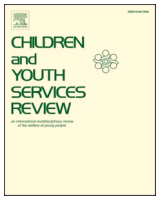
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Support needs of parents of adolescents with mental health problems: a quantitative study

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ABSTRACT

This study explores the support needs of parents of adolescents with mental health problems. Given the increasing prevalence of mental health problems among adolescents and the critical role of parents in their care, understanding these needs is essential for developing effective interventions. This study aimed to describe and prioritize the most frequently reported support needs, examine their associations with adolescents' characteristics (e.g., diagnosis, age, gender), and explore how these needs relate to parents' mental health. A total of 217 parents of adolescents aged 12–17 receiving mental health care participated. Parents reported their perceived support needs using a newly developed instrument (ISN-PAMH), along with measures of psychological distress and life satisfaction. Parents prioritize informational and educational support, particularly related to understanding mental health conditions, treatment options, and managing adolescent crises. Instrumental support from mental health and educational professionals was also highly valued. Significant differences in support needs were found across diagnostic categories, with parents of adolescents with comorbid internalizing and behavioral disorders reporting greater emotional and socio-emotional support needs, and parents of adolescents with neurodevelopmental disorders emphasizing emotional validation and community acceptance. Parents' perceived support needs were linked to their mental health, with higher support needs correlating with greater psychological distress and lower life satisfaction. These findings underscore the importance of providing families with multilevel support that addresses both adolescents' and parents' mental health. The study offers valuable insights for designing effective, family-centred mental health programs and policies.

1. Introduction

Adolescence is marked by significant transformations, including physical maturation, the development of self-regulation and complex reasoning, identity formation, and a heightened sensitivity to peer influence (Steinberg et al., 2014). These developmental changes influence family dynamics, particularly the parent–child relationship, often resulting in increased conflict and reduced warmth and communication (Oliva & Parra, 2023; Suizzo, 2020; Weymouth et al., 2016). This period requires substantial adaptation in parenting approaches and family functioning (Smetana & Rote, 2019). Parents must recalibrate behavioral management and monitoring strategies to support autonomy while maintaining clear boundaries. They also face challenges in expressing emotional support and adjusting communication styles (Lansford et al., 2023; Mak & Cheung, 2008; Oliva & Parra, 2023). In parallel, they play a critical role in equipping adolescents with competencies essential for adult life (Lansford et al., 2023). These evolving demands reshape family dynamics and introduce new developmental needs during this stage of life.

Parenting becomes significantly more complex when adolescents experience mental health problems. The typical challenges of this developmental stage are intensified, with significant implications for both family functioning and the well-being of parents (Cohn et al., 2020; Davis & Carter, 2008; Lobato et al., 2022; Pinquart, 2018). A recent systematic review and meta-analysis estimates the prevalence of diagnosed mental health disorders in adolescence at approximately 15%, with a higher incidence of internalizing problems (Sacco et al., 2024). This issue has been widely examined from various perspectives, consistently showing that greater symptom severity is associated with increased emotional and physical strain on parents (Gross et al., 2008;

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Martin et al., 2024; Meltzer et al., 2011). Additionally, social stigma and the difficulty of adjusting to adolescents' evolving needs have been identified as key factors negatively impacting parents' quality of life (Hurley et al., 2019; Martin et al., 2023). In this context, the accumulation of stress and uncertainty about the future can contribute to anxiety and depressive symptoms in parents (Gerkensmeyer et al., 2008; Hasson-Ohayon et al., 2014). Acute crises, such as self-harm or suicide attempts, can exacerbate this psychological burden, demanding constant coordination with specialized services and sustained support at home (Rodríguez-Meirinhos et al., 2018). In turn, compromised parental mental health not only reduces caregivers' capacity to offer consistent support and supervision but can also negatively influence the course of adolescents' psychopathology (Meltzer et al., 2011; Nicholson & Clayfield, 2004), hindering their recovery and limiting the effectiveness of therapeutic interventions (Campbell et al., 2021). Evidence further indicates that when parents themselves experience mental health problems, adolescents are at increased risk for developing or worsening psychiatric symptoms (e.g., Achtergarde et al., 2015; Hosman et al., 2009; Lieb et al., 2002).

Given the central role that parents play in adolescents' care and recovery, understanding their specific support needs is critical for designing interventions that address not only adolescents' symptoms but also the broader family environment that supports recovery (Miklowitz et al., 2020; Pine et al., 2024). Although adolescents' mental health problems affect the entire family system, parents are typically the primary caregivers and coordinate help-seeking, treatment, and day-to-day support. Identifying their support needs could therefore inform the development of targeted support programs that promote positive parenting and enhance parents' ability to manage the challenges of caring for a child with mental health problems (Pereira et al., 2024).

However, previous research has primarily focused on parents of children with disabilities or specific diagnoses, particularly autism spectrum disorders (e.g., Battanta et al., 2024; Smith & Anderson, 2014). Although these studies have provided valuable insights, there is limited understanding of the needs of parents of adolescents with a broader range of mental health problems (Martin et al., 2023). Additionally, much of the existing work relies on qualitative methods with small sample sizes (Rodríguez-Meirinhos et al., 2018), which limits generalizability and the development of scalable preventive efforts. In this regard, recent literature highlights the importance of expanding research to include more diverse clinical profiles and family contexts (Pereira et al., 2024).

There is broad consensus in the literature on the importance of providing these parents with clear, accessible information about mental health and available support resources (Hurley et al., 2019; Pereira, Wichaikhum, et al., 2024). Inadequate guidance can delay help-seeking and reinforce misconceptions about severity and prognosis (Hasson-Ohayon et al., 2014; Jivanjee et al., 2008), while contributing to feelings of uncertainty and diminished parental self-efficacy (Martin et al., 2024). In addition to information, parents require socioemotional support. Feelings of isolation and stigma can increase the risk of treatment dropout and undermine the therapeutic alliance, ultimately reducing the effectiveness of interventions aimed at adolescents (Hurley et al., 2019; van der Sanden et al., 2013).

At the practical level, strategies such as strengthening support networks, offering parents respite programs, and improving coordination among institutions have been proven effective in reducing parental burden and promoting continuity of care, particularly during the transition to adulthood (Johnson et al., 2019; Pereira, Wichaikhum, et al., 2024). These findings underscore the need for psychoeducational interventions that enhance parental competencies and foster supportive social environments, enabling parents to actively engage in their adolescents' recovery process (Arbuthnott & Lewis, 2015; Shorey & Pereira, 2023).

Despite these advances, further research is needed to assess the specific needs of parents of adolescents with mental health problems. Recent studies emphasize the importance of acknowledging family complexity and basing interventions on empirical evidence to ensure they accurately reflect families' lived experiences and are more likely to be effective (Hurley et al., 2019; Pereira, Wichaikhum, et al., 2024). Identifying specific support needs is central to meeting quality standards for evidence-based programs (Jiménez & Hidalgo, 2016). A systematic needs assessment would enable the design of tailored interventions to both the characteristics of the target population and the contexts in which they are implemented (Asmussen & Brim, 2018). Therefore, identifying the specific needs of parents of adolescents with mental health problems within the Spanish context is particularly relevant for shaping public policy and developing psychoeducational programs that align with local sociocultural factors and the structure of available services (Antolín-Suárez et al., 2016; Collishaw, 2015; Whiteford et al., 2013). This issue is particularly pressing in Spain, where adolescents' mental health has become an increasing public health and social concern. Available evidence points toward a high burden of mental health problems among Spanish adolescents. This burden has increased the demand for mental health services, while access to appropriate support remains limited (Ministerio de Sanidad, 2022, 2025; Ramos et al., 2024; Soriano et al., 2025). Within this context, and despite previous Spanish work emphasizing the need to generate evidence on family support needs and parenting competencies to design context-sensitive programs (Antolín-Suárez et al., 2016), quantitative evidence on the specific support needs prioritized by Spanish parents of adolescents receiving mental health care remains scarce. More broadly, there is a pressing need to promote comprehensive family support strategies that address not only adolescent mental health but also the well-being and positive parenting of caregivers (Arbuthnott & Lewis, 2015; Mak & Cheung, 2008).

Building on these considerations, this study aims to examine the support needs of parents of adolescents receiving care in mental health services. Specifically, the first objective is to identify the most frequently reported needs, prioritizing the types of support parents consider the most critical. To deepen this analysis, the second objective examines whether adolescent-related factors, such as diagnosis, are associated with variations in reported needs. Finally, the third objective explores the relationship between parents' perceived support needs and their mental health, operationalized through indicators of psychological well-being (life satisfaction) and psychological distress.

2. Method

2.1. Participants

The sample for the present study comprised 217 parents of adolescents (54% girls, 46% boys) aged 12 to 17 years ($M = 14.39$, $SD = 1.65$) who were receiving care in mental health services. The majority of respondents were mothers (86.2%, $n = 187$), with fathers comprising 13.8% ($n = 30$). The mean age of the parents was 46.01 years ($SD = 5.94$). No significant differences were found between mothers and fathers in terms of age, $t(32.11) = -1.78$, $p = .08$, or educational level, $\chi^2(3) = 7.66$, $p = .054$.

According to parent reports, 70.9% of adolescents lived in two-parent households, 20.8% in single-parent households, and 8.3% in reconstituted families. Regarding socioeconomic status, 46.8% of households had a monthly income between €1000 and €2000, 29.2% had a monthly income below €1000, and 24% had a monthly income above €2000.

Parents also reported that 38.6% of adolescents had been receiving mental health care for more than three years. Information on adolescents' mental health diagnoses was obtained from their treating clinicians. The sample comprised adolescents with behavioral disorders (13.4%), internalizing disorders (37.3%), comorbid internalizing and behavioral disorders (13.4%), and neurodevelopmental disorders (35.9%).

2.2. Instruments

Sociodemographic and clinical data. Sociodemographic information was collected through an ad hoc questionnaire specifically designed for this study. Parents reported their own gender and age, family structure, time receiving mental health care, monthly household income, and other relevant sociodemographic characteristics. In addition to parent-reported information, data on adolescents' primary mental health diagnoses were obtained from their treating clinicians. Diagnoses were based on ICD-10 codes and were grouped into four diagnostic categories for the analyses to differentiate broad diagnostic profiles while maintaining a parsimonious classification that allowed meaningful statistical comparisons across groups. The four diagnostic groups used in the analyses were: (1) behavioral disorders (e.g., oppositional defiant disorder, conduct disorder, and disruptive behavior disorder); (2) internalizing disorders (e.g., anxiety disorders, mood disorders, and eating disorders); (3) comorbid internalizing and behavioral disorders; and (4) neurodevelopmental disorders (e.g., autism spectrum disorder, attention-deficit/hyperactivity disorder, and tic disorders).

Parents' support needs. Perceived support needs were assessed using the *Inventory of Support Needs for Parents of Adolescents with Mental Health Problems* (ISN-PAMH), an ad hoc instrument developed for this study. The inventory consists of 53 items, with parents rating the relevance of each need for themselves and their family on an 11-point Likert scale ranging from 0 (*not at all necessary*) to 10 (*very necessary*). Participants were instructed to respond based on their current situation. The full English and Spanish versions of the instrument are provided in Appendix A.

The ISN-PAMH was developed based on the taxonomy of parental needs identified in the systematic review by Rodríguez-Meirinhos et al. (2018). The 82 support needs identified in the review served as the conceptual framework for the development of the inventory. During the item development process, these support needs were operationalized into 53 inventory items. In most cases, a single support need was represented by one inventory item. However, conceptually similar support needs were combined into a single item to reduce redundancy and improve the feasibility of the inventory. In addition, support needs that were less frequently identified in the systematic review were not represented as separate items, contributing to a concise and practical inventory. Thus, participants completed the final 53-item of the inventory.

Following House's (1981) conceptualization of social support, the selected needs were categorized into three main types (i.e., informational, socioemotional, and instrumental support), further divided into ten specific dimensions. Content validity was established through expert review by a panel of professionals in clinical psychology, mental health, family intervention, and caregiving. The panel comprised one clinical psychologist with expertise in child and adolescent mental health and family interventions, one psychologist from social services specializing in family intervention, one primary care physician specializing in family care, and two researchers with extensive experience in parenting support, adolescence, and psychometric instrument development. The experts ranged in age from 35 to 63 years ($M = 49.40$, $SD = 13.39$) and were selected based on their expertise and availability. Each expert independently reviewed the inventory items and identified those requiring revision in terms of conceptual relevance, consistency with the theoretical framework, or clarity of wording. The research team compiled and compared all feedback. When differing opinions or suggestions arose, the team contacted the experts as needed to clarify the issues and reach consensus regarding the final wording and inclusion of the items in the inventory.

Table 1 presents an overview of the inventory's structure. Reliability analyses indicated strong internal consistency, with Cronbach's alpha coefficients ranging from .68 to .94. Detailed reliability statistics for each category and dimension can be found in Table 2.

Life satisfaction. Life satisfaction was assessed using the 5-item *Satisfaction with Life Scale* (SWLS; Diener et al., 1985; Spanish

Table 1
Categories and Dimensions of the ISN-PAMH.

Category	Dimension (item range)
Informational and Educational Support (IES): Encompasses the provision of information, guidance, and educational support related to mental health conditions, available services and rights, and effective parenting practices for caregivers of adolescents with mental health problems	(1) *Guidance on Mental Health Issues*: Includes informational and educational support regarding diagnosis and potential treatment options (Items 1 and 2). (2) *Guidance on Resources, Services, and Rights:* Includes information about support services, educational and employment opportunities, and legal rights available to adolescents with mental health problems and their families (Items 3 to 6). (3) *Guidance on Parenting Issues:* Includes informational and educational support related to the developmental processes of adolescents with mental health problems and effective parenting strategies (Items 7 to 14).
Socio-Emotional Support (SES): Refers to the support aimed at addressing caregivers' emotional needs and fostering their sense of connection and acceptance within their social environment. This includes managing emotional responses to their child's mental health problems (e.g., fear, frustration, guilt) and seeking understanding, validation, and encouragement from family, peers, and the broader community.	(4) *Emotional Support:* Involves support aimed at helping caregivers cope with the emotional impact of their child's mental health problems, including feelings of fear, frustration, helplessness, guilt, and loss, as well as fostering acceptance, optimism, parental self-efficacy, and emotional well-being (Items 15 to 25). (5) *Community Acceptance and Informal Support Network:* Reflects the need for societal understanding and acceptance of adolescents with mental health problems, as well as the importance of support from family, friends, and other caregivers in similar situations (Items 26 to 30).
Instrumental Support (IS): Related to the provision of tangible help and assistance from social educational or healthcare services.	(6) *Support for Caregiver Rest and Well-being*: Refers to tangible support that enables caregivers to attend to their own physical and emotional needs. This includes having time for rest and self-care, maintaining relationships with others, and accessing medical or psychological services to address health problems related to caregiving stress (Items 31 to 35). (7) *Economic Resources and Service Availability:* Refers to structural and practical support that enables caregivers to balance employment with caregiving responsibilities, and ensures the existence of inclusive leisure, vocational, and residential services tailored to adolescents with mental health conditions (Items 36 to 37). (8) *Support from Educational Services and Professionals:* Refers to the practical and institutional support provided by educational settings and staff to ensure the inclusion, non-discrimination, and adequate response to the needs of adolescents with mental health problems. This includes teacher training, the use of inclusive materials, and school-based strategies to manage challenges without overburdening families (Items 38 to 40). (9) *Support from Mental Health Services and Treatments:* Reflects the need for structural and organizational support that enhances the responsiveness, accessibility, coordination, and continuity of mental health care, while promoting family involvement in

(*continued on next page*)

Table 1 (*continued*)

Category	Dimension (item range)
	decision-making and crisis management (Items 41 to 47). (10) *Support from Mental Health Professionals:* Refers to professional-level support characterized by clinical expertise, respectful and nonjudgmental treatment, clear and honest communication, continuity in care, and responsiveness to the needs of both adolescents and their caregivers (Items 48 to 53).

Table 2
Means, standard deviations, and Cronbach's alpha coefficients for the ISN-PAMH categories and dimensions.

ISN-PAMH categories and dimensions	*M*	*SD*	*α*
Informational and Educational Support	7.94	2.07	.93
Guidance on Mental Health Issues	8.25	2.34	.75
Guidance on Resources, Services, and Rights	8.03	2.11	.80
Guidance on Parenting Issues	7.82	2.33	.91
Socio-Emotional Support	7.16	2.47	.94
Emotional Support	6.95	2.71	.94
Community Acceptance and Informal Support Network	7.60	2.73	.91
Instrumental Support	7.46	2.16	.92
Support for Caregiver Rest and Well-being	6.60	2.88	.88
Economic Resources and Service Availability	7.24	3.06	.68
Support from Educational Services and Professionals	8.27	2.49	.84
Support from Mental Health Services and Treatments	7.04	2.65	.87
Support from Mental Health Professionals	8.32	2.43	.91

Note. Correlations among the ISN-PAMH dimensions ranged between .24 and .67.

validation by Atienza et al., 2000). Participants rated items (e.g., "In most ways my life is close to ideal") on a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree), with higher scores indicating greater life satisfaction. In the current study, the scale demonstrated high internal consistency (Cronbach's α = .89).

Psychological distress. Psychological distress was measured using the 28-item *General Health Questionnaire* (GHQ-28; Goldberg, 1972; Spanish validation by Lobo et al.,1986). This widely used instrument evaluates psychological problems experienced in the past few weeks across four dimensions: somatic symptoms, anxiety and insomnia, social dysfunction, and depressive symptoms. Participants responded to items (e.g., "Lost much sleep over worry?") on a 4-point Likert scale ranging from 0 (not at all) to 3 (much more than usual), with higher scores indicating greater psychological distress. Internal consistency for the total scale was excellent (Cronbach's α = .89).

2.3. Procedure

The present study used data from a broader research project aimed at identifying the support needs and parenting competencies of families of adolescents with mental health problems. The project focused on families of adolescents receiving care within the Andalusian public mental healthcare system to better understand their support needs and inform the development of services and family interventions. It adopted a multi-informant design, collecting information from adolescents, their primary caregivers, and treating clinicians.

Participants were recruited through 12 second- and third-level public mental health services of the Andalusian Public Health System, specifically Community Mental Health Units and Child and Adolescent Mental Health Units located in southern Spain.

Eligible participants were mothers, fathers, or primary caregivers of adolescents aged 12–17 years who were currently receiving mental health care. Participants were also required to reside in the same household as the adolescent and to be their primary caregiver. Because the broader project required participation from both the adolescent and the primary caregiver, and both were expected to complete a battery of self-report measures, families were excluded if either the adolescent or the caregiver had an intellectual disability or was experiencing an acute mental health crisis that could compromise the valid completion of the assessment.

Clinicians working in the participating services were informed about the study and trained on the inclusion and exclusion criteria. They identified 522 potentially eligible families, informed the primary caregiver about the study, and requested permission for the research team to establish contact. Families were subsequently selected using a quota sampling strategy based on four variables: adolescent gender (female or male), age group (12–14 or 15–17 years), primary referral problem (externalizing, internalizing, or other —e.g., social, attentional, or thought problems—, following Achenbach & Rescorla, 2001), and caregivers' highest educational level (basic education: primary, secondary, or vocational training; or higher education: high school diploma, advanced vocational training, or university degree). The target was a minimum of 10 participants per subgroup; however, this was not achieved in seven subgroups because of the limited number of eligible families. The overall participation rate was 75.96%, resulting in 230 participating families.

Although the broader project collected information from adolescents, primary caregivers, and clinicians, the present study focused on data provided by parents. Therefore, families in which the primary caregiver was not the adolescent's mother or father (n = 5) were excluded because their number was insufficient to constitute a meaningful comparison group. In addition, families of adolescents with psychotic disorders (n = 8) were excluded because the sample size was too small to permit meaningful comparisons across diagnostic categories. Consequently, the final sample comprised 217 parents.

Data collection took place during a one-hour assessment session at the participating mental health services. Adolescents and their primary caregivers completed the study measures independently, while clinicians provided information on adolescents' mental health diagnoses. Written informed consent was obtained from all participants prior to data collection. No financial compensation was provided. The study was approved by the Biomedical Research Ethics Committee of Andalusia (Spain).

2.4. Data analyses

Primary statistical analyses were conducted using IBM SPSS version 29. Descriptive statistics were first calculated to characterize the sample and summarize parents' perceived support needs. Means and standard deviations were computed for the ISN-PAMH categories and dimensions, as well as for each individual item. To identify the support needs most strongly prioritized by parents, ISN-PAMH items were ranked from highest to lowest mean score. The highest-ranked 33% of items (i.e., the 17 items with the highest mean scores) were highlighted to provide a descriptive summary of the most salient needs reported by parent.

To examine the associations between adolescent-related variables and parents' perceived support needs, a series of univariate analyses of variance (ANOVAs) were conducted for each ISN-PAMH categories and dimensions. Adolescent gender, age, time receiving mental health care, and diagnostic category were examined as grouping variables. This approach was selected because the aim was to identify whether specific categories and dimensions of parents' perceived support needs differed according to adolescent-related characteristics. For grouping variables with more than two categories, Bonferroni-adjusted post hoc comparisons were conducted.

Prior to the ANOVAs, univariate normality was inspected using skewness and kurtosis values and normality plots. Homogeneity of variances was evaluated using Levene's test. The ISN-PAMH variables

showed some deviations from normality, mainly negative skewness, consistent with the generally high levels of support needs reported by parents. When Levene's test indicated unequal variances, Welch's ANOVA was inspected and the corresponding results were interpreted with caution. For grouping variables with more than two categories, Bonferroni-adjusted post hoc comparisons were conducted.

Finally, Pearson correlation analyses were conducted to examine the associations between parents' perceived support needs and their mental health, as indicated by life satisfaction and psychological distress. Statistical significance was set at $p < .05$.

3. Results

3.1. Parents' support needs

Descriptive statistics for the ISN-PAMH categories and dimensions are presented in Table 2. Overall, parents reported moderate to high levels of perceived support needs across all dimensions, with particularly elevated scores in the *Informational and Educational Support* category. Among specific dimensions, *Support from Mental Health Professionals* and *Guidance on Mental Health Issues* emerged as the most highly rated needs. In contrast, lower mean scores were observed for the *Support for Caregiver Rest and Well-being* dimension.

Item-level descriptive statistics are shown in Table 3, where items are ranked from highest to lowest mean score. The 17 highest-rated items are highlighted to illustrate the needs most strongly prioritized by parents.

As shown in Table 3, the highest-rated support needs were mainly related to *Instrumental Support*. Within this category, parents particularly prioritized continuity of care, access to clinicians with specialized expertise in adolescent mental health, inclusive practices in educational settings, clear and honest communication about treatment and prognosis, and continuous follow-up aimed at preventing crises.

Informational and Educational Support needs were also prominent, especially those related to understanding their adolescent's mental health problems, managing symptoms and crises, setting limits and rules, improving communication, and distinguishing normative adolescent behaviour from warning signs of mental health difficulties.

3.2. Relationship between adolescent characteristics and parents' support needs

Differences in parents' perceived support needs were examined according to adolescent gender, age, time receiving mental health care, and diagnostic category.

Analyses by adolescent gender revealed a statistically significant difference in the *Educational Services and Professionals* dimension, ($F(1) = 7.46$, $p < .001$, $\eta^2 = .03$). Parents of boys reporting higher support needs in this dimension ($M = 8.77$, $SD = 2.02$) than parents of girls ($M = 7.84$, $SD = 2.79$). No other significant gender differences were identified across the other ISN-PAMH categories and dimensions.

Regarding time receiving mental health care , a significant difference emerged for the *Educational Services and Professionals* dimension ($F(1) = 2.73$, $p = .03$, $\eta^2 = .05$). Parents of adolescents who had been receiving mental health care for more than three years reported higher support needs ($M = 8.85$, $SD = 2.01$) than those whose child had been receiving care for less than six months ($M = 7.34$, $SD = 3.08$). No significant associations emerged between adolescent age and any of the ISN-PAMH categories or dimensions.

Significant differences were also found across adolescents' diagnostic categories for several ISN-PAMH categories and dimensions. Specifically, diagnostic category was significantly related to *Socio-Emotional Support* ($F(3) = 4.30$, $p < .01$, $\eta^2 = .05$), *Instrumental Support* ($F(3) = 2.97$, $p = .03$, $\eta^2 = .04$), *Emotional Support* ($F(3) = 3.31$, $p = .02$, $\eta^2 = .04$), *Community Acceptance and Informal Support Network* ($F(3) = 6.92$, $p < .001$, $\eta^2 = .09$), *Economic Resources and Service Availability* ($F(3) = 2.84$, $p = .04$, $\eta^2 = .03$), *Support from Educational Services and Professional* ($F(3) = 6.39$, $p < .001$, $\eta^2 = .08$), and *Support from Mental Health Professionals* ($F(3) = 4.40$, $p < .01$, $\eta^2 = .06$). No other ISN-PAMH categories or dimensions showed significant differences based on diagnostic category.

Post hoc analyses (see Table 4) revealed differential prioritization of support needs across diagnostic groups. Specifically, parents of adolescents with comorbid internalizing and behavioral disorders reported the highest needs in *Socio-Emotional Support* and *Emotional Support*. Parents of adolescents with neurodevelopmental disorders also reported elevated needs, particularly in C*ommunity Acceptance and Informal Support Network*, *Instrumental Support*, *Support from Educational Services and Professionals*, and *Support from Mental Health Professionals*. In contrast, parents of adolescents with behavioral disorders generally reported lower perceived needs across most categories and dimensions.

3.3. Relationship between parents' support needs and their mental health

Pearson correlation between the ISN-PAMH categories and dimensions, life satisfaction, and psychological distress are presented in Table 5.

Higher levels of perceived support needs were generally associated with lower levels of life satisfaction and higher levels of psychological distress across multiple categories and dimensions. The strongest relationships were observed in the *Emotional Support* dimension, where greater need was significantly correlated with both reduced life satisfaction and increased psychological distress.

Additionally, a higher perceived need for *Guidance on Parenting Issues* was linked to poorer psychological outcomes. Similarly, the need for *Support for Caregiver Rest and Well-being* also showed notable associations with both measures.

4. Discussion

The purpose of this study was to examine the support needs of parents of adolescents with mental health problems, focusing on the support needs parents prioritize and whether these needs differ by adolescent-related variables, such as adolescent diagnostic category. Additionally, this study examined the relationship between parents' perceived support needs and their mental health, operationalized through indicators of psychological well-being (life satisfaction) and psychological distress.

Consistent with recent systematic reviews (Martin et al., 2025; Rodríguez-Meirinhos et al., 2018) and previous studies on the needs of caregivers of adolescents with mental health or neurodevelopmental disorders (Baena et al., 2023; Brown et al., 2012; Colombet et al., 2023), parents identified informational and educational support as their most critical needs. Specifically, they emphasized the importance of receiving clear information to help them understand and manage their child's mental health difficulties, differentiate clinical symptoms from normative adolescent behaviour, and navigate treatment and medication-related issues (Martin et al., 2025).

This finding is consistent with previous research indicating that parents often perceive themselves as having limited knowledge about available resources as well as the symptoms and warning signs of mental health disorders (Ward & Gwinner, 2014). Indeed, a lack of clear guidance on where to seek help is one of the main barriers to adolescents accessing mental health services (Hansen et al., 2021). Frequently, parents must independently seek out this information, rather than receiving it directly from professionals (Brown et al., 2012). Even when information is provided at the outset, it is often perceived as useful but insufficient, frequently overly medicalized and lacking a holistic approach (Ahmed et al., 2014; Harden, 2005), which can contribute to parental feelings of helplessness (Harden, 2005). Conversely, access to adequate, ongoing information can promote parenting reskilling and empower caregivers (Harden, 2005). Therefore, it is crucial to ensure

Table 3
Ranking of support needs.

Rank	(Item number) Item content	Category	*M*	*SD*
1	(53) That my child is always seen by the same doctors or psychologists	IS	8.70	2.61
2	(48) That health professionals have experience treating adolescents with mental health problems	IS	8.68	2.67
3	(39) That my child's school uses resources and materials that do not discriminate against students with mental health problems	IS	8.57	2.65
4	(50) That health professionals provide honest information and use clear language about my child's treatments, medication, and progress	IS	8.53	2.86
5	(38) That my child's teachers have experience working with adolescents with mental health problems	IS	8.39	2.70
6	(5) Information about education and employment options for my child	IES	8.30	2.29
7	(1) Information about my child's mental health problems (diagnosis, symptoms, treatments)	IES	8.28	2.72
8	(9) Training on how to manage my child's symptoms and crises	IES	8.26	2.83
9	(10) Training about how to put limits and resolve conflicts with my child	IES	8.24	2.79
10	(2) Training to differentiate between typical adolescent behavior and signs of mental health problems	IES	8.23	2.53
11	(11) Training to improve communication and provide support to my child	IES	8.22	2.81
12	(3) Information about resources and support services for adolescents under 18 years old with mental health problems and their families	IES	8.21	2.63
13	(47) That mental health services provide continuous follow-up to prevent problems, not only intervene during crises	IS	8.18	2.49
14	(6) Information about the rights of adolescents with mental health problems and their families, especially when turning 18	IES	8.20	2.48
15	(28) That my child's teachers and peers understand and accept his/her mental health challenges	SES	8.15	2.89
16	(7) Information about the changes my child will experience during adolescence (friendships, autonomy, sexuality)	IES	8.07	2.49
17	(52) That mental health professionals are available when my child suffers a crisis	IS	8.06	3.07
18	(51) That mental health professionals listen to and consider the family's opinions in treatment decisions	IS	8.01	3.01
19	(46) That mental health services continue involving the families after the child turns 18	IS	7.99	3.05
20	(49) That mental health professionals are respectful and do not blame the family for my child's mental health problems	IS	7.95	3.20
21	(8) Training to help my child be more autonomous	IES	7.92	2.82
22	(40) That the school can address issues with my child without constantly calling the family	IS	7.87	3.15
23	(37) That there are leisure activities, educational and employment opportunities, and residential services accessible and adapted to adolescents with mental health problems	IS	7.87	3.32
24	(12) Training to adapt to the new responsibilities of being a parent of an adolescent with mental health problems	IES	7.75	2.98
25	(18) Support to cope with helplessness and frustration when my child does not improve	SES	7.61	3.17
26	(29) That my child's friends understand and accept his/her mental health challenges	SES	7.59	3.23
27	(13) Guidance on how to organize the family life after knowing that my child suffers from a mental health problem (task division, schedule…)	IES	7.57	2.91

(*continued on next page*)

Table 3 (*continued*)

28	(26) That society understands and accepts my child's mental health problems	SES	7.57	3.13
29	(41) That mental health services improve the care they provide (shorter wait times, more frequent appointments, availability during holidays)	IS	7.55	3.18
30	(19) Support to remain optimistic about my child's future	SES	7.52	2.96
31	(30) To have the support of friends, relatives, and other parents of adolescents with mental health problems	SES	7.43	3.07
32	(4) Information about resources and support services for adolescents over 18 and their families	IES	7.43	3.16
33	(27) That extended family members understand and accept my child's mental health problems	SES	7.29	3.48
34	(24) Support to manage anger and frustration when my child's behavior affects the family	SES	7.19	3.34
35	(23) Support to cope with helplessness and frustration when unable to help my child during a crisis	SES	7.18	3.30
36	(15) Support to accept and understand my child's mental health problems	SES	7.16	3.44
37	(16) Support to manage fears that my child's symptoms are out of control and could lead to self-harm or harm to others	SES	7.15	3.60
38	(20) Support to feel more confident and competent as a parent	SES	7.04	3.23
39	(42) That mental health services better address my child's needs	IS	7.02	3.42
40	(31) Time to rest and take care of myself	IS	6.95	3.32
41	(32) Access to caregiver support services	IS	6.95	3.35
42	(35) Access to medical or psychological help for caregiver health issues caused by anxiety, stress, and insomnia	IS	6.87	3.55
43	(17) Support to manage frustration caused by how mental health services operate (access barriers, few appointments, legal limits on family involvement)	SES	6.85	3.49
44	(43) That mental health services consider and address my needs as a caregiver	IS	6.67	3.37
45	(36) Access to financial help and support to balance caregiving and work	IS	6.62	3.70
46	(14) Guidance to help siblings understand and adapt to my child's mental health problems	IES	6.54	3.77
47	(45) That mental health services improve coordination among professionals and services	IS	6.48	3.76
48	(25) Support to process feelings of loss from family changes (future plans, network of friends, employment, and finances)	SES	6.28	3.64
49	(22) Support to not feel guilty about my child's mental health problems (not being a good mother, not noticing the problems before, not attending to his/her needs…)	SES	6.28	3.83
50	(21) Support to manage fears about my child becoming more independent and autonomous	SES	6.26	3.67
51	(34) More time to spend with my partner or friends	IS	6.24	3.54
52	(33) More time to spend with my other children or family members	IS	6.03	3.64
53	(44) That mental health services listen to and consider the family's opinions when admitting my child for emergency care	IS	5.65	4.09

Note. IES = Informational and Educational Support; SES = Socio-Emotional Support; IS = Instrumental Support.

that parents receive continuous, accessible information, particularly regarding where and how to obtain support. This information should ideally come from educational and health professionals but can also be disseminated through public websites and other accessible platforms (Martin et al., 2025).

Beyond informational needs, parents also emphasized the need for training and support to strengthen core parenting competencies, such as communication skills and the ability to set appropriate norms and boundaries. Positive parenting, characterized by open communication, warmth, clear limits, and autonomy promotion, has been linked to fewer anxiety symptoms in adolescents (Nieto-Casado et al., 2022). Previous research has also shown that parents of adolescents with mental health problems often report low levels of parental self-efficacy (Martin et al., 2025). Many describe modifying their parenting style, either by avoiding conflict or by becoming overly controlling and overprotective, in response to their child's difficulties. These adjustments are frequently accompanied by feelings of frustration, exhaustion, and, at times, a sense of failure in fulfilling their caregiving role (Harden, 2005; Martin et al., 2025). Addressing these challenges calls for more comprehensive parenting support, offering multilayered and diverse forms of support (Kuhn & Laird, 2014; Martin et al., 2025). Programs should prioritize the promotion of positive parenting practices that can promote the positive development of adolescents with mental health problems (Nieto-Casado et al., 2022).

Continuing with parents' perceived support needs, *instrumental support*, particularly from educational and mental health professionals, emerged as one of the highest priorities. These results are consistent with previous research on families of children and adolescents with

Table 4
Descriptive statistics and mean differences in ISN-PAMH categories and dimensions across adolescents' diagnostic categories.

	BD		ID		CD		ND	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Informational and Educational Support	7.22_{a}	2.55	7.86_{a}	2.01	8.46_{a}	2.07	8.10_{a}	1.88
Guidance on Mental Health Issues	7.39_{a}	2.59	8.29_{a}	2.34	8.67_{a}	2.39	8.36_{a}	2.20
Guidance on Resources, Services, and Rights	7.28_{a}	2.51	8.01_{a}	2.03	8.52_{a}	1.69	8.14_{a}	2.13
Guidance on Parenting Issues	7.15_{a}	2.85	7.67_{a}	2.27	8.37_{a}	2.41	8.02_{a}	2.09
Socio-Emotional Support	6.14_{a}	2.83	6.83_{ab}	2.59	8.13_{b}	2.29	7.51_{ab}	2.10
Emotional Support	6.00_{a}	2.93	6.77_{ab}	2.67	8.15_{b}	2.35	7.05_{ab}	2.69
Community Acceptance and Informal Support Network	6.45_{a}	3.03	6.96_{a}	3.16	8.07_{ab}	2.91	8.51_{b}	1.50
Instrumental Support	6.79_{a}	2.75	7.28_{a}	2.22	7.16_{a}	2.63	7.99_{a}	1.46
Support for Caregiver Rest and Well-being	5.95_{a}	3.21	6.30_{a}	3.02	6.73_{a}	3.06	7.10_{a}	2.47
Economic Resources and Service Availability	6.74_{ab}	3.25	6.67_{a}	3.20	7.29_{ab}	3.21	8.00_{b}	2.64
Support from Educational Services and Professionals	7.96_{ab}	2.86	7.53_{a}	2.74	8.24_{ab}	3.05	9.17_{b}	1.31
Support from Mental Health Services and Treatments	6.44_{a}	3.00	7.20_{a}	2.55	6.51_{a}	3.33	7.28_{a}	2.29
Support from Mental Health Professionals	7.32_{a}	3.19	8.26_{ab}	2.56	7.70_{ab}	3.15	8.98_{b}	1.22

Note. BD = Behavioral Disorders; ID = Internalizing Disorders; CD = Comorbid Internalizing and Behavioral Disorders; ND = Neurodevelopmental Disorders. Means with different subscripts indicate statistically significant differences ($p < .05$) between groups, as determined by Bonferroni post hoc comparisons.

Table 5
Correlations between ISN-PAMH categories and dimensions and parents' life satisfaction and psychological distress.

	Life Satisfaction	Psychological Distress
Informational and Educational Support	-.16*	.24***
Guidance on Mental Health Issues	-.14*	.16*
Guidance on Resources, Services, and Rights	-.08	.18**
Guidance on Parenting Issues	-.17*	.26***
Socio-Emotional Support	-.18**	.30***
Emotional Support	-.22**	.34***
Community Acceptance and Informal Support Network	-.04	.15*
Instrumental Support	-.10	.25***
Support for Caregiver Rest and Well-being	-.15*	.27***
Economic Resources and Service Availability	-.07	.20**
Support from Educational Services and Professionals	-.09	.13*
Support from Mental Health Services and Treatments	-.05	.24***
Support from Mental Health Professionals	-.06	.14*

Note. *$p < .05$; **$p < .01$; ***$p < .001$.

neurodevelopmental disorders, which has identified instrumental support as crucial (Baena et al., 2022, 2024; Brown et al., 2012). Notably, parents' perceptions of social support are not only closely linked to parental wellbeing (Dunst, 2022; Dunst, 2023) but also to their children's mental health outcomes (Yan et al., 2024). Both formal and informal support have been identified as key predictors of family well-being, particularly in households raising children with neurodevelopmental conditions, and especially as children mature (Dunst, 2023).

In contrast, support needs concerning parental wellbeing were the least frequently reported, a pattern consistent with what Martin et al. (2025) describe as the "self-care paradox". Parents of adolescents receiving mental health services tend to prioritize their children's well-being over their own, viewing themselves primarily as facilitators of their child's recovery. This dynamic can foster feelings of shame, guilt, or embarrassment when contemplating their own needs, creating barriers to seeking self-care (Martin et al., 2025). Such emotions are often tied to the sense of not deserving self-care (Martin et al., 2025) or the notion that personal needs should be kept private (Armitage et al., 2020; Stapley et al., 2016). Some parents even perceive their own well-being as secondary or dependent on their child's, further reinforcing the tendency to neglect themselves in favour of focusing entirely on their child. However, as Antolín-Suárez et al. (2025) emphasize, this perspective often overlooks a fundamental principle: caring for oneself is essential to effectively care for others—a concept often captured by the "oxygen mask" metaphor, where parents must secure their own mask before assisting their children. Supporting this, research shows that when parents experience greater satisfaction of their own psychological needs, they are more likely to engage in positive parenting practices, which in turn promote the satisfaction of their children's psychological needs (Rodríguez-Meirinhos et al., 2021).

The results also revealed significant differences in parents' perceived support needs depending on their child's diagnosis. Specifically, parents of adolescents with behavioral disorders reported fewer overall support needs, while those of adolescents with comorbid internalizing and behavioral disorders reported higher levels of socio-emotional and emotional support needs. This pattern is consistent with prior research indicating that internalizing–externalizing comorbidity is associated with specific challenges, such as poorer overall functioning and increased use of mental health services compared to children with a single diagnosis (Essau & de la Torre-Luque, 2021; Oland & Shaw, 2005) or those with comorbid internalizing disorders (Dol et al., 2022).

These findings also align with research on the families of children with intellectual disabilities. For instance, Douma et al. (2006) found that parents of children with intellectual disability and comorbid emotional and behavioral problems reported greater support needs than those whose children had only one comorbid condition (Douma et al., 2006). In addition, evidence suggests that children and adolescents with co-occurring symptoms may respond differently to treatment (Pliszka, 1989) and may require more comprehensive interventions, thereby increasing parents' emotional support needs (Russo & Beidel, 1994). Overall, parents of adolescents with comorbid internalizing–externalizing disorders may face additional and unique demands compared to families of adolescents with a single diagnosis or other forms of comorbidity. This variability underscores the importance of tailoring support services to address the distinct characteristics and needs of different family profiles.

This study also found that parents of adolescents with neurodevelopmental disorders (i.e., autism, ADHD, tic disorders) reported higher support needs related to community awareness and support from educational and mental health professionals. Notably, time receiving mental health care was not related to perceived support needs, suggesting a persistent demand for continuous support among these families, who often face long-term challenges (Brown et al., 2012; Derguy et al., 2015). These parents regularly deal with social stigma and prejudice, from the point of diagnosis through their child's development, often feeling judged and misunderstood (Laugesen & Groenkjaer, 2015; Mazumder & Thompson-Hodgetts, 2019; Trew, 2024). Improving social awareness is consistently identified as one of the most pressing concerns among parents and extended family members (Baena et al., 2024; Mazumder & Thompson-Hodgetts, 2019; Trew, 2024). Compared to

caregivers of children with other mental health conditions, families of individuals with autism are more likely to report adverse family impact, lack of service coordination, and difficulties accessing appropriate care (Vohra et al., 2014). Similarly, parents of children with ADHD often describe their experience as an ongoing "battle with services" (Laugesen & Groenkjaer, 2015), further increasing their dependence on professional and institutional support.

Evidence also suggests that the educational system represents a particularly stressful context for these families (Trew, 2024). Parents often describe it as a "battlefield" (Laugesent & Groenkjaer, 2015), expressing concerns about bullying during adolescence (Elkins et al., 2003), poor coordination with teachers (Baena et al., 2022; Laugesen & Groenkjaer, 2015), and dissatisfaction with educators' training and attitudes (Baena et al., 2022). Although some families report high satisfaction with the services they receive (Srinivasan et al., 2021), the social inclusion of their children in school remains one of the most pressing needs (Brown et al., 2012). Consequently, support needs related to the educational system tend to be higher among parents of adolescents with neurodevelopmental disorders compared to those caring for youngsters with other mental health conditions.

Importantly, this study also found that most reported support needs were associated with greater psychological distress, while needs related to guidance on mental health and parenting, emotional support, and support for caregiver rest and wellbeing were linked to lower levels of life satisfaction. These findings are consistent with previous research establishing that unmet support needs among parents of children and adolescents with autism or medical conditions were related to lower parental wellbeing and satisfaction, alongside high levels of emotional distress (Ekas et al., 2023; Kim & Lee, 2025). Paradoxically, although parents did not prioritize needs related to emotional support and caregiver rest and wellbeing, these needs showed some of the strongest associations with both negative and positive indicators of parents' mental health. As noted earlier, parents often prioritize their child's needs above their own, frequently experiencing guilt or shame when considering self-care (Martin et al., 2025). Nonetheless, substantial evidence indicates that parental well-being is closely linked to adolescents' mental health outcomes (Adhikari et al., 2025; Giannakopoulos et al., 2009), with negative parenting practices acting as a mediator in this relationship (Adhikari et al., 2025).

Taken together, these findings underscore the need for family-centred interventions within mental health services. Traditionally, parent-focused interventions have centred on behavioral parent training and behaviour management strategies (e.g., *The Incredible Years* Program, *The Triple P* Program), which have shown efficacy in addressing externalizing behaviours (Fonagy et al., 2015) and comorbid internalizing difficulties (Zarakoviti et al., 2021), without diminishing the overall impact of the intervention (Leijten et al., 2020). Moreover, family support programs in the context of adolescent mental health have generally yielded positive outcomes for both adolescents and parents, particularly in improving parents' mental health and parenting skills. In this regard, multilevel programs that integrate instructional, informational, advocacy, and emotional support components have proven particularly effective, highlighting the importance of offering diverse, tailored supports that address the multifaceted needs of families (Kuhn & Laird, 2014). However, despite their demonstrated importance (Corcoran et al., 2017), interventions explicitly designed to promote parents' well-being and address the broader family impact of adolescent mental health problems remain limited (Martin et al., 2023).

4.1. Limitations

This study provides valuable evidence on the support needs of parents of adolescents with mental health problems, identifying differences across diagnostic groups and examining links to both positive and negative aspects of parents' mental health. However, several limitations should be noted.

First, the cross-sectional and primarily descriptive design limits causal inference and the interpretability of the results. Longitudinal studies are needed to better understand the directionality and underlying mechanisms of these relationships. In addition, the present study relies exclusively on self-reported questionnaires. Future studies could benefit from multi-informant approaches in order to provide a more comprehensive assessment. Second, although the sample size was relatively large for a clinical population, participants were recruited from a specific sociocultural and healthcare context, namely the Public Mental Health System in southern Spain, which may restrict the generalizability of the results to other cultural contexts. In this setting, mental health care is mainly delivered through public community mental health services, with more specialized care provided by a reduced number of child and adolescent mental health units. These services often face lengthy waiting lists, limited treatment time, fragmentation across different administrative bodies, and limited availability of family specialized intervention programs. Moreover, the instrumental and economic support available to these families could vary across regions and countries. Because the organization of mental health services vary widely across Europe (Signorini et al., 2017), and attitudes toward mental health and stigma may also vary across cultures, the generalisability of the present fundings to other sociocultural contexts should be interpreted with caution. Future research should replicate these findings across diverse cultural and service settings.

Third, because the sample was limited to parents of adolescents receiving care in public mental health services, the findings may not be generalizable to families of adolescents with mental health problems who do not access these services. These families may have different, and potentially greater, support needs due to barriers to care or other factors limiting access to mental health services. Future research should examine the support needs of families who are not engaged with mental health services to better understand potential unmet needs and barriers to accessing care. Fourth, the sample showed an underrepresentation of fathers, as data were collected from the primary caregiver, most often the mother, a pattern also observed in previous studies (Martin et al., 2025). Future work should aim to include both caregivers, specifically recruiting more fathers, to allow for the examination of gender differences. Fifth, although family support is a broader concept that encompasses the needs and involvement of the entire family system (including those of siblings, grandparents, and other relatives who may play an important caregiving or support role) this study focused exclusively on parents. This focus was justified because parents typically assume primary responsibility for adolescents' daily care, treatment coordination, help-seeking, and healthcare decision-making. Nevertheless, our findings should not be interpreted as representing the support needs of the family as a whole. Future research should adopt a broader family perspective by examining the support needs and experiences of other family members, as well as the ways in which these needs interact within the family system. Finally, it is worth noting the limitations related to diagnostic categories. Specifically, families of adolescents with psychotic disorders were excluded due to small group size, which may have affected group comparability. Future studies could employ purposeful sampling to ensure the inclusion and analysis of parents of adolescents with psychotic disorders, by intentionally selecting participants meeting this specific criterion, ensuring adequate representation of this group This approach would enable a more rigorous examination of the specific support needs and psychological adjustment of parents in this subgroup, which may differ from those of parents with other mental health problems.

4.2. Strengths and practical implications

Despite these limitations, this study offers several important theoretical and practical contributions. First, it provides a validated inventory of parental needs for parents of adolescents with mental health problems, offering both a solid foundation for future research and a

practical tool for clinicians to identify and address specific parents' support needs. Second, by employing a quantitative approach and conducting comparative analysis across diagnostic categories, the study addresses a well-documented gap in the literature regarding the importance of considering heterogeneity in how adolescents present mental health problems (Martin et al., 2025). This methodological approach has also allowed us to identify specific needs, highlighting the value of multilevel interventions that combine various forms of support to address family complexity. Finally, the findings emphasize the importance of not only assessing perceived and expressed needs but also recognizing the critical role of professional needs assessment. Although parents rated well-being support as less urgent, it showed some of the strongest associations with both positive (psychological well-being) and negative (psychological distress) indicators of parents' mental health, highlighting the importance of structured, quantitative needs assessments within adolescent mental health services.

CRediT authorship contribution statement

Lucía Antolín-Suárez: Conceptualization, Data curation, Funding acquisition, Investigation, Methodology, Project administration, Supervision, Writing – original draft, Writing – review & editing. **Ana Rodríguez-Meirinhos:** Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Writing – original draft, Writing – review & editing. **Francisco J. Nieto-Casado:** Conceptualization, Data curation, Formal analysis, Methodology, Investigation, Writing – original draft, Writing – review & editing. **Sofía Baena:** Conceptualization, Writing – original draft, Writing – review & editing.

Declaration of generative AI and AI-assisted technologies in the writing process

During the preparation of this work the authors used OpenAI's ChatGPT (version GPT-4o) in order to assist in refining the language and improving the clarity of the translated tex. After using this tool/service, the authors reviewed and edited the content as needed and take full responsibility for the content of the publication.

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.childyouth.2026.109202.

Data availability

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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