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## Parent-adolescent Discrepancies Regarding Adolescent Psychopathology and its Relation to Parental Characteristics in a Clinical Sample

*This study investigated the differences between adolescents' own perceptions of their psychopathology and perceptions by clinically depressed parents of their adolescents' psychopathology. The study also examined parental characteristics that accounted for discrepancies between parents and adolescents. The clinical sample consisted of 61 adolescents and their parents who were diagnosed with a major depressive disorder. The adolescents and parents evaluated the adolescents' psychopathology in separate interviews with the Child Behavior Checklist (CBCL) and the Youth Self-Report (YSR). Parents reported on current depressive symptoms and parenting practices using questionnaires. The results revealed that parent-adolescent discrepancies were greater in regard to affective and anxiety problems compared to oppositional defiant and conduct problems. Parental rejection was associated with differences in scores for affective problems after controlling for parents' current depressive symptoms and adolescents' age and gender. The findings highlight the importance of considering adolescents' affective and anxiety problems when treating depressed*

*parents. Furthermore, the findings suggest that parental rejection may play a pivotal role when interpreting the discrepancy concerning adolescents' affective problems.*

Researchers and practitioners have shown specific interest in evaluating the concordance in perceptions of parents and children on child psychopathology and factors associated with the agreement. Parent-child agreement on child psychopathology has several possible determinants. First, child characteristics such as age or gender may affect parent-child agreement. Several studies reported that the agreement increased as children got older (Grills & Ollendick, 2002; Kiss *et al.*, 2007). Child gender has mixed effects on parent-child agreement, with several studies revealing no gender differences (Garber, Slyke, & Walker, 1998; Grills & Ollendick, 2002). Second, agreement on child psychopathology assessment appears to vary according to the nature of a child's problems. Parent-child concordance appears to be better for externalizing symptoms and observable behaviors than for internalizing or internal states (Salbach-Andrae *et al.*, 2009). In a study with male adolescents, parents, and teachers, the parent-adolescent concordance in externalizing symptoms was higher than internalizing symptoms, whereas parent-teacher or teacher-adolescent agree-

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ments regarding internalizing and externalizing symptoms were not significantly different (Youngstrom *et al.*, 2000).

Although previous studies investigated the parent-child agreement in general population samples (Ferdinand *et al.*, 2004; Toorn *et al.*, 2010; Vassi *et al.*, 2008; Youngstrom *et al.*, 2000), research on parent-child agreement in clinical settings is relatively limited. It is important to examine the discrepancies between informants' ratings in clinical research, given that discrepancies between informants are related to poor prognoses or may hinder informants' participation in treatment (De Los Reyes & Kazdin, 2005; Ferdinand *et al.*, 2004 & 2006). Moreover, the comparison of perceptions of adolescents and clinically depressed parents in clinical populations remains obscure, as previous studies on informant discrepancies have focused on clinically referred adolescents and their parents rather than clinically depressed parents and their adolescent children (Barbosa *et al.*, 2002; Berg-Nielsen *et al.*, 2003; Renouf & Kovacs, 1994).

Agreement between depressed parents and their children has been a particularly important issue since parental depression may affect children's perceptions and adjustment. Previous research indicated that distressed mothers tended to over-generalize or report their child's behavioral problems poorly, suggesting the presence of parental bias due to depression (Kinsman & Wildman, 2001; Najman *et al.*, 2000). On the other hand, other studies suggested a somewhat accurate perception of depressed parents (Conrad & Hammen, 1989; Kinard, 1995; Tarullo *et al.*, 1995), suggesting "depressive realism," or an increased sensitivity, which could help them report their children's problems more accurately. The studies on depressive realism demonstrate that depressed individuals perceive their children somewhat accurately without unrealistic optimism.

Parental characteristics that can explain issues in the discrepancy between children and their parents have not been extensively examined. Family communication between children and parents appears to influence their agreement (Grills & Ollendick, 2002). In a clinically referred sample of

children with psychiatric problems, the agreement between parents and teachers in the ratings of ADHD and oppositional defiant disorder (ODD) was associated with parenting stress; however, it was not associated with parental depressed mood (Oord, Prins, Oosterlaan, & Emmelkamp, 2006). There are limited numbers of studies on how family factors influence discrepancies. The identification of parental characteristics related to increased discrepancy among depressed parents could provide intervention targets as well as a detailed picture of family dynamics in treating depressed parents.

This study compared and contrasted the perceptions of psychopathology between children and depressed parents in a clinical sample, focusing on relatively understudied adolescent samples. Children of depressed parents have been considered to be at an increased risk for developing psychopathologic problems, which are perceived differently by each family member. How to interpret discrepancies between children's and parents' perceptions was an important issue for developing an effective intervention in clinical settings. Whereas many researchers have investigated psychopathology using internalizing and externalizing scales (Salbach-Andrae *et al.*, 2009; Vassi *et al.*, 2008), a few general population studies have examined the discrepancies in psychopathology using the scales based on the Diagnostic and Statistical Manual (DSM) (Toorn *et al.*, 2010). In this study, agreement between depressed parents and adolescents based on the DSM-oriented scales would be investigated in order to facilitate the use of information in practices. Based on the findings with children of depressed parents, we hypothesized that parents and adolescents would show higher agreement in the cases of oppositional defiant and conduct problems than in affective and anxiety problems. Comparing perspectives on different psychopathologies in a clinical sample will provide important insights into parent-adolescent interactions in families with depressed parents and make a helpful contribution by improving practitioners and researchers' utilization of the information on adolescents' psychopathology.

Furthermore, the present study extended previous research by examining whether discordance was

associated with parental characteristics such as current depressive symptoms and parenting behaviors. We further predicted that both parents' depressive symptoms and parenting behaviors would explain the discrepancy between adolescents and parents. Understanding whether parents' depressive symptoms and parenting behaviors contribute to the discrepancy would provide important information on the dyadic relationship between adolescents and parents, which could be used as a target for intervention.

## METHODS

### *Participants*

Sixty-one children and adolescents between the ages of 10 to 18 years old ( $M = 14.52$ ;  $SD = .37$  years) and their 41 depressed parents (32 mothers, 9 fathers) participated in this study. Thirty-two (52%) were male, and 29 (48%) were female. Adolescents were primarily Caucasian and African-American, consisting of 29 (48%) African-Americans, 26 (43%) Caucasians, 4 (6%) multi-ethnic Americans, and 2 (3%) Latino/Hispanic Americans. The primary language for all participants was English. The mean age of mothers was 42.71 ( $SD = 6.73$ ) and the mean age of fathers was 44.85 ( $SD = 7.29$ ). Median annual family income was \$45,000. With regard to education, three (7%) parents had not completed high school, four (10%) parents were high school graduates, fourteen (34%) parents had some college education, nine (22%) parents were college graduates, nine (22%) parents had completed a graduate school education, and two (5%) parents did not report their education level. With regard to marital status, twenty-three (55%) depressed parents were currently married or cohabiting. Twenty-five percent of families were separated or divorced and twenty percent of families were never married or widowed.

### *Measures*

*Adolescents' adjustment* Adolescents' psychopathology was evaluated by the Child Behavior Checklist subscales (CBCL: Achenbach & Rescorla, 2001) and Youth Self Report Scale (YSR: Achenbach &

Rescorla, 2001). The CBCL consists of 113 items that assess parent-reported problems and 7 sections on competencies for ages 6-18. Items are scored 0 to 2 depending on the degree to which the statement characterizes the child. The CBCL demonstrates acceptable psychometric properties and provides normative data (Achenbach & Rescorla, 2001). The YSR was modeled on the CBCL, but is completed by youth aged 11-18 years. The YSR consists of 112 items assessing self-reported problems and 7 sections on competencies. The CBCL and YSR are widely used in clinical research, and normative data are available. The reasons for choosing the outcome measures are (1) their wide use in clinical studies of adolescents' disorders; (2) their acceptable psychometric properties; and (3) recommendations from a review article on rating scales (e.g., Myers & Winters, 2002).

As to scoring the CBCL and YSR, the present clinical study applied the DSM-oriented approach, constructing scales for affective problems, anxiety problems, somatic problems, attention deficit hyperactivity problems, oppositional defiant problems, and conduct problems (Achenbach *et al.*, 2003). The subscales of affective and anxiety problems in the CBCL and the YSR consist of 13 items and 6 items respectively. Both somatic and attention deficit hyperactivity problems subscales in the CBCL and the YSR are comprised of 7 items. The subscale of oppositional defiant problems in the CBCL and the YSR consists of 5 items. Whereas the subscale of conduct problems in the CBCL consists of 17 items, the subscale of conduct problems in the YSR consists of 15 items excluding 2 items of cruel to animals and vandalism in the CBCL. Since the items for conduct problems were not identical for the CBCL and YSR, the 2 items in the CBCL were excluded in further analyses in order to coincide the CBCL and YSR for conduct problems. Internal consistencies for the YSR were .81 for affective problems, .75 for anxiety problems, .69 for somatic problems, .70 for attention deficit/hyperactivity problems, .70 for oppositional defiant problems and .78 for conduct problems. Internal consistencies for the CBCL were .84 for affective problems, .75 for anxiety problems, .79 for somatic problems, .85 for attention deficit/

hyperactivity problems, .84 for oppositional defiant problems and .89 for conduct problems.

*Depressive symptoms* The Center for Epidemiological Studies-Depression scale (CES-D; Radloff, 1977) was used to measure parents' depressive symptoms over a one-week recall period. The CES-D consisted of 20 items with a self-report format, with 16 items describing negative feelings or behaviors and the remaining 4 items relating positive feelings and behaviors (reverse-scored). The CES-D was originally developed to measure depressive symptoms in the general adult population. The psychometric properties were found to be satisfactory (Beekman *et al.*, 1997; Olino *et al.*, 2012). The parents were asked to respond on a 4-point scale ranging from 0 (rarely or none of the time) to 3 (most or all of the time). Scores ranged from 0 to 60, with higher scores on the scale indicative of greater levels of depressive symptomatology. In the present study, the internal consistency of the CES-D was .91.

*Parenting behavior* Parenting behavior was assessed using subscales of the parent version of the Children's Report of Parent's Behavior Inventory (CRPBI; Schaefer, 1965). The subscales in the present study were characterized by acceptance/warmth and rejection/control. The parent rated the degree of similarity between the behavior described and their actual behavior on a 3-point scale ranging from 0 to 2. The response format is not like (0), somewhat like (1), and like (2). Each subscale of the CRPBI consisted of 18 items in a self-report format. The internal consistency for parent-report parental acceptance and rejection were .86 and .83, respectively.

*Procedure* We recruited depressed patients from the Clinical Psychiatric Research Center (CPRC), Department of Psychiatry at a private university medical center, diagnosed with major depression and with at least one adolescent child between the ages of 10 and 18 living at home at least 50% of the time. The sample also included depressed parents who responded to the advertisement recruiting depressed patients in the regional newspapers.

Parents were excluded from the study if they had been hospitalized for a serious medical problem, or suffered from alcohol abuse and dependence or non-alcohol psychoactive substance use disorders. Because this study focused on major depressive disorder, parents were excluded if they had a current presentation of manic episode.

Trained clinical trial coordinators conducted telephone screening in order to determine the eligibility of participants in the study. Participants were diagnosed as depressed based on the Diagnostic and Statistical Manual of Mental Disorder (DSM-IV) criteria, using the Mini International Neuropsychiatric Interview (M.I.N.I.; Sheehan *et al.*, 2001). Interviewers had bachelor's degrees in the area of public health or psychology and were trained by a board certified child psychiatrist. The telephone script was approved by the University Committee on Human Research. A clinical psychologist separately interviewed both parents and adolescents who agreed to participate in the study at the clinic. Prior to data collection for this study, both parents and adolescents were asked to sign informed consent and assent forms. The University Committee on Human Research approved the consent and assent forms prior to use in this study. Each screening booklet took approximately one hour to complete, and the family received monetary compensation in appreciation of their participation. While conducting an individual interview with adolescents, interviewers ensured that each adolescent understood the task. Interviewers confirmed that each adolescent completed the booklet in an appropriate manner before ending the interview with the adolescent.

## RESULTS

### *Product-moment Correlations*

Table 1 shows the Pearson product-moment correlations among the DSM-oriented problems, along with their respective means and standard deviations. Items common to the CBCL and YSR were used. Raw scores for each dimension were computed from these common items and used in

Table 1. Mean, Standard Deviations, and Correlations among CBCL and YSR Scores

| Variables                | 1      | 2      | 3      | 4      | 5      | 6      | 7      | 8      | 9      | 10     | 11     | 12   |
|--------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|------|
| Parent-reported          |        |        |        |        |        |        |        |        |        |        |        |      |
| 1. affective             |        |        |        |        |        |        |        |        |        |        |        |      |
| 2. anxiety               | .69*** | --     |        |        |        |        |        |        |        |        |        |      |
| 3. somatic               | .56*** | .56*** | --     |        |        |        |        |        |        |        |        |      |
| 4. AD/H                  | .58*** | .52*** | .46*** | --     |        |        |        |        |        |        |        |      |
| 5. oppositional defiant  | .65*** | .59*** | .45*** | .69*** | --     |        |        |        |        |        |        |      |
| 6. conduct               | .62*** | .57*** | .41**  | .58*** | .74*** | --     |        |        |        |        |        |      |
| Adolescent-reported      |        |        |        |        |        |        |        |        |        |        |        |      |
| 7. affective             | .23    | .13    | .09    | .14    | .18    | .43*** |        |        |        |        |        |      |
| 8. anxiety               | .19    | .25    | .02    | .17    | .11    | .33**  | .60*** | --     |        |        |        |      |
| 9. somatic               | .15    | .34**  | .27*   | .04    | .24    | .30*   | .47*** | .38**  | --     |        |        |      |
| 10. AD/H                 | .19    | .20    | .10    | .40**  | .28*   | .38**  | .39**  | .46*** | .27*   | --     |        |      |
| 11. oppositional defiant | .27*   | .19    | .26*   | .31*   | .44*** | .65*** | .41**  | .38**  | .29*   | .61*** | --     |      |
| 12. conduct              | .27*   | .21    | .06    | .37    | .47*** | .53*** | .43*** | .34*** | .29*** | .38*** | .66*** | --   |
| <i>M</i>                 | 1.56   | 1.07   | 1.08   | 4.22   | 3.44   | 3.60   | 1.93   | 1.18   | 1.18   | 4.33   | 3.21   | 4.71 |
| <i>SD</i>                | 1.16   | 0.98   | 0.92   | 3.85   | 2.81   | 4.86   | 1.03   | 0.95   | 0.87   | 2.78   | 2.21   | 3.74 |

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

producing the correlations. As shown in Table 1, whereas the correlations between adolescents and depressed parents as to affective problems and anxiety problems were not significant ( $r = .23$ ;  $r = .25$ ,  $ns$ ), the correlations between adolescents and depressed parents as to somatic problems, AD/H, oppositional defiant problems, and conduct problems ( $r = .27$ ,  $p < .05$ ;  $r = .40$ ,  $p < .01$ ;  $r = .44$ ,  $p < .001$   $r = .53$ ,  $p < .001$ ) were significantly positive.

*Multivariate Analysis on Discrepancies*

Discrepancies were measured with standardized difference scores as recommended by previous studies to achieve most consistent estimates among informant discrepancies and informant characteristics (De Los Reyes & Kazdin, 2005). Standardized difference score is obtained by subtracting one informant's standardized score from the other informant's standardized score. In order to create the standardized difference score in the present study, rating on adolescents' adjustment from YSR and CBCL were converted into Z scores and the adolescent's ratings were then subtracted from the score of the parent's rating of DSM oriented

Table 2. Correlation among Adolescent-Parent Rating Discrepancies (Standardized Difference Score), Parents' Depressive Symptoms and Parenting

|                          | Parents' depressive symptoms | Parenting  |           |
|--------------------------|------------------------------|------------|-----------|
|                          |                              | Acceptance | Rejection |
| SDS-Affective            | .25                          | -.26*      | .40**     |
| SDS-Anxiety              | .30*                         | -.26*      | .25       |
| SDS-Somatic              | .10                          | -.12       | .26*      |
| SDS-AD/H                 | .25                          | -.14       | .22       |
| SDS-Oppositional defiant | .15                          | -.11       | .19       |
| SDS-Conduct              | .10                          | -.15       | .22       |

\*  $p < .05$ ; \*\*  $p < .01$

problems. With this process, positive scores imply that parents reported more problems than adolescents, and negative scores imply that adolescents reported more problems than their parents. The intraclass correlations for standardized difference scores for affective and anxiety problems were .23 and close to 0, respectively.

Table 2 shows the correlations of standardized difference scores with parents' depressive symptoms

Table 3. Hierarchical Regression Analyses for Standardized Difference Scores in Affective and Anxiety Problems

| Variable            | SDS-Affective problems |         | SDS-Anxiety problems |         |
|---------------------|------------------------|---------|----------------------|---------|
|                     | $R^2$                  | $\beta$ | $R^2$                | $\beta$ |
| Model 1             | .08 ( $F = 1.59$ )     |         | .10 ( $F = 2.13$ )   |         |
| Child age           |                        | -.09    |                      | -.11    |
| Child gender        |                        | -.10    |                      | -.06    |
| Depressive symptoms |                        | .24     |                      | .28*    |
| Model 2             | .20 ( $F = 2.78^*$ )   |         | .14 ( $F = 1.80$ )   |         |
| Child age           |                        | -.12    |                      | -.13    |
| Child gender        |                        | -.07    |                      | -.06    |
| Depressive symptoms |                        | .14     |                      | .22     |
| Parental acceptance |                        | .12     |                      | -.13    |
| Parental rejection  |                        | .46*    |                      | .09     |

\* $p < .05$ ; \*\* $p < .01$

and parenting behavior. The standardized difference score placed the parents' and adolescents' ratings on the same  $z$  distribution. Standardized difference scores for affective problems were significantly related to parental acceptance and parental rejection ( $r = -.26$ ,  $p < .05$ ;  $r = .40$ ,  $p < .01$ ). Standardized difference scores for anxiety problems were significantly related to parents' depressive symptoms and parental acceptance ( $r = .30$ ,  $p < .05$ ;  $r = -.26$ ,  $p < .05$ ), and somatic problems were significantly related to parental rejection ( $r = .26$ ,  $p < .05$ ).

We then analyzed the effects of depressive symptoms and parenting behavior on standardized difference scores. In the hierarchical regression, the standardized difference scores were used as the criterion variable. The variance inflation factor values to detect the effect of intercorrelation were small enough not to consider multicollinearity. Parents' depressive symptoms, child age, and child gender were entered in the first step and then parenting behavior of acceptance and rejection entered in the second step as independent variables. As shown in Table 3, after controlling for child age and gender and parents' depressive symptoms, parental rejection was significantly related to the standardized difference scores for affective problems ( $\beta = .46$ ,  $p < .05$ ). In the regression model, parenting behavior significantly predicted discrepancy, 20% of the variance with child age, child gender, and

depressive symptoms. A greater level of parental rejection was related to greater parent-adolescent discrepancies on affective problems.

#### Discussion

This study first investigated the discrepancies between adolescents and depressed parents in their perceptions of adolescents' psychopathology using a clinical sample. The analyses indicated that the agreement between adolescents and their parents was greater on oppositional defiant problem and conduct problem, compared to affective problem and anxiety problem. Adolescents reported more affective and anxiety problems compared to their parents who perceived that their children had fewer problems. The results are consistent with previous studies that investigated the parent-child concordance on their child's psychopathology and suggested a higher concordance in externalizing behavior than in internalizing behavior among adolescents that suffered from psychiatric disorders or in the general population (Grills & Ollendick, 2002; Salbach-Andrae *et al.*, 2000). A study that compared parent- and teacher-reported behaviors about child depression and anxiety in the general population indicated that parent-reported syndrome about their child's depression and anxiety were only marginally related to child-reported depression and anxiety compared to teacher-reported syndromes (Mesman & Koot,

2000). A previous study also revealed that adolescents and mothers had different perceptions of adolescents' depressive and suicidal symptoms (Csorba *et al.*, 2003).

Consistent with previous studies, the present study, which used a clinical sample, revealed less agreement between adolescents and parents concerning adolescents' affective and anxiety problems in comparison to observable oppositional defiant and conduct problems. Adolescents may not reveal or express their internal problems to their parents, especially when they suffer from depressive symptoms. It is not possible to determine whether adolescents over-report internalizing problems or whether depressed parents are unaware of them. The extent to which adolescent- or parent- reports might be biased is unknown. Future research should clarify the accuracy of reports between parents and adolescents using other criteria such as clinician interviews and physiological assessments and how informants' depressive symptoms are related to the discrepancy.

Furthermore, this study investigated how parental characteristics accounted for the discordance between adolescents and parents. Previous studies showed that concordance between mothers' and children's reports of somatic and emotional symptoms was affected by maternal distress but not by a child's age and gender (Garber *et al.*, 1998). In line with the previous study, a child's age and gender did not seem to contribute significantly to standardized differences in perceptions. Unexpectedly, parents' depressive symptoms did not significantly explain the discrepancies for affective problems in the present study. Given that the results revealed that parenting behavior, rather than current depressive symptoms, was significantly associated with the discrepancy between adolescents and depressed parents concerning affective problems, parenting factors might mediate the association between parental depressive symptoms and adolescents' affective problems.

Multivariate models indicated that parental rejection was associated with greater parent-adolescent discrepancies in the standardized difference scores. Previous studies showed that maternal depressive symptoms were related to more negative

and less positive behaviors (Dietz *et al.*, 2008; Foster, Garber, & Durlak, 2008) and harsh negative parenting was related to higher levels of depressive symptoms in children (Dallaire *et al.*, 2006). Research using community samples showed that maladaptive parental behavior is associated with an increased risk to develop general psychiatric disorders or internalizing disorders in children of parents with general psychiatric disorders, suggesting the mediating role of maladaptive parental behavior (Compas *et al.*, 2010; Johnson *et al.*, 2001). This study showed that parenting factors contributed to the discrepancy between adolescents and parents for affective problems and expanded on previous studies that suggest parenting behaviors as a mediating link between parental depression and children's psychopathology.

With regard to clinical implications, the results showed that assessing parent-adolescent discrepancies could be important to understand the adjustment of adolescent children of depressed parents. Practitioners need to be aware of the risks for developing affective and anxiety problems that adolescents face. Each informant could provide specific information that clinicians need to consider. Moreover, the findings suggest that this discrepancy in awareness between adolescents and parents can be an important indicator of the quality of parent-adolescent relationships in clinical settings.

The mechanism in terms of how parental rejection is associated with the discrepancies is not clear. One possible explanation is that the discrepancy is associated with a greater level of depressive symptoms in either adolescents or parents that are related to negative recall or rumination. A previous study showed that, compared to non-depressed informants, those with more depressive symptoms may recall information or instances that are more negative (De Los Reyes & Kazdin, 2005). Another possible explanation is that the discordances in informants' reports reflect difficulties in family relationships, such as communication. Parental rejection is speculated to be related to a lack of communication between parents and adolescents that might be associated with increased levels of discordances between parents and adolescents. A

previous study identified a lack of communication between parents and children as an influencing factor on parent-child interaction in structured interviews (Grills & Ollendick, 2002). Future research is needed to investigate how parental characteristics account for the informant discrepancies in families of depressed individuals.

It is unexpected that parental acceptance does not seem to explain significantly the discrepancy between adolescents and parents concerning adolescents' affective problems. One possible explanation is that the positive aspect of parenting behavior is related to adjustment rather than maladjustment. For example, previous research showed that low levels of perceived parental control, high levels of maternal warmth, and low levels of maternal over-involvement were associated with resilient outcomes in adolescent children of mothers with a history of depression (Brennan, Brocque, & Hammen, 2003). This finding can also be related to the clinical sample characteristics of the present study. Previous research suggests that the predictive significance of positive parenting may be more pronounced in a comparatively more normative sample. Given that the sample of the present study was recruited in clinical settings, the influence of parental rejection may be stronger than for parental acceptance.

A limitation to our study was the small sample size in the clinical study that may limit the generalizability of our findings. The sample also included some clustered subsets with the dataset. With a larger sample without clustering, the analyses could include additional variables to provide more detailed information on factors that influence the discordance in parent-adolescent reports. Second, the association cannot be examined as causative since the analyses are based on cross-sectional data; subsequently, this study contributed to an understanding of the discrepancy in ratings as an indicator of the current parent-adolescent relationship quality. Third, most measures were exclusively self-reported. Future research including multiple raters would increase the general confidence in the results. Despite the limitations of this study, the findings highlight clinicians' need to consider adolescents'

affective and anxiety problems when treating depressed parents. Adolescents' internal feelings, of which depressed parents might not be aware, should be assessed with consideration for prevention and early intervention. Researchers and practitioners need to incorporate discrepant information in order to improve the health of adolescents in caring for families with depressed individuals. Moreover, when rarely overlapping information on adolescents' psychopathology exists, researchers and practitioners need to investigate family relationships as a source of the discrepancy. Given that discrepancies between adolescents and their depressed parents in their perceptions of adolescents' affective problems are related to parental characteristics, parental rejection can be a potential target for intervention among families with depressed individuals.

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