Notes

**Measurements**

***Demographics***

Demographic questionnaire derived primarily from the PhenX toolkit. This questionnaire gathers data about the participating parent/guardian, their partner (who might be the other parent of the youth), and the youth’s grandparents (e.g., country of origin). Additionally, information on friendships and bullying from both parents’ and youth’s perspectives, as the quality and quantity of friendships can act as early indicators of social functioning and predictors of future outcomes. Furthermore, data on the youth’s school performance is available, from both parent and youth, including questions related to repeating a grade, detentions, suspensions, and overall academic performance. School performance serves as an early indicator of potential challenges or as a predictor of future resilience or difficulties.

***Mental health assessment***

To assess mental health, both categorical and dimensional approaches are available. The categorical approach identifies the presence or absence of disruptive or abnormal behaviors using diagnostic criteria (e.g., DSM-IV, APA, 2000). Conversely, the dimensional approach places these behaviors on a frequency and severity continuum (e.g., Child Behavior Checklist, CBCL, Achenbach & Edelbrock, 1983; Lavigne et al., 1996). Both methods have their merits and limitations, and extensive research supports their use (Moreland & Dumas, 2008). The diagnosis of anxiety disorders continues to evolve, integrating both categorical and dimensional approaches. The DSM-5 advocates for the use of both methods (Bystritsky et al., 2013), addressing the limitations of the traditional categorical approach, such as measurement error, distorted comorbidity rates, and insufficient coverage of subthreshold presentations (T. A. Brown & Barlow, 2009).

*Parent report:*

Categorical Assessment:

The ABCD dataset employs the validated computerized Kiddie Schedule for Affective Disorders and Schizophrenia for DSM-5 (KSADS-5) for categorical diagnostic assessment. Created by Drs. Joan Kaufman and Ken Kobak with NIH SBIR support (Kobak et al., 2013), KSADS-5 includes three versions: a clinician-administered version, a parent self-administered version (reporting on the youth), and a youth self-administered version (self-reporting) (Kobak & Kaufman, 2015). These self-administered versions display strong agreement with the clinician-administered version, showing diagnostic concordance rates between 88% and 96%, with good to excellent reliability (Kobak et al., 2013). Parents complete the KSADS-5 modules at baseline, with annual in-person reassessments. Modules on externalizing, psychotic, and eating disorders are repeated during bi-annual follow-ups, as parents are reliable reporters for these behaviors in the studied age range, unlike internalizing behaviors where discrepancies between parent and adolescent reports are common. The 2016 updated DSM-5 Schedule for Affective Disorders and Schizophrenia in School-Aged Children (K-SADS-PL DSM-5) is a semi-structured interview for parents and youth aged 6-18. It categorizes diagnoses as "certain," "possible," "in remission," or "not present."

Dimensional Assessments:

Parents annually report on the Child Behavior Checklist (CBCL) (Achenbach, 2009). Additionally, starting at age 12, youth self-reports are collected using the Youth Self-Report (YSR) (Achenbach, 2009), and teacher reports are gathered using the Brief Problem Monitor (BPM-T). These assessments are normed by informant, age, sex, and ethnicity.

### Children

\*\*Categorical Assessment\*\*:

To complement parental assessments, adolescents provide self-reports in selected mental health domains for several reasons. First, research shows that parent and youth reports begin to diverge in early adolescence (Grills & Ollendick, 2002; Fisher et al., 2006; Rockhill et al., 2007; Rothen et al., 2009), with worse agreement for internalizing disorders compared to externalizing ones (Rey et al., 1992; Grills & Ollendick, 2002; Foley et al., 2004; Rothen et al., 2009), though not always (Verhulst & van der Ende, 1992). Second, parents' own depression and anxiety can color their reports of their children's mental health (Rothen et al., 2009). Third, youth self-reports may offer predictive insights beyond parental reports in some areas (Sourander et al., 2006a; Sourander et al., 2006b; Rothen et al., 2009). Based on this literature, adolescents self-report on mood disorders, separation anxiety, social anxiety, generalized anxiety, sleep, and suicidality. They complete the suicidality section of the KSADS-5 during shorter bi-annual in-person assessments starting in the first year. Other sections are included in the longer bi-annual assessments with imaging, and potentially additional KSADS-5 modules as developmentally appropriate.

\*\*Dimensional Assessment\*\*:

Starting at age 12, we collect dimensional assessments of psychopathology and function from the youth using the Youth Self-Report (YSR) (Achenbach, 2009).

### Family History

\*\*Family History of Psychopathology\*\*:

The "family history method" involves informants providing information on the presence or absence of various disorders in multiple family members. While it has relatively low diagnostic sensitivity compared to direct assessments, its specificity is generally reasonable (Andreasen et al., 1986; Rice et al., 1995). In the ABCD study, we use a version of the Family History Assessment Module Screener (FHAM-S) (Rice et al., 1995). Parents report on symptoms related to alcohol use disorder, substance use disorder, depression, mania, psychosis, and antisocial personality disorder in all first and second-degree blood relatives, including full and half-siblings, parents, grandparents, aunts, and uncles.

\*\*Self-Report of Psychopathology\*\*:

The primary caregiver parent completes the Adult Self Report (Achenbach, 2009) bi-annually. This approach captures similar behavioral dimensions relevant to psychopathology across youth self-reports, parent reports of youth behavior, and parent self-reports, facilitating family-based psychopathology studies.

\*\*Teacher Reports\*\*:

To obtain converging evidence of the youth's behavior, we request permission to ask the youth's teacher to complete the Brief Problem Monitor – Teacher Form (Achenbach, 2009) at each assessment wave.

### Additional Assessments

\*\*Six-Month Phone Assessments\*\*:

The ABCD study includes brief phone assessments of the child approximately six months between each in-person assessment. Besides evaluating substance use, we employ the Brief Problem Monitor (Achenbach, 2009) to measure current dimensional psychopathology from the youth's perspective.

\*\*One-Year Follow-Up In-Person Assessments\*\*:

Both parents and children will participate in annual in-person assessments. Every two years, a longer assessment battery similar to the baseline will be administered. In the intervening years, a shorter battery lasting about 2-3 hours will be used. We reassess all demographic questionnaire aspects that could change over time.

At the one-year assessment, we also start administering the Adverse Life Events Scale (Tiet et al., 2001; Grant et al., 2004) from the PhenX collection, asking for both parent and youth reports about events that the youth has experienced.

### Measurements

\*\*Demographics, Socioeconomic Status, School Performance, and Friendships\*\*:

Collecting comprehensive demographic information about the youth and their families is crucial because environmental factors significantly influence the health and development of children and adolescents. This also allows for accurate characterization of the study sample. Consequently, the assessment includes an extensive demographic questionnaire, largely derived from the PhenX toolkit, as summarized in Table 2. The questionnaire covers details about the participating parent/guardian, their partner (which may include the youth's other parent), and the youth’s grandparents (e.g., their country of origin). Additionally, we gather information on friendships and bullying from both the parent’s and the youth’s perspectives, as the quantity and quality of friendships can be early indicators of social functioning and future outcomes. Furthermore, we collect data from both parent and youth regarding the youth’s performance in school, including questions about repeating a grade, detentions/suspensions, and overall school performance. School performance may serve as an early indicator of potential challenges or as a predictor of future resilience or difficulties.

\*\*Parents’ Mental Health Assessment\*\*:

Assessment of mental health can follow either a categorical or dimensional approach. The categorical approach relies on diagnostic criteria to identify the presence or absence of disruptive or abnormal behaviors (e.g., as outlined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, APA, 2000). In contrast, the dimensional approach places behaviors along a continuum of frequency and/or severity (e.g., Child Behavior Checklist, CBCL, Achenbach & Edelbrock, 1983; Lavigne et al., 1996). Each approach has its own merits and drawbacks, supported by extensive research traditions (Moreland & Dumas, 2008)

The diagnosis of anxiety disorders is constantly evolving and adapting. In clinical practice and research, both structural and dimensional approaches to diagnosis are being utilized, with the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) advocating for the use of both (Bystritsky et al., 2013). The ongoing debate over the merits of dimensional versus categorical methods has been a driving force behind the establishment of DSM-5. Scholars have long recognized the limitations of the DSM's mostly categorical approach, which include measurement error, distorted rates of comorbidity, and insufficient coverage of subthreshold presentations (T. A. Brown & Barlow, 2009). These drawbacks have been highlighted in various studies, leading to the need for a more comprehensive and refined method of diagnostic classification (I,e,.

*Categorical assessment*

The validated computerized Kiddie Schedule for Affective Disorders and Schizophrenia for DSM-5 (KSADS-5) serves as the base for the categorical diagnostic assessment in the ABCD dataset. Developed by Drs. Joan Kaufman and Ken Kobak with NIH SBIR support (Kobak et al., 2013), KSADS-5 includes three versions: a clinician-administered version, a parent self-administered version (reporting on the youth), and a youth self-administered version (self-reporting) (Kobak and Kaufman, 2015). These self-administered versions exhibit strong agreement with the clinician-administered version, achieving diagnostic concordance rates between 88% and 96%, and kappas indicating good to excellent reliability (Kobak et al., 2013). Parents complete the KSADS-5 modules at baseline and measurement is repeated at annual in-person assessments. Modules on externalizing, psychotic, and eating disorder are collected again during shorter, bi-annual follow-ups. These domains are emphasized because parents are particularly reliable reporters for these behaviors in the studied age range, unlike internalizing behaviors where discrepancies between parent and adolescent reports may arise.

The updated 2016 DSM-5 Schedule for Affective Disorders and Schizophrenia in School-Aged Children (K-SADS-PL DSM-5) is a semi-structured interview for both parents and children/adolescents aged 6-18. This tool, compatible with DSM-5 diagnostics, allows categorization of diagnoses as "certain," "possible," "in remission," or "not present."

*Dimensional assesments*

Parents report to the Child Behavior Checklist (CBCL) (Achenbach, 2009) annually. Additionally, the Youth Self-Report (YSR) (Achenbach, 2009) is used to gather youth self-reports beginning at age 12, as well as the Brief Problem Monitor (BPM-T) to gather teacher reports. Quantitative tests such as the CBCL, YSR, and BPM-T are normed by informant, age, sex, and ethnicity.

### Children

\*\*Categorical Assessment\*\*:

To complement parental assessments, we also asked adolescents to provide self-reports in selected mental health domains for several reasons. First, research indicates that parent and youth reports begin to diverge in early adolescence (Grills & Ollendick, 2002; Fisher et al., 2006; Rockhill et al., 2007; Rothen et al., 2009), with worse agreement for internalizing disorders compared to externalizing ones (Rey et al., 1992; Grills & Ollendick, 2002; Foley et al., 2004; Rothen et al., 2009), though not always (Verhulst & van der Ende, 1992). Second, parents' own depression and anxiety can bias their reports of their children's mental health (Rothen et al., 2009). Third, youth self-reports may offer predictive insights beyond parental reports in some areas (Sourander et al., 2006a; Sourander et al., 2006b; Rothen et al., 2009). Based on this literature, we have adolescents self-report on mood disorders, separation anxiety, social anxiety, generalized anxiety, sleep, and suicidality. They will complete the suicidality section of the KSADS-5 during shorter bi-annual in-person assessments starting in the first-year follow-up. Other sections will be included in longer bi-annual assessments that involve imaging, and potentially additional KSADS-5 modules as developmentally appropriate.

\*\*Dimensional Assessment\*\*:

Starting at age 12, we will collect dimensional assessments of psychopathology and function from the youth using the Youth Self-Report (YSR) (Achenbach, 2009).

### Family History

\*\*Family History of Psychopathology\*\*:

The "family history method," where informants provide information on the presence or absence of various disorders in multiple family members, is the most commonly used approach to assess family history. Although it has relatively low diagnostic sensitivity compared to direct assessments, its specificity is generally reasonable (Andreasen et al., 1986; Rice et al., 1995). In the ABCD study, we use a version of the Family History Assessment Module Screener (FHAM-S) (Rice et al., 1995). Parents report the presence or absence of symptoms related to alcohol use disorder, substance use disorder, depression, mania, psychosis, and antisocial personality disorder in all first and second-degree blood relatives of the youth, including full and half-siblings, parents, grandparents, aunts, and uncles.

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Both parents and children will participate in annual in-person assessments. Every two years, a longer assessment battery similar to the baseline will be administered. In the intervening years, a shorter battery lasting about 2-3 hours will be used. We reassess all demographic questionnaire aspects that could change over time.

Despite the recognized burden of anxiety disorders, they remain among the most prevalent untreated psychiatric conditions (Bandelow & Michaelis, 2015). Nearly one in three adolescents suffers from anxiety disorders, making it the most common mental health issue in this age group (Merikangas et al., 2010). Although less conspicuous than bipolar disorder, depression, and schizophrenia, anxiety disorders can be equally debilitating (Bystritsky et al., 2013). They contribute to reduced productivity, higher rates of morbidity and mortality, and increased substance abuse (Bystritsky et al., 2013; Koen & Stein, 2011; Leon et., 1995; Loeb et al., 2012).

The term "anxiety" encompasses a broad range of specific mental challenges, complicating its conceptualization and description. Anxiety disorders such as separation anxiety disorder, generalized anxiety disorder (GAD), panic disorder, social anxiety disorder (SAD), specific phobias, and post-traumatic stress disorder (PTSD) exhibit varying prevalence rates and symptom presentations (Kessler et al., 2010). Additionally, the comorbidity with other mental health conditions further complicates the anxiety phenotype (Kessler et al., 2010). The diverse manifestations and overlapping features of anxiety disorders make them particularly challenging to understand, explain, and treat effectively for researchers, clinicians, and those affected by these conditions.

Evaluating anxiety symptomatology in adolescents presents numerous challenges. It is well-documented that a combination of biological, psychological, and sociocultural factors can influence the risk and resilience for developing maladaptive responses to social or environmental contexts (Luthar et al., 2000; Sanislow et al., 2010). Studies show that individuals with anxiety disorders exhibit specific structural brain differences compared to healthy controls. Notably, significant reductions in gray matter volume (GMV) have been consistently observed in the anterior cingulate cortex (ACC) and insular cortices (Bora et al., 2012; Bromis et al., 2018; Radua et al., 2010), which are considered general markers of psychopathology (Goodkind et al., 2015).

Anxiety disorders, as conceptualized in the DSM-5, also display GMV differences in fronto-parietal and ventral attention networks, including the ventrolateral prefrontal cortex (PFC) and temporo-parietal junction, areas implicated in attentional control and anxiety symptomatology (Sylvester et al., 2012). Comparing anxiety to major depressive disorder (MDD), studies highlight potential distinctions in frontotemporal regions. Using machine learning techniques, these regions have shown greater accuracy in differentiating between MDD and GAD than clinical questionnaires (Hilbert et al., 2017; Zhao et al., 2017). Other studies have found significant correlations between generalized anxiety similarity and cortical thickness similarities in the left caudal ACC and pericalcarine cortex (Yoo & Kim, 2023).

Gathering information about a child’s functioning typically involves input from multiple informants, including the child and parents (Achenbach, 2006). Mental health issues can vary across different contexts (Bauducco et al., 2024; Beesdo et al., 2009). Children and adolescents may exhibit mental health concerns in certain environments, such as at home or school, but not in others, like during peer interactions. These contextual variations are evident across various domains, including conduct problems, attention, hyperactivity, and anxiety (Beesdo et al., 2009).

However, the reliability of parent reports for assessing children's experiences, especially for non-observable functions like emotions, has been questioned (Eiser & Morse, 2001). Parental assessments often differ from children’s self-perceptions, potentially due to biases, superficial observations, or the nature of the parent-child relationship. Conversely, children frequently lack objective self-perception (Barrett et al., 1991; Martin et al., 2004). Research indicates discrepancies and varying accuracy in symptom reporting, with no clear consensus on which group reports internalized symptoms more accurately, while parents tend to be more precise in identifying externalized symptoms (Silverman & Eisen, 1992).

Important information on a child's functioning may be provided by the individual being evaluated as well as by other informants (Achenbach, 2006). Different situations can provoke varying levels of mental health issues (Bauducco et al., 2024; Beesdo et al., 2009). Consequently, children and adolescents may exhibit mental health concerns in specific environments, such as at home or school, but not in others, like peer interactions. These contextual variations in the manifestation of mental health issues are evident across several domains, including conduct problems, attention and hyperactivity, and anxiety (Beesdo et al., 2009). However, questions have been raised about whether parent reports may be used to assess children's experiences, particularly in light of research showing reduced parent-child agreement for non-observable functioning like emotion (Christine Eiser & Morse, 2001). Parents' assessments often differ from their children's self-perceptions. Many studies have indicated that parents' evaluations of their children can be biased, superficial, and influenced by their relationship with the child. Similarly, children frequently lack an objective self-perception (Barrett et al., 1991; Martin et al., 2004). Many studies have explored these discrepancies and the accuracy of symptom reporting appears to diverge based on the type of symptoms: there is less consensus on which group reports internalized symptoms more accurately, whereas parents seem to be more precise in identifying externalized symptoms (Silverman & Eisen, 1992).

This conflict arises because children often value their behavior differently than parents do [10], and the complexity increases as they age and report worse health—particularly emotional health—compared to their parents' assessments [16]. Multiple studies indicate that these differences stem from parents downplaying their children's symptoms of anxiety and depression [17–20]. Notably, children tend to report internalized symptoms like depression and anxiety at higher rates than their parents. Conversely, there is higher agreement between both groups when evaluating externalized symptoms such as hyperactivity or defiant behavior [9,21]. Several contextual factors influence the degree of agreement or disparity between reports.

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Therefore, pinpointing the contexts in which mental health issues arise can improve treatment planning and enhance treatment outcomes (National Institute of Mental Health, 2020). Given the concerns about mental health indicators in early childhood stemming from various factors, a multi-informant assessment approach has proven beneficial for the clinical diagnosis of mental disorders. This approach, which involves gathering information from multiple sources, is the most common strategy for assessing contextual variations in mental health (Kraemer et al., 2003). This includes the reports of those who spend a significant amount of time or have close relationships with the index patient (Achenbach, 2006). By considering reports from informants who vary in the specific contexts in which they observe patients’ behavior (e.g., home vs. school vs. peer interactions), mental health practitioners can learn how consistently or inconsistently patients express concerns across different settings (Dirks et al., 2012).

While integrating multiple informants provides a broader understanding of a child's psychological functioning, incorporating advanced neuroimaging techniques, such as structural Magnetic Resonance Imaging (sMRI), can offer insights into the biological underpinnings of mental health disorders. sMRI provides detailed images of brain structures, allowing researchers and clinicians to identify structural abnormalities associated with various mental health conditions.

Higher socioeconomic status is associated with an underestimation of children's mental health difficulties by parents, while lower socioeconomic status has the opposite effect [22]. Additionally, family characteristics such as parenting style, lack of communication, and parent-child conflict are linked to higher levels of disagreement [23–32]. In contrast, parental acceptance and family cohesion correlate with lower levels of discrepancy [9,25]. These observed discrepancies are often attributed to informant bias and measurement errors [26]. However, such disparities could also reflect underlying family issues that may contribute to the development of psychopathologies, thereby providing valuable insight into the nature and progression of child and adolescent psychopathology [27].

Child and adolescent mental health patients lead complex lives (i.e., collectively referred to as “children” unless otherwise spec- ified). Indeed, mental health concerns arise out of an interplay among biological, psychological, and sociocultural factors that pose risk for, or offer protection against, developing maladaptive reactions to environmental or social contexts (e.g., Cicchetti, 1984; Luthar, Cicchetti, & Becker, 2000; Sanislow et al., 2010). How- ever, not all contexts elicit mental health concerns to the same degree (e.g., Carey, 1998; Kazdin & Kagan, 1994; Mischel & Shoda, 1995). Therefore, patients may display concerns within some contexts, such as home and school, but not others, such as within peer interactions. In fact, these contextual variations in displays of mental health concerns occur within a variety of mental health domains including social anxiety, attention and hyperactiv- ity, and conduct problems (e.g., Bögels et al., 2010; Dirks, De Los Reyes, Briggs-Gowan, Cella, & Wakschlag, 2012; Drabick, Gadow, & Loney, 2007, 2008; Kraemer et al., 2003). Thus, iden- tifying the specific contexts in which patients display concerns may facilitate treatment planning and boost treatment efficacy (e.g., De Los Reyes, 2013; National Institute of Mental Health [NIMH], 2008).

However, different situations raise different levels of mental health issues (e.g., Carey, 1998; Kazdin & Kagan, 1994; Mischel & Shoda, 1995). As a result, patients may express concerns in certain settings, like the home and school, but not in others, like peer relationships. In actuality, these contextual differences in how mental health issues manifest themselves arise in a number of mental health areas, such as conduct issues, attention and hyperactivity, and social anxiety (e.g., Bögels et al., 2010; Dirks, De Los Reyes, Briggs-Gowan, Cella, & Wakschlag, 2012; Drabick, Gadow, & Loney, 2007, 2008; Kraemer et al., 2003).

Thus, iden- tifying the specific contexts in which patients display concerns may facilitate treatment planning and boost treatment efficacy (e.g., De Los Reyes, 2013; National Institute of Mental Health [NIMH], 2008).

Due to concerns about mental health indicators at early ages stemming from the interaction of many factors, a multi-informant assessment approach has been deemed beneficial to clinical diagnosis of mental disorders. The most prevalent strategy for assessing contextual variations in mental health is the multi-informant assessment approach (Kraemer et al., 2003).

This includes the reports of those who spend a significant amount of time or have close relationships with the index patient (De Los Reyes et al., 2015).

Specifically, this approach involves taking reports from informants who share close relationships with the patients about whom they are providing reports, or at minimum spend a significant amount of time observing patients’ behavior (Achenbach, 2006). By considering reports from informants who vary among each other in the specific contexts in which they observe patients’ behavior (e.g., home vs. school vs. peer interac- tions), mental health professionals may gain an understanding as to how consistently or inconsistently patients display concerns across contexts (Dirks et al., 2012). For child patients, these informants most often include parents, teachers, and patients themselves (Hunsley & Mash, 2007). Further, trained raters might also com- plete reports, such as clinical interviewers and independent ob- servers of patients’ behavior on standardized clinical tasks (e.g., structured social interactions) or unstandardized home or school observations (Groth-Marnat, 2009).

Parents' perceptions may differ from their children's self-perceptions. According to reports, parents' assessments of their kids are frequently biased, somewhat superficial and influenced by their relationship the child. In a similar vein, children frequently lack an objective self-perception (Barrett et al., 1991; Martin et al., 2004).

In the case of the pediatric population, one of the most widely used sources of information, in addition to the child’s own self-report, is that of their parents or caregivers [5]. Although the use of multiple informants in mental health assessment in the infant population benefits the understanding of the psychological functioning of children, discrepancies have been observed between the self-reports and the data provided by parents [6], and also between parents and teachers [7,8], generating new challenges for clinical practice, research, and theory related to child psychiatry and psychopathology [9].

These discrepancies have been extensively studied [10,11], showing that children as young as 6 years old may report independently regarding their health, as compared to parental reporting [12,13]. Furthermore, studies in the 1970s indicated that girls tend to be more reliable informants than boys [14]. Moreover, when externalized problems are analyzed, it seems that parents tend to be more precise than their children; however, when internalized symptoms are analyzed, there seems to be less agreement about which group reports symptoms better [15]. This disagreement stems from the fact that children value their behavior more positively than parents do [10]; although, it becomes more complicated towards adolescence, where they seem to report poorer health than parents, especially in emotional health [16]. Various studies support that these discrepancies are based on an underestimation of anxious and depressive symptoms by the parents [17–20]. In this sense, it has been observed that children tend to report more internalized symptoms such as depression and anxiety than their parents do. However, when externalizing symptoms such as defiant behavior or hyperactivity are under evaluation, some studies have found a higher level of agreement between both groups [9,21].

Additionally, there are certain contextual factors that associate with higher agreement or discrepancy between reports. It has been observed that when there is a higher socioeconomic level, parents tend to underestimate the problems related to their children’s mental health, while in lower socioeconomic levels, the opposite happens [22]. Furthermore, family factors, such as parenting style, lack of communication, and conflict between parents and children, have been associated with higher levels of discrepancy in both reports [23–32], while family cohesion and parental acceptance have shown fewer discrepancies [9,25]. Traditionally, these observed differences have been interpreted as a function of measurement errors and informant bias [26]. However, such discrepancies may be significant to understand the nature and course of child and adolescent psychopathology, as they may reflect underlying family problems, which potentially contribute to the development of psychopathologies [27].**(Caqueo-Urízar et al., 2022)**

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THIS IS NICE:

Along with the child's self-report, one of the most popular sources of information for the pediatric population is the child's parents or other primary caregivers [5]. There are differences between self-reports and the information provided by parents [6], as well as between parents and teachers [7, 8], which creates new problems for clinical practice, research, and theory on child psychiatry and psychopathology [9], even though the use of multiple informants in mental health assessment in the infant population improves our understanding of the psychological functioning of children.

Parents' perceptions may differ from their children's self-perceptions. According to reports, parents' assessments of their kids are frequently biased, somewhat superficial and influenced by their relationship the child. In a similar vein, children frequently lack an objective self-perception (Barrett et al., 1991; Martin et al., 2004).

Numerous studies have examined these discrepancies [10,11], demonstrating that children as young as 6 years old may report on their own health in contrast to parental reporting [12,13]. Moreover, research conducted in the 1970s revealed that girls are typically more reliable informants than boys [14]. Furthermore, there appears to be less consensus regarding which group reports symptoms more accurately when internalized symptoms are examined, while parents appear to be more accurate than their children when externalized difficulties are examined [15]. This dispute arises from the fact that children place a higher value on their behavior than do their parents [10], but it gets more complicated as they get older and appear to report worse health than their parents, particularly in terms of their emotional health [16]. Numerous research provide evidence that these differences stem from the parents' minimizing their children's anxiety and depression symptoms [17–20]. In this regard, it has been noted that children report internalized symptoms like depression and anxiety at higher rates than do their parents. However, other studies have revealed a higher level of agreement across both groups when externalizing symptoms like hyperactivity or defiant behavior are evaluated [9,21].  
Furthermore, several contextual factors are linked to greater agreement or difference between reports. Higher socioeconomic levels have been found to cause parents to underestimate their children's mental health difficulties, whilst lower socioeconomic levels had the opposite effect [22]. Additionally, both reports have linked higher levels of disagreement to family characteristics such parenting style, lack of communication, and parent-child conflict [23–32], whereas parental acceptance and family cohesion have demonstrated lower levels of discrepancy [9,25]. These observed discrepancies have often been explained by informant bias and measurement errors [26]. However, because they can be a reflection of underlying family issues that could contribute to the development of psychopathologies, such disparities could be important to understanding the nature and progression of child and adolescent psychopathology [27].In 2022, Caqueo-Urízar et al

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ paragraph about what is up with the existing differences between youth and parent:

There are notable differences between self-reports and parental information [6], as well as between reports from parents and teachers [7, 8], which poses significant challenges for clinical practice, research, and theoretical frameworks in child psychiatry and psychopathology [9]. Nonetheless, incorporating multiple informants in mental health assessments enhances our understanding of children's psychological functioning.

Parents' assessments often differ from their children's self-perceptions. Research indicates that parents' evaluations of their children can be biased, superficial, and influenced by their relationship with the child. Similarly, children frequently lack an objective self-perception (Barrett et al., 1991; Martin et al., 2004). Numerous studies have explored these discrepancies [10,11], revealing that even children as young as six can report on their own health, contrasting with parental reports [12,13]. Additionally, research from the 1970s suggests that girls are generally more reliable informants than boys [14].

The accuracy of symptom reporting appears to diverge based on the type of symptoms: there is less consensus on which group reports internalized symptoms more accurately, whereas parents seem to be more precise in identifying externalized difficulties [15]. This conflict arises because children often value their behavior differently than parents do [10], and the complexity increases as they age and report worse health—particularly emotional health—compared to their parents' assessments [16]. Multiple studies indicate that these differences stem from parents downplaying their children's symptoms of anxiety and depression [17–20]. Notably, children tend to report internalized symptoms like depression and anxiety at higher rates than their parents. Conversely, there is higher agreement between both groups when evaluating externalized symptoms such as hyperactivity or defiant behavior [9,21].

Several contextual factors influence the degree of agreement or disparity between reports. Higher socioeconomic status is associated with an underestimation of children's mental health difficulties by parents, while lower socioeconomic status has the opposite effect [22]. Additionally, family characteristics such as parenting style, lack of communication, and parent-child conflict are linked to higher levels of disagreement [23–32]. In contrast, parental acceptance and family cohesion correlate with lower levels of discrepancy [9,25]. These observed discrepancies are often attributed to informant bias and measurement errors [26]. However, such disparities could also reflect underlying family issues that may contribute to the development of psychopathologies, thereby providing valuable insight into the nature and progression of child and adolescent psychopathology [27].