work and learning environments. Additional research is needed to understand how psychological safety is assessed in an adolescent emergency care setting in order to determine associated health equity improvement needs.

Strengths
A strength of this study is the first hand accounts of participant experiences; to our knowledge, this is the first study method of inquiry and data analysis of findings applied to this question. These research results were generated by participants with diverse gender identify and sexual orientation, from various areas nationally and internationally which strengthens the validity of the study and suggests generalizability within the LGBTQ+ community. Participants’ definition of emergency services expands understanding of emergency service locations beyond traditional healthcare settings to include church leaders, friends, LGBTQ+ activists, school counselors, and hotlines. Therapeutic communication, which resulted in significant illuminations, strengthened participants as well. Crist and Tanner’s method of analysis is a strength of this study; iterative levels of analysis throughout the research process generated significant meaning from participant narratives and researcher interactions.

**Limitations**

Covid 19 restrictions limited participation, and in some cases limited the researcher’s ability to see full facial expressions during the interview due to mask wearing. Interviews conducted on Zoom were at times challenging. Most participants in this study were homeless or living in unstable housing which made access to a transient community difficult.

In conclusion, this research—which has strong implications for clinical practice, policy, and research—establishes that youth who identify as LGBTQ+ seeking emergency care for suicidality do not feel safe. Based on these findings it would be appropriate to advance culturally congruent care by: evaluating patient coping and control means, assuring closed loop communication *with me about me*—which requires that the adolescent is seen, and their voice is
heard—creating safe and accepting environments, and addressing associated vulnerabilities of the adolescent presenting with healthcare needs to address suicidality.

Psychological safety is measured in the work environment and in learning environments to determine how individuals are seen and/or heard in these settings in an effort to improve safety. Psychological safety is not measured in the adolescent emergency care setting and adolescents who identify as LGBTQ+ seeking emergency care for suicidality do not feel safe. The future of healthcare must include the assessment of psychological safety along with environmental and behavioral safety to develop individualized care plans which are culturally congruent, safe, and effective. Importantly, future research must seek to understand ways in which psychological safety is assessed in the healthcare setting if we are to more deeply understand and effectively address the impact on health equity.
## Table 1

### Participant demographics

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<th>Ethnicity</th>
<th>Gender Identity</th>
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