RESEARCH ARTICLE

Parent-Child Agreement on the Mini International Neuropsychiatric Interview for Children and Adolescents (MINI-KID)

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Abstract

Objective: Multiple informants are often used in the assessment of child psychopathology; however, parent-child agreement is low in child psychiatry. The objective of this exploratory study was to assess informant agreement on the Mini International Neuropsychiatric Interview for Children and Adolescents (MINI-KID) in a clinical sample of children with mental disorders and their parents, and to examine health and demographic factors associated with agreement. **Method**: MINI-KID results were analyzed for 88 parent-child dyads. Children were between 8-17 years old and were receiving in- or outpatient services for at least one mental disorder at a pediatric hospital. Kappas were calculated to assess parent-child agreement and logistic regression models were used to identify factors associated with agreement. **Results**: Agreement was low to moderate (κ=0.19-0.41) across the MINI-KID modules. Household income was associated with agreement for major depression, generalized anxiety, and attention-deficit hyperactivity disorder. Recruitment setting and parent psychological distress were associated with agreement for generalized anxiety and separation anxiety, respectively. Age, sex, and child disability/impairment were not associated with agreement. **Conclusions**: Parent-child agreement on the MINI-KID was low to moderate, and few factors were associated with agreement. These initial findings reaffirm the need for multiple informants when assessing psychopathology in children and can be used by health professionals to facilitate parent-child discussions in clinical settings in child psychiatry.

Key Words: child, agreement, parent, psychiatric disorder, reliability

Résumé

Objectif: De multiples informateurs sont souvent utilisés pour évaluer la psychopathologie de l'enfant; cependant, l'entente parent-enfant est faible en psychiatrie de l'enfant. L'objectif de la présente étude exploratoire était d'évaluer l'entente des informateurs à l'égard du mini-entretien neuropsychiatrique international pour enfants et adolescents (MINI-KID) dans un échantillon clinique d'enfants souffrant de troubles mentaux et de leurs parents, et d'examiner les facteurs de santé et démographiques associés à l'entente. **Méthode**: Le résultats du MINI-KID ont été analysés pour 88 dyades parent-enfant. Les enfants avaient entre 8 et 17 ans et recevaient des services ambulatoires ou hospitalisés pour au moins un trouble

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mental dans un hôpital psychiatrique. Les kappas ont été calculés pour évaluer l'entente parent-enfant et des modèles de régression logistique ont servi à identifier les facteurs associés à l'entente. **Résultats**: L'entente était de faible à modérée (κ = 0,19-0,41) dans tous les modules du MINI-KID. Le revenu du ménage était associé à l'entente pour la dépression majeure, l'anxiété généralisée, et le trouble de déficit de l'attention avec hyperactivité. Les paramètres du recrutement et la détresse psychologique parentale étaient associés à l'entente pour l'anxiété généralisée et l'angoisse de séparation respectivement. L'âge, le sexe et la déficience/incapacité de l'enfant n'étaient pas associés à l'entente. **Conclusions**: L'entente parent-enfant au MINI-KID était faible à modérée, et peu de facteurs étaient associés à l'entente. Ces premiers résultats réaffirment le besoin de multiples informateurs pour évaluer la psychopathologie des enfants et peuvent être utilisés par les professionnels de la santé pour animer les discussions parent-enfant dans les milieux cliniques de psychiatrie de l'enfant.

Mots clés: entente parent-enfant, trouble psychiatrique, fiabilité

Multiple informants are often used in the assessment of child psychopathology to maximize the amount and quality of information collected (De Los Reyes et al., 2015; De Los Reyes & Kazdin, 2005), and inform decision-making (Dudley et al., 2015). While family-centered approaches to care advocate for multi-informant perspectives, challenges arise when discrepancies are observed. Evidence from child psychiatry suggests that parent-child agreement is low-to-moderate (Becker et al., 2016; Hamblin et al., 2016; Landis & Koch, 1977). Population studies have reported kappa (κ) agreement ranging from κ=0.14-0.63 (Berman et al., 2016; Jensen et al., 1999; Van Roy et al., 2010). Similarly, findings from clinical samples have reported agreement ranging from κ=0.18-0.35 (Choudhury et al., 2003; Comer & Kendall, 2004; Van Der Meer et al., 2008). Because symptoms of externalizing disorders are more easily observable, parent-child agreement tends to be higher compared to internalizing disorders (Edelbrock et al., 1986; Martin et al., 2004; Salbach-Andrae et al., 2009); however, this finding is not always consistent (Hamblin et al., 2016).

Agreement is typically stronger for adolescents (vs. children) (Becker et al., 2016; Duncan et al., 2018; Edelbrock et al., 1986; Grills & Ollendick, 2002; Jensen et al., 1999), females (Kolko & Kazdin, 1993; Van Roy et al., 2010), individuals with more severe symptoms (Duncan et al., 2018), and families with higher household incomes (Van Roy et al., 2010). Parent psychopathology is associated with lower parent-child agreement; however, this finding may be disorder-dependent (Affrunti & Woodruff-Borden, 2015; Becker et al., 2016; Popp et al., 2017). Literature is inconsistent, as many studies find these factors are not associated with agreement (Affrunti & Woodruff-Borden, 2015; Becker et al., 2016; Choudhury et al., 2003; Klein, 1991; Popp et al., 2017). Notably increased parent-child discrepancy for psychopathology has been shown to predict a poorer prognosis for children, including referral to mental health services, need for professional help, and increased behavioural

or emotional problems (Ferdinand et al., 2004). To ensure the best possible outcomes for children, there is an impetus to investigate the magnitude of and factors associated with (dis)agreement.

The Mini International Neuropsychiatric Interview for Children and Adolescents (MINI-KID) is a brief, diagnostic interview designed to identify mental disorders in children (Sheehan et al., 2010). It includes parent and child versions, has a low cost, and short administration time, making it an appealing tool for clinicians and researchers (Duncan et al., 2018; Leffler et al., 2015). Previous studies on the MINI-KID have shown mixed results with respect to parent-child agreement. While one study found good concordance between parent and child assessments (κ=0.46-0.94) (Sheehan et al., 2010), others found agreement to be low (κ=0.15-0.20) (Butler et al., 2018; Duncan et al., 2018). However, no studies have assessed parent-child agreement on the MINI-KID in a clinical sample of children with mental disorder. The aims of this exploratory study were to: (1) examine parent-child agreement on the MINI-KID, and (2) explore which demographic and health factors are associated with agreement in a clinical sample of children with mental disorders and their parents. It was hypothesized that parent-child agreement will be low-to-moderate, with externalizing disorders having more agreement compared to internalizing disorders. Additionally, we hypothesized that agreement would be positively associated with child age, female children, and household income, and negatively associated with parent psychopathology.

Method

Data Source

Data come from a cross-sectional study of children receiving mental health services at an academic pediatric hospital (Ferro et al., 2019). Children were eligible for the study if they were aged 4-17 years; classified as having a mental

disorder; currently receiving mental health services; and both informants had sufficient command of the English language. A total of 259 eligible children were identified. Of these, 144 (56%) provided consent, and 100 (39%) participated.

Eligible children and parents were contacted and provided information about the study. Interview and questionnaire responses were collected electronically. All interviews were conducted by a single trained interviewer. For inpatients, interviews for children and parents were typically conducted on the same day, and all were conducted within two days. For outpatients, interviews were conducted during a single research study visit. Informed consent was obtained for all participants.

Measures

Child Psychopathology. The MINI-KID was completed by parents and children. The MINI-KID is a structured, diagnostic interview used to assess DSM-5 and ICD-10 disorders in children aged 6–17 years (Sheehan et al., 2010). Responses to the MINI-KID are binary (yes/no), indicating the presence or absence of the disorder. The MINI-KID has previously demonstrated strong psychometric properties in clinical and general populations (Boyle et al., 2017; Duncan et al., 2018; Sheehan et al., 2010).

Child Disability/impairment. The World Health Organization Disability Assessment Schedule (WHODAS) 2.0 is a 36-item self-report measure of 30-day disability/impairment (Üstün et al., 2010). Parents responded to each item using a five-point scale ranging from '1' (none) to '5' (extreme/cannot do), higher scores indicate higher functional impairment. The WHODAS 2.0 has shown robust psychometric properties including, confirmed factor structure, measurement invariance, test-retest reliability (intraclass correlation coefficient, ICC=0.93-0.96), and internal consistency (α=0.91-0.94) in child populations, including those with mental disorders (Kimber et al., 2015; Tompke et al., 2019; Üstün et al., 2010).

Parent Psychological Distress. Parent psychological distress was measured by computing the sum of responses on the Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977) and the State Trait Anxiety Inventory (STAI; Spielberger, 1983) scales. Both scales have strong psychometric properties, including replicated factor structures, measurement invariance, construct validity, test-retest reliability, and internal consistency in various adult populations (Dol et al., 2020; Ferro & Speechley, 2012; Julian, 2011; Okun et al., 1996). The CES-D is a 20-item self-report measure that asks parents how often they felt symptoms using a 4-point likert scale from '0' (rarely)

to '3' (most of the time) (Radloff, 1977). The STAI includes 20-items focused on 'trait anxiety' scored from '1' (almost never) to '4' (almost always) (Spielberger, 1983). Higher scores on each scale indicate greater impairment.

Sociodemographic Factors. Relevant sociodemographic factors such as child and parent age and sex, household income, and care setting were collected. Parent-reported household income was coded as gross annual household income above or below $75,000, the Canadian median household income (Statistics Canada, 2017).

Data Analysis

The outcome of interest was parent-child agreement. Agreement was defined as the parent and child both endorsing the presence or absence of a given disorder on the MINI-KID, while disagreement was defined as either the parent or child endorsing the disorder, while the other did not. Kappa was used to estimate level of agreement, such that κ≤0 (poor), κ=0.01-0.20 (slight), κ=0.21-0.40 (fair), κ=0.41-0.60 (moderate), κ=0.61-0.80 (substantial), and κ≥0.81 (almost perfect) (Landis & Koch, 1977). Dyads (with vs. without agreement) were compared using Wilcoxon rank-sum tests for continuous variables (child age, parent age, parent psychosocial distress, parent report WHODAS 2.0) and Fisher's Exact test for binary variables (child/parent sex, household income, recruitment site). Backwards-elimination logistic regression was used to identify factors associated with parent-child agreement in a final, adjusted model. Based on the exploratory nature and limited sample size of this study, the threshold for variable retention and significance level for all hypothesis tests was set at p<0.10, a more liberal α compared to commonly accepted significance levels (Bursac et al., 2008; Dunkler et al., 2014).

Results

Sample Characteristics

Twelve parent-child dyads were excluded due to missing data; thus, 88 dyads were analyzed. Sample characteristics are shown in Table 1. Participating children had a mean age of 14.5 (SD 2.2) years and were 71.6% female. Most parents were female (84.1%) and had a mean age of 45.8 (SD 6.7) years. Approximately half (51.1%) of participants reported an annual household income <$75,000. Major depressive disorder and phobia were the most common disorders endorsed by both parents and children, 60.2% and 52.3%, respectively (Table 2).

Table 1. Characteristics of the study sample	
	Mean (SD)
Child age, years	14.5 (2.2)
Child disability/impairment, WHODAS 2.0	2.40 (0.66)
Parent age, years	45.8 (6.7)
Parent psychosocial distress	65.3 (16.7)
	n (%)
Female child	63 (71.6)
Female parent	74 (84.1)
Household income <$75,000	45 (51.1)
Inpatient	35 (39.8)

Table 2. Dyad responses on the MINI-KID				
	Agreement Count (%)		Disagreement Count (%)	
	Parent: Yes Child: Yes	Parent: No Child: No	Parent: No Child: Yes	Parent: Yes Child: No
Major depressive disorder	53 (60.2)	13 (14.8)	9 (10.2)	13 (14.8)
Generalized anxiety	41 (46.6)	14 (15.9)	10 (11.4)	23 (26.1)
Separation anxiety	13 (14.8)	48 (54.5)	11 (12.5)	16 (18.2)
Phobia	46 (52.3)	16 (18.2)	16 (18.2)	10 (11.4)
ADHD	16 (18.2)	41 (46.6)	16 (18.2)	15 (17.0)
Oppositional defiant/ conduct disorder	25 (28.4)	37 (42.0)	8 (9.1)	18 (20.5)

Parent-Child Agreement

Table 3 shows the estimates of agreement between parents and children on the MINI-KID. Agreement was moderate for oppositional defiant/conduct disorder [κ=0.41 (0.22, 0.59)], but fair for major depressive disorder [κ=0.37 (0.16,0.59)], attention-deficit hyperactivity disorder (ADHD) [κ=0.23 (0.02, 0.44)], phobia [κ=0.33 (0.13, 0.54)], and separation anxiety [κ=0.27 (0.06, 0.49)], and slight for generalized anxiety [κ=0.19 (-0.01, 0.39)].

Disagreement type was evaluated to determine if parents or children were more frequently endorsing disorders (Table 2). In general, when disagreement existed it was more common for parents to endorse presence of a disorder. Exceptions existed for ADHD, where approximately equal numbers of parents and children endorsed the disorder, and for phobia where children more commonly provided endorsement.

Factors Associated with Parent-Child Agreement

Unadjusted analyses comparing factors between dyads with vs. without agreement generally did not reveal significant differences between groups (Table 4). Results of the adjusted analyses are shown in Table 5. The only factor retained in more than one model was household income, which was associated with parent-child agreement for major depressive disorder [OR=0.29 (0.12, 0.71)], generalized anxiety [OR=0.44 (0.21, 0.95)], and ADHD [OR=2.18 (1.03, 4.61)]. Receiving inpatient services was associated with agreement on generalized anxiety [OR=2.38 (1.08, 5.28)], and parent psychological distress for separation anxiety [OR=0.97 (0.95, 0.99)]. Child and parent age and sex, and WHODAS 2.0 score were not retained in any model. No associations were found for oppositional defiant/conduct disorder or phobia.

Table 3. Parent-child MINI-KID agreement across mental disorders			
	Kappa	90% Confidence interval	
		Lower limit	Upper limit
Major depressive disorder	0.37	0.16	0.59
Generalized anxiety	0.19	-0.01	0.39
Separation anxiety	0.27	0.06	0.49
Phobia	0.33	0.13	0.54
ADHD	0.23	0.02	0.44
Oppositional defiant/conduct disorder	0.41	0.22	0.59

Discussion

This study was the first to examine parent-child agreement on the MINI-KID in a clinical sample of children with mental disorders. In line with our hypotheses, agreement was low-to-moderate across all disorders, and some agreements were associated with household income, parent psychosocial distress, and receiving inpatient services. Externalizing disorders did not show a greater degree of agreement compared to internalizing disorders and no association was observed between parent-child agreement and age, sex, or child disability/impairment.

The finding of low-to-moderate agreement aligns with previous reports of parent-child discrepancies when using the MINI-KID in other settings (Butler et al., 2018; Duncan et al., 2018), and suggests that this association also extends to clinical samples. This finding is consistent with previous reports of low parent-child agreement in clinical samples when using other measures of child psychopathology (Choudhury et al., 2003; Comer & Kendall, 2004; Van Der Meer et al., 2008). It has been suggested that low agreement in population samples may be a reflection of less stable or severe symptoms and low prevalence of mental disorders (Boyle et al., 2017). However, in our clinical sample, prevalence of disorders was higher than the general population and symptoms warranted mental health services, yet agreement was no better than moderate. It is likely that factors beyond the presence and severity of mental disorder may influence agreement, including family functioning, ethnicity, or social desirability (De Los Reyes & Kazdin, 2005).

Although literature suggests that parent-child agreement is typically higher for externalizing disorders (Edelbrock et al., 1986; Martin et al., 2004; Salbach-Andrae et al., 2009), our findings did not support this association. Instead, we showed that oppositional defiant/conduct disorder had similar agreement to major depressive disorder and ADHD had the second-lowest agreement. While unexpected overall, this finding is consistent with other investigations using the MINI-KID, which showed similar agreement for internalizing and externalizing disorders (Duncan et al., 2018).

When there was disagreement between parents and children, it was more common that parents reported disorders. This finding is consistent with previous literature suggesting that parents overreport psychopathology, relative to their children, particularly in clinical populations (Grills & Ollendick, 2002; MacLeod et al., 1999; Martin et al., 2004; Smith, 2007). Because parents often initiate accessing mental health services for their children, based on their own threshold for determining need, it was expected that within this clinical sample, parents more frequently endorsed the presence of mental disorders (De Los Reyes & Kazdin, 2005).

Household income was the only covariate associated with parent-child agreement for more than one disorder. Interestingly, lower income was associated with agreement for internalizing disorders, while higher income was associated with agreement for externalizing disorders. Few studies have examined the association of income on parent-child agreement; however, one report found that household income and agreement are positively associated (Van Roy et al., 2010). However, this study examined the influence of parent-child agreement on a composite measure (Van Roy et al., 2010), which could explain the discrepant findings with internalizing disorders in our sample. While there may be increased barriers to service access for low-income households, our sample is composed of children who were receiving mental health services. The process of overcoming barriers/accessing mental health services may improve awareness of differing perspectives among parents and children, thereby increasing agreement. However, this is speculative and the association between household

Table 4. Unadjusted associations of parent-child agreement

	Major depressive disorder		Generalized anxiety		Separation anxiety		Phobia		ADHD		Oppositional defiant/ conduct disorder	
	Disagree (n=22)	Agree (n=66)	Disagree (n=33)	Agree (n=55)	Disagree (n=27)	Agree (n=61)	Disagree (n=26)	Agree (n=62)	Disagree (n=31)	Agree (n=57)	Disagree (n=26)	Agree (n=62)
Mean (SD)												
Child age, years	14.0 (2.6)	14.7 (2.1)	**14.0 (2.2)**	**14.8 (2.2)**	14.1 (2.9)	14.7 (1.8)	14.4 (2.2)	14.6 (2.3)	14.7 (2.2)	14.4 (2.2)	14.6 (2.4)	14.5 (2.2)
Child disability/ impairment, WHODAS 2.0	82.5 (21.3)	87.7 (24.5)	84.8 (26.6)	87.3 (22.0)	87.9 (26.3)	85.7 (22.7)	82.3 (23.3)	88.1 (23.9)	85.4 (23.9)	86.9 (23.8)	86.7 (24.0)	86.2 (23.8)
Parent age, years	44.4 (8.2)	46.3 (6.1)	45.2 (7.8)	46.2 (6.0)	45.1 (8.3)	46.2 (5.9)	45.7 (7.0)	45.9 (6.6)	45.1 (7.4)	46.2 (6.3)	47.0 (6.3)	45.3 (6.8)
Parent psychosocial distress	63.1 (16.5)	66.1 (16.8)	65.1 (16.5)	65.5 (17.0)	71.1 (18.7)	62.8 (15.2)	68.7 (19.4)	63.9 (15.3)	66.5 (19.8)	64.7 (14.9)	64.7 (19.1)	65.6 (15.8)
Frequencies (%)												
Female child	15 (68.2)	48 (72.7)	25 (75.8)	38 (69.1)	19 (70.4)	44 (72.1)	20 (76.9)	43 (69.4)	22 (71.0)	41 (71.9)	16 (61.5)	47 (75.8)
Female parent	19 (86.4)	55 (83.3)	27 (81.8)	47 (85.5)	21 (77.8)	53 (86.9)	22 (84.6)	52 (83.9)	24 (77.4)	50 (87.7)	21 (80.8)	53 (85.5)
Household income <$75,000	**16 (72.7)**	**29 (43.9)**	**21 (63.6)**	**24 (43.6)**	17 (63.0)	28 (45.9)	14 (53.9)	31 (50.0)	**12 (38.7)**	**33 (57.9)**	12 (46.2)	33 (53.2)
Inpatient	7 (31.8)	28 (42.4)	**9 (27.3)**	**26 (47.3)**	11 (40.7)	24 (39.3)	13 (50.0)	22 (35.5)	14 (45.2)	21 (36.8)	10 (38.5)	25 (40.3)

Results in bold were statistically significant (p<0.10).

Table 5. Adjusted associations of parent-child agreement

	Major depressive disorder OR (90%CI)	Generalized anxiety OR (90%CI)	Separation anxiety OR (90%CI)	Phobia OR (90%CI)	ADHD OR (90%CI)	Oppositional defiant/conduct disorder OR (90%CI)
Child age, years	1.09 (0.89, 1.32)	1.13 (0.94, 1.36)	1.19 (0.99, 1.43)	1.08 (0.89, 1.31)	0.96 (0.79, 1.18)	1.01 (0.83, 1.23)
Child disability/impairment, WHODAS 2.0	1.01 (0.50, 2.06)	0.94 (0.49, 1.83)	0.82 (0.42, 1.61)	1.85 (0.94, 3.62)	1.25 (0.65, 2.41)	0.98 (0.51, 1.91)
Parent age, years	1.04 (0.98, 1.11)	0.99 (0.93, 1.06)	1.01 (0.94, 1.07)	0.99 (0.93, 1.06)	1.04 (0.98, 1.11)	0.96 (0.91, 1.02)
Parent psychosocial distress	1.02 (0.99, 1.04)	1.00 (0.97, 1.02)	**0.97 (0.95, 0.99)**	0.98 (0.96, 1.01)	0.99 (0.97, 1.02)	1.00 (0.97, 1.03)
Female child	1.05 (0.40, 2.74)	0.54 (0.22, 1.29)	1.10 (0.44, 2.78)	0.66 (0.26, 1.69)	1.29 (0.54, 3.09)	1.96 (0.86, 4.46)
Female parent	1.08 (0.31, 3.74)	1.91 (0.67, 5.51)	2.56 (0.90, 7.28)	0.82 (0.26, 2.60)	1.86 (0.69, 5.01)	1.28 (0.44, 3.74)
Household income <$75,000	**0.29 (0.12, 0.71)**	**0.44 (0.21, 0.95)**	0.51 (0.22, 1.19)	1.09 (0.47, 2.52)	**2.18 (1.03, 4.61)**	1.35 (0.61, 2.97)
Inpatient	1.07 (0.39, 2.90)	**2.38 (1.08, 5.28)**	1.20 (0.47, 3.11)	0.59 (0.26, 1.38)	0.67 (0.30, 1.47)	1.07 (0.46, 2.48)

Those in bold are statistically significant (p<0.10). Parent-child disagreement is the reference category.

income and agreement across internalizing and externalizing disorders warrants further study in different service settings with larger and more socioeconomically diverse samples.

Parent psychosocial distress and receiving inpatient services were found to be associated with separation anxiety and generalized anxiety, respectively. Our finding that parent psychosocial distress was associated with poorer agreement for separation anxiety aligns with most previous literature (Affrunti & Woodruff-Borden, 2015; Becker et al., 2016; Popp et al., 2017). Studies have suggested that this association may be disorder-dependent, and that the effect is strongest when assessing separation anxiety (Affrunti & Woodruff-Borden, 2015; Becker et al., 2016). Receiving inpatient services showed the strongest association with agreement for generalized anxiety. Receiving inpatient mental health services could be contextualized as a proxy for severity, which may condition parents to be more attuned to the mental health of their children, resulting in better agreement. Further study is needed to understand the nature of these associations, including whether factors such as parental mental health and disorder severity/impairment moderate parent-child agreement.

Associations were not found for age, sex, or child disability/impairment. Although some previous studies have reported higher parent-child agreement with female children and increased child age (Becker et al., 2016; Duncan et al., 2018; Edelbrock et al., 1986; Grills & Ollendick, 2002; Jensen et al., 1999; Kolko & Kazdin, 1993; Van Roy et al., 2010), our findings align with studies reporting no such effect (Affrunti & Woodruff-Borden, 2015; Becker et al., 2016; Choudhury et al., 2003; Klein, 1991; Popp et al., 2017). Such inconsistent findings may be a function of differing methodologies and sample compositions. The majority of our sample were adolescents with little variability in age and nearly

three-quarters were female; thus, limiting our ability identify potential age or sex effects.

The findings of this study should be considered in the context of the following limitations. First, as an exploratory study, our sample size was small, and participants were recruited from a single site. Thus, the study may have been underpowered to detect significant associations between sociodemographic and health factors and parent-child agreement, and findings may not generalize to broader populations. Second, many families declined participation. While reasons for non-participation was not explored, the low participation rate may increase the possibility of selection bias. Third, we were unable to corroborate parent and child responses on the MINI-KID with physician diagnoses of child mental disorders.

Conclusion

Our initial findings support literature suggesting that parent-child agreement is low to moderate in a clinical sample of children with mental disorders and that few factors predict agreement. Findings emphasize the need to collect information from multiple informants when assessing mental disorder in children. While future research should continue to investigate informant discrepancies in larger and more diverse samples, and in different settings, such as non-academic hospitals and residential care, health professionals should be aware of informant discrepancies among clinical samples of children with mental disorder.

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Conflicts of Interest

The authors have no financial relationships to disclose.

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