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Parents' role in adolescent depression care: primary care provider perspectives

Ana Radovic, MD, MSc^{a,b}, Kerry Reynolds, PhD^c, Heather L. McCauley, ScD^{a,b}, Gina S. Sucato, MD, MPH^{a,b,d}, Bradley D. Stein, MD, PhD^{c,e}, and Elizabeth Miller, MD, PhD^{a,b}

^aChildren's Hospital of Pittsburgh of UPMC, University of Pittsburgh School of Medicine

^bDepartment of Pediatrics, University of Pittsburgh School of Medicine

^cRAND Corporation, University of Pittsburgh School of Medicine

^dGroup Health, University of Pittsburgh School of Medicine

^eDepartment of Psychiatry, University of Pittsburgh School of Medicine

Abstract

Objective—To understand how primary care providers (PCPs) perceive barriers to adolescent depression care to inform strategies to increase treatment engagement.

Study design—We conducted semi-structured interviews with 15 PCPs recruited from community pediatric offices with access to integrated behavioral health services (i.e., low system-level barriers to care) who participated in a larger study on treating adolescent depression. Interviews addressed PCP perceptions of barriers to adolescents' uptake of care for depression. Interviews were audio-recorded, transcribed, and coded for key themes.

Results—Although PCPs mentioned several adolescent barriers to care, they thought parents played a critical role in assisting adolescents in accessing mental health services. Important aspects of the parental role in accessing treatment included transportation, financial support, and social support. PCP's perceived that parental unwillingness to accept the depression diagnosis, family dysfunction and trauma were common barriers. PCPs contrasted this with examples of good family support they believed would enable adolescents to attend follow-up appointments and have a "life coach" at home to help monitor for side effects and watch for increased suicidality when starting antidepressants.

Address correspondence to: Ana Radovic, Division of Adolescent and Young Adult Medicine, Oakland Medical Building, 3420 Fifth Avenue Pittsburgh, PA 15213, phone: 412.692.7227, fax: 412.692.8584; ana.radovic@chp.edu.

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Conclusions—In this PCP population, which had enhanced access to mental health specialists, PCPs primarily reported attitudinal barriers to adolescent depression treatment, focusing mainly on perceived parent barriers. The results of these qualitative interviews provide a framework for understanding PCP perceptions of parental barriers to care, identifying that addressing complex parental barriers to care may be important for future interventions.

Keywords

primary health care; depressive disorder; adolescent; parents

Adolescent depression is an under-treated mental health problem contributing to poor functioning, risky behaviors and medical comorbidities as an adolescent and adult.¹⁻⁴ Almost 12% of adolescents are diagnosed with major depression or dysthymia;⁵ only one-third of those receive mental health care.² National organizations call on pediatric primary care settings to fill this gap of mental health care need⁶ partly through depression screening and referral.⁷ A recent primary care study shows that although half of adolescents with a positive mental health screen are referred for mental health services, one-third will refuse the referral, and less than 20% of those screening positive will be seen by a mental health professional.⁸ Primary care interventions addressing barriers to care with the goal of increasing adolescent engagement with mental health services are urgently needed.

Studies among parents have identified that when they do not recognize and acknowledge depression, adolescents are less likely to access mental health care.^{9, 10} Parents may not seek care for their adolescent child due to a difficulty identifying depressive symptoms are present,¹¹ negative treatment attitudes,¹² structural barriers (eg, access, transportation, financial)¹³ and poor parent-adolescent communication.¹¹ Primary care providers (PCPs) experience more difficulty with making a diagnosis and are less likely to refer to therapy and prescribe antidepressants when a parent does not agree with treatment.^{14, 15} Many PCPs feel parental involvement is needed for adolescents to follow through with referrals.¹⁶

PCPs are particularly well positioned to assess both adolescent and parent barriers to mental health care because they have an established relationship with families. In fact, primary care is a setting where adolescents frequently present with emotional problems,¹⁷ and several interventions supporting PCPs in providing mental health services have been helpful to increase access.^{18, 19} Ideally, PCP-initiated conversations about a potential need for mental health care triggers shared decision making about depression treatment, incorporating perspectives of the adolescent, parent, and PCP.²⁰ Our prior work demonstrated that PCPs perceive that there are both parent and adolescent barriers to participating in depression treatment and they are often different from each other.²¹ To inform strategies to increase treatment engagement, we conducted follow-up interviews with PCPs to inquire how they perceived and attempted to address parent and adolescent barriers.

METHODS

Participants (n=15) were drawn from a larger cohort of primary care providers (PCPs; pediatricians, pediatric nurse practitioners and physician assistants; N=58) who had completed a survey about treating adolescent depression in primary care and who expressed

interest in providing further comments on the survey findings.²² Qualitative methods can describe experiences, concerns, and beliefs of participants with great fidelity, while allowing for clarifying discussions about existing quantitative results. Richer and more detailed perspectives can be elicited as compared with standard quantitative surveys.

PCPs were part of a large regional pediatric practice network serving approximately 46,000 adolescents. The network has an integrated behavioral health model in place with routine depression screening of all 15–17 year olds and co-located mental health therapists. Protocols based on diagnosis and severity are used by mental health therapists to facilitate access to co-located or affiliated child psychiatrists or to connect patients with community mental health resources. An integrated electronic health record is used to facilitate communication between PCPs and mental health specialists. PCPs also had an opportunity to attend a network-hosted series of four presentations in the year prior to the survey on the evaluation and management of common child and adolescent mental health conditions, including depression. As a result, patients in this practice network face fewer structural barriers to treatment than may be typical.¹² Thus, the current study was able to focus attention on pediatric PCPs' perceived non-structural barriers to depression care (eg, negative attitudes and beliefs). Individual demographic statistics for the sample of 15 PCPs were not collected to preserve confidentiality. The larger PCP survey sample was 67% female, 95% White and 5% Asian/Pacific Islander, with a mean age of 46 years (*SD* 11). Interviews were conducted from October 2012, to December of 2012.

PCPs self-selected into this study, by identifying interest in the survey phase of the larger project. Each interview was conducted by telephone by the first author and digitally recorded, with consent obtained verbally. At the time, she was an adolescent medicine fellow physician who had completed a pediatrics residency, and identified herself this way. Interview data were not linked to prior survey results. Interviewees were asked to refrain from using patient or participant identifiers, but if used, these were removed from transcripts along with clinic location to preserve confidentiality and patient privacy. Semi-structured interview scripts first asked the PCPs to describe their roles in treating adolescent depression and then about three main topic areas: antidepressant prescribing, influential factors on treatment decisions, and barriers to depression treatment. In this manuscript, findings from the barriers to depression treatment section are highlighted. Specifically, interviewees were asked about their views on barriers to care in general, whether they think there are differences between adolescent and parent barriers, and how they can identify and address barriers that apply to a patient and family. These questions were constructed as a qualitative follow-up study²³ to our survey study²¹ where we found that PCPs perceive the continued presence of and differences between adolescent and parental barriers in an integrated behavioral health model. Interviewees were encouraged to provide case examples. Interviews lasted approximately 30 minutes. Each interviewee received \$50 upon interview completion. This study was approved by the Institutional Review Board at the University of Pittsburgh and the University of Pittsburgh CTSI pediatric practice-based research network, Pediatric PittNet.

Statistical analyses

The interviews were audiotaped, transcribed verbatim, and coded using ATLAS.ti version 7. The approach of qualitative description as described by Sandelowski - a comprehensive summary of phenomena while staying close to the data - was used to describe PCP opinions and beliefs about barriers to depression care.²⁴ Using a content analysis approach,^{22, 25} the first three interviews were reviewed by two investigators (AR and HM) and an initial list of codes focusing on key areas of interest was generated with additional review by a supervising investigator (EM): access, antidepressants, barriers, case studies, clinician characteristics, collaborative care, communication styles, depression characteristics, facilitators, identifying depression, influential factors, PCP responsibility, screening, substance use, and treatment. All interviews were coded by two investigators (AR and HM), compared for agreement, and finalized. Additions of new codes or changes in code definitions were determined via consensus among the research team. No new sets of codes emerged after approximately six interviews were completed, suggesting content saturation was achieved. Final sample size was determined by content saturation as well as achieving a sample of PCPs from various clinic locations. Patterns and concepts were retrieved related to factors influencing initiation of mental health care. The current analysis focuses specifically on PCP perspectives and experiences with barriers to depression care.

RESULTS

In line with our assumptions that the integrated behavioral healthcare model in which providers were situated would allow us to focus on attitudinal as opposed to structural barriers, most PCPs felt access to care was facilitated in this setting. Identified factors that improved access included: evening hours, increased patient comfort with therapy within the PCP office, most therapists accepting all insurances, expedited treatment in crisis situations, and facilitated access to a psychiatrist. PCPs mentioned ongoing challenges with scheduling, therapists cutting back hours, limitations with types of diagnoses therapists would see, and visit adherence requirements. PCPs indicated that benefits of the integrated delivery model included improved efficiency, greater confidence in the quality of care, being able to refer to a known colleague, improved communication using the same electronic health record, and a team model where the PCP can receive feedback from therapists on diagnostic and treatment decisions. One PCP emphasized that due to reduced structural barriers, their primary focus now is on attitudinal barriers:

“had you called me seven years ago, I could’ve just gone on and on with complaints, but at this point, it’s been such a dramatic improvement by having care right on site. Our work really now is encouraging and convincing people that the care will be very helpful” (PCP 15)

Additional structural barriers

PCPs did identify some structural barriers to care that persist including their own time constraints limiting their capacity to identify and address depression among multiple patient concerns. They also described families’ difficulty fitting therapy visits into a busy schedule. PCPs also mentioned families had insufficient resources such as a lack of transportation,

ability to pay copays and session limits or restrictions on in-network providers according to specific health insurance policies.

PCP perceptions of adolescent attitudinal barriers to care

PCPs mentioned several adolescent barriers to care: lack of insight about symptoms experienced, not accepting their diagnosis, downplaying severity of symptoms, refraining from discussing symptoms with the PCP or family due to depressive symptoms like feeling hopeless or guilty and not wanting to burden the family with their troubles. PCPs described adolescents refusing treatment due to desire to manage symptoms on their own, feeling needing treatment implies personal weakness, and not being willing to confide in a therapist. PCPs thought stigma and labeling also play a role, compounded by prior poor experiences with the mental health system (for themselves, a family member or peer).

PCP perception of parental barriers: parents as gatekeepers to adolescent's mental health care

PCPs described barriers being more prominent in the adolescent or in the parent in different cases. Regardless, most PCPs felt that if the parent desired treatment for the adolescent, it was fairly easy to facilitate treatment, but if the parent did not desire treatment and the adolescent did, this situation would be fairly difficult for the PCP to address. Parents were seen as responsible for prioritizing obtaining depression care for their adolescent child, and if this did not occur, then adolescents would not have the means (i.e. transportation, motivation, etc.) to receive the care they need.

“I think in a lot of cases—at least in the patients that I have seen, I feel like it’s more a barrier for the parent. The adolescent would go if the parent would say, ‘Well, we’re going to go.’” (PCP 5)

All but one PCP described barriers distinct to parents (Table), which are briefly summarized below. The most common parental barriers PCPs mentioned were: not accepting the depression diagnosis, need to miss work for appointments, feeling overwhelmed, and being involved in family discord or trauma. PCPs described difficulty with eliciting and addressing parental barriers, especially when parents deny there is a problem.

PCPs described interactions with parents who disagreed with a positive depression screen and felt that the depressive symptoms were consistent with normal adolescent development, or stated that symptoms were simply situational, e.g. due to a divorce, and would improve on their own. PCPs perceived these parental attitudes as hindering adolescent access to depression care. Some PCPs described parents insisting on a medical work-up for somatic complaints prior to agreement with a mental health diagnosis. Other PCPs felt parents genuinely had trouble identifying depressive symptoms due to adolescents keeping these symptoms from their parents. PCPs mentioned how some parents refused to accept the diagnosis and would instead tell the child, especially boys, to deal with their problems on their own – continuing to refuse care even after the PCP would have a private conversation about the importance of treatment with the parent. A PCP gave an example of a mother not accepting depressive symptoms in her child:

“she actually had some suicidal ideation. And the mother was furious ... I mean she didn’t believe it. She thought that the girl had just made it up. And I don’t know because she left furious. The encounter went no further.” (PCP 5)

Multiple PCPs mentioned the barrier of parents having to miss work especially when appointments were only available during daytime hours. Some PCPs perceived that work conflicts were presented by the parent as an excuse for other barriers such as possible parent-adolescent interpersonal conflict. This was evident in a PCP’s frustration with a mother mentioned in the previous quote (PCP 5) who refused to come in with her child as she was at work, even in the face of the adolescent endorsing suicidality.

PCPs described uncertainty about whether adolescents with limited family support would be able to receive adequate treatment. Multiple PCPs used the word “chaotic” to describe these families with multiple ongoing issues, who would likely have difficulty organizing mental health services for the troubled adolescent. Low family support was seen as contributing to the mental illness in addition to undermining access to or engagement in treatment. A PCP mentioned that some parents worry about the child disclosing problems going on at home. One PCP offered the example of guiding a reluctant mother to realize there was trauma occurring when both children had behavioral problems in separate schools on the day an abusive grandfather was scheduled to pick them up.

PCPs unaware of what barriers to care exist

Several PCPs remarked that they are often unaware of the barriers affecting adolescents and parents, even in situations where they felt they knew a family well. They gave examples of families who refused care and seemed to stop communication, preventing any further conversation about treatment or existing barriers. Even with follow-up phone calls, PCPs were unable to determine the factors preventing some families from obtaining care.

How PCPs address barriers

PCPs mentioned several techniques they use to try to address barriers to depression care including psychoeducation. PCPs explained neurobiological mechanisms and related this to family history to help families understand the etiology of depression may be out of their control and they should not feel guilty for the adolescent’s diagnosis. PCPs discussed how adolescent-specific symptoms relate to depression and their overall functioning. Others explained how medication and therapy may be helpful and what to expect from treatment including that if one therapist is ineffective, another should be sought or if medication isn’t initially needed, it may be added later if therapy is not producing significant results. Several PCPs reassured patients about the confidentiality of the diagnosis and treatment. One PCP would share personal experiences with mental health issues to normalize the treatment process.

PCPs also observed that some situations, such as past or ongoing trauma in a family, make it difficult to address barriers to care, noting PCPs had neither the time nor training to take on the role of case manager. Some PCPs would try to address this by coordinating care by personally calling the mental health specialist or introducing the patient to an on-site therapist; PCPs would connect the patient with transportation resources, community

resources, or look into mental health services at the school if the family was not supportive of initiating treatment.

Others elaborated on communication techniques they would use including having a private conversation first with the adolescent about recognizing symptoms and the importance of treatment before bringing the parent into the discussion. Other PCPs would advocate for school accommodations needed due to decreased functioning.

PCPs mentioned using frequent follow-up to continue to address mental health concerns even if behavioral health was not accessed or accepted at a prior visit. This provides the family with time to consider diagnosis or treatment and the PCP to readdress mental health at each visit. A PCP explained that they used the medical record to note when there is a mental health problem so it can be re-addressed at follow-up visits for other complaints. In this way, unlike a mental health provider, the PCP relationship allows PCPs to continue to see patients for other medical care and have opportunities to readdress mental health problems at future visits, instead of losing follow-up with the patient.

“It’s a primary care place. We can do chronic care. We don’t have to say, ‘You missed two visits, therefore, you are being discharged from our practice.’ We don’t have to say, ‘You have 6 months of family intervention.’ So I think it’s just a really nice place where this all fits together.” (PCP 3)

Factors facilitating access to care

PCPs identified that the integrated behavioral health model used in this sample of PCPs’ practices and having an established relationship with a family were important factors to facilitating access to care.

Several PCPs remarked that family support made a significant difference with regard to their treatment decisions, especially whether or not they would prescribe an antidepressant. If there was good family support, PCPs felt more confident that adolescents would attend follow-up appointments and have a “life coach” at home who would help with monitoring for side effects especially suicidal thoughts when starting antidepressants. Several PCPs mentioned that when parents have identified the mental health problem themselves, are motivated and prioritize seeking care, these are the biggest facilitators to the adolescent getting care. These parents were described as making multiple phone calls until appointments are set up, bringing an adolescent who won’t open up several times until he or she would talk to a therapist, and even asking a neighbor to transport the youth when the parent could not miss work or had other childcare duties.

“If I had to pick one thing, it’s family support. The parent doesn’t give up on the kid when things go bad, they just keep bringing them back, keep encouraging them, keep trying to find things that will help.” (PCP 9)

DISCUSSION

Even in a primary care environment with access to onsite mental health providers, this sample of PCPs described multiple barriers for adolescents to participate in depression

treatment. Some of these structural barriers such as cost, transportation, missing school and other activities have been found in prior studies.^{13, 26} Overall most PCPs felt access was greatly improved with the integrated behavioral health model. In a survey study of a larger sample of this PCP population, we found that PCPs recognized that parents and adolescents experience different barriers to treatment, but PCPs may not fully understand the importance of individual barriers specific to parents or to adolescents.²¹ In this qualitative study, we found PCPs did identify those barriers adolescents have mentioned in the literature including a preference for self-management,^{9, 27} stigma and embarrassment,^{28, 29} a desire to not appear weak,^{30, 31} and concerns about confidentiality and reluctance to open up with a provider.^{30–32} The most unique and less described theme which emerged in these interviews was challenges PCPs face working with parents in addressing adolescent depression. Although some of their comments may seem to blame parents, PCPs focused on addressing parental barriers as an area of difficulty they experience even where structural barriers to mental health care access have been improved with the integrated behavioral health model. In almost every interview, PCPs underscored the critical role of the parent in facilitating treatment entry, regardless of the adolescent's desire for treatment.

We provide qualitative data describing PCPs' perceptions of parental barriers to treatment. It is important to note that it provides no objective evidence for the presence of these parental barriers. PCPs' focus on parental barriers may be the result of an actor-observer attribution bias,³³ whereby the PCP may ascribe the cause of barriers to care being due factors outside of the PCP's control, such as parents' behavior. Whether this potential bias influences PCPs' behavior and communication style is worth exploring. The PCPs' challenges in addressing parental barriers may also be complicated by PCPs' difficulty using communication techniques to effectively elicit and address parental views on depression treatment decision-making.³⁴ This may occur due to multiple factors including the PCP not being aware of their own biases,³⁵ not understanding how sociocultural factors may influence parents' perspectives,³⁶ inadequately explaining treatment options, or not using effective listening techniques with the parent.³⁷ For example, in our prior survey, we identified that PCPs in the overall sample infrequently speak with parents alone at adolescent well-child visits.³⁸ These factors may all lead to ineffective PCP-parent communication and result in the PCP perceiving that the parent is not seeking to address the adolescent's depression. Recently developed tools that could help enhance effective PCP-parent-adolescent communication, such as applying motivational interviewing skills, are available in short instructional videos on the American Academy of Pediatrics website through the Mental Health Initiative.³⁹

PCPs discussed perceiving a complex array of parental negative attitudes and beliefs around depression treatment. Negative beliefs and attitudes around treatment and past treatment experiences predict a low perceived need for depression treatment in young adults,⁴⁰ but these constructs have not been used to describe parental behavior around depression treatment. PCPs suspected some parents felt guilt or embarrassment or held beliefs the child should be able to manage symptoms on their own. PCPs often mentioned parental skepticism about treatment including that treatment is not safe (i.e. antidepressants) or not effective (i.e. therapy). PCPs particularly placed emphasis on the parents' perception of the salience of the diagnosis. Prior studies confirm that without recognizing that symptoms are significant, parents are not motivated to seek treatment for their adolescent.⁹ In addition,

parents with poor prior experiences with the mental health care system may also be less likely to seek care for their adolescent.¹² Additionally, parents' self-efficacy or confidence may be limited by family conflict including parent-child conflict³ or limited family supports.¹²

The PCPs in this study perceived that in an environment with improved access to mental health care, they described still struggling with addressing their perceived parental barriers to depression care. Unfortunately few interventions exist to address parent barriers^{18, 41} focusing instead on access and other structural barriers.⁴² PCPs mentioned several approaches they use to address barriers to care including: psychoeducation around depression etiology and treatment options and expectations, relating symptoms to the adolescent's overall functioning, reassurance around confidentiality concerns, coordinating care and access to financial/transportation resources, and scheduling multiple follow-up visits to readdress diagnosis and treatment options. PCPs also described communication techniques they use to address diagnosis and treatment with the adolescent first and subsequently involve the parent. This approach is in line with literature around transition in chronic diseases such as cystic fibrosis and congenital heart disease where at times overinvolved parents can become a burden to the adolescent's independence around self-care.^{43, 44}

There are a handful of studies that describe interventions which include parental components. For example, a motivational interviewing intervention for suicidal adolescents identified in the emergency department was designed to address both adolescent and parent barriers and resulted in increased participation in mental health referrals.⁴⁵ An online format for psychoeducation for parents is feasible in a primary care setting⁴¹ and allows opportunities for parental peer-to-peer discussions, although few online mental health interventions for children have involved parents.⁴⁶ Findings from this study highlight that PCPs desire interventions which focus more intentionally on addressing perceived parents' barriers to initiating treatment for their depressed adolescent through both clinical and community-based interventions. Future studies should elicit parental perspectives on their reasons for not initiating depression treatment, especially to guide intervention development, although barriers around social norms and parents' own mental health experiences may be difficult to elicit. Future studies should also investigate how PCP perceptions of parental barriers impact their own practice.

This qualitative study explored how PCPs perceive barriers to adolescent depression treatment and highlighted the critical, and often missed, role of parents. As is common with many qualitative studies, the sample size was small which may limit generalizability of the study findings. Nonetheless content saturation was achieved around the main theme of parental barriers,⁴⁷ which provides some confidence that the results capture prevailing perceptions among this group of PCPs. A key limitation is that the interview sample, drawn from a larger survey sample, consisted of volunteers interested in providing feedback on mental health care within primary care. Thus, these PCPs may have been motivated to participate due to holding strong opinions about this topic and may not reflect the perspectives of less interested PCPs.

Despite these limitations, the findings in this study regarding PCP perceptions of parental barriers are important to inform interventions directed at increasing adolescent treatment participation. Parents are facilitators to mental health treatment in depressed adolescents.^{10, 11, 48} Even prior to interacting with a PCP, adolescents often seek help first from their parents.⁴⁹ PCPs place greater weight on parental concerns than validated depression screening tools when making clinical decisions about mental health referral.⁵⁰ PCPs in this study expressed the desire for interventions which assist them to improve communication with parents around depression diagnosis and treatment for adolescents including those interventions which increase parents' mental health literacy^{10, 11} and address perceived complex parental barriers to care. Future research should investigate whether interventions with substantial parental barrier components are effective at increasing participation in adolescent mental health care.

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ABBREVIATIONS

PCP Primary Care Provider

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Table 1

PCPs' perceptions of depression treatment barriers specific to parents

Theme	Number of PCPs who mention theme	PCP Quote
Parental acceptance of teen's depression diagnosis or need for treatment (i.e. denial, feel symptoms are normal teen behavior, situational, or due to medical problem)	10 PCPs	<p>"The mother absolutely refused to do anything. She, she just flatly refused. You know, she said, 'I know she's depressed, and we're okay.' ... the mother told me that, um, there were some issues going on at home. Financial issues that made home life rough and that she felt that that was part of the depression. That's about as far as we could get." (PCP 5)</p> <p>"Kids are like, 'I really want to talk to somebody but my mom just doesn't believe in doing that.' Or like, 'My grandfather doesn't believe in my going there and they just think that you need to walk it out.' ... And they are just crying for help, but their parents are like, 'Listen. You're fine. Get over it.' As a provider, I try to talk to them [parents] privately. And I say, 'Listen, I really recommend this.' And I've had parents look at me straight in the eye and be like, 'No. They're fine. See you later.'" (PCP 13)</p> <p>"I do see a lot of parents who even with a PHQ-9 that's positive, who say well, you know, I just think it's typical adolescent moodiness or, well yeah, they want to sleep all the time, but what teenager doesn't? And so a lot of parents-maybe not a lot, but some parents certainly don't want to think about their child having depression, they want to chalk up a lot of the symptoms just to, 'Oh, they're just being a teenager.'" (PCP 14)</p>
Parental fear/guilt/embarrassment	5 PCPs	<p>"[The parents worry] 'the doctors are going to think it's my fault because they're going to claim that oh, I wasn't strict enough or I was too strict,' so I think there's a lot of guilt involved, there's a lot of fear involved." (PCP 2)</p> <p>"Fear that this was something the family couldn't handle on their own." (PCP 8)</p>
Parental negative attitudes toward depressed teen	4 PCPs	<p>"...she had sent her in suicidal, and mom didn't come in. And I had asked-I had called mom and said, 'I need you here.' And she said that she couldn't take off work and that, and that-then she dumped a bunch of other stuff on, like she had had this young lady had had a miscarriage and did I know that? Did I know that she wasn't taking her meds and stuff? And I was-I don't know. I get very angry. All I could think of was, 'Wow, then why aren't you here?'" (PCP 6)</p> <p>"Especially, I think sometimes not even in girls, but in boys. Like they are kind of like, 'Suck it up. You're fine.'" (PCP 13)</p>
Parent-parent or parent-child conflicts (i.e. custody, communication, emotional abuse)	4 PCPs	<p>"Sometimes the parent that has the child doesn't want to rock the boat and contact this parent because they've stepped out, and it's just better that way. Or three, it becomes one of these power plays where, 'They only need it because you're so terrible.'" (PCP 3)</p> <p>"But I just-I get really frustrated. It's sad-I get so angry with some of these parents. I really do. I feel like they place pressure on the kids, that they push them and they aren't willing to recognize when they are down. That they-I just, sometimes I feel like I want a parent-ectomy. That I want a-for these kids who are really sad and suffering. And it's not always the case. Believe me, some kids are depressed inside a very functional, beautiful home, but generally that's not the case; that there is a lot of social stress." (PCP 10)</p>
Parents' low resources and social support	4 PCPs	<p>"I think another problem is the family situations because if they are really chaotic families, the kids kind of just fend for themselves and they are left out-you know, it's hard enough for the family to take care of themselves, let alone get the kids help." (PCP 7)</p> <p>"So I mean it's kind of a two-edged sword and it certainly contributes to the disease itself I think when you aren't in a supportive environment and then when you don't even have the support to get treatment for it." (PCP 14)</p>
Parent skepticism or concerns about treatment	4 PCPs	<p>"There's a lot of skepticism about the therapy, more from the parents to a degree than the kids, [the parents think] 'this isn't going to help, I don't want my kid to have to be on medication forever.'" (PCP 2)</p> <p>"In fact, one of the last barriers is to recognize that it is a real disease. It is a process that needs to be treated, and it really helps to treat depression." (PCP 8)</p>
Parents not getting mental health care for themselves	3 PCPs	<p>"I think the same thing that would keep teens out are probably keeping parents out from getting the care they need as well." (PCP 15)</p> <p>"I think the mom-she probably had some anxiety and depression herself, and so she didn't want people to think that her daughter was crazy, she said. And so she didn't really follow through ever with much. She was ... pretty overwhelmed, too." (PCP 7)</p>
Parental futility about encouraging teen to get help	1 PCP	<p>"And his mother isn't pushing it. You know. She's like, 'He won't go. He won't, you know.'" (PCP 10)</p>

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Theme	Number of PCPs who mention theme	PCP Quote
Parent concerns about confidentiality	1 PCP	“You know, and sometimes I get concerned about maybe what the family secrets are. You know, what can we disclose, what can't we disclose? What might come out if you go and talk to someone or, 'You can't ask us questions. I don't want you asking-I don't want you seeing my child alone.'” (PCP 3)