JOURNAL OF
CONTEMPORARY MEDICINE

DOI:10.16899/jcm.1148404
J Contemp Med 2022;12(5):710-715

Original Article / Orijinal Araştırma

Adolescent-Parent Agreement in terms of Symptoms of Adolescents Diagnosed with Anxiety Disorder

Anksiyete Bozukluğu Tanılı Ergenlerin Belirtileri Açısından Ergen-Ebeveyn Uyumu

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Abstract

Aim: Considering the role of the parent in the children and adolescent's access to treatment, it is important that the symptoms are adequately noticed by the parents. In this study, it was aimed to examine the adolescent-parent agreement in terms of symptoms of adolescents with anxiety disorder.

Material and Method: 100 adolescents who applied to the child and adolescent psychiatry outpatient clinic and were diagnosed with anxiety disorder according to the DSM-5 diagnostic criteria were included in the study. In the study, the sociodemographic form and the Revised Child Anxiety and Depression Scale (RCADS) adolescent and parent form were used for data collection.

Results: When the parent and adolescent forms of RCADS were compared, the adolescent scores were significantly higher than the parents in all subscales and scale total scores, except for the separation anxiety subscale. The ICC (95% CI) value between the parent and adolescent forms of RCADS ranged from 0.06 to 0.74.

Conclusion: In our study, it was found that adolescents scored their symptoms higher than their parents, and the correlation between parent-child reporting was low-moderate. Age, gender, comorbidity, and parental psychopathology were among the factors affecting adolescent-parent agreement.

Keywords: Anxiety, adolescent, parent, awareness

Öz

Amaç: Çocuk ve ergenin tedaviye erişiminde ebeveynin rolü göz önünde bulundurulduğunda, semptomların ebeveyn tarafından yeterince fark edilmesi önem taşımaktadır. Bu çalışmada, anksiyete bozukluğu olan ergenlerin semptomları açısından ergen-ebeveyn uyumunun incelenmesi amaçlanmıştır.

Gereç ve Yöntem: Çocuk ve ergen psikiyatri polikliniğine başvuran ve DSM-5 tanı kriterlerine göre anksiyete bozukluğu tanısı alan 100 ergen çalışmaya dahil edildi. Çalışmada veri toplama amacı ile sosyodemografik form ve Çocuklar için Anksiyete ve Depresyon Ölçeği (ÇADÖ) ergen ve ebeveyn formu kullanıldı.

Bulgular: ÇADÖ ebeveyn ve ergen formları karşılaştırıldığında, ayrılık anksiyetesi alt ölçeği dışında diğer tüm alt ölçek ve ölçek toplam puanında çocuk puanları ebeveyne göre anlamlı olarak daha yüksekti. ÇADÖ ebeveyn ve ergen formları arasındaki ICC (%95 CI) değeri 0,06 ila 0,74 aralığındaydı.

Sonuç: Çalışmamızda ergenlerin belirtilerini ebeveynlerinden daha yüksek puanladıkları, ebeveyn-ergen bildirimi arasındaki korelasyonun düşük-orta düzeyde olduğu saptanmıştır. Yaş, cinsiyet, komorbidite ve ebeveyn psikopatolojisi ergen-ebeveyn uyumunu etkileyen faktörlerdendi.

Anahtar Kelimeler: Anksiyete, ergen, ebeveyn, farkındalık

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Received *(Geliş Tarihi)*: 25.07.2022 **Accepted *(Kabul Tarihi)*:** 05.09.2022

INTRODUCTION

Anxiety disorder is among the most common psychiatric disorders observed in children and adolescents. Girl gender, family history of depression and anxiety, temperamental frustration and low effortful control predispose to anxiety disorder.[1] While the presence of anxiety disorder in childhood and adolescence creates a strong predisposition to experience similar situations in adult life, the probability of developing psychopathology (such as depression and substance use) in addition to anxiety disorder increases with age.[2]

It is important to obtain information from different sources (especially parents and children) when evaluating children and adolescents for psychopathology including anxiety disorder. In terms of the presence and severity of the adolescent's psychopathology, the adolescents and their parents are mostly in agreement at a very low rate.[3] This difference of opinion may also affect the search for treatment, adherence to treatment and treatment success. There are many reasons why the adolescent and parent disagree about the adolescent's symptoms. Poor communication between the adolescent and the parent, the lack of insight of the adolescent or the parent about the symptoms, the parent's psychopathology or stress are among these reasons.[4] In addition to studies showed that gender, age, symptom severity and socioeconomic level affect child-parent agreement,[5-7] there are also studies reported that these factors have no effect.[5,8]

In the presence of parental psychopathology and poor family relationships, the rate of parent-child disagreement regarding the child's symptoms (especially internalizing), is increasing.[9] Depending on the type of parent's psychopathology, parental awareness may vary in terms of the child's anxiety symptoms. Anxious or depressed parents tend to report much more symptoms about their children than parents without psychopathology.[10,11]

Due to the symptoms are more observable in externalizing disorders, child-parent agreement may be stronger.[12] However, the child-parent agreement weakens in internalizing disorders. It has been shown that parents describe the child's depressive symptoms as milder and rarer than the child's self-report.[13-15] In both clinical and community samples, it was observed that child-parent agreement was poorer in anxiety measurement made with semi-structured interview and evaluation scales.[16-18]

Despite this, many adolescents with anxiety disorder do not receive treatment for their symptoms.[19] Untreated anxiety disorder is more likely to become chronic and to have comorbid psychopathology. Considering the role of the parent in the child and adolescent's access to treatment, it is important that the symptoms are adequately noticed by the parents. Although there are many studies in the literature investigating adolescent-parent agreement in terms of symptoms of adolescents with anxiety disorders, the results show variability. In this study, it was aimed to investigate the adolescent-parent agreement in terms of the symptoms of adolescents with anxiety disorder and to contribute to the literature.

MATERIAL AND METHOD

One hundred adolescents (12-17 years) who applied to the child and adolescent psychiatry outpatient clinic of XXXXX between May-June 2022 and were newly diagnosed with anxiety disorder according to DSM-5 diagnostic criteria were included in the study. Adolescents with mental retardation and pervasive developmental disorders were not included in the study. In the study, the sociodemographic form and the Anxiety and Depression Scale for Children (CASS) adolescent and parent form were used for data collection. Data were collected at the first interview, when the adolescents were diagnosed with anxiety disorder. Anxiety disorder diagnosis and comorbid psychiatric diagnoses were made according to DSM-5 diagnostic criteria and by two child psychiatrists (authors) in the outpatient clinic. Since all adolescents came to the examination accompanied by their mothers, the parent form was filled only by the mothers. Parents' psychopathology was recorded in line with their self-report. However, parents who were previously diagnosed by psychiatrist were considered to have psychopathology. The study was carried out with the permission of University Clinical Research Ethics Committee (Date: 2022, Decision No: 2022/1937). All procedures were carried out in accordance with the ethical rules and the principles of the Declaration of Helsinki.

Revised-Anxiety and Depression Scale for Children (RCADS): The scale includes 47 items. 6 subscale points (generalized anxiety disorder [6 items], separation anxiety disorder [7 items], panic disorder [9 items], obsessive-compulsive disorder [6 items], social anxiety disorder [9 items], major depressive disorder [10 items] item) and a total score can be obtained. The scale is scored as 0=never, 1=sometimes, 2=often, and 3=always. The Turkish validity and reliability study was conducted by Görmez et al. in the 8-17 age group.[20] (Cronbach's alpha: 0.95)

Statistical analysis: The conformity of the data to the normal distribution was examined using the Shaphiro Wilk test. In addition, one-way analysis of variance (ANOVA) and LSD multiple comparison tests were used for normally distributed features in the comparison of numerical data in more than two independent groups, and Kruskal Wallis test and All pairwise multiple comparison test were used for non-normally distributed features. Inter-rater reliability between child and parent scale and/or subscale values was evaluated using ICC (Intraclass corelation coefficent) two-way random effects model within-class correlations. ICCs agreement representation was defined as "excellent" (above 0.90), "good" (0.75–0.90), "moderate" (0.50–0.75), and "poor" (less than 0.50) based on the 95% CI.[21] Scale score differences between parent and child assessments were analyzed by Paired t-test and the relationship between assessments was analyzed by Pearson correlation coefficient. The relationships between age variables and the scale and/or subscale were also tested with the Spearman correlation coefficient. As descriptive statistics, mean±standard deviation for numerical variables, number and percentage values for categorical variables are given. SPSS Windows version 24.0 package program was used for statistical analysis and $P<0.05$ was considered statistically significant.

RESULTS

One hundred adolescents aged 12-17 years with a diagnosis of anxiety disorder were included in the study. Of the adolescents, 71 (71%) were girls and 29 (29%) were boys. The mean age was 14.58±1.71. While 42% of adolescents were attending secondary school, 58% were attending high school. 62% of adolescents diagnosed with anxiety disorder had a comorbid psychiatric diagnosis (28% depressive disorder, 26% attention deficit hyperactivity disorder [ADHD], 6% obsessive compulsive disorder [OCD], 2% conduct disorder). Of the comorbid psychiatric diagnoses, 54.8% were internalizing disorders (depressive disorder, OCD) and 45.2% were from externalizing disorders (ADHD, conduct disorder). While the presence of psychiatric disorders in mothers of adolescents was 5% (anxiety disorder 4%, depressive disorder 1%), this rate was 12% (anxiety disorder 6%, personality disorder 4%, depressive disorder 2%) in their fathers.

Considering the mean RCADS scores, the child form separation anxiety subscale score is 4.88±3.62, the generalized anxiety subscale score is 8.89±4.08, the panic subscale score is 10.81±7.37, the social phobia subscale score is 14.06±6.24, obsession-compulsion subscale score was 8.30±4.37, depression subscale score was 14.03±7.22 and total scale score was 60.61±26.29. In the parent form, the separation anxiety subscale score is 4.45±4.14, the generalized anxiety subscale score is 6.79±4.00, the panic subscale score is 6.12±5.62, the social phobia subscale score is 11.47 6.22, obsession-compulsion subscale score was 5.05±3.80, depression subscale score was 11.66±6.06, and total scale score was 45.3422.57.

When the parent and child forms of RCADS were compared, the child scores were significantly higher than the parents in all subscales and scale total scores, except for the separation anxiety subscale (**Table 1**). Concordance between parent and child forms of RCADS was measured by ICC (95% CI). The ICC value ranged from 0.06 to 0.74 and was statistically significant except for the obsession-compulsion subscale score (**Table 1**).

From the point of view of the comorbid mental disorder; While all subscale and total scale scores were significantly higher than the parents, except for the separation anxiety subscale score of the adolescents with internalizing disorder, all subscale and total scale scores were significantly higher than the parents, except for the depression subscale score of the adolescents with externalizing disorder (**Table 2**). The ICC value ranged from -0.67 to 0.82 in cases with comorbid internalizing disorder, and it was significant in the subscales of separation anxiety, generalized anxiety, panic, and social phobia. In cases with accompanying externalizing disorder, the ICC value ranged from -1.32 to 0.74, and it was significant only in the separation anxiety subscale (**Table 2**).

The ICC value in female adolescents ranged from 0.01 to 0.76, and it was significant in all subscales and scale total scores. In male adolescents, the ICC value ranged from 0.01 to 0.64 and was significant only in the social phobia subscale (**Table 3**). There was a significant difference between the mean scores of the adolescent-parent forms in both genders, but this difference was higher in girls (**Table 3**).

Table 1. Comparison of scale and subscale scores of parent and adolescent forms

Scale	ICC (95% CI)	r (95% CI)	Paired t-test (95% CI)
Separation anxiety	0.61 (0.42 0.74)	0.44 (0.26 0.62)	0.43 (-0.39 1.25)
Generalized anxiety	0.51 (0.24 0.68)	0.39 (0.20 0.57)	2.10 (1.21 2.99)
Panic	0.46 (0.11 0.66)	0.39 (0.20 0.57)	4.69 (3.23 6.15)
Social fobia	0.50 (0.26 0.67)	0.36 (0.17 0.55)	2.59 (1.19 3.99)
Obsession compulsion	0.26 (0.06 0.49)	0.20 (0.00 0.39)	3.25 (2.22 4.28)
Depression	0.41 (0.14 0.60)	0.28 (0.09 0.47)	2.37 (0.77 3.97)
Total scale score	0.42 (0.11 0.62)	0.32 (0.13 0.51)	15.27 (9.57 20.96)

Bold ones mean statistically significant. (p<0.05). ICC=Inter-rater reliability, CI=Confidence intervals, r=Pearson Correlation coefficent

Table 2. Examination of ICC Reliability, Correlation and Mean Differences of Child and Parent scale and/or subscale values according to cadolescents' comorbid psychiatric diseases

	ICC (95% CI)	r (95% CI)	Paired t-test (95% CI)
Internalizing			
Separation anxiety	0.35 (0.21 0.69)	0.22 (-0.09 0.53)	-0.12 (-1.91 1.68)
Generalized anxiety	0.62 (0.20 0.82)	0.45 (0.19 0.71)	2.47 (1.02 3.92)
Panic	0.49 (0.01 0.74)	0.37 (0.06 0.68)	5.00 (1.98 8.02)
Social fobia	0.50 (0.04 0.74)	0.34 (0.04 0.64)	3.38 (0.99 5.78)
Obsession compulsion	-0.10 (-0.67 0.34)	-0.07 (-0.38 0.25)	3.98 (2.02 5.93)
Depression	0.43 (-0.07 0.70)	0.33 (-0.03 0.69)	3.65 (0.72 6.57)
Total scale score	0.44 (-0.05 0.71)	0.32 (0.01 0.63)	18.50 (8.21 28.79)
Externalizing			
Separation anxiety	0.34 (0.22 0.69)	0.86 (0.37 1.00)	1.75 (0.39 3.11)
Generalized anxiety	0.39 (-0.18 0.70)	0.34 (-0.12 0.80)	2.46 (0.51 4.42)
Panic	0.25 (-0.24 0.59)	0.25 (-0.16 0.66)	6.18 (3.57 8.78)
Social fobia	0.46 (-0.07 0.74)	0.41 (-0.02 0.84)	4.39 (1.47 7.31)
Obsession compulsion	0.41 (-0.15 0.71)	0.34 (-0.03 0.71)	3.75 (1.84 5.65)
Depression	-0.05 (-1.32 0.52)	-0.02 (-0.41 0.36)	1.32 (-2.59 5.23)
Total scale score	0.28 (-0.30 0.63)	0.24 (-0.20 0.67)	19.64 (7.30 31.98)

Bold ones mean statistically significant (p<0.05). ICC=Inter-rater reliability, CI=Confidence intervals, r=Pearson Correlation coefficent

Table 3. Examination of ICC Reliability, Correlation and Mean Differences of Child and Parent scale and/or subscale values according to gender

Gender	ICC (95% CI)	r (95% CI)	Paired t-test (95% CI)
Female			
Separation anxiety	0.64 (0.48 0.76)	0.65 (0.41 0.74)	0.53 (-0.22 1.29)
Generalized anxiety	0.40 (0.17 0.59)	0.45 (0.22 0.64)	2.01 (0.96 3.06)
Panic	0.34 (0.07 0.56)	0.43 (0.26 0.79)	4.64 (2.93 6.36)
Social fobia	0.32 (0.11 0.52)	0.35 (0.12 0.55)	2.77 (1.03 4.52)
Obsession compulsion	0.22 (0.01 0.43)	-0.27 (0.40 0.53)	2.79 (1.61 3.96)
Depression	0.39 (0.17 0.57)	0.41 (0.30 0.88)	2.81 (1.12 4.51)
Total scale score	0.31 (0.07 0.52)	0.37 (0.16 0.65)	15,51 (8.84 22.17)
Male			
Separation anxiety	0.04 (0.01 0.40)	0.04 (-0.30 0.36)	0.17 (-2.08 2.45)
Generalized anxiety	0.16 (0.01 0.46)	0.19 (-0.24 0.69)	2.31 (0.55 4.07)
Panic	0.14 (0.05 0.44)	0.21 (-0.30 0.99)	4.79 (1.84 7.75)
Social fobia	0.37 (0.03 0.64)	0.39 (0.03 0.89)	2.14 (-0.23 4.51)
Obsession compulsion	0.02 (0.01 0.29)	0.03 (-0.53 0.63)	4.38 (2.23 6.53)
Depression	0.01 (0.01 0.24)	-0.14 (-0.45 0.21)	1.28 (-2.49 5.04)
Total scale score	0.11 (0.01 0.42)	0.13 (-0.37 0.74)	14.69 (3.07 26.31)

Bold ones mean statistically significant (p<0.05). ICC=Inter-rater reliability, CI=Confidence intervals, r=Pearson Correlation coefficent

When the adolescent-parent agreement is examined in terms of the education level of the adolescents; in the group attending secondary school, the ICC value ranged from 0.01 to 0.73 and was significant in all subscale and scale total scores. In the high school attendance group, the ICC value was between 0.01 and 0.56 and was significant except for the obsession-compulsion subscale. The difference between the average scores of the adolescent-parent forms in the group attending high school was higher than the group attending secondary school (**Table 4**).

Since all parent forms were filled by the mothers, the effect of the presence of psychiatric disorder in the mother on child-parent agreement was evaluated. In the group without maternal psychiatric disorder (95%), the ICC value ranged from -0.05 to 0.74 and was significant in all subscales and scale total scores. In the group with maternal psychiatric disorder (5%), the ICC value was between -9 and 0.97 and was not statistically significant. The difference between the mean scores of the adolescent-parent forms was higher in the group with maternal psychiatric disorder (**Table 5**).

Table 4. Examination of ICC Reliability, Correlation and Mean Differences of Child and Parent scale and/or subscale values according to adolescents' education level

Education Level	ICC (95% CI)	r (95% CI)	Paired t-test (95% CI)
Secondary School			
Separation anxiety	0.55 (0.30 0.73)	0.55 (0.26 0.75)	0.31 (-0.94 1.56)
Generalized anxiety	0.33 (0.05 0.56)	0.35 (0.06 0.75)	1.71 (0.31 3.12)
Panic	0.21 (0.02 0.46)	0.29 (-0.13 0.91)	4.19 (2.01 6.37)
Social fobia	0.32 (0.04 0.56)	0.34 (0.04 0.67)	2.05 (-0.18 4.28)
Obsession compulsion	0.24 (0.02 0.50)	0.28 (-0.45 0.60)	2.41 (0.80 4.01)
Depression	0.28 (0.01 0.53)	0.29 (-0.45 0.72)	1.71 (-0.73 4.16)
Total scale score	0.31 (0.03 0.55)	0.35 (0.06 0.77)	12.12 (3.15 21.09)
High School			
Separation anxiety	0.29 (0.03 0.51)	0.29 (0.03 0.45)	0.52 (-0.60 1.63)
Generalized anxiety	0.35 (0.09 0.56)	0.41 (0.15 0.61)	2.38 (1.20 3.56)
Panic	0.31 (0.03 0.54)	0.40 (0.19 0.78)	5.05 (3.04 7.06)
Social fobia	0.35 (0.10 0.55)	0.38 (0.13 0.62)	2.98 (1.14 4.83)
Obsession compulsion	0.09 (0.01 0.30)	-0.10 (-0.26 0.52)	3.86 (2.50 5.23)
Depression	0.23 (0.01 0.45)	0.25 (0.01 0.59)	2.84 (0.68 5.01)
Total scale score	0.23 (0.01 0.45)	0.29 (0.04 0.62)	17.55 (10.01 25.10)

Bold ones mean statistically significant (p<0.05). ICC=Inter-rater reliability, CI=Confidence intervals, r=Pearson Correlation coefficent

Table 5. Examination of ICC Reliability, Correlation and Mean Differences of Child and Parent scale and/or subscale values according to maternal psychopathology

	ICC (95% CI)	r (95% CI)	Paired t-test (95% CI)
With maternal psychopathology			
Separation anxiety	0.51 (-3.49 0.95)	0.36 (-1.83 2.83)	1.60 (-3.25 6.46)
Generalized anxiety	0.71 (-1.40 0.97)	0.83 (-0.50 0.99)	1.20 (-2.46 4.86)
Panic	-3 (-9 0.60)	-0.50 (-0.99 0.39)	2.80 (-3.43 9.03)
Social fobia	0.60 (-2.27 0.96)	0.43 (-0.80 0.97)	2.60 (-4.98 10.18)
Obsession compulsion	-0.27 (-2.17 0.81)	-0.17 (-0.90 0.99)	3.80 (-2.24 9.84)
Depression	0.70 (-3.90 0.97)	0.43 (-0.98 0.99)	1.20 (-6.01 8.40)
Total scale score	-0.83 (-7.50 0.79)	-0.30 (-0.99 0.99)	13.20 (-15.80 42.19)
Without maternal psychopathology			
Separation anxiety	0.61 (0.42 0.74)	0.44 (0.26 0.62)	0.37 (-0.47 1.22)
Generalized anxiety	0.50 (0.22 0.68)	0.37 (0.18 0.57)	2.15 (1.22 3.07)
Panic	0.46 (0.10 0.66)	0.38 (0.20 0.57)	4.79 (3.27 6.31)
Social fobia	0.50 (0.25 0.67)	0.36 (0.17 0.55)	2.59 (1.14 4.04)
Obsession compulsion	0.27 (-0.05 0.50)	0.21 (0.01 0.41)	3.22 (2.15 4.28)
Depression	0.40 (0.12 0.60)	0.27 (0.07 0.47)	2.43 (0.77 4.10)
Total scale score	0.43 (0.12 0.63)	0.33 (0.13 0.52)	15.38 (9.46 21.31)

Bold ones mean statistically significant (p<0.05). ICC=Inter-rater reliability, CI=Confidence intervals, r=Pearson Correlation coefficent

DISCUSSION

In this study, child-parent agreement was evaluated in terms of mental symptoms of 100 adolescents diagnosed with anxiety disorder. In our study, it was found that adolescents scored their symptoms higher than their parents, and the correlation between parent-child reporting was at a low-moderate level. There is a very weak agreement between parent-child reporting for anxiety disorder. In older children(adolescents), child-parent agreement may be better (but still weak) compared to younger children.[22,23] It is thought that the older child can express themself better against both their parents and practitioner; the relatively better agreement may be influenced from this. On the other hand, many studies reported that there is no relationship between age and child-parent agreement.[8,24,25] In our study, adolescent-parent mean score difference was greater in the older group who went to high school than the group who went to secondary school. Such inconsistent findings may be due to differing methodologies and samples. Our sample already consisted of adolescents with little variability in age. Therefore, it was difficult to interpret the effect of age on adolescent-parent agreement in our study.

There are similar inconsistent results on the effect of gender on child-parent agreement. In addition to studies reporting no effect of gender,[5,22,26] there are also publications showing better child-parent agreement in girls, like the results of our study.[5-7]

In studies conducted with RCADS, it has been shown that parent-child agreement is at a moderate-good level in healthy samples, and this agreement is much lower in those with internalizing symptoms.[27,28] In our study, which had a clinical sample, all of whom were diagnosed with anxiety disorder, in accordance with the literature adolescent-parent agreement was found low-moderate.

In RCADS, the highest parent-child agreement was found in the separation anxiety subscale, and the lowest in the generalized anxiety disorder subscale.[27,28] Similarly, in our study, the highest agreement was in the separation anxiety subscale. In addition, the only subscale in which no significant difference was found between the parent-child mean scores was the separation anxiety subscale. Situations such as separation anxiety significantly affecting the parent-child relationship and/or preventing the children from attending school or causing the parent to wait at school may lead to increased awareness of the parent and seek treatment.[29]

In addition to studies stating that there is a very high agreement between parent-child reporting in externalizing symptoms,[15,30] there are also studies in the literature showing that externalizing symptoms do not make a significant difference in terms of agreement.[29,31] In our study, it was determined that the parent-child agreement was better in patients with internalizing disorder in addition to anxiety disorder, and the difference in scores between parent-child scores was lower compared to those with externalizing disorder. It is thought that parent-child communication may be more impaired in the presence of externalizing disorder, and oppositional and/or destructive behaviors may reduce the child's insight.[25]

In our study, the difference between adolescent-parent mean scores was much higher in the presence of maternal psychopathology. It has also been shown in previous studies that child-parent disagreement is much higher in the presence of parental psychopathology, especially in the clinical sample as in our study.[8,26,32] However, since the number of mothers with psychopathology (5%) was very low in our study, the comparison made in terms of psychopathology remains quite limited.

CONCLUSION

The small clinical sample is one of the limitations of the study. Another limitation is that anxiety disorder was considered as a diagnostic cluster in our study, and we did not examine whether there was a difference in parent-child agreement in terms of sub diagnostic groups. Since all the parent forms in the study were filled by the mothers, the difference between father and mother awareness was not reflected in our study. In addition, there were patients using drugs for comorbidity in the sample, but there was no detailed data on these patients, and the effect of this parameter on child-parent agreement was not observed.

In our sample of adolescents with anxiety disorder, the adolescent-parent agreement was low to moderate, and age, gender, comorbidity, and parental psychopathology affected this agreement. In all psychopathologies in the childhood and adolescence, one of the biggest factors in helping the children get help is the parent's awareness of symptoms. The need for parental cooperation is inevitable not only in the search for treatment, but also in the continuation of treatment. For this reason, it is very important to know the factors affecting parental awareness in psychopathologies such as anxiety disorder, which is very common in childhood.

ETHICAL DECLARATIONS

Ethics Committee Approval: The study was carried out with the permission of University Clinical Research Ethics Committee (Date: 2022, Decision No: 2022/1937).

Informed Consent: All patients signed the free and informed consent form.

Referee Evaluation Process: Externally peer-reviewed.

Conflict of Interest Statement: The author has no conflicts of interest to declare.

Financial Disclosure: The author declared that this study has received no financial support.

Author Contributions: All of the authors declare that they have all participated in the design, execution, and analysis of the paper, and that they have approved the final version.

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