Leveraging Primary Care Settings to Reduce Adolescent Suicide: Voices of Youth and Caregivers

by

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DISSERTATION ABSTRACT

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Title: Leveraging Primary Care Settings to Reduce Adolescent Suicide: Voices of Youth and Caregivers

Suicidal thoughts and behaviors (STBs), particularly among adolescents with marginalized identities, are alarmingly high. Improving prevention requires increased identification and treatment of acute, proximal, and modifiable behavioral health (BH) factors related to STBs (i.e., online victimization, anhedonia, sleep disturbances). Marginalized adolescents face individual- and systemic- level stressors (i.e., discrimination) that can increase BH concerns and STBs. BH concerns are raised in over 50% of pediatric primary care visits, making primary care providers (PCPs) important “gateway providers” to triage adolescents at risk of STBs. To optimize this prevention approach, this mixed-methods study aimed to understand how adolescents and caregivers perceive their BH discussions with PCPs, and how adolescents’ perceptions vary depending on their experiences of discrimination.

Thirty-three adolescents with depression and current or past STBs (Mage = 15.1 years, 63.6% female, 45.45% Black, 45.45% White) and their caregivers were recruited from primary care. Adolescents and caregivers completed interviews soliciting their experiences with discussing STB-related BH concerns with PCPs. Results indicated that caregivers reported youth’s BH symptoms to PCPs more than youth did, but 42.1% of adolescent’s BH concerns still were not discussed by either caregiver or adolescent. Participants identified facilitators (i.e., client-initiated discussion, supportive providers, screening tools, discussing related concerns, adequate assessment and follow-up) and barriers (i.e., low symptom salience, perception of PCPs, client knowledge, limited opportunities for caregiver participation, cultural misunderstandings and transgressions from PCPs) for these BH conversations. Mixed-methods analyses revealed that adolescent's perceptions of BH conversations varied by their previous experiences of discrimination, and that the most reported experience of discrimination was based on weight. These findings suggest that supportive providers, timely follow-up referrals, and culturally sensitive care can promote BH discussions with PCPs and ideally guide adolescents into appropriate treatment to prevent STBs. As implied by youth who experienced discrimination, it is imperative that PCPs deliver culturally sensitive care that also accounts for the intersecting stressors that vary depending on adolescents' identities. Findings also highlight the importance of considering how weight-based discrimination impacts adolescent STBs and how PCPs can mitigate these impacts in healthcare settings as well.

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TABLE OF CONTENTS

LIST OF FIGURES

Figure Page

LIST OF TABLES

CHAPTER 1: INTRODUCTION

Overview of Presenting Research

The escalating rates of suicidal thoughts and behaviors (STBs) among adolescents over the past decade, combined with the fact that suicide is one of the top three leading causes of death in this age group, underscores the need for action (Kann et al., 2018; National Institute of Mental Health, 2024; Wester et al., 2018). Efforts must focus on prevention and intervention initiatives for adolescents who experience high risks of STBs and have been historically underserved and marginalized. Underserved populations with marginalized identities face daily sociocultural and systemic influences that engender high risk of STBs and preceding behavioral health (BH) concerns. For example, these disparities are evident when comparing the high rates of STBs among Ethnic-Racial Minoritized (ERM) adolescents compared to majority White adolescent populations. One approach to decrease STBs is to treat the BH concerns that increase risk of STBs. Given that BH concerns are raised in over 50% of pediatric primary care visits (Martini et al., 2012), primary care providers (PCPs) serve as “gateway providers,” or the first clinician to identify concerns and facilitate appropriate referrals to treatment (Stiffman et al., 2004). The potential for PCPs to transform and enhance care for adolescents struggling with BH has been championed in major policy reports and research (Bitar et al., 2009) and can decrease the risk of STBs that marginalized youth experience, including ERM adolescents. It is imperative to understand how leveraging this avenue can promote culturally sensitive care and equitably reduce STBs and related BH concerns among marginalized adolescents.

Suicidal Thoughts and Behaviors Among Adolescents

STBs entail suicidal ideation (i.e., consideration or desire to end one's own life; Cha et al., 2018), attempted suicide (i.e., non-fatal self-inflicted act with intent to die), and suicide (i.e., fatal self-inflicted act with the intent to die; Bridge et al., 2006). The risk of STBs increases during adolescence (Davis et al., 2022). Potential reasons for this increase include the general rise in psychopathology, behavioral health concerns, and substance use. Additionally, adolescents have greater cognitive capacity to process STBs, increased stressors related responsibility, and autonomy to enact STBs (Bridge et al., 2006). At least 19% of high school-aged youth in the United States have considered suicide, and among them, over one-third have attempted suicide (Cha et al., 2018). Sadly, the number of youths seeking medical treatment at emergency departments because of suicide attempts has almost doubled since 2007 (Ivey-Stephenson et al., 2020). STBs among adolescent populations are a resounding public health issue.

Notably, adolescents with marginalized identities are at a higher risk of STBs compared to adolescents with majority identities (Akkas, 2023). These adolescents include ethnic-racial minorities (ERM), queer youth, and disabled youth, along with other minoritized statuses. For example, as illustrated in Figure 1.1, Black and Hispanic high school students have reported higher suicide attempts than White high school students over the past decade (Ivey-Stephenson et al., 2020). Similar trends exist among sexual and gender minoritized adolescents as well. Queer youth have experienced STBs significantly more than heterosexual youth (Akkas, 2023) and a striking 40% of transgender adolescents have considered suicide (Austin et al., 2022). Finally, youth with neurodevelopmental and/or physical disabilities have reported more suicide attempts compared to peers without disabilities (Moses, 2017). These examples are not exhaustive of all the other experiences of marginalization and social positions that are relevant when understanding STB risk, but they highlight a need to address such disparities when improving STB interventions for adolescents.

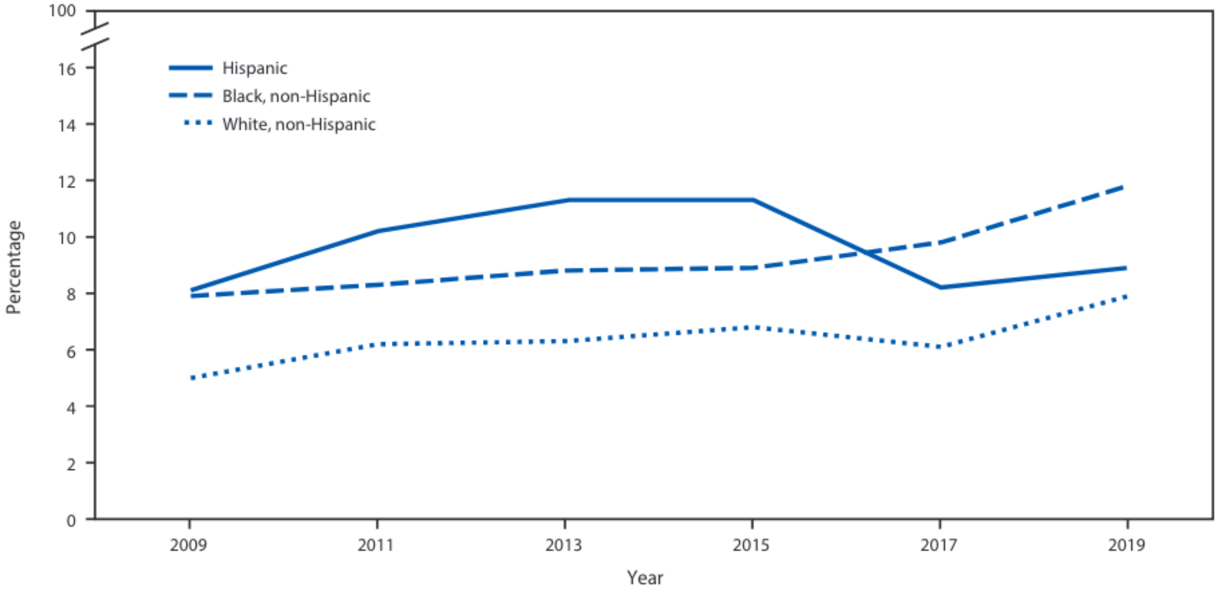


Figure 1.1. Percentage of high school students who attempted suicide during the 12 months before the Youth Risk Behavior Surveys, 2009 –2019 (Ivery-Stephenson et al., 2020).

Frameworks Related to STB Risk and Disparities

Existing models and frameworks illuminate the external structures that increase adolescents' risk of STBs, specifically among youth with marginalized identities. Selected frameworks that inform the current research include the Minority Stress Model (Meyer, 2003), the Structural Racism and Suicide Prevention Systems Framework (Alvarez et al., 2022), and the Intersectionality Framework (Crenshaw, 1991). Although certain frameworks are more explicitly developed to understand how experiences of marginalization related to ethnic-racial identity and/or sexual identity relate to mental health and behavioral health concerns, these concepts can be applied to understand these dynamics for other marginalized adolescents at risk of STBs.

Minority Stress Model

The Minority Stress Model was originally developed to understand the negative impacts of stigma and queer individuals' physical and mental health outcomes (Meyer, 2003). This model can be applied to understand various factors increasing STB risk across various statuses and identities (i.e., disability, sexuality, gender). The model poses that in additional to general life stressors (e.g., economy, school responsibilities), distal stressors (e.g., external events, discriminatory legislation, anti-gay violence, oppressive or exclusive spaces) and proximal stressors (e.g., internal conflict, fear of rejection due to minority identity, internalized homophobia, internalized social messages) exist. These stressors, which lie across systemic and individual levels, amplify distress and can be responsible for adolescent STBs. Understanding the Minority Stress Model also sheds light on the fact that these stressful processes may influence adolescent STBs differently depending on context (e.g., coping skills, social support), and do not necessarily pre-determine one's risk of STBs.

Structural Racism and Suicide Prevention Systems Framework

Beyond individual-level factors, racial/ethnic disparities among youth suicide trends are attributable to social, developmental, cultural, and ecological factors (Alvarez et al., 2022). The Structural Racism and Suicide Prevention Systems Framework (Alvarez et al., 2022) critically highlights how structural racism across macrosystems (i.e., broader society and policies), mesosystems (i.e., interactions across settings), and microsystems (i.e., families, schools, and neighborhoods) interact to increase an individual's risk of suicide, and inequitably interferes with access to suicide prevention and intervention. Structural racism refers to how social structures, institutions, policies, and cultural factors have disadvantaged people of color and limited their access to power (Alvarez et al., 2022). For instance, policies that limited Black American's access to mortgages and segregated housing have had decades-long impacts on financial security, neighborhood resources, and safety (National Public Radio, 2017), which can subsequently increase risk factors around STBs, impact help-seeking behaviors, and complicate access to necessary care (Cauce et al, 2002; Castro-Ramirez et al., 2021). These patterns have been evident across various subgroups of ERM adolescents and suggest that other structural inequities outside of race-based discrimination exist and largely impact adolescent STBs.

Intersectionality Framework

Another important framework that also considers context alongside individual experiences is the Intersectionality Framework, which posits that an individual's multitude of identities intersect to create a unique experience that is distinct from the experiences related to any single identity (Crenshaw, 1991). Although not directly related to adolescent STBs, this model highlights important considerations to understand which youth may be particularly vulnerable and unable to access necessary care. Experiences related to stress, oppression, discrimination, or privilege all vary greatly depending on the social identity. For example, a transgender Black female adolescent experiences different oppressive and distressing experiences that may put her at different risk of STBs than a cisgender Black female adolescent, or a cisgender White male adolescent with a physical disability. These layered identities also mean that youth with multiple marginalized identities may be exposed to multiple oppressive or discriminatory stressors across different contexts. It is important to consider intersecting identities and related frameworks to develop more targeted, inclusive prevention strategies that account for the unique challenges and resiliency factors that adolescents at-risk of STBs experience.

Current Interventions for STBs & Integration into PCP Settings

The current approaches to addressing adolescent STBs require improvements. Adolescent STBs are targeted through various modalities, including Dialectical Behavioral Therapy, family-focused Cognitive Behavioral Therapy, Interpersonal Psychotherapy, Psychodynamic therapy, stress-reduction interventions, and medication management (Bridge et al., 2006; Glenn et al., 2020; Esposito-Smythers et al., 2019; Harris et al., 2022; McCauley et al., 2018; Robinson et al., 2016). However, recent meta-analyses indicate that these psychological interventions are not more effective at decreasing adolescent STBs than control conditions (Harris et al., 2022), possibly due to few interventions developed specifically for STBs or adolescent STBs (Bridge et al., 2006; Harris et al., 2022). One prevention effort is to increase the identification and treatments of acute, proximal, and modifiable BH concerns related to STBs (Harris et al., 2022; Williamson et al., 2022).

In addition to targeting BH antecedents to STBs, it is critical that STB interventions are more culturally sensitive and generalizable to adolescents with various social identities and statuses. Traditionally, systemic racism, oppressive structures, minority stress, and intersectionality have not been highlighted within prevention and intervention efforts for STBs. For example, although Dialectical Behavioral Therapy for Adolescents (DBT-A) is the most established and effective intervention for adolescent STBs, the DBT-A clinical trials predominantly included white adolescents and do not explore the efficacy or experiences among youth with other existing identities (Glenn et al., 2020). STB interventions developed and/or evaluated for marginalized adolescents, such as Black adolescents or queer adolescents, are significantly limited (Robinson et al., 2024). This inevitably limits our knowledge of the effectiveness of existing interventions for adolescents who may hold marginalized identities and experience the associated stressors. The above frameworks offer potential avenues for enhancing suicide and self-harm prevention efforts by addressing relevant social stressors and behavioral health concerns in a culturally sensitive manner, with the goal of effectively reducing adolescent STBs.

PCP Settings to Discuss Acute, Proximal, and Modifiable BH Concerns Related to STBs

There are several behavioral health symptoms predictive of STBs that could be more systematically targeted to improve equitable prevention and intervention of adolescent STBs. Three important examples of such BH concerns include anhedonia, sleep disturbances, and online victimizations. Anhedonia, a common characteristic of major depression, is a strong predictor of STBs (Ducasse et al., 2018). Sleep disturbances (e.g., insomnia, sleep duration) have also been identified as warning signs for STBs (Goldstein et al., 2008). Lastly, targets of cyberbullying or online victimization (OV) have been linked to increased suicidal behavior in youth (Nixon, 2014). These three BH concerns often increase during adolescence and disproportionately impact adolescents with marginalized identities (Deer et al., 2018; Goldstein et al., 2021; Weinstein et al., 2021). One fruitful avenue to addressing these BH concerns is through Primary Care Provider (PCP) settings. To optimize this prevention approach, it is essential to first understand how adolescents and caregivers perceive BH discussions with PCPs. Enhancing these discussions may result in more effective, sensitive strategies for preventing adolescent STBs.

PCPs as Gateway Providers

PCPs are uniquely positioned to serve as gateway providers to specialized outpatient care for adolescents. Not only do adolescents with mental health (MH) and BH concerns tend to visit PCPs more consistently, but also caregivers typically consult with PCPs when they notice their youth is struggling with socioemotional and behavioral problems (Asarnow et al., 2002; Godoy

& Carter, 2013; Nordin et al., 2012). The routinization of pediatric visits throughout childhood and adolescence (i.e., well-child visits, school- or sports-mandated physicals, gynecology appointments) allows PCPs to develop long-term connections with families and adolescents over time (Godoy & Carter 2013). This established sense of trust and familiarity can also encourage adolescents to discuss sensitive topics with PCPs, which in turn improves their perception of their providers (Brown & Wissow, 2009). Furthermore, youth and caregivers may also feel less stigma communicating BH challenges with a PCP compared to with a MH provider. The importance of having a trusted provider relationship and a destigmatized environment to discuss BH concerns may be especially salient for adolescents and families with marginalized identities (Bitar et al., 2009). Furthermore, given high rates of inpatient MH treatment for ERM youth (Malhotra et al., 2015) there is an important need to provide marginalized adolescents with discussions and resources in PCP settings to access appropriate outpatient interventions instead. Current literature describes whether anhedonia, sleep, and OV are mentioned in PCP settings, however, there is less emphasis on how youth and caregivers want these discussions to be improved. Improving these discussions can facilitate treatment seeking and support to mitigate STB among adolescents, especially marginalized adolescents. The following section explores patterns of discussing anhedonia, sleep, and online bullying in PCP settings specifically.

Anhedonia

Anhedonia refers to reduced motivation and ability to experience pleasure (Auerbach et al., 2015; Ho & Summers, 2013; Treadway & Zald, 2011), and has been repeatedly identified as a risk factor for STBs among adolescents and adults (Auerbach et al., 2015; Cai et al., 2023; Ducasse et al., 2018; Yang et al., 2021; Yang et al., 2022). Compared to depressed adolescents with suicidal ideation, depressed adolescents who have attempted suicide reported more severe anhedonia (Auerbach et al., 2015). This remains true even when controlling for symptoms of depression and anxiety (Auerbach et al., 2015). A more recent study found that greater anhedonia is associated with suicidal ideation, but not with past suicide attempts (Yang et al., 2021). These mixed findings may be a result of varying cultural contexts as one sample was comprised of American adolescents and the other of Chinese adolescents. This reemphasizes the need to understand contexts and cultural backgrounds by diversifying research samples even if it's within one geographical region.

Regardless, there is a concerning link between anhedonia and suicidal thoughts among adolescents. Overall, anhedonia increases during adolescence, making it critical to address and prevent STBs (Yang et al., 2022). Furthermore, social anhedonia, a component of anhedonia characterized by a loss of interest in friends, is strongly associated with suicidal ideation (Yang et al., 2021; Yang et al., 2022). As the value and prioritization of social hierarchies typically increases during adolescence, this form of anhedonia may be especially risky regarding adolescent STBs.

Because anhedonia is a core feature of depression, anhedonia, specifically, may not be assessed or discussed in PCP settings. Rather, the discussions focus on depression more generally. In 2007, the American Academy of Pediatrics' (AAP) released Guidelines for Adolescent Depression in Primary Care (GLAD-PC) to improve the identification and treatment of adolescent depression (Zuckerbot et al., 2007). One way to explore adolescents' depressive symptoms, particularly anhedonia, is through standardized measures. The GLAD-PC recommends measures such as the Columbia Depression Scale, Kutcher Adolescent Depression Scale, and the Patient Health Questionnaire-9 (PHQ-9; Chowdhury & Champion, 2020).

Between 2017 and 2020, PHQ-9s were used to screen youth depression during 81% of the well child visits that occurred (Davis et al., 2022). 12 – 14-year-olds attending their first well child visit were more likely to be screened, which is promising, but brings up the question of how frequently providers are screening returning patients if symptoms change (Davis et al., 2022).

Using screenings can lead to referrals for treatment and follow-up. Conducting screenings opens the door to further discussion and referral to appropriate care. Previous samples found that follow-up appointments with PCPs to reevaluate depression were limited (Chowdhury & Champion, 2020). Between 55 – 67% of youth with moderate to moderately severe depression were provided mental health referrals, leaving a significant proportion of youth potentially without further appropriate resources even after being screened for depression (Chowdhury & Champion, 2020). A lack of referrals or follow-up has potential to deter youth and families from disclosing anhedonia, even if symptoms increase or are challenging.

Besides standardized screenings, adolescents' experiences with providers and beliefs impact discussions about depressive symptoms with providers. Among a sample of predominantly White adolescents within the United States, many who sought help for depression within PCP settings reported wanting to still be seen as normal if they are struggling with depression (Wisdom et al., 2006). Youth report concerns of being judged or having their privacy and confidentiality violated if they disclose their depression symptoms (Wisdom et al., 2006). These worries may impede youth from confiding in PCPs about their anhedonia. Perhaps unsurprisingly, youth felt more comfortable with providers who fostered authentic, empathetic connections, and encouraged autonomy in depression discussions and treatment decisions (Wisdom et al., 2006). According to PCPs, adolescents' own lack of insight of their symptoms, downplaying of symptoms or lack of disclosure because of hopelessness or to avoid burdening family are also reasons for not accessing care for depression (Radovic et al., 2015).

Sleep disturbances

Sleep is necessary for typical growth and development during childhood and adolescence. Unfortunately, adolescents on average receive less hours of sleep (i.e., 7 hours or less) and experience more sleep disturbances (i.e., insomnia, short sleep duration, variable sleep timing, and poor sleep quality; Crowley et al., 2018; Honaker & Meltzer, 2016; Joseph et al., 2023; Owens et al., 2014; Wheaton et al., 2018). Such shifts in sleep patterns may be caused by biological changes in circadian rhythms and sleep pressure, which accompany puberty, along with social and academic pressures that reinforce poor sleep patterns (Crowley et al., 2018; Honaker & Meltzer, 2016). Unfortunately, short sleep duration and sleep disturbances have negative impacts on youth wellbeing, including increased STB risks (Glenn et al., 2021; Goldstein et al., 2008; Goldstein et al., 2021; Honaker & Meltzer, 2016; Joseph et al., 2023; Owens et al., 2014; Williamson et al., 2022 Owens et al., 2014).

Youth who obtain less than 5 hours or greater than 10 hours of sleep are at a higher risk of suicidality compared to youth receiving a total sleep time of 8 hours (Owens et al., 2014). This pattern may be more salient among youth with marginalized identities. For example, additional studies highlight that insufficient sleep is linked to even higher odd of STBs among Black adolescents than other adolescents (Joseph et al., 2023; Owens et al., 2014; Yip, 2015) of STBs. This higher prevalence may also be a function of environmental contexts, systemic structures, and historical impacts of racism, that marginalized youth are more commonly faced with (Guglielmo et al., 2018; Joseph et al., 2023; Yip, 2015). For example, relevant circumstances that can exacerbate sleep disturbances include household crowding, shared sleeping areas, co-sleeping, noise pollution, chronic stress, and rumination related to discrimination (Goldstein et al., 2021). Of note, different cultural norms or beliefs about sleep among marginalized communities can determine whether caregivers find it necessary to disclose youth's sleep disturbances to PCPs.

Fortunately, identification and intervention of sleep disturbances can occur in PCP settings. Unfortunately, discussions about sleep patterns during adolescence are less common compared to during infancy and toddlerhood (Meltzer et al., 2014). As indicated by provider report, parental report, and medical visit documentation, screening for adolescent sleep problems is infrequent (Honaker & Meltzer, 2016). Structural barriers, such as limited appointment duration, are barriers to adequately discussing sleep in PCP settings (Honaker & Meltzer, 2016). In fact, PCPs report concern that assessing sleep during appointments can detract from other pressing symptoms, and often providers only ask one question about sleep (e.g., duration, insomnia; Honaker & Meltzer, 2016). There are in fact multiple domains of sleep to assess, including sleep satisfaction, alertness, timing of sleep, and sleep efficiency (Meltzer et al., 2021). The integration of standardized screening tools allows the detection of sleep disturbances and problematic sleep habits within urban youth patient populations, when parents previously denied their child having sleep problems (Honaker & Saunders, 2018). Such tools are not always integrated in PCP settings, however.

Despite the implementation of standardized assessments or measures, knowledge about sleep influences discussions about sleep in PCP settings. Across countries, including the United States, United Kingdom, and Italy, PCPs report possessing inadequate knowledge and receiving insufficient training on youth sleep problems (Faruqui et al., 2011; Honaker & Meltzer, 2016;

Papp et al., 2002). Even during pediatric focused residency programs, education around sleep disorders is insufficient (i.e., less than 5 hours; Honaker & Meltzer, 2016), likely impacting PCP’s initiation or depth of conversations around adolescent sleep. This limited knowledge may also explain why most youth who report or are screened for sleep disturbances do not receive treatment recommendations or further evaluation (Meltzer et al., 2014). Adolescents and parents may be privy to this limited knowledge or recommendations, or they may opt out of discussing sleep because previous conversations with PCPs have been futile.

Another common barrier to screening sleep includes PCPs’ beliefs that parents will voluntarily raise sleep concerns if a problem exists (Honaker & Meltzer, 2016). The reality is only a minority of parents report their youth’s sleep problems to PCPs (Honaker & Meltzer, 2016), and they are more likely to discuss medical problems over behavioral concerns. This can partially be explained by parents having limited knowledge about appropriate sleep needs for adolescents. One study found that many parents from multiracial and ethnic minority backgrounds have limited knowledge about sleep and underestimate sleep needs (Owens & Jones, 2011). Even when parents do disclose sleep problems with PCPs, their perception of their adolescent's sleep may be an inaccurate or an idealized report of their child’s sleep (Honaker & Meltzer, 2016; Short et al., 2013). Compared to adolescent self-report and actigraphy data, parents typically report earlier bedtimes, and later waketimes on weekends, and a greater length of sleep (Short et al., 2013). This still leaves sleep disturbances inaccurately assessed or unaddressed. Importantly, cultural contexts for reporting sleep should also be considered. Including adolescents’ self-report on sleep disturbances may be important for accuracy (Meltzer et al., 2021). Unfortunately, approximately one-third of PCPS directly ask adolescents (Honaker

& Meltzer, 2016). To our knowledge, studies regarding adolescents' perspectives of discussing sleep problems with PCPs do not exist.

Online Victimization

Online victimization (OV), also known as cyberbullying, refers to "disparaging remarks, images, or behaviors that cause harm on an online platform" (Tynes et al., 2010, cited by Biernesser et al., 2023). Based on youth report, one in six youth have experienced online victimization (Kann et al., 2018). Although not a mental health symptom, experiencing OV is a risk factor for psychosomatic symptoms and mental health distress, including STBs (Hinduja & Patchin, 2010; John et al., 2018). In fact, within pediatric emergency department settings, more youth with mental health complaints experience OV compared to youth without mental health complaints (Hellstrand et al., 2021).

Online platforms may pose an additional threat to youth with marginalized identities as this can be an additional avenue to experience various forms of discrimination (Tynes et al., 2015; Weinstein et al., 2021). As internet forums and social media access continues to grow, and discriminatory messages around sexuality, gender, nationality, and race, and other aspects of one's identity or appearance remain present, marginalized youth may be significantly impacted (Tynes et al., 2008; Weinstein et al. 2021). For example, the impacts of online racial discrimination are harmful and associated with anxiety and depressive symptoms, even when controlling for experiences of in-person bullying (Tynes et al., 2015). These impacts and risks related to STBs may be especially salient to youth with multiple intersecting marginalized identities (Espinoza & Wright, 2018).

It is unknown how frequently PCPs are screening for OV, however, rates on screening for bullying in PCP settings are known. In general, only about 50% of medical providers, predominantly nurse practitioners, ask about experiences of bullying (Hutson et al., 2019). This limited screening may be due to few screening tools. Recently Healthcare Provider's Practices, Attitudes, Self-confidence, and Knowledge Regarding Bullying (HCP-PACK) survey was established. Information on the use and efficacy of HCP-PACK was not able to be located. Providers who believed that bullying is negatively impacting youth and believed in their ability to improve the bullying problem were more likely to inquire about bullying experiences (Hutson et al., 2019). Conversely, providers that believed bullying is normative and non-problematic screened for bullying less (Hutson et al., 2019). When providers intervene, common methods include providing counseling, referring to MH professional, contacting school guidance counselor, providing family with educational materials (Hutson et al., 2019).

Compared to providers and parents, youth likely have the best insight on their experiences of OV. Given that, it is important to understand the facilitators and barriers that influence their disclosure of OV with PCPs. Adolescent focus groups uncovered confusion and disbelief that healthcare providers can support adolescents impacted by bullying (Vessey et al., 2017). For example, youth noted that questions about school are more general, and not specifically about bullying, so disclosing bullying feels tangential or out of context to a healthcare concern. Common perceptions also include that it is uncomfortable or too personal to discuss bullying with PCPs without a strong patient-provider relationship, if parents are in attendance, or if there are concerns providers will maintain confidentiality. Furthermore, most youth doubted providers are equipped with resources to solve or help them with bullying issues. Youth viewed providers as having a more involved role if the bullying was creating significant stress and suicidal ideation.

In sum, screening procedures in PCP settings for anhedonia, sleep, and bullying have been perfunctory, and providers and caregivers have identified a few general facilitators and barriers to discussing these issues with PCPs. Extant literature on these BH discussions with PCPs does not adequately integrate perspectives from adolescents experiencing STBs, however, especially those with marginalized identities as well. Soliciting the perspectives of these young people can empower them to take action to promote their behavioral health, combat structural biases and inequities, and reduce disparities in behavioral health and STBs.

Additional Facilitators to and Barriers of Communicating with PCPs

Although not specific to anhedonia, sleep, or OV, previous research has identified multiple facilitators and barriers that patients face when seeking and/or utilizing MH services (Kodjo & Auinger, 2004). These facilitators and barriers may also be relevant to adolescents at-risk of STBs and caregivers when communicating and seeking treatment for BH concerns with PCPs. The following section expands on potential facilitators and barriers to communicating BH concerns with PCPs, although they have not been explicitly explored in relation to the BH concerns of interest. Certain factors may be particularly relevant to those with marginalized identities.

Severity of BH concerns and perceived consequences

At an individual level, severity of symptoms could either facilitate or hinder treatment seeking (Planey et al., 2019). Previous research finds that, generally, service utilization was greater when caregivers recognized adolescents' depression symptoms (Breland et al., 2014). In other words, higher parent-reported youth internalizing problems were strongly associated with seeking help for adolescents. This pattern of discussing and seeking BH support for adolescents has been evident among families with marginalized identities as well. Black caregivers, for example, were more likely to seek treatment as a function of high symptom severity among their youth. Interestingly, adolescents with greater psychological distress and symptom severity took longer to seek help after experiencing STBs (Lustig et al., 2021). This contradicts more recent evidence where Black youth were more likely to utilize treatment services as their externalizing behaviors increased (Planey et al., 2019). Potential reasons that adolescents do not disclose symptoms, even when the severity is high, may be fear of clinicians' responses or negative consequences, such as involuntary hospitalization, removal from the home, or separation from family members (Castro-Ramirez et al., 2021; Planey et al., 2019). Caregivers also may be weighing the consequences of leaving adolescents' symptoms untreated or undiscussed (Godoy & Carter, 2013). Overall, adolescents' recognition of their emotional distress or parents' recognition of youth's symptoms may influence their disclosure of BH concerns with PCPs. These patterns may also vary across cultural groups and social identities.

Stigma

Stigma is a common barrier to seeking psychological treatment (Carbonell et al., 2024), but the influence of stigma on discussing sleep, anhedonia, and OV with PCPs has been less explored. In general, young people commonly report stigma, embarrassment, and negative perceptions of help-seeking as primary reasons to avoid seeking or accessing help for their mental health (Radez et al., 2021). Adolescents may also value self-reliance over help-seeking (Radez et al., 2021). Parental stigma or embarrassment may also interfere with discussing their adolescent's BH concerns. Different MH concerns appear subject to varying degrees of shame or stigma (Hazell et al., 2022), and so stigma may impact discussions around anhedonia, sleep, and OV differently. Research on this is limited. Furthermore, because individuals from marginalized communities, such as ERM youth, report higher stigma around MH concerns and help-seeking generally (Abdullah & Brown, 2011), it is important to explore if discussions around BH concerns are stigmatized and undisclosed by marginalized adolescents at-risk of STBs.

Experiences with providers

Experiences with health-care providers can influence help-seeking behaviors with PCPs. Large reports with youth and adult patients indicate that negative interactions with providers deter patients from engaging in their healthcare (Eriksen et al., 2023). Negative experiences with providers can include burdens to accessing care, failure to obtain necessary information, lack in timely or personalized care, or challenges with trusting provides (Breland-Noble et al., 2013; Eriksen et al., 2023). Disengaging in care because of these negative experiences may result in reluctance to share sensitive information (van Ryan, 2002), such as BH concerns. These negative impacts and challenges with trust may be especially true for adolescents and caregivers with marginalized identities, who have faced historical and ongoing discrimination in healthcare. On the other hand, positive experiences with providers, embedded in trust and culturally sensitive rapport, have facilitated help-seeking and continuity in MH treatment for marginalized individuals as well (Planey et al., 2019). To improve BH discussions with PCPs, it is important to identify previous experiences with providers, and how they have shaped adolescents' and caregivers' comfort disclosing BH concerns.

Mismatch in cultural background

Cultural background can also influence youth and families' communication with providers. Relevant cultural factors include language, communication styles, values, ethnicity, religion, race, sexual identity, disability status, and more. Differences in cultural experiences and potential misunderstandings between providers and families have been identified as barriers to treatment seeking, especially among ERM individuals (Cooper et al., 2003; Park et al., 2020). Mismatches between these backgrounds with a PCP may be especially notable when adolescents or caregivers with marginalized identities are working with a PCP who holds majority identities. In addition to power dynamics that can make marginalized patients feel uncomfortable with PCPs who hold non-marginalized identities, PCPs may be unfamiliar with patients' lived experiences that are relevant to consider when discussing concerns (i.e., acculturative stress, familial norms, discrimination, historical trauma; Castro-Ramirez et al., 2021). Furthermore, the Western medical conceptualizations and assessment tools within healthcare may differ from the religious, spiritual, or personal beliefs that patients rely on to conceptualize their BH concerns (Bitar et al., 2009). The evidence that treatment outcomes improve when patients and providers are matched based on their cultural identities is mixed (Park et al., 2020), and so it is important to explore how differences in cultural backgrounds may be impacting the early stages of discussing BH concerns with PCPs.

Perceived Discrimination

Unfortunately, experiences or perceived experiences of discrimination are not uncommon for adolescents, especially with marginalized identities (Douglass et al., 2016; Green et al., 2021). Encounters with discrimination, at an individual or systemic level, may be predictive of more difficult communication with PCPs (Castro-Ramirez et al., 2021; Hausmann et al., 2011). Across ERM populations, perceived discrimination in non-health care settings is associated with underutilization of MH care (Burgess et al., 2008). Even when discriminatory experiences significantly contribute to individual's distress, individuals may find it difficult or inappropriate to express that in a PCP setting that could potentially reinforce these experiences of discrimination (Castro-Ramirez et al., 2021). In line with suggestions from Alvarez et al.'s Systemic Racism and Suicide Prevention Framework (2022), it is also imperative to measure and mitigate interpersonal discrimination that adolescents face (Alvarez et al., 2022). Exploring adolescents' experiences of discrimination with adults within and outside healthcare settings has the potential to identify methods to improve discussions and primary care prevention efforts for a large subgroup of adolescents at risk of STBs.

Integrating Caregiver and Adolescent Perspectives about Discussing BH Concerns

Little research has captured the perspectives that both adolescents and caregivers have when discussing anhedonia, sleep, and OV with PCPs. Parents typically are the first to identify and voice concerns about young children's behaviors, making parents active agents of change for initiating treatment (Godoy & Carter, 2013). Sometimes caregivers may also be the agent of change when adolescents feel too embarrased to discuss their symptoms with providers (Radez et al., 2021). Over time, however, adolescents may become more accurate reporters of their internalizing symptoms, social interactions, and sleep (Asarnow et al., 2002; Short et al., 2013), and sometimes parents may be in denial of their youth's symptoms (Radez et al., 2021). Due toor fear of parents' judgement, or concerns about burdening parents, adolescents do not always share their symptoms with caregivers (Wecht et al., 2023). Furthermore, adolescents may be attending primary care clinics without parental accompaniment or knowledge (Asarnow et al., 2002). Given these changes in roles and valuable insights from both parties, there is a deep need to explore the experiences of both adolescents and caregivers when identifying the facilitators and barriers to discussing BH concerns with PCPs.

CHAPTER 2: CURRENT STUDY

Parent Grant and Studies

The current study drew data from three separate R34 studies conducted under an P50 Center grant at the ETUDES Center (Enhancing Triage and Utilization for Depression and Emergent Suicidality). a collaboration primarily between the University of Pittsburgh and Children’s Hospital of Philadelphia. Although the background of this dissertation emphasized the risk of STBs among adolescents with various marginalized identities, this dissertation analyzes data from the ETUDES samples, which intentionally oversampled for Black adolescents, ensuring representation from at least one minoritized group. The ETUDES Center projects focused on developing and evaluating interventions for adolescents at-risk of STBs, with a particular focus on Black adolescents at-risk of STBs. These three separate ETUDES studies are the Transdiagnostic Sleep and Circadian Intervention Study (TSC), the Geospatial and Ecological momentary assessment Technology and Activity Engagement (GET ActivE), and the Social Media Intervention for Online-Victimized Youth (SMILEY). Analyzing data across the three studies provides more perspectives and information to improve the generalizability for enhancing PCP and patient discussions about BH concerns related to STBs.

Geospatial and Ecological momentary assessment Technology and Activity Engagement (GET ActivE)

The objective of this research is to evaluate the feasibility and effectiveness of delivering digital Behavioral Activation therapy (BA) via an app, with the support of a health coach, to reduce anhedonia, depression, and STBs among adolescents seeking primary care services, with special attention to the needs of Black youth.

Transdiagnostic Sleep and Circadian Intervention (TSC)

The objective of this research is to use health-equity informed implementation science methods to establish the feasibility, acceptability, and appropriateness of sleep-focused intervention, TSC, for youth at-risk for depression and STBs.

Social Media Intervention for Online Victimized Youth (SMILEY)

The objective of this research is to evaluate the feasibility of an automated intervention delivered via a social media-based chatbot to reduce: a) online victimization (OV) frequency and perceived stress related to OV (primary outcomes) and b) depression severity and risk for suicidal thoughts and behaviors (STB; secondary outcomes). The sample will include adolescents seeking primary care services who report online victimization (OV), with special attention to the needs of Black and/or sexual and gender minority (SGM) youth.

Aims

The purpose of this study was to explore youth and caregiver perceptions about discussing specific BH concerns related to STBs (i.e., anhedonia, sleep problems, cyberbullying) with PCPs, as well as whether these perceptions vary by experiences of discrimination. Given the exploratory nature of the study, initial hypotheses were not established.

Aim 1: Determine whether youth and caregivers discussed mental health problems with PCPs.

Aim 2: Identify youth and caregiver perceptions about experiences, barriers to, and facilitators of discussing youth MH with PCPs.

Aim 3: Examine how youth and caregiver perceptions (preferences, barriers, facilitators) of MH discussions with PCPs vary according to experiences of discrimination.

Chapter 3: METHODOLOGY

Mixed Methods Research

A convergent mixed methods research design was used to approach the research aims. This design involves the collection and analysis of quantitative and qualitative datasets separately, and then the merging of databases to combine the results (Creswell & Plano Clark, 2018). Utilizing quantitative and qualitative data facilitates breadth and depth in understanding participants' beliefs and experiences. This approach is particularly indicated for understanding the experiences of Black families, given the limited research on this topic, and may address research biases and epistemological problems that stem from predominantly Eurocentric beliefs and samples. Conducting mixed methods research can also integrate community engaged research involvement to foster more equitable collaborations and tangible implication for improving mental health discussions with providers (Key et al., 2019). Community engaged research ranges from gaining information from a researcher within the community to a community initiating a research project with the involvement of researcher. This study used a community-based participatory approach to seek feedback from key advisory groups, comprised of youth and caregivers, and incorporated feedback as much as possible regarding the research process. Ultimately, utilizing a mixed methods approach is intended to amplify marginalized and underrepresented individuals' perspectives by incorporating qualitative interviews to expand on experiences reported by largely Black youth and caregivers, as sampled.

Participants and Recruitment

Recruitment

Participants (N = 64) were enrolled in this study from pediatric primary care practices within Children's Hospital of Philadelphia, University of Pittsburgh Medical Center Children's

Hospital of Pittsburgh, and Children's Community Pediatrics, through the main ETUDES Center Pediatric Primary Care study (STUDY22020069). Participants were referred if they a) were between 12-18 years old, b) able to speak English, c) experiencing current depression or suicidal behavior, as indicated by a PHQ-9-M score $\geq$ 11; or suicidal thoughts in past two weeks as indicated PHQ-9M item #9 $\geq$ 1, and/or past month suicidal thought, and/or prior history of attempt as indicated by items on the PHQ-9-M. Parents or caregivers also needed a) to be at least 18 years old, b) their child to be willing to participate in the study, c) to be able to speak English, d) to be the biological/adoptive parents or have court documentation that they can provide consent for research as a legal guardian of a youth. Research staff conducted additional eligibility screening and approached participants via telephone to inform them which interventions they were eligible for and to allow participants to decide which intervention study they were interested in. Participating parents/caregivers provided informed consent and adolescents provided assent; youth who were age 18 or turned 18 during the study provided informed consent.

Each study had additional criteria. Youth in the GETActivE study must have also experienced anhedonia (PHQ-9M anhedonia item $\geq$ 1). To be included in the TSC study, participants must have also reported sleep problems (PHQ-9-M sleep item $\geq$ 2). Participants in the SMILEY study must have experienced online victimization, where they reported at least one type of OV "a few times" or at least two types of OV "once."

Participants were excluded if a) youth experienced conditions that might impair their ability to effectively participate in ETUDES interventions, such as current manic or psychotic episode, presence of a life-threatening medical condition requiring immediate treatment, obstructive sleep apnea or restless legs syndrome, intellectual or developmental disability precluding comprehension of research study procedure, b) youth did not have access to a phone and/or tablet, or c) caregivers were not the biological parent or court-appointed guardian of the youth being interviewed. Table 1.1 presents data on the sample characteristics.

Table 1.1 Demographic details for youth participants

	GA (N=10)	**SMILEY (N=13)**	**TSC (N=10)**	**Overall (N=33)**
Age				
Mean (SD)	14.7 (1.57)	15.8 (1.72)	14.6 (1.90)	15.1 (1.78)
Sex assigned at Birth				
Female	8 (80.0%)	10 (76.9%)	9 (90.0%)	27 (81.8%)
Male	2 (20.0%)	3 (23.1%)	1 (10.0%)	6 (18.2%)
Gender				
Female	6 (60.0%)	8 (61.5%)	7 (70.0%)	21 (63.6%)
Male	1 (10.0%)	2 (15.4%)	2 (20.0%)	5 (15.2%)
Transgender Female	0 (0%)	2 (15.4%)	1 (10.0%)	3 (9.1%)
Non-binary / Queer	1 (10.0%)	1 (7.7%)	0 (0%)	2 (6.1%)
Other	1 (10.0%)	0 (0%)	0 (0%)	1 (3.0%)
Missing	1 (10.0%)	0 (0%)	0 (0%)	1 (3.0%)
Sexual Orientation				
Bisexual	1 (10.0%)	4 (30.8%)	2 (20.0%)	7 (21.2%)
Gay	0 (0%)	0 (0%)	1 (10.0%)	1 (3.0%)
Lesbian	0 (0%)	1 (7.7%)	0 (0%)	1 (3.0%)
Other	1 (10.0%)	2 (15.4%)	1 (10.0%)	4 (12.1%)
Pansexual	1 (10.0%)	0 (0%)	0 (0%)	1 (3.0%)
Straight	6 (60.0%)	6 (46.2%)	6 (60.0%)	18 (54.5%)
Missing	1 (10.0%)	0 (0%)	0 (0%)	1 (3.0%)
Race				
Black	5 (50.0%)	4 (30.8%)	6 (60.0%)	15 (45.5%)
White	5 (50.0%)	6 (46.2%)	4 (40.0%)	15 (45.5%)
Black, White	0 (0%)	3 (23.1%)	0 (0%)	3 (9.1%)
Hispanic				
No	10 (100%)	11 (84.6%)	10 (100%)	31 (93.9%)
Yes	0 (0%)	1 (7.7%)	0 (0%)	1 (3.0%)

Unknown	0 (0%)	1 (7.7%)	0 (0%)	1 (3.0%)

Table 1.1 Demographic details for youth participants, continued

	GA (N=10)	**SMILEY (N=13)**	**TSC (N=10)**	**Overall (N=33)**
Parent education				
Eighth grade or less	1 (10.0%)	0 (0%)	0 (0%)	1 (3.0%)
High school graduate, GED	2 (20.0%)	0 (0%)	0 (0%)	2 (6.1%)
Attended college without four-year degree	2 (20.0%)	7 (53.8%)	0 (0%)	9 (27.3%)
Four-year college graduate	4 (40.0%)	2 (15.4%)	0 (0%)	6 (18.2%)
Professional Degree	1 (10.0%)	2 (15.4%)	0 (0%)	3 (9.1%)
Missing	0 (0%)	2 (15.4%)	10 (100%)	12 (36.4%)
Family income				
< $24,999	0 (0%)	2 (15.4%)	0 (0%)	2 (6.1%)
$25,000 – $49,999	4 (40.0%)	2 (15.4%)	0 (0%)	6 (18.2%)
$50,000 – $74,999	2 (20.0%)	2 (15.4%)	0 (0%)	4 (12.1%)
$75,000 - $99,999	1 (10.0%)	0 (0%)	0 (0%)	1 (3.0%)
$100,000 or more	3 (30.0%)	5 (38.5%)	0 (0%)	8 (24.2%)
Missing	0 (0%)	2 (15.4%)	10 (100%)	12 (36.4%)

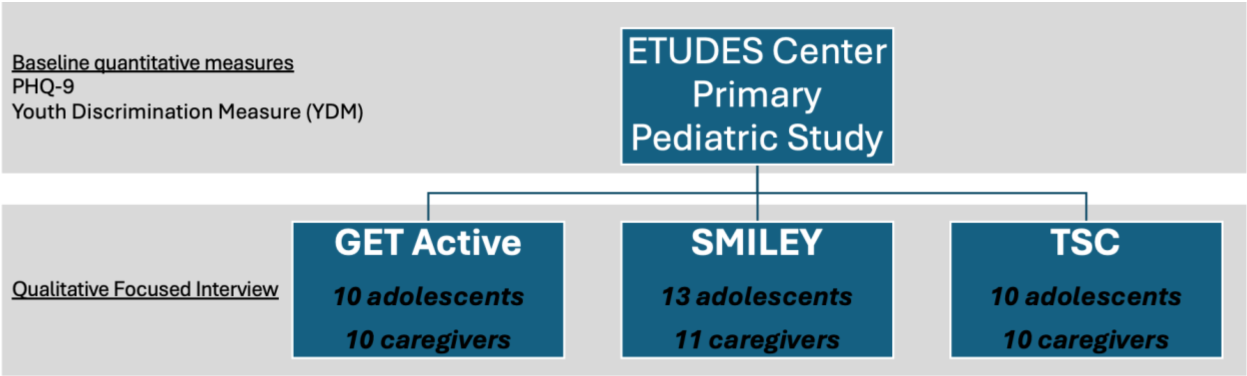


Figure 1.2. Illustration of the study sample recruitment workflow and instruments.

Data Collection

Participants completed clinician administered and self-report measures during a Baseline visit via phone/online/virtual session. Each participant individually completed a qualitative interview with a trained center-grant staff member over the phone or HIPAA compliant video conference software. The interviews explored youths and caregivers’ experiences with receiving and discussing mental health care in pediatric primary care to examine barriers and facilitators to implementation and key intervention development. The interviews took up to 60 minutes and were recorded and transcribed. Youth and caregivers each received $50 for participating in the qualitative interview.

Instruments

Quantitative Assessment Measures

Youth Discrimination Measure (YDM). The YDM is adapted from the Perceived Discrimination measure (Phinney et al., 1998) and the YDM used in the Adolescent Brain Cognitive Development (ABCD) Study (Nagata et al., 2021) to assess adolescent’s perceived discrimination due to ethnic background, national origin, sexual orientation, and weight. This is a 7-item self-report measure. Participants can endorse whether they have experienced discrimination based on the previous items, and frequency of perceived discrimination. Using a 5-point Likert scale ranging from 1 (Almost Never) to 5 (Very Often), youth indicate the frequency of being treated unfairly by teachers, adults, and students. Higher scores indicate greater frequency of experiencing discrimination.

Focused Interview

Qualitative Focused Interview

The Consolidated Framework for Implementation Research (CFIR) was used to guide interview development, as the focus across studies was on developing and/or adapting scalable interventions in routine primary care practice. An implementation science expert worked collaboratively with the center's qualitative team and members from each R34 study to develop and revise an interview guide. Questions were also revised based on feedback from a caregiver and youth advisory board. Qualitative interviews were conducted and recorded by trained center-grant staff members. Youth and caregivers were interviewed separately. See Table # for a list of interview questions that were asked and analyzed for this study.

Table 1.2. Interview prompts which youth and caregivers responded to

<table>
<tr><th colspan="2">Teenager</th><th>Caregiver</th></tr>
<tr><td colspan="2"><i>“Have you discussed [sleep or sleep problems/negative online experiences/low interest]* with one of your providers in primary care?”</i></td><td><i>“Have you discussed [sleep or sleep problems/negative online experiences/low interest]* with one of your teen’s providers in primary care?”</i></td></tr>
<tr><td>If yes:</td><td colspan="2"><i>“What type of provider(s) have those conversations been with?”</i>
<i>“What has gone well about those conversations?”</i>
<i>“What could be improved about those conversations?”</i></td></tr>
<tr><td>If no:</td><td colspan="2"><i>“Tell me what you think has kept those conversations from happening in primary care?”</i></td></tr>
<tr><td colspan="3"><i>“Sometimes providers and families have trouble connecting or have misunderstandings because they come from different backgrounds—such as race, ethnicity, culture, language, or education level. Has this ever happened when discussing your teen’s mental health with one of your teen’s providers in primary care? If so, tell me more.”</i></td></tr>
<tr><td colspan="3">*The specific mental health problem that was asked corresponded with the study they were recruited for (i.e., TSC, GET ActivE, SMILEY).</td></tr>
</table>

Data Analysis

Qualitative analysis

To determine whether youths and caregivers discussed mental health concerns with PCPs, the responses to "Have you discussed [sleep or sleep problems/negative online experiences/low interest] with one of your providers in primary care?" To identify barriers and facilitators to discussing mental health concerns with PCPs, steps in the qualitative analysis included: 1) auto-transcription of recorded interviews and removal of identifying information; 2) preliminary exploration and familiarization of the data by reading through transcripts; 3) developed codebook to identify barriers, facilitators, and culturally relevant experiences; 4) two Clinical Psychology graduate student coders open-coded four randomly selected interview transcripts from each R34 study (two caregivers and two adolescents) together, 5) met weekly to refine definitions for codes, or removed irrelevant codes to establish the codebook (see Table 1.3); 6) each coder individually double-coded 20% of the interviews, which were randomly selected, from each study to establish intercoder agreement (kappa = .74 (on paragraph level)); 7) discrepancies were resolved through discussion and consultation with research advisors to reach consensus, and the codebook was updated as needed; 8) coders each individually coded 33 interviews through NVivo14 by segmenting and labeling the text; 9) conducted a thematic analysis to identify emergent themes by aggregating similar codes together and discussed with three research advisors over several meetings; and 10) stratified themes by reporter and BH concern to identify convergence or divergence across categories. The graduate student coders identified as cisgender women of color (Indian American and Mexican American, respectively).

Quantitative data

The YDM measure includes a question about being discriminated against by other peers/students. Given the study's purpose to investigate experiences between youth and providers, the question about discriminatory experiences with peers was removed from the analysis. On the YDM measure, most participants did not endorse discrimination based on their ethnic background, national origin, sexual orientation, or weight individually. Similarly, most participants reported that they almost never or rarely were treated unfairly by teachers or adults. As a result, the YDM data was stratified into binary categories: no previous discrimination and endorsed previous discrimination. The criteria for this dichotomization are included below in Table 1.4.

Table 1.3. Codebook applied for coding transcripts

Codes	Definition	Exemplars
Facilitator	Comments that highlight an experience that promoted discussion, or suggestions to encourage discussions about BH concerns	"The doctor gave me a questionnaire" (Youth) "They listen to what I'm saying without judging" (Youth) "I think there should be support groups for teens to discuss" (Caregiver)
Barrier	Comments that highlight any experienced interference with discussions about BH concerns, or negative experiences during a discussion.	"The doctors never really talk about my son's low interest. They literally just say... they scored low. ...They don't get into detail about it." (Caregiver) "It doesn't work" (Youth)
Culturally Relevant	Comments related to identity or values that have impacted client's decision or comfortability discussing behavior health problems with providers Ex: values, cultural norms, cultural conceptualizations about mental health, acculturation, Black Lives Matter movement, racism, cultural mistrust, experiences of marginalized identities	"It was race. I don't know. I just know that I didn't get the help I was looking for." (Caregiver) "I would think so because like I said we're African American and it seems like our culture is a little bit different from what they're used to." (Caregiver) "There are some social boundaries because he's a lot older than I am and he's also a cis guy." (Youth)

Table 1.4. Criteria applied to dichotomize Youth Discrimination Measure (YDM) responses

Previous discrimination	**No previous discrimination**
Answered **Yes** or **Don't Know to any** of the following: *In the past 12 months, have you felt discriminated against* *1) because of your race, ethnicity, or color?* *2) because you are (or your family is) from another country?* *3) because someone thought you were gay, lesbian, or bisexual?* *4) because of your weight?*	Answered **No to all** of the following**:** *In the past 12 months, have you felt discriminated against* *1) because of your race, ethnicity, or color?* *2) because you are (or your family is) from another country?* *3) because someone thought you were gay, lesbian, or bisexual?* *4) because of your weight?*
OR	AND
Answered **Sometimes, Often, Very Often to any** of the following: *How often do the following people treat you unfairly or negatively because of your ethnic background?* *1) Teachers* *2) Other adults outside of school*	Answered **Almost Never, Rarely to all** of the following: *How often do the following people treat you unfairly or negatively because of your ethnic background?* *1) Teachers* *2) Other adults outside of school*

Qualitative and Quantitative Data Integration

Following a convergent design, the quantitative and qualitative findings were merged to explore the intersections between identified themes, and socioecological factors – specifically experiences of discrimination (Creswell et al., 2011). This was done by stratifying the qualitative data by experiences of discrimination, and reviewing the coded content related to barriers, facilitators, and cultural misunderstandings. Venn diagram joint displays were utilized to illustrate how themes varied between youth who had or had not experienced discrimination previously (McRudden et al., 2021).

Chapter 4: RESULTS

Aim 1 results: Determine whether youth and caregivers discussed mental health problems with PCPs.

Results from the "yes/no" questions during the interview showed of the total 66 participants, 27 (40.91%) participants reported discussing their mental health problems with their primary care providers, 12 (18.18%) reported discussing with a therapist, 1 (1.52%) reported discussing with both, and 1 (1.52%) reported discussing with a school counselor. Figure 2.1 illustrates the proportion of adolescent-caregiver dyads that reported youths' BH symptoms to a PCP specifically (57.9%). More caregivers (57.58%) discussed their youth's mental health problems with a PCP than their own child did (27.27%), as shown in Figure 2.2.

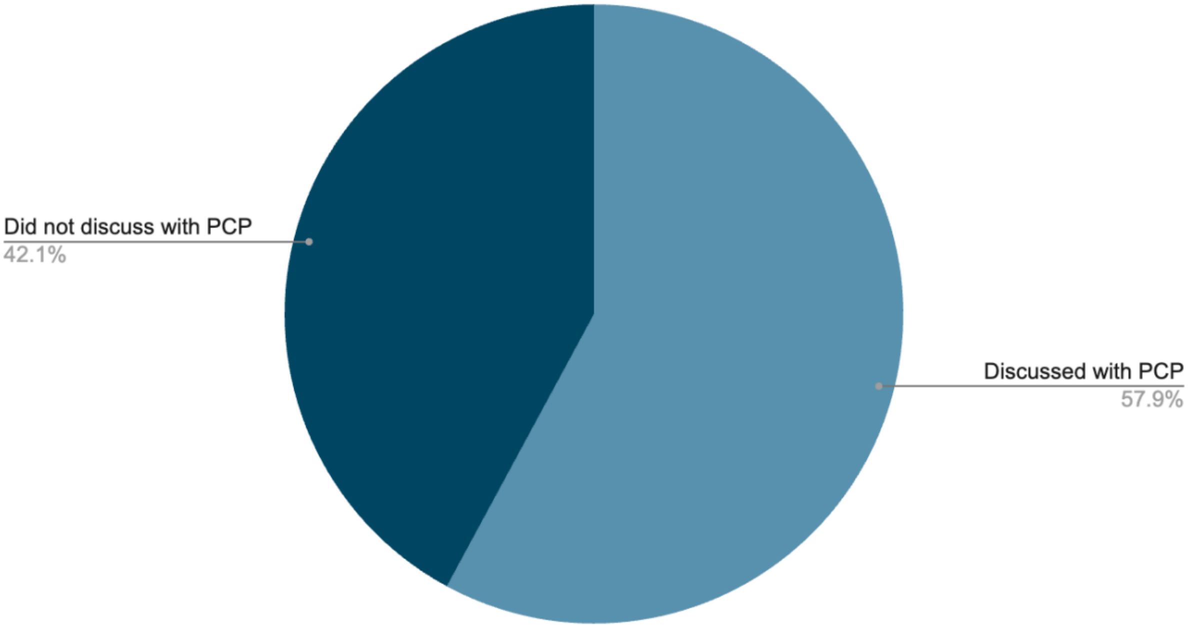


Figure 2.1. Proportion of participants who discussed youth's behavioral health concerns with a Primary Care Provider

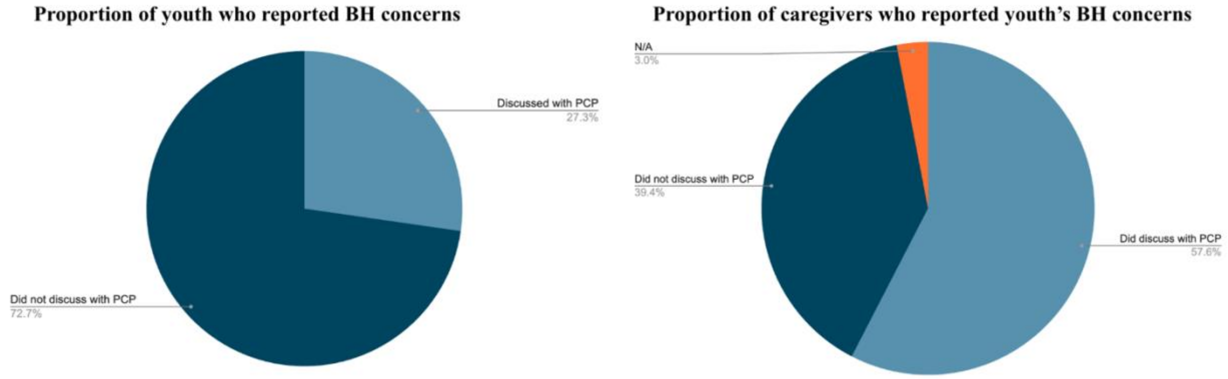


Figure 2.2. Proportion of participants, stratified by youth or caregiver, who discussed youth's behavioral health concerns with a Primary Care Provider

The occurrence of these discussions with different providers was examined across the three studies. Participants discussed sleep disturbances and anhedonia with PCPs more than they discussed online victimization with PCPs. Online victimization was discussed with therapists more than sleep and anhedonia were, however. As shown in Table 2, 12 participants (50%) in the TSC study discussed sleep disturbances with their PCP, while 3 (13.6%) discussed with their therapists. In the GA study, ten participants (50%) discussed anhedonia with their PCP and seven (15%) discussed with their therapists. Conversely, only six participants (25%) from the SMILEY study disclosed OV to their PCPs and seven (29.17%) reported to a therapist or school counselor.

Table 2.1. Frequency of all Participants Reporting Youth's BH Concerns Behavioral, Across Health Concerns

	Sleep		OV		Anhedonia	
	N	%	N	%	N	%
Discussed with PCP	11	50	6	25	10	50
Discussed with therapist	3	13.64	6	25	3	15
Discussed with both	1	4.55	0	0	0	0
Discussed with school counselor	0	0	1	4.17	0	0
Not discussed	6	27.27	11	45.83	7	35
Not applicable	1	4.55	0	0	0	0
Total participants	22		24		20	

Table 2.2 Frequency of Youth and Caregivers Reporting Youth’s BH Concerns Behavioral, Across Health Concerns

	Sleep				OV				Anhedonia			
	Caregiver		Youth		Caregiver		Youth		Caregiver		Youth	
	N	%	N	%	N	%	N	%	N	%	N	%
Discussed with PCP	8	66.67	3	30	4	36.36	2	15.38	6	60	4	40
Discussed with therapist	0	0	3	30	2	18.18	4	30.77	1	10	2	20
Discussed with both	1	8.33	0	0	0	0	0	0	0	0	0	0
Discussed with school counselor	0	0	0	0	0	0	1	7.69	0	0	0	0
Not discussed	2	16.67	4	40	5	45.45	6	46.15	3	30	4	40
Not applicable	1	8.33	0	0	0	0	0	0	0	0	0	0
Total participants	12		10		11		13		10		10	

Aim 2: Identify youth and caregiver perceptions about facilitators, barriers, and experiences when discussing youth MH with providers (i.e., PCPs and therapists).

Discussions about sleep disturbances, online victimization, and anhedonia were **initiated by youth and caregivers** more than by providers. Caregivers described initiating conversations more than youth, however. One caregiver illustrated this by saying, “We’ve been made aware that sometimes doctors don’t listen to people, and we want to make [them] know that this is a concern.” Many youths and caregivers found **screening tools** (e.g., brief questionnaires about depression symptoms, questions about daily sleep) helpful for exploring mental health with PCPs. Others broached these topics with providers through discussion of **related concerns**, such as disruptions in daily routines, trauma symptoms, medication changes, and general depression.

When asked what went well about discussions, the most common response was having **supportive, validating providers,** who provided honest communication, warmth, nonjudgemental-ness, suggestions, and psychoeducation. Clients described a **need for detailed assessment and follow-up care from providers**. This includes providers examining the antecedents of symptoms and providing timely interventions. One youth recommended that providers “take a step back and talk about [sleep disturbances].” For interventions, caregivers desired exploration of non-pharmaceutical options that could foster support, vulnerability, or integrated routinized care (see Table 2). One parent mentioned an experience with immediate intervention in a pediatric visit, "They had somebody right there come in and tell her different ways to deal with her stress, but not necessarily offering a service." Another parent proposed providers organize a "Reddit teen support group...to offer for kids to talk to."

When asked about existing barriers to discussing mental health with providers, youth and caregivers pointed to individual factors and beliefs. Many youth and caregivers did not disclose mental health issues, especially online victimization, if symptoms were **not salient** or particularly recent. For example, one youth mentioned "I wanted to talk about other things." Some participants also perceived PCP settings as **inappropriate or ineffective resources** for mental health support. For instance, one youth reported, "I just feel like they can't really do much." A couple of youths and caregivers noted that **limited knowledge** about symptoms also impeded discussions with providers. One youth reported "[anhedonia is] a hard issue to talk about because I don't really know where it comes from." Caregivers' responses also illustrated insufficient understanding of their youth's symptoms was attributed to limited communication with their youth.

The interview responses revealed a barrier unique to caregivers specifically. **Limited opportunities for caregiver participation** obstructed their discussions in PCP settings. For example, older adolescents may request to meet with a provider individually, or providers may assess youths' symptoms privately. Even if parents recognized the legal systems that enforce privacy, this was very challenging for some parents, who consequently felt uninformed. One caregiver said, "The doctors...don't give you but so much information about your children and I hate that."

In response to various prompts, youth and caregivers described various **misunderstandings and transgressions from providers related to aspects of their culture or identity**. One area of misunderstandings stemmed from race-related experiences. When discussing online victimization with a White male provider, one youth reported that "I was talking about a very hard racism experience...[The provider] just didn't really understand." Other examples of culturally insensitive care included refusal of gender-affirming care for gender diverse youth, misunderstandings about sexual orientation, and challenges with generational and age differences. For example, one caregiver recounted a challenging generational divide with a psychiatrist, and a youth stated that "when I talk to my therapist ... there are some social boundaries because [my therapist is] a lot older than I am and he's also a cis guy."

Table 2.3. Themes about participants' experiences, facilitators, and barriers when discussing behavioral health with providers

Themes	**Type**	**Exemplars**
Client initiated discussion	Facilitator*	"[Youth] definitely informed the pediatrician that sleep is tough" (Caregiver 1) "We've been made aware that sometimes doctors don't listen to people and we want to make [them] know that this is a concern." (Caregiver 2)
Provider screening	Facilitator*	"They start asking them different questionnaires about how you're feeling, bullying." (Caregiver 3) "They make you fill out this little tablet each time." (Youth 1)
Related complaints	Facilitator*	"It's been brought up as a topic of discussion as part of his trauma treatment" (Caregiver 4) "I mentioned it whenever I was going to see if I could get on medication." (Youth 2)

Table 2.3. Themes about participants' experiences, facilitators, and barriers when discussing behavioral health with providers, continued

Themes	**Type**	**Exemplars**
Supportive, validating provider	Facilitator*	"Yeah, I definitely feel that they've always listened to us and respected that there's a problem there" (Caregiver 5) "She was very understanding. There was no shame in it."(Youth 3)
Detailed assessment and follow-up care	Facilitator*	"I wish that there was more to be done than just suggesting the melatonin, or more restful sleep" (Caregiver 6) "It would be nice if there would be some other person that we could respond to. Maybe if it's not that doctor, maybe somebody else in the practice that we could go to a couple of times a year." (Caregiver 7)
Low salience of symptoms	Barrier	"Just other things happening in my life, like with my parents. Because that was the main reason I got a therapist" (Youth 4) "I just see it as being a part of life. It's not really something that I thought needed to be brought to anyone's attention." (Caregiver 8)
Perception of PCPs as inappropriate or ineffective resource	Barrier	"It really feels abnormal for anyone to talk to their pediatrician about the internet" (Youth 5)
Limited client knowledge	Barrier	"Well, I think that it's just a hard issue to talk about because I don't really know where it comes from." (Youth 6) "My teen hasn't really went into detail about it much... so I don't really think about it." (Caregiver 9)
Limited opportunities for caregiver participation	Barrier	"My daughter's 17 and she doesn't want me to be involved basically" (Caregiver 10) "I mean, he's 13. So now when we go for his physicals and stuff, the questions that they ask are not with me." (Caregiver 11)

Table 2.3. Themes about participants' experiences, facilitators, and barriers when discussing behavioral health with providers, continued

Themes	Type	Exemplars
Misunderstandings and transgressions related to culture and identity	Barrier*	"We're African American and it seems like our culture is a little bit different from what they're used to." (Caregiver 12) "Some [providers].. suggest that being trans or not being straight is the problem instead of things that are actually going on." (Youth 10)
*Theme categorized as facilitator or barrier based on researcher perception, not explicitly labelled as such by participants.		

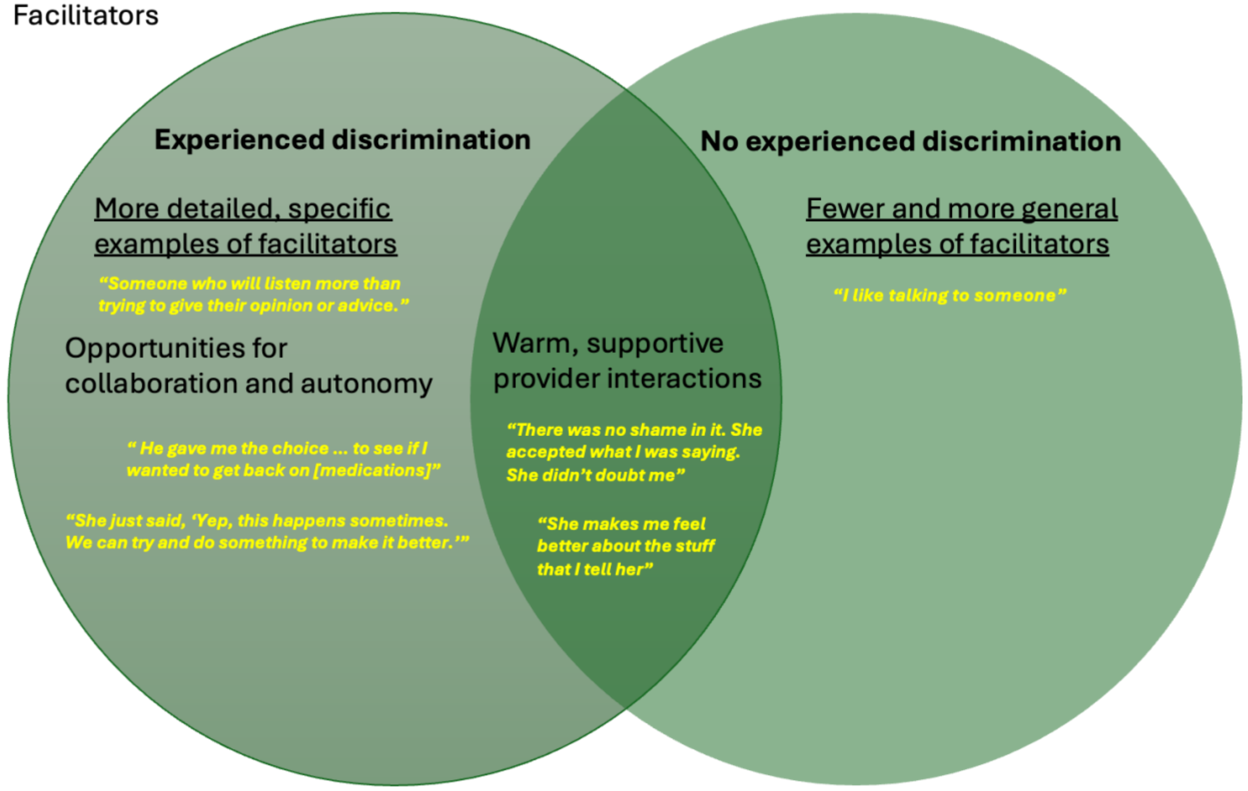
Aim 3: Examine how youth perceptions (preferences, barriers, facilitators) of MH discussions with providers vary according to youth's experiences of discrimination

Over half of the youth (60%) reported a prior experience of discrimination by teachers or other adults based on their ethnicity, nationality, weight, and/or sexual orientation. The most common form of discrimination that youth experienced was related to their weight.

Youths' responses when discussing MH symptoms with providers revealed divergent and convergent themes (See Figure 2.1) depending on previous experiences of discrimination. Many identified themes were related to process-oriented aspects of therapy (Huey et al., 2014), specifically client-provider interactions. A provider's demeanor during patient care was identified as an important facilitator, with youth reiterating the need for **warm, supportive, validating providers** (i.e., providers who listened to their concerns non-judgmentally). Youth who had prior experiences of discrimination emphasized the importance of **collaboration and autonomy** when discussing with providers.

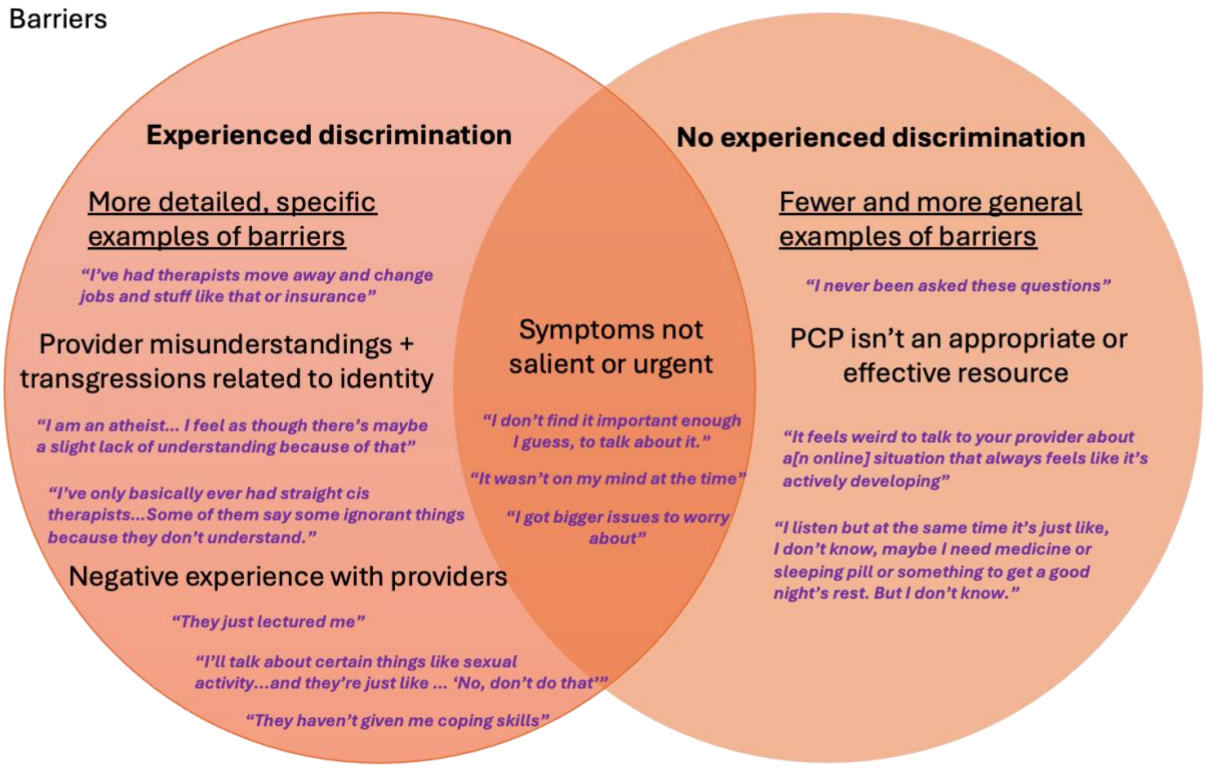
When asked about experiences, cultural misunderstandings, and barriers to the discussions, convergent and divergent themes arose (see Figure 2.2). Both groups of youth restated barriers and experiences related to **low salience** of symptoms. Many youths who previously experienced discrimination described their **providers misunderstanding their culture or identity**, as noted in Aim 2 results as well. The experiences related to identity were quite salient to the youth, as these comments related to identity often arose organically, not only in response to the interview prompt about cultural misunderstandings. Youth who experienced discrimination also made several comments about past **negative experiences with providers.** These results highlight the potential impact of adaptation and skills-based models to address these barriers.

Facilitators



Facilitators were derived from responses to the following questions:
"Have you discussed [sleep problems/negative online experiences/low interest] with your providers in primary care?"
"What type of provider(s) have those conversations been with? What has gone well about those conversations? What could be improved about those conversations?"

Figure 2.3. Comparison of themes identified as facilitators between youth who have and have not experienced discrimination



Barriers

Experienced discrimination

More detailed, specific examples of barriers

"I've had therapists move away and change jobs and stuff like that or insurance"

Provider misunderstandings + transgressions related to identity

"I am an atheist... I feel as though there's maybe a slight lack of understanding because of that"

"I've only basically ever had straight cis therapists...Some of them say some ignorant things because they don't understand."

Negative experience with providers

"They just lectured me"

"I'll talk about certain things like sexual activity...and they're just like ... 'No, don't do that'"

"They haven't given me coping skills"

Symptoms not salient or urgent

"I don't find it important enough I guess, to talk about it."

"It wasn't on my mind at the time"

"I got bigger issues to worry about"

No experienced discrimination

Fewer and more general examples of barriers

"I never been asked these questions"

PCP isn't an appropriate or effective resource

"It feels weird to talk to your provider about a[n online] situation that always feels like it's actively developing"

"I listen but at the same time it's just like, I don't know, maybe I need medicine or sleeping pill or something to get a good night's rest. But I don't know."

Barriers were derived from responses to the following questions:
"Have you discussed [sleep problems/negative online experiences/low interest] with your providers in primary care?"
"Tell me what you think has kept those conversations from happening in primary care?"
"Sometimes providers and families have trouble connecting or have misunderstandings because they come from different backgrounds—such as race, ethnicity, culture, language, or education level. Has this ever happened when discussing with your teen's providers in primary care? If so, tell me more."

Figure 2.4. Comparison of themes identified as barriers between youth who have and have not experienced discrimination

Chapter 5: DISCUSSION

This study examined adolescent and caregiver perceptions about BH conversations in primary care, and explored the variations by youth's experiences of discrimination. The specific BH concerns examined were sleep disturbances, anhedonia, and online victimization as they are risk factors of adolescent STBs. The goal of investigating how these symptoms are discussed was to improve and inform prevention efforts in PCP settings for adolescent STBs. The sample included adolescents with various majority group identities, adolescents with various marginalized identities spanning race, sexuality, and gender, and their caregivers. Through qualitative and mixed-methods analyses, the study produced important takeaways.

Within PCP settings, a large portion of adolescents who experienced anhedonia, sleep disturbances, and online victimization went undetected, revealing inadequate care and a key opportunity for increasing prevention efforts around STBs. Adolescents also appeared to participate in these discussions with PCPs less than caregivers did, substantiating a need to empower adolescents to disclose their concerns and seek help through supportive avenues. Adolescent- and caregiver-reported facilitators and barriers emphasized the positive impact that supportive providers, follow-up referrals, and culturally sensitive care can have on discussing BH concerns and opting into appropriate treatment to prevent STBs. Especially evident from youth who previously experienced discrimination, it is imperative that PCPs deliver culturally sensitive care that also accounts for the intersecting stressors that vary depending on adolescents' identities. Strikingly, adolescents in our sample reported weight-based discrimination as the most common form of discrimination. Given frequent mentions of weight in healthcare settings, this finding poses an important future direction for mitigating weight-based discrimination and having effective discussions about BH concerns with PCPs to ultimately reduce STBs.

Aim 1: Frequency of Discussing BH Concerns with PCPs

Almost 50% of youth had STB-related symptoms (i.e., sleep disturbances, anhedonia, online victimization) that went undetected or unexplored in PCP settings. Previous literature also showed most youth did not discuss mood with their PCPs and only a small portion of parents intended to discuss their youth’s mental health symptoms during well-child visits (Brown & Winsow, 2010). Findings from a large nation-wide dataset from Norway depict that the number of PCP encounters that focus on adolescent psychological conditions is about half the number of encounters for other adolescent ailments (i.e., respiratory conditions, musculoskeletal conditions; Caspi et al., 2024. These trends suggest that BH concerns related to mental health and STBs are prevalent among adolescents who attend PCP appointments, however discussions are not occurring enough. This is concerning, as early evaluations and interventions are critical for preventing STBs, especially in already at-risk populations like our sample. Stigma (Brown & Winsow, 2010) and parental denial (Radovic et al., 2012) about youth’s symptoms may interfere with these symptoms being adequately discussed, however. Unfortunately, if these symptoms are not being disclosed with PCPs, then disclosure of these symptoms may not be arising at all or getting the attention that they deserve.

Within our sample, youth disclosed their symptoms with PCPs less than their caregivers did. Previous research illustrates that parents often are the first to voice concerns about young children’s behavior (Godoy & Carter, 2013), and our findings convey that parents continue to have an important role for adolescent mental health. The average age of our sample was 15 years old. Within that stage of adolescence, it may still be normative for adolescents to be less involved in care, or for adolescents not to have extensive mental health literacy to describe their BH concerns or symptoms (Jorm, 2000). Directing discussions to adolescents and empowering them to engage in these discussions early on, however, can allow providers to build trust, continuity, and offer more personalized and applicable care over time.

Online victimization was discussed with PCPs less often than sleep disturbances and anhedonia. Our results resemble those from Caspi et al.'s study (2024) where PCP encounters in Norway focused on adolescent depression symptoms and sleep disturbances more than STBs, but online victimization was not included in the results at all. Knowing the impact that OV has on adolescent distress and STBs, this lack of screening in PCP settings appears to be a large shortcoming. Perhaps this is unsurprising since online victimization has not been recognized as a behavioral health challenge for as long as sleep and anhedonia have. Over 70% of online bullying is not reported to adults in school settings (MDLinx, 2023), and in-person bullying, which has similar impacts as online victimization, is only discussed during 50% of medical visits (Hutson et al., 2019). Online spaces and integration of technology are often a core component of adolescent's lives, however. In fact, over 90% of teens in America spend time online daily (Pew Research Center, 2023), and the generation has even earned the title of "digital natives," emphasizing the integral, permanent role that online platforms will continue to have (Subrahmanyam & Šmahel, 2010). Youth may benefit when providers inquire about youth's experiences online, along with other relevant cultural phenomena and contexts broadly, outside of just health concerns. Although PCPs may not be trained to adequately address these social challenges, failing to mention it may be leaving a subset of adolescents vulnerable and unsupported if they do not share this anywhere else.

Aim 2: Facilitators, Barriers, Experiences, and Cultural Misunderstandings when Discussing BH Concerns with Providers

Several facilitators and barriers were identified based on youth and caregiver responses. Themes ranged from client-level and provider-level factors.

Facilitators & Related Experiences

Across the entire sample, facilitators included client's self-disclosure about symptoms or related complaints, provider screening tools, detailed assessments with follow-up care, and feeling supported by providers.

Perhaps unsurprisingly, support and validation from providers were highly valued by adolescents at risk of STBs, and caregivers. These interactions reflect practices of unconditional positive regard, a therapeutic approach, that embodies acceptance and support to facilitate emotional expression and exploration (Yao & Kabir, 2023). If patients feel this sense of regard, support, and validation from PCPs, this may effectively increase comfort disclosing sensitive BH concerns. Subsequently, this may increase openness to further help-seeking behaviors. Even process-oriented models to improve the cultural sensitivity of interventions for marginalized populations posit that client-therapist interactions and behaviors have a significant role on the effectiveness of interventions (Huey et al., 2014).

Our findings also point to opportunities for encouraging youth and their caregivers to discuss BH concerns related to STBs. For example, the findings resemble previous data that screening tools are administered to varying degrees, to assess sleep problems, bullying, and depression during well-child visits (Davis et al., 2022; Godoy & Carter, 2013; Honaker & Meltzer, 2016; Hutson et al., 2019). Screening tools can encourage adolescents and caregivers to speak up and seek help for BH concerns even if they are reluctant. This approach can still be enhanced however. Time constraints may interfere with consistent use of screening tools and previous studies show that Black youth are less likely to be screened in primary care compared to White and Latine youth (Davis et al., 2022; Honaker & Meltzer, 2016). As highlighted by our own participants and in previous literature, timely follow-up care may significantly enhance the utility of screening tools (Breland-Noble et al., 2011; Chowdhury & Champion, 2020). Potential approaches to integrating these two facilitators in PCP settings is through triage processes and integrated health settings.

Enforcing a triage process that requires consistent screenings and subsequently routes youth to resources can improve the utility of screenings (Hacker et al., 2016) and encourage discussions of behavioral health concerns with PCPs. In instances where medical record-integrated screenings are not available, PCPs can increase the efficiency of this process and selectively administer screenings that are patient-centered by inquiring what patient’s top concerns are and using relevant screening tools. Integrated behavioral health models of care aim to achieve this triage process by including team-based approaches in health care settings to quickly intervene and manage behavioral and biopsychosocially influenced health problems until symptoms improve (Godoy & Carter, 2013; Williams, 2020). This might entail having mental health providers, counselors, supportive peer groups, or group therapy co-located in the PCP setting for youth who have met criteria on a mental health screening. This arrangement encourages more thorough assessments of the causes and impacts of mental health challenges and provides an opportunity for intervention. Although limited by resources, another suggestion is to strive for universal primary mental health providers for all youth, not just youth who meet criteria for mental health challenges at the time of PCP screenings. Essentially, equipping youth with routine visits with a PCP and a mental health provider could decrease stigma surrounding mental health disclosures, break down the binary categorization of mentally healthy individuals and mentally ill individuals without individuals in between who would benefit from tools or preventative strategies (Williams, 2020). Of importance, even when providers do conduct consistent screenings, it is important they consider implicit biases in these screening procedures and interpret results in a way that fits families' situations to avoid over- or under-pathologizing, and to minimize risks of further exacerbating disparities between majority groups and marginalized groups.

Barriers & Cultural Misunderstandings

Youth and caregivers did not discuss mental health symptoms if symptoms were not salient, knowledge about symptom presentation or etiology was limited, or PCP settings were not considered appropriate or effective resources. Responses from our data suggest there are multiple possibilities for why participants did not believe PCPs would be helpful for their BH concerns. For example, patients who have previously sought help may have felt stuck in a "revolving door" where they were unable to establish referrals or follow-up services in a timely, seamless manner (Breland-Noble et al., 2011). Roundabout experiences like these may deter families from disclosing symptoms and explain why participants did not perceive PCPs as appropriate or effective resources for addressing mental health needs. As illustrated by a select number of participants, patients may not have been made aware that certain BH concerns, specifically OV, are reasonable to share with PCPs. Samples of youth have previously expressed surprise that bullying and related mental health problems are within the scope of medical providers (Vessey et al., 2017), which may largely reflect opinions about appropriateness of reporting OV to a PCP. These results indicate the importance of modifying perceptions of PCPs to accurately reflect the potential services and follow-up offered, so that patients make informed decisions about disclosing BH concerns with PCPs.There are multifaceted approaches to address barriers around the perception that PCP settings may not be appropriate or effective spaces for these conversations. On an individual provider level, PCPs can explicitly mention MH check-ins as one purpose of the appointment. To maintain these impacts and provide an appropriate space, it is important for PCPs to cultivate trust and longevity with families through routinized care with a PCP or a Primary Mental Health Provider (Radez et al., 2021; Williamson, 2020), even if these are brief check-ins. In the spirit of collaborative approaches and expanding typical approaches, field may also benefit from learning where youth, especially marginalized youth, and caregivers feel safe discussing BH concerns and STB-related challenges, so that prevention and intervention efforts be appropriately modified. Using this information, representatives from primary care settings can integrate psychoeducational and advocacy efforts in community-based outreach (Godoy & Carter, 2013). With the purpose of decreasing stigma and increasing mental health literacy, outreach can include screening tools, and conversations about common MH challenges, the associated consequences on daily activities (i.e., inattention, difficulty maintaining schedules, academic challenges, changes in social patterns), and how these relate to STBs. On an organizational level, PCPs settings can work to cultivate a culture that normalizes mental health discussions. Integrating online pre-screening tools can also prime youth and caregivers to consider disclosing these mental health concerns (Vessey et al., 2017).

Provider misunderstandings and transgressions related to youth’s identities were a serious barrier to discussing BH concerns. Many participants described discriminatory experiences with providers that conveyed negative perceptions about the quality of their care. Often times these sentiments stemmed from providers misunderstanding youths’ identities or delivering biased care. Our data exposes the troubling reality that discriminatory, uninformed, or biased care from

PCPs is occurring, and deteriorates prevention efforts for adolescent STBs. Discriminatory care, including microaggressions or minimization of oppressive experiences, is experienced more frequently by marginalized patients than patients with majority identities, and are significantly harmful to patient provider interactions and decrease the likelihood of patients discussing their symptoms (Godoy & Carter, 2013; Schuller & Crawford, 2020). We observed that participants in the current study faced cultural misunderstandings and discriminatory acts towards their sexual orientation, gender identity, religion, age, race, and ethnicity. Research on discrimination in healthcare settings often emphasizes race-based discrimination (Alvarez et al., 2022), which does deserve appropriate redress, and our findings also importantly emphasize the need for culturally sensitive care across a vast range of marginalized identities.

Patterns within the current data and specific responses from participants underscore the importance of validating clients, especially with a marginalized identity, and intentionally decreasing discriminatory actions from PCPs. Interview responses from youth and caregivers implied that feeling misunderstood or facing transgressions could have been addressed if providers broached conversations about identity. On an individual level, PCPs can employ broaching behaviors. Broaching behaviors, often used in the context of MH counseling, refers to providers intentionally raising conversations about how societal experiences that accompany social identities may impact the client's presenting concerns, or how differences in patient-provider identities influence their relationship (Day-Vines et al., 2021). Broaching may also involve PCPs engaging in critical self-reflection to identify biases and completing training to increase knowledge and cultural humility. Stating to a client how societal power structures create challenges for a client's various identities is one form of broaching that requires providers to conceptualize how sociopolitical, external influences are responsible for many of risk factors that youth face (Day-Vines et al., 2021). This acknowledgment can remove potential blame or biased care that PCPs deliver to marginalized youth with BH concerns, and increase comfort for hte patient. Systemic barriers that contribute to discrepancies between PCPs identities and patients' identities can contribute to provider-based generalizations and misunderstandings that impair effective BH communication. Previous research also highlights the positive impact that cultural understanding from providers has on treatment engagement (Chu et al., 2022). Increasing the diversity among PCPs by training providers of various backgrounds and lived experiences may also increase cultural understanding among providers and facilitate critical discussions about BH concerns among adolescents with marginalized identities at risk of STBs.

Aim 3: Variability in Facilitators and Barriers Depending on Youth's Experiences of Discrimination

Mixed methods analyses detected convergent and divergent facilitators and barriers between youth who had and had not experienced discriminatory acts. The merged data illustrated that adolescents who had experienced discrimination provided more detailed responses, suggesting that these discriminatory experiences may have been impressionable in how they view interactions with PCPs and choose to seek help from PCPs in the future. This insight from adolescents can be leveraged to co-create and establish strategies to increase comfortability and effectiveness of discussing BH concerns and accessing necessary treatment. Through quantitative measures, our study found that most youth reported facing discrimination from adults. Contrary to expectations given well-documented racial biases in healthcare, we saw that discrimination based on race or ethnicity were not the most common experiences. In fact, the most endorsed discriminatory experience was related to weight, followed by sexual orientation, race, and ethnicity. This striking emphasis on weight was not initially considered when developing this research question and was also not uncovered during the qualitative interviews.

The result about weight-based discrimination does reflect important aspects of intersectionality, however. A large portion of our sample included female adolescents and Black adolescents, and Black females comprised a notable portion of the youth who reported weight-based discrimination. Historically and currently, females, especially in Black communities, are often subject to societal attention, evaluation, and scrutiny about body weight and size (Bucchianeri et al., 2013), which may partially explain these results. Weight-based discrimination increases adolescents' risk of psychological distress and STBS, and may be exacerbated through online victimization and anhedonia, both risk factors for STBs (Puhl & Lessard, 2020; Sutin et al., 2018). Also, given the routine focus on weight in PCP settings (e.g., discussing weight as an indicator of health), PCPs must try not to unintentionally perpetuate weight-based discrimination (e.g., relying solely on Body Mass Index to assess risk even though BMI tends to overestimate health risk in Black populations compared to White populations) when discussing health and body size. Overall, these results imply that understanding weight-based discrimination and intersecting experiences are a necessary future direction for improving BH discussions with PCPs and decreasing STB risk.

Facilitators

Regardless of prior discriminatory experiences, youth described supportive, caring providers as important facilitators for discussing BH concerns related to STBs. This was also detected in Aim 2 of the study. Previous research found similar themes where being connected, feeling respected, listened to and not judged facilitated MH help seeking (Radez et al., 2021; Wisdom et al., 2006). Feeling heard and believed may be especially valuable for youth who have been historically invalidated, dismissed, or discriminated against due to their marginalized identity. In fact, how providers behave and deliver interventions is a core cultural adaptation for psychotherapy for youth of color (Park et al., 2022). This facilitator is also consistent with models of both cultural competency and cultural humility, suggesting this may be a useful approach for increasing discussions about BH concerns and treatment options for a range of adolescents at risk of STBs (Huey, 2014).

Youth who experienced discrimination indicated that collaboration and autonomy with providers was an important facilitator to discussing their BH symptoms. As previously mentioned, increased autonomy during adolescence and involvement in medical-decision making is typically deemed developmentally appropriate (Brown & Wissow, 2010; Lee et al., 2010; Radovic et al., 2016). In fact, research shows that young people are more likely to seek treatment when doing so feels like their choice (Radez et al., 2021). Collaborative approaches in therapy have been especially touted with working with marginalized communities (Hope, 2022), and similarly, our findings reenforce that collaborative approaches are important for addressing BH concerns among adolescents who have experienced discrimination and are at risk of STBs. With this information, PCPs can support adolescent development, promote autonomy, and integrate collaborative care by delivering psychoeducation about risk factors and symptoms that require immediate intervention and describing treatment options so teens can engage in shared decision-making about their BH (Wisdom et al., 2006). Depending on teen's developmental level and family beliefs about promoting autonomy, PCPs may need to help teens establish privacy from caregivers in the office to encourage feelings of autonomy and honesty about teens' behavioral health concerns (Wisdom et al., 2006). Since caregivers in our study noted dissatisfaction that restricted involvement in adolescents' primary care prevented conversations about BH concerns, adolescents can be informed about potential benefits of collaborating with parents and be empowered to decide the extent of parental involvement. PCPs can also provide psychoeducation to parents that it is developmentally appropriate for adolescents to make some of their own decisions, and appropriately share information with parents.

Barriers

The mixed methods analysis illuminated how novel and previously identified barriers, from Aim 2, related to youth's experiences of discrimination. A key finding was that low salience or urgency of symptoms inhibited youth from discussing MH symptoms with PCPs, regardless of previous experiences of discrimination. Among youth who had not experienced discrimination, a common theme was the perception that PCPs are ineffective or inappropriate resources. Youth who had prior experiences of discrimination described provider misunderstandings and transgressions, along with a new, broader theme – negative experiences with providers. Interestingly, we see a potential division in the sample where there are youth who have not discussed BH concerns with PCPs but are hesitant due to low expectations, and youth who have experienced negative, culturally salient interactions with PCPs and now have low. This classification suggests that different approaches are needed to engage adolescents who have and have not experienced discrimination into BH discussions and treatment.

Challenges with recalling BH concerns may impact effective prevention for adolescent STBs. Consistent with literature about depressive symptoms (e.g., anhedonia), sleep challenges, and peer victimization being related to impaired memory function, it is possible that adolescents do not find the symptoms salient at the time because of difficulty retrieving that autobiographical information (Gradisar et al., 2006; Vaillancourt et al., 2011). Alternatively, adolescents at-risk of STBs may have a higher risk of other more acute socioemotional stressors and crises or be preoccupied with other aspects of their life (i.e., social interactions with peers) than recurring symptoms they may be desensitized to (i.e., lack of interest, sleep challenges). One potential solution is to utilize ecological momentary assessments (EMAs) in between PCP visits so adolescents may report symptoms when they are most salient, and thus prompt PCPs during appointments to discuss the symptoms and personalized intervention strategies for recurring symptoms (Rofey et al., 2010). Integration of EMAs could normalize, promote exploration, and guide treatment for BH concerns with PCPs to explore preventative measures if symptom salience increases at a later point. This may also address adolescents' preferences for disclosing information via electronic assessments rather than directly to an in-person provider (Bradford & Rickwood, 2015).

Youth who had previously experienced discrimination described providers misunderstanding their identities or displaying transgressions, and negative interactions with providers as barriers. The mixed-methods results suggest that some adolescents may be facing discriminatory encounters or misunderstandings based on more than one aspect of their identity (e.g., sexuality and religion). These multiple experiences of discrimination may decrease chances of effective and trusted communication about BH concerns with PCPs and thus increase STB risk (Burgess et al., 2008; Haussman et al., 2011; Williams et al., 2019). While cultural misunderstandings and transgressions are considered negative experiences, the examples of more general negative interactions that adolescents provided included PCPs not providing effective tools. Multi-generational transmission of such negative experiences can contribute to cultural mistrust (Lindsey et al., 2006), and so PCPs can play a role in reversing these effects by implementing the facilitators identified in this research and continuing to explore ways to increase inclusivity and social justice into PCP spaces. These multipronged efforts can work towards minimizing barriers that prevent adolescents who have experienced discrimination from disclosing and accessing care for the BH concerns that can potentially prevent STBs.

Strengths and Limitations

This study had several strengths ranging from the sample, methodology and insights derived from this research. The sample was comprised of notable heterogeneity and allowed us to integrate the perspective of adolescents with various majority and minoritized identities, which psychological research has not historically emphasized. The inclusion of both adolescents and their caregivers across multiple large health systems increases generalizability and addresses gaps in the current literature. This mixed-methods study involved the development of a codebook that was intended specifically for this research question, and unveiled nuanced results that would have been overlooked if using only a qualitative or only quantitative approach. Striking insights emerged about experiences of discrimination, especially weight-based discrimination and how intersecting identities relate to comfort when discussing BH concerns related to STBs. The consideration of sociocultural influences on communication patterns and STB risk, including at a systemic level, is another strength. Additionally, this research provides updates on the under recognition of sleep disturbances and OV in adolescent primary care, which have been previously underexplored in PCP settings.

Limitations included components of the interview and study design. The study would have benefitted from more detailed clarification and follow-up questions to get specific examples from participants during the interviews. About one-third of the sample were not asked to share experiences about cultural misunderstandings with providers, which likely limited the depth of findings on this important topic. This study did not include providers’ perspectives, which may have illuminated additional system-level barriers and beliefs that shape how BH discussions occur in PCP settings. Experiences of discrimination were conceptualized into binary categories which may not reflect the nuanced impacts of other individual and system-level discrimination.

Implications and Future Directions

Adolescents at risk of STBs experience BH concerns that need to be discussed more often and in a culturally sensitive way in PCP settings. This is essential so adolescents can engage in appropriate care. Efforts towards improving cultural sensitivity also importantly address the STB disparities that adolescents with marginalized identities face. Implications from this study support initiatives to improve provider's cultural sensitivity, increase timely integrated care potentially through integrated behavioral health care, and modify organization and system level structures to reduce sociocultural and policy barriers to accessing necessary treatment for BH concerns related to adolescent STBs.

Future directions stem from the limitations and implications. Specifically, research should continue to explore and prioritize marginalized youth's experiences of discussing STB risk factors with PCPs. These insights should inform modifications and collaborative strategies that can then be evaluated and refined. It is essential to understand how adolescents' experience of weight-based discrimination and other intersecting experiences or identities relate to their STB risk to improve detection and support for related BH concerns. Future research must explore how additional sociocultural factors and system-level structures may be impacting discussions and access to necessary care for adolescent STBs. Finally, efforts should be directed toward implementing and evaluating both individual and policy-level changes that aim to normalize discussions about adolescent BH concerns and STBs, increase access to culturally sensitive care.

Conclusion

Adolescents and caregivers described several barriers to and some facilitators they faced when speaking with PCPs about STB-related behavioral health concerns. Importantly, this research contributed perspectives from adolescents at-risk of STBs with various identities and caregivers, which have been less common in this field. Findings suggest a need to increase discussion of BH concerns in PCP settings to route adolescents to appropriate care, otherwise these conversations may not be occurring. PCPs can normalize discussions of STB-related concerns in primary care and organize more effective integrated behavioral health care. Promoting culturally humble assessment and immediate action (e.g., referrals, bringing in a mental health provider to teach skills) may especially facilitate these discussions. Experiences around facilitators and barriers also varied in relation to youth's experience with discrimination. Youth who had previously experienced discrimination from an adult shared challenges around their identity being misunderstood by providers and expressed the value in being provided autonomy and collaborative opportunities in PCP settings. Findings underscore the importance of co-creating strategies in primary and integrated care settings to improve care for youth with minoritized identities experiencing STBs.

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