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RESEARCH ARTICLE

Examining the Relationship Among Parental-Reported Problems, Self-Reported Problems, and Psychiatric Diagnosis in Children and Adolescents[1]

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Abstract

The study aims to investigate the relationship among psychiatric diagnosis, parental reported problems, and the Revised Child Anxiety and Depression Scale-Child Version (RCADS-CV) results of children. The sample of the study consisted of 78 children and adolescents (36 girls and 42 boys), and statistical analyses were made using the chi-square test and Fisher's exact test. Relationships identified between the following pairs: worry problems with Generalized Anxiety Disorder (GAD), distraction problems with Attention Deficit and Hyperactivity Disorder (ADHD), hyperactivity problems with Tic and Tourette's Syndrome, obsession problems with Obsessive-Compulsive Disorder (OCD), unhappiness with Major Depressive Disorder or dysthymia, and avoidance of communication with autism spectrum disorder. Furthermore, when examining the relationship between psychiatric diagnoses and diagnoses according to the RCADS-CV, we found other relationships, such as the psychiatric diagnosis of separation anxiety and RCADS-CV separation anxiety, as well as the psychiatric diagnosis of separation anxiety and RCADS-CV social phobia. Lastly, when investigating the relationship between parentally reported problems and RCADS-CV diagnoses, several associations emerged, including the relation between obsession problems and RCADS-CV OCD diagnosis, relationship problems and RCADS-CV's OCD diagnosis, unhappiness problems, and RCADS-CV's depression diagnosis. In conclusion, our findings demonstrate a substantial overlap among parentally reported problems, psychiatric diagnoses, and diagnoses based on RCADS-CV.

Keywords: *Parental-reported problems, self-reported problems, psychiatric diagnosis, children, adolescent.*

Öz

Bu araştırmanın amacı, çocuklarda psikiyatrik tanı, ebeveynlerin bildirdiği sorunlar ve Çocuklarda Anksiyete ve Depresyon Ölçeği – Yenilenmiş Formu (ÇADÖ-Y) sonuçları arasındaki ilişkiyi araştırmaktır. Araştırmanın örneklemini 36 kız ve 42 erkek olmak üzere 78 çocuk ve ergen oluşturmuş olup, istatistiksel analizler Ki-kare testi ve Fisher'in Kesin Olasılık testi kullanılarak yapılmıştır. Çalışma, ebeveynlerin çocukları hakkında bildirdiği sorunlar ile belirli psikiyatrik tanılar arasında önemli ilişkiler ortaya koymuştur. Buna göre aralarında ilişki bulunan tanı ve sorun çiftleri şöyledir: Yaygın Anksiyete Bozukluğu (YAB) ile endişe sorunları, Dikkat Eksikliği ve Hiperaktivite Bozukluğu (DEHB) ile dikkat dağınıklığı sorunları, Tik ve Tourette Sendromu ile hiperaktivite sorunları, Obsesif-Kompulsif Bozukluk (OKB) ile takıntı sorunları, mutsuzluk ile Majör Depresif Bozukluk veya distimi tanıları, otizm spektrum bozukluğu tanısı ile iletişimden kaçınma sorunlarıdır. Ayrıca, psikiyatrik tanılar ile ÇADÖ-Y'nin işaret ettiği tanılar arasındaki ilişkiyi incelendiğinde; ayrılık anksiyetesi psikiyatrik tanısı ile ÇADÖ-Y ayrılık anksiyetesi ; ayrılık anksiyetesi psikiyatrik tanısı ile ÇADÖ-Y sosyal fobi tanısı arasında ilişki bulunmuştur. Son olarak, ebeveynler tarafından bildirilen sorunlar ile ÇADÖ-Y tanıları arasındaki ilişkiye bakıldığında, takıntı sorunları ile ÇADÖ-Y OKB tanısı, ilişki sorunları ile ÇADÖ-Y OKB tanısı, mutsuzluk sorunları ile ÇADÖ-Y depresyon tanısı arasındaki ilişki bulunmuştur. Sonuç olarak, bulgularımız ebeveynlerin bildirdiği sorunlar, psikiyatrik tanılar ve ÇADÖ-Y'ye dayalı tanılar arasında önemli bir örtüşme olduğunu göstermektedir.

Anahtar Kelimeler: *Anne baba tarafından bildirilen sorunlar, öz bildirime dayalı sorunlar, psikiyatrik tanı, çocuk, ergen*

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Introduction

It can be argued that arriving at a psychiatric diagnosis is often easier for adults than for children. Adults who voluntarily seek psychiatric assistance tend to provide more accurate information about their issues, leading to more precise diagnostic decisions by psychiatrists. Conversely, children do not typically seek psychiatric services independently, and they may struggle to articulate the problems they are experiencing. Children are usually brought to clinics due to concerns observed by their parents. Moreover, in child and adolescent psychiatry, often a multi-informant approach is used (Booth et. al., 2023). These informants may be either children themselves, parents, or teachers (De Los Reyes and Epkins, 2023). Although there is usually some alignment between parentally reported problems, psychiatric diagnoses, and the assessment tools or self-report scales used by psychiatrists, occasional discrepancies may arise. For this reason, psychiatric assessments of children based on parental observations can differ significantly from the evaluation process used for adults (Stranger & Lewis, 1993; Basgul & Topcu, 2020). In the evaluation process, achieving consensus between the child and the parents can significantly facilitate obtaining accurate results. When there is a lack of agreement between these two parties, challenges may arise in the treatment process (Yeh & Wiesz, 2001).

Research has indicated that the information provided by children and parents often differs and rarely aligns (Melton et al., 2016). One explanation for this disparity is that children and parents may offer different yet equally valid perspectives. For example, a child who exhibits unusual behaviors in a school environment may not display these behaviors at home and may exhibit typical behaviors (Mash & Wolfe, 2015). Moreover, children, due to their developmental stage, may not possess a full awareness of their psychiatric functioning. Children and parents may also have differing assessments of which behaviors are problematic, and a child's behavior may vary across different settings (Rescorla et al., 2012; Bradley & Corwyn, 2013). Besides, lack of communication among family members may be the reason behind the discrepancy between child and parent reports (Caqueo-Urízar et. al., 2022). The discrepancy may also stem from the child's developmental stage, as younger children may not accurately evaluate their problems due to a lack of cognitive maturity, while in older ages, as children become more independent, parents may decrease their contact with them, which may decrease their accuracy of evaluation (Hyland et. al., 2022).

Studies have shown that self-report-based assessments yield better results in some diagnoses, while assessments based on parental statements are more effective in others. For example, when it comes to internalizing disorders, where children experience their emotions, self-report assessments tend to provide more accurate information. In contrast, for externalizing disorders, where parents play a significant role in shaping their children's behavior, parental assessments tend to be a more reliable source of information (De Los Reyes & Kazdin, 2005). Choudhury et al. (2003) found a weak correlation between child and parental reports of anxiety disorders. Similarly, Cantwell and colleagues (1997) noted that in anxiety disorders among children and adolescents, self-reported symptoms outnumber parent-reported ones. Likewise, Caqueo-Urízar and colleagues (2022) found that emotional symptoms reported more in children's self-report than their parental reports. Moreover, parent-child agreement was low both in depressive symptom severity and the diagnosis of major depressive disorder (Baumgartner et al., 2020). On the other hand, parents tend to report more symptoms in cases of attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), and conduct disorders. Another study investigated the relationship between children's affective disorders and parental reports. This study revealed that parents tend to underestimate depressive symptoms in children with major depressive disorder while exaggerating depressive symptoms in children with dysthymia and conduct disorder (Boerner et al., 2017). Consequently, there are differences between self-reports and parental reports depending on the type of disorder. Given this information, a critical

issue in psychopathology is determining which source of information is more relevant in assessing the problems experienced by children and their families. Additionally, Riley argues that relying solely on parents' observations is insufficient and advocates for the inclusion of self-report questionnaires for children. However, evaluating solely based on self-reports may not always be feasible, and psychiatrists should also consider the child's reactions to these self-reports (Riley, 2004). Despite the lack of consistency among children, parents, and assessment tools, gathering information from various sources remains crucial in the diagnosis and treatment process (Peverill et al., 2021).

When analyzing the relevant literature, it becomes evident that there are limited studies addressing parent-reported problems and psychiatric diagnoses (Sheldrick et al., 2012; Eiser & Morse, 2001). Furthermore, exploring the correlation between children's self-report questionnaires (RCADS-CV) and parental observations can provide valuable insights for future research and practices. The present study aims to investigate the relationship among the issues parents observe in their children, the responses on self-report questionnaires, and the psychiatric diagnoses these children receive.

Within the scope of this research, we will seek answers to the following questions:

1. Is there a relationship between psychiatric diagnoses and those determined based on the RCADS-CV?
2. Is there a relationship between problems reported by parents and the diagnoses determined according to the RCADS-CV?
3. Is there a relationship between problems reported by parents and a psychiatric diagnosis?

Method

Participants

The research was designed based on the relational screening model, which is commonly used for examining relationships among two or more variables (Gliner et al., 2015). In this study, we examined the relationship among problems

reported by parents, the responses provided by children on the self-report scale (RCADS-CV), and psychiatric diagnoses. Psychiatric diagnoses were made by a psychiatrist based on DSM-5 criteria through a psychiatric evaluation. The study sample consisted of 3rd to 12th-grade students who sought treatment at a private child and adolescent psychiatry clinic in Istanbul. The total number of participants was 78 children, comprising 36 girls and 42 boys. In non-parametric analysis ten participants per parameter has been stated as sufficient (Aguinis and Harden, 2009), and the present study has exceeded this number to achieve a sufficient sample size. We employed the convenience sampling method when collecting data (Karasar, 2012). The data were collected from scales based on children's self-reports and scales completed by parents regarding their children.

Measures

Sociodemographic Form. This form was created by the researchers to collect the following information about the participants: age, gender, number of siblings, birth order, parental age, parents' education levels, parental status (alive or not, together or not), and any history of illness, surgery, accidents, or febrile seizures among the participants.

Revised Child Anxiety and Depression Scale (RCADS-CV). The RCADS-CV is a clinical symptom screening scale based on the DSM-IV for assessing depression and anxiety disorders in children and adolescents. Adapted from the Spence Child Anxiety Scale, it was developed by Chorpita et al. (2000) and comprises 47 items divided into six sub-dimensions: separation anxiety, social phobia, obsessive-compulsive disorder, panic disorder, generalized anxiety disorder, and major depressive disorder. Total scores are calculated based on the six dimensions. Internal consistency values for the scale are as follows: .82 for social phobia, .79 for panic disorder, .76 for separation anxiety disorder, .76 for major depressive disorder, .73 for obsessive-compulsive disorder, and .77 for generalized anxiety disorder (Chorpita et al., 2000). The Turkish adaptation of the scale, conducted by Görmez et al. (2017), consists of 47 items with a 4-point Likert scale (Never, Sometimes, Often, Always). Confirmatory factor analysis confirmed the original 6-factor structure,

with an internal consistency coefficient of .95. Internal consistency values for sub-dimensions range from .75 to .86 (Görmez et al., 2017).

Child Symptom Inventory-4: Parent Checklist. This scale, developed by Gadow and Sprafkin (1994), comprises a total of 97 items. It assesses a range of conditions including ADHD, ODD, conduct disorder, GAD, OCD, schizophrenia, depression, dysthymia, eating disorders, autism spectrum disorder, social phobia, enuresis, encopresis, and vocal and motor tics. Parents of children aged 5–12 complete the inventory, rating the frequency of symptoms they observe in their children. The scale employs a 4-point Likert structure (Never, Sometimes, Often, Very Often). A study by Sprafkin et al. (2002) demonstrated that the scale exhibits an acceptable level of internal consistency and test-retest reliability.

Adolescent Symptom Inventory-4: Parent Checklist. Comprising a total of 120 items, this scale was developed by Gadow and Sprafkin (2002) to assess the frequency of behavioral and emotional symptoms observed by parents in children aged 12–18. It covers a range of psychopathologies including ADHD, ODD, conduct disorder, GAD, OCD, panic disorder, social phobia, separation anxiety disorder, MDD, dysthymic disorder, bipolar disorder, schizophrenia, anorexia nervosa, bulimia nervosa, and schizoid personality disorder (Gadow et al., 2002).

Data Analyses

Data were gathered from participants who sought treatment at a private child and adolescent psychiatry clinic in Istanbul between 2019 and 2020. The study utilized the Revised Child Anxiety and Depression Scale-Child Version (RCADS-CV), completed by the children, the Child Symptom Screening Inventory, completed by parents, and the Screening Inventory of Adolescent Symptoms. The first part of the Child and Adolescent Symptom Screening Inventory included the Child Adolescent Anxiety and Depression Scale diagnoses and scores, the psychiatrist's diagnoses noted in the files, and the Child and Adolescent Symptom Screening Inventory. Additionally, the complaints provided by families in the "problems

you observe in your children" section were evaluated. Data analysis was conducted using IBM SPSS Statistics software, version 23.

Results

Demographics of Participants

As indicated in Table 1, the study group comprises 78 children: 36 (46.2%) girls and 42 (53.8%) boys.

Table 1. Demographics of participants

Variables	Groups	n	%
Gender	Female	36	46.2
	Male	42	53.8
	Total	78	100
Education Level of Mother	Primary	5	6.4
	High School	20	25.6
	Undergraduate	45	57.7
	Graduate	8	10.3
	Total	78	100
Education Level of Father	Primary	7	9
	High School	13	16.7
	Undergraduate	46	59
	Graduate	12	15.4
	Total	78	100
Parenthood Status	Together	66	84.6
	Divorced	12	15.4
	Total	78	100
Kin Marriages between Parents	Present	4	5.1
	Not Present	74	94.9
	Total	78	100
Birth Order of Participants	First	51	65.4
	Second	18	23.1
	Third	9	11.5
	Total	78	100
Number of Siblings	0 (Only child)	14	17.9
	1	40	51.3
	2 or more	24	30.8
	Total	78	100
Physical Illness	Present	23	29.5
	Not Present	55	70.5
	Total	78	100
Accident	Present	7	9
	Not Present	71	91
	Total	78	100
Surgery	Present	11	14.1
	Not Present	67	85.9
	Total	78	100

Note. P: Present; NP: Not Present

There were no missing data so data from all 78 participants were used. Regarding the education level of the participants' parents, a significant majority have attained a university degree (mother: 57.7%; father: 59%). It was reported that 66 (84.6%) of the participants' parents were together, while 12 (15.4%) were divorced. In 4 cases (5.1%), the parents shared a kinship bond. Among

the participants, 14 (17.9%) were only children, 40 (51.3%) had one sibling, and 24 (30.8%) had two or more siblings. When examining birth order, the majority, 51 (65.4%), were the first-born, followed by 18 (23.1%) who were second-born, and 9 (11.5%) who were third-born. A total of 23 (29.5%) participants had a history of physical illness, 7 (9.0%) had experienced prior accidents, and 11 (14.1%) had undergone surgical operations.

Is there a relationship between psychiatric diagnoses and those considered according to RCADS-CV?

In this study, we first examined the relationship between psychiatric diagnoses and those considered according to RCADS-CV. The results of the Chi-Square analysis concerning the relationship between diagnoses made by RCADS-CV and the psychiatric diagnoses of the children can be found in Table 2. As illustrated in Table 2, a chi-square test analysis was conducted to determine if there's a significant relationship between diagnoses based on RCADS-CV scores and those made by psychiatrists. For the 2x2 tables (sd=1), Fisher's Exact Test (FET) was employed when the expected value was less than 5 in any of the cells.

Table 2. Chi-square test results regarding the relationship between diagnoses determined by RCADS-CV and the psychiatric diagnoses of children

Diagnoses	Diagnosis	Separation Anxiety		Generalized Anxiety		Panic Disorder		Social Phobia		OCD		Depression	
		P	NP	P	NP	P	NP	P	NP	P	NP	P	NP
Diagnosis of ADHD	P	9	35	5	39	10	34	3	41	4	40	8	36
	NP	9	25	3	31	9	25	6	28	5	29	5	29
	X² /Fet	,391		---		,146		---		---		,167	
	P	,532		1.000		,703		,167		,492		,683	
Diagnosis of ODD	P	0	4	0	4	0	4	0	4	0	4	1	3
	NP	18	56	8	66	19	55	9	65	9	65	12	62
	Fet/P	,568		1,000		,567		1,000		1,000		,525	
Diagnosis of OCD	P	1	9	2	8	2	8	1	9	3	7	1	9
	NP	17	51	6	62	17	51	8	60	6	62	12	56
	Fet/P	,438		,271		1,000		1,000		,085		1,00	
Diagnosis of GAD	P	5	21	4	22	9	17	6	20	6	20	3	23
	NP	13	39	4	48	10	42	3	49	3	49	10	42
	X² /Fet	,325		---		2,23		---		---		---	
	P	,569		,430		,136		,053		,053		,526	
Diagnosis of Social phobia	P	1	3	2	2	1	3	2	2	2	2	0	4
	NP	17	57	6	68	18	56	7	67	7	67	13	61
	Fet/P	1,000		,051		1,000		,063		,063		1,000	
Diagnosis of Separation Anxiety	P	3	0	0	3	0	3	2	1	1	2	0	3
	NP	15	60	8	67	19	56	7	68	8	67	13	62
	Fet/P	**,011**		1,000		1,000		**,034**		,311		1,000	
Diagnosis of MDd or dysthymia	P	3	10	0	13	2	11	3	10	1	12	6	7
	NP	15	50	8	57	17	48	6	59	8	57	7	58
	Fet/P	1,000		,339		,503		,167		1,000		**,006**	
Diagnosis of SLD	P	2	4	1	5	1	5	1	5	0	6	1	5
	NP	16	56	7	65	8	64	12	60	9	63	12	60
	Fet/P	,617		,490		1,000		,533		1,000		1,000	
Diagnosis of Tic or Touretts's Disorder	P	1	4	1	4	2	3	0	5	1	4	0	5
	NP	17	56	7	66	17	56	9	64	8	65	13	60
	Fet/P	1,000		,427		,590		1,000		,468		,583	
Diagnosis of Autism Spectrum Disorder	P	1	4	0	5	2	3	0	5	0	5	1	4
	NP	17	56	8	65	17	56	9	64	9	64	12	61
	Fet/P	1,000		1,000		,590		1,000		1,000		1,000	

Note. P: Present; NP: Not present

As the test result provides only the significance value, the p-value is presented in the table. A significant relationship was observed between the diagnosis of separation anxiety made by the psychiatrist and both separation anxiety and social

significant relationship was detected for other diagnostic groups (p>.05).

Is there a relationship between problems reported by parents and diagnoses based on

Table 3. Results of the chi-square test analysis on the relationship between diagnoses determined by RCADS-CV and problems reported by parent

Diagnoses/Problems		Separation Anxiety		Generalized Anxiety		Panic disorder		Social phobia		Obsessive compulsive disorder		Depression	
Diagnoses/Problems		P	NP	P	NP	P	NP	P	NP	P	NP	P	NP
The problem of worry	P	6	24	4	26	8	22	4	26	4	26	5	25
	NP	12	36	4	44	11	37	5	43	5	43	8	40
	X² /Fet	,260		---		,141		---		---		,001	
	p	,610		,476		,707		,727		,727		,1000	
		P	NP	P	NP	P	NP	P	NP	P	NP	P	NP
The problem of distraction	P	10	25	5	30	10	25	2	33	4	31	8	27
	NP	8	35	3	40	9	34	7	36	5	38	5	38
	X² /Fet	1,08		1,12		,611		---		---		1,75	
	p	,299		,290		,434		,175		1,000		,186	
		P	NP	P	NP	P	NP	P	NP	P	NP	P	NP
The problem of hyperactivity	P	0	5	1	4	1	4	0	5	2	3	0	5
	NP	18	55	7	66	18	55	9	64	7	66	13	60
	Fet/p	,584		,427		1,000		1,000		,099		,583	
		P	NP	P	NP	P	NP	P	NP	P	NP	P	NP
The problem of obsession	P	2	14	4	12	5	11	4	12	5	11	1	15
	NP	16	46	4	58	14	48	5	57	4	58	12	50
	Fet/p	,335		,051		,520		,080		*,015*		,283	
		P	NP	P	NP	P	NP	P	NP	P	NP	P	NP
The problem of relationship	P	10	35	2	43	12	33	4	41	2	43	10	35
	NP	8	25	6	27	7	26	5	28	7	26	3	30
	X² /Fet	0,44		---		,307		---		---		2,36	
	p	,834		,065		,579		,482		*,032*		,124	
		P	NP	P	NP	P	NP	P	NP	P	NP	P	NP
The problem of behavior	P	2	16	1	17	7	11	2	16	2	16	5	13
	NP	16	44	7	53	12	48	7	53	7	53	8	52
	Fet/P	,216		,673		,123		1,000		1,000		,164	
		P	NP	P	NP	P	NP	P	NP	P	NP	P	NP
The problem of unhappiness	P	4	14	1	17	5	13	4	14	2	16	8	10
	NP	14	46	7	53	14	46	5	55	7	53	5	55
	Fet/P	1,000		,673		,758		,199		1,000		*,001*	
		P	NP	P	NP	P	NP	P	NP	P	NP	P	NP
The problem of anger	P	0	10	0	10	2	8	0	10	0	6	1	9
	NP	18	50	8	60	17	51	9	59	9	63	12	56
	Fet/P	,105		,587		1,000		,595		1,000		1,000	
		P	NP	P	NP	P	NP	P	NP	P	NP	P	NP
The problem of social anxiety	P	2	4	0	6	1	5	1	5	1	5	0	6
	NP	16	56	8	64	18	54	8	64	8	64	13	59
	Fet/P	,617		1,000		1,000		,533		,533		,582	
		P	NP	P	NP	P	NP	P	NP	P	NP	P	NP
Inability to leave mother	P	0	6	1	5	1	5	0	6	0	6	1	5
	NP	18	54	7	65	18	54	9	63	9	63	12	60
	Fet/P	,327		,490		1,000		1,000		1,000		1,000	
		P	NP	P	NP	P	NP	P	NP	P	NP	P	NP
The problem of fear	P	2	4	2	4	2	4	0	6	1	5	0	6
	NP	16	56	6	66	17	55	9	63	8	64	13	59
	Fet/P	,617		,113		,630		1,000		,533		,582	
		P	NP	P	NP	P	NP	P	NP	P	NP	P	NP
The problem of avoiding communication	P	2	4	0	6	2	4	2	4	0	6	2	4
	NP	16	56	8	64	17	55	7	65	9	63	11	61
	Fet/P	,617		1,000		,630		,139		1,000		,260	

Note. P: Present; NP: Not present

phobia diagnoses from the RCADS-CV (p<.05). Additionally, a notable relationship was identified between the diagnosis of MDD or dysthymic disorder given by the psychiatrist and the RCADS-CV's diagnosis of depression (p<.05). No

RCADS-CV?

Furthermore, this study probed the relationship between diagnoses determined by RCADS-CV and the issues highlighted by parents. The outcomes of

the Chi-Square test analysis in this regard are displayed in Table 3.

As shown in Table 3, a chi-square test analysis was conducted to determine if there's a significant relationship between diagnoses based on the RCADS-CV scale scores and the problems reported by parents. For the 2x2 tables (sd=1), Fisher's Exact Test (FET) was utilized when the expected value was less than 5 in any of the cells. As the test result only indicates the significance value, the p-value is presented in the table. According to the analysis results, significant relationships were found between RCADS-CV's OCD and the obsession problem, RCADS-CV's OCD and the relationship problem, and RCADS-CV's depression and the unhappiness problem

Table 4. Chi-square analysis results on the relationship between psychiatrist diagnoses and problems reported by parents

Diagnoses/Problems		ADHD		ODD		OCD		GAD		Social Phobia		Separation Anxiety		MDD or Dysthymia		SLD		Tic or Tourette's		Autism	
Diagnosis/problems		P	NP	P	NP	P	NP	P	NP	P	NP	P	NP	P	NP	P	NP	P	NP	P	NP
Problem of worry	P	20	10	3	27	3	27	16	14	3	27	2	28	7	23	3	27	3	27	0	30
	NP	24	24	1	47	7	41	10	38	1	47	1	47	6	42	3	45	2	46	5	43
	X^2/Fet	2,09		---		---		8,77		----		----		1,56		---		---		---	
	p	,149		,292		,733		,003		,292		,557		,212		,670		,367		,150	
Problem of distraction	P	28	7	3	32	2	33	11	24	3	32	2	33	6	29	4	31	3	32	3	32
	NP	16	27	1	42	8	35	15	28	1	42	1	42	7	36	2	41	2	41	2	41
	X^2/Fet	14,36		---		---		,104		---		,585		,010		---		---		---	
	p	,000		,321		,171		,747		,321				,919		,400		,652		,652	
Problem of hyperactivity	P	4	1	1	4	2	3	3	2	0	5	0	5	0	5	0	5	2	3	0	5
	NP	40	33	3	70	8	65	23	50	4	69	3	70	13	60	6	67	3	70	5	68
	Fet/p	,380		,237		,120		,326		1,000		1,000		,583		1,000		,031		1,000	
Problem of obsession	P	8	8	2	14	6	10	8	8	2	14	0	16	2	14	1	15	1	15	1	15
	NP	36	26	2	60	4	58	18	44	2	60	3	59	11	51	5	57	4	58	4	58
	X^2/Fet	,336		---		---		2,52		---		---		---		---		---		---	
	p	,562		,185		,004		,113		,185		1,000		1,000		1,000		1,000		1,000	
Problem of relationship	P	27	18	2	43	5	40	12	33	1	44	1	44	8	37	4	41	3	42	2	43
	NP	17	16	2	31	5	28	14	19	3	30	2	31	5	28	2	31	2	31	3	30
	X^2/Fet	,557		---		---		2,13		---		---		,095		---		---		---	
	p	,455		1,000		,735		,145		,305		,571		,758		1,000		1,000		,645	
Problem of behavior	P	11	7	2	16	3	15	9	9	0	18	0	18	4	14	3	15	1	17	0	18
	NP	33	27	2	58	7	53	17	43	4	56	3	57	9	51	3	57	4	56	5	55
	X^2/Fet	,210		---		---		2,92		---		---		---		---		---		---	
	p	,647		,226		,689		,087		,568		1,000		,483		,132		1,000		,584	
Problem of unhappiness	P	11	7	2	16	0	18	8	10	0	18	0	18	10	8	1	17	1	17	0	18
	NP	33	27	2	58	10	50	18	42	4	56	3	57	3	57	5	55	4	56	5	55
	X^2/Fet	,210		---		---		1,30		---		---		*,001*		---		---		---	
	p	,647		,226		,105		,254		,568		1,000		*,001*		1,000		1,000		,584	
Problem of anger	P	7	3	2	8	0	10	5	5	1	9	0	10	4	6	1	9	1	9	0	10
	NP	37	31	2	66	10	58	21	47	3	65	3	65	9	59	5	63	4	64	5	63
	Fet/P	,500		,078		,344		,287		,429		1,000		,056		,574		,506		1,000	
Problem of social anxiety	P	1	5	0	6	1	5	2	4	0	6	1	5	1	5	1	5	0	6	1	5
	NP	43	29	4	68	9	63	24	48	4	68	2	70	12	60	5	67	5	67	4	68
	Fet/P	,080		1,000		,574		1,000		1,000		,216		1,000		,392		1,000		,337	
Problem of inability to leave mother	P	4	2	0	6	0	6	2	4	0	6	0	6	2	4	2	4	0	6	1	5
	NP	40	32	4	68	10	62	24	48	4	68	3	69	11	61	4	68	5	67	4	68
	Fet/P	,691		1,000		1,000		1,000		1,000		1,000		,260		,065		1,000		,337	
Problem of fear	P	2	4	0	6	0	6	4	2	0	6	0	6	1	5	1	5	1	5	1	5
	NP	42	30	4	68	10	62	22	50	4	68	3	69	12	60	5	67	4	68	4	68
	Fet/P	,395		1,000		1,000		,091		1,000		1,000		1,000		,391		,337		,337	
Problem of avoiding communication	P	2	4	0	6	0	6	1	5	0	6	1	5	2	4	1	5	0	6	2	4
	NP	42	30	4	68	10	62	25	47	4	68	2	70	11	61	5	67	5	67	3	69
	Fet/P	,395		1,000		1,000		,657		1,000		,216		,260		,392		1,000		,045	

Note. ADHD: Attention Deficit Hyperactivity Disorder; ODD: Oppositional Defiant Disorder; OCD: Obsessive Compulsive Disorder; GAD: generalized Anxiety Disorder; MDD: Major Depressive Disorder; SLD: Special Learning Disorder; P:Present; NP: Not Present

(p<.05). No significant relationship was observed between other diagnostic groups and the problems reported by parents (p>.05).

Is there a relationship between problems reported by parents and psychiatric diagnoses?

As illustrated in Table 4, a chi-square test analysis was conducted to determine if there was a significant relationship between the diagnoses made by the psychiatrist and the problems reported by parents. For the 2x2 tables (sd=1), Fisher's Exact Test (FET) was utilized when the expected value was less than 5 in any of the cells. Since the test result only provides the significance value, the p-value is included in the table. The analysis results showed significant relationships between: the anxiety problem and the diagnosis of GAD, distraction and the ADHD diagnosis, hyperactivity and tic or Tourette's disorder, obsession and the OCD diagnosis, unhappiness and the diagnosis of MDD or dysthymic disorder, communication avoidance and the diagnosis of Autism (p<.05). No significant relationships were found for other diagnoses and problem groups (p>.05).

Discussion

In this study, we explored the relationship between problems reported by parents of children attending a private psychiatry clinic and the diagnoses these children received. Additionally, we examined the relationship between diagnoses derived from the Revised Child Anxiety and Depression Scale (RCADS-CV)—which the children completed—and both the issues raised by the parents and the diagnoses given by the child psychiatrist.

Self-report measurement tools with established validity are supportive instruments in child and adolescent clinical practice (Jeffrey et. al., 2020). In that manner, Revised Child Anxiety and Depression Scale (RCADS-CV) was compared with both diagnosis and parents reports of children to see the possible discrepancies and overlapping. In addition, gathering information from different sources is often necessary in child

psychiatric evaluation (McDonald et. al., 2021) because every source may provide equally important information in different settings. Therefore, parent reports was compared with both children self-reports and psychiatric diagnoses. Comparing these information may ensure new insights to the nature of different diagnosis as some diagnosis heavily aligns with parents reports some, on the other hand some diagnosis more accurately in accord with self-reports.

The range of diagnoses for the children included: attention deficit and hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), obsessive-compulsive disorder (OCD), generalized anxiety disorder (GAD), social anxiety disorder, separation anxiety disorder, major depressive disorder (MDD), dysthymic disorder, specific learning disorder (SLD), tic disorder or Tourette's syndrome, enuresis, encopresis, autism spectrum disorder, post-traumatic stress disorder (PTSD), sexual orientation disorder, and trichotillomania. Parents highlighted concerns such as impulsivity, distraction, hyperactivity, obsession, relationship and behavior issues, unhappiness, anger, social anxiety, urinary and fecal incontinence, fear, communication avoidance, self-harm, suicidal ideation, and appetite loss. In examining the relationship between parent-reported issues and psychiatric diagnoses, we identified links between worry and GAD, distraction and ADHD, hyperactivity with tic disorders or Tourette's syndrome, and obsession with OCD.

Upon analyzing the RCADS-CV scores, a correlation emerges between feelings of unhappiness and scores indicative of depression. Further examination of the relationship between the RCADS-CV scores and psychiatric diagnoses reveals that the psychiatric diagnosis of separation anxiety disorder aligns with RCADS-CV scores for separation anxiety, generalized anxiety, obsessive-compulsive disorder, and total anxiety.

Both MDD and dysthymia are correlated with RCADS-CV depression scores. Social phobia is linked to RCADS-CV generalized anxiety scores. Separation anxiety disorder correlates with RCADS-CV separation anxiety scores. Social phobia disorder aligns with total anxiety scores on

the RCADS-CV. In conclusion, there is a substantial congruence between issues reported by families, psychiatric diagnoses, and scores on the RCADS-CV scale.

Relationship Between Psychiatric Diagnoses and Diagnoses According to RCADS-CV

The study findings indicated a notable correlation between the RCADS-CV scores for separation anxiety, generalized anxiety, OCD, and total anxiety, and the psychiatric diagnosis of GAD. Conversely, there was no discernible correlation between the RCADS-CV depression score and the diagnoses of MDD and dysthymic disorder. A recent qualitative study showed that children with depression disorders may often feel embarrassed about their feelings, which makes it harder for them to disclose their symptoms (Radez et al., 2022). Therefore, participants in the present study may underscore their symptoms of depression. In addition, this may be the result of the small sample size used in the present study. Furthermore, there was a link between RCADS-CV generalized anxiety scores and the diagnosis of social phobia, as well as between the RCADS-CV scores for separation anxiety, social phobia, and total anxiety, and the psychiatric diagnosis of separation anxiety disorder. It was observed that RCADS-CV scores did not vary in relation to the psychiatric diagnoses of ADHD, SLD, tic or Tourette's disorder, and autism. This might suggest that the RCADS-CV isn't a predictive tool for these particular diagnoses. When considering the OCD diagnosis, no significant difference emerged in RCADS-CV scores. Potential reasons could include the reluctance of children and adolescents to disclose their symptoms, prevalent lack of insight in OCD, or a predilection towards ego-dystonic OCD (Canavera, 2009). Diagnostically, a pronounced correlation was identified between the psychiatric diagnosis of separation anxiety and the RCADS-CV's diagnoses of both separation anxiety and social phobia. Moreover, a significant relationship was observed between the diagnosis of MDD and dysthymic disorder and the RCADS-CV depression diagnosis. These results underscore the reliability and validity of the RCADS-CV as an instrument that not only corroborates clinical diagnoses but also aligns with the concerns voiced by families, especially concerning depression and separation anxiety disorders.

Relationship Between Problems Reported by Parents and Diagnoses According to RCADS-CV

Based on the research results, RCADS-CV scores did not display significant variations in relation to problems such as anxiety, distraction, hyperactivity, obsession, relationship issues, behavioral concerns, anger, social anxiety, difficulties in separating from the mother, fear, and avoidance of communication. The only distinct difference observed was in the depression score, which was higher among participants who reported unhappiness. Such findings can be attributed to the disparities between self-reports and parent-reported evaluations. For instance, the overarching anxiety focus of the RCADS-CV may explain its consistent scores across varying anxiety-related problems. Additionally, parents might use the term "obsession" not in the context of compulsive symptoms but to describe tic-like repetitive movements or their children's stubborn behavior. This perception could be a significant reason why the OCD sub-score of the RCADS-CV remains unchanged in relation to obsession-related issues. The limited sample size also likely influences these results. A study by Aras et al. (2007) revealed that 25.9% of patients at a child psychiatry clinic received a depression diagnosis stemming from unhappiness complaints. Given that children and adolescents are often referred to psychiatric clinics by their families, our research concurs with Aras et al. (2007) in suggesting a relationship between reported unhappiness and depression diagnoses according to RCADS-CV. Several studies indicate that parents tend to underreport depressive symptoms compared to the children's self-reports, while being more likely to highlight behavioral issues (Epanchin and Rennells, 1989; Edelbrock et al., 1985). This contrast from our study might stem from cultural nuances and familial dynamics specific to our region.

Moreover, we observed notable correlations between certain reported problems and their corresponding RCADS-CV diagnoses: obsession and RCADS-CV's OCD diagnosis; relationship

issues and RCADS-CV's OCD diagnosis; and unhappiness and RCADS-CV's depression diagnosis. These findings align with Rapaport et al. (2000), who noted that children often conceal their OCD symptoms, leading parents to inadvertently downplay these symptoms. Conversely, Canavera et al. (2009) found a weak concordance between children with OCD and their parents, both diagnostically and symptomatically. Yet, similar to Rapaport et al., parents reported more symptoms than children. This discrepancy could be attributed to a lack of insight into OCD or a sense of shame associated with symptom disclosure (Canavera et al., 2009). In another study, there was no observed relationship between the child's depression scales and those of their parents. Instead, parents predominantly concentrated on behavioral problems in their children, rather than emotional states like unhappiness (Epanchin & Rennell, 1989). Parental reports of emotional issues were found to be fewer than those derived from self-reports (Edelbrock et al., 1985; Caqueo-Urízar et al., 2022). The findings of this research corroborate the relationship between unhappiness and the RCADS-CV depression diagnosis, aligning with prior studies. Furthermore, the observed correlation between OCD and relationship issues is supported by the study of Piacentini et al. (2003). In their investigation into the impact of OCD on the social functioning of children and adolescents, they found that OCD caused significant familial issues for over half of the participants. Additionally, 33% of parents noted that OCD led to substantial social challenges for their children. Jansen et al. (2020) stated that difficulties in understanding social cues, and facial expressions, as well as struggles in mentalizing, are common in patients with OCD. It was also noted that parents reported more problems in home, school, family, and academic settings than their children did.

The Relationship Between Parental Reported Problems and Psychiatrist Diagnoses

This study reveals statistically significant relationships between certain parental reported problems and specific psychiatric diagnoses. These include the association between worry and a GAD diagnosis; distraction and ADHD diagnosis; hyperactivity and a diagnosis of Tic and/or Tourette Syndrome; obsession and OCD diagnosis; unhappiness with dysthymia or major depressive disorder; and avoidance of communication with an autism spectrum disorder diagnosis. The identification of ADHD in children whose parents reported distraction problems is expected. However, the lack of an ADHD diagnosis in children reported as hyperactive, coupled with the link to tic and/or Tourette's disorder, may arise from parents equating motor movements in children with tic disorders to hyperactivity. Moreover, both ADHD and Tourette's Syndrome are neurodevelopmental disorders and their high comorbidity rates has been shown in clinical studies range between 36% and 62% (Comings et al., 1985; Jankovich and Rohaidy, 1987) and this phenomenon was explained with shared genetic structure (Yang et al., 2021). Another study noted hyperactivity symptoms in 24% of children aged 6–12 and 57% aged 12–16 with Tourette's disorder (Cavanna et al., 2013). Consequently, this study corroborates the idea that attention problems reported by parents or teachers may align with an ADHD diagnosis upon psychiatric evaluation. Another observation from this research is that while parents can recognize anxiety in their children, studies indicate families often underestimate their children's anxiety levels compared to self-reports (Caqueo-Urízar et al., 2022; Lagattuta et al., 2012). Given cultural nuances in parent-child relationships, Turkish culture, which often sees parents closely interact with their children, might allow for better detection of mood shifts. This underscores the value of cross-cultural studies in this domain. Lastly, issues identified as relationship problems align with symptoms of autism disorder (American Psychological Association [APA], 2013). The observed link between reported relationship problems and autism might be attributable to the core autism symptoms: difficulties in forming relationships and social interaction inadequacies. Guinchat et al. (2012) revealed that families can detect communication and social interaction issues in their children as early as 22.3 months old, on average. In conclusion, evaluations based on

parental reports play a pivotal role in psychiatric assessments and diagnoses, and parents' observations generally find resonance.

Implications

The present study offers a new perspective on the discrepancy between child and parent reports in child psychiatry, especially in a Turkish sample. The alignments and discrepancies in different diagnoses may provide new insights into the nature of various diagnoses, as the degree of accuracy varies across informants for different diagnoses. Furthermore, the Revised Child Anxiety and Depression Scale-Child Version (RCADS-CV) is mostly aligned with psychiatric diagnoses. The findings of the present study suggest that the RCADS-CV is a valid scale and may be more widely used in clinical settings.

In the future, a study design incorporating diverse psychiatric tools, particularly those examining clusters of disorders beyond anxiety, and a larger sample size would provide new insights into understanding the discrepancies among parental reports, child self-reports, and psychiatric diagnoses.

Limitations

While the insights from this study enrich the existing literature, they come with certain limitations. The study's small sample size and its confinement to a private clinic pose significant constraints. Future research would benefit from more expansive and varied sample sizes. Moreover, relying solely on the RCADS-CV and not incorporating scales for other psychiatric disorders presents another limitation. Conducting further research using diverse measurement tools will address this gap meaningfully.

Conclusion

Results from this study highlight a correlation between parent-reported problems, psychiatric diagnoses, and self-reported disorders. Given these findings, it's evident that utilizing multidimensional evaluations is crucial for diagnostic processes in clinical assessments.

Additionally, considering the variations in alignment between parental and self-reports, it's advisable to tailor or contemplate the assessment type based on the issues presented by children and adolescents.

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