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Suicide and Life-Threatening BEHAVIOR

ORIGINAL ARTICLE

The effect of parent–adolescent discrepancies in reports of familial dysfunction and depression on suicidal ideation in adolescents

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Abstract

Introduction: Parents and adolescents are often discrepant in their reports of adolescent psychosocial factors. Few studies have addressed parent–adolescent discrepancies in subjective ratings of familial dysfunction and depression as longitudinal predictor variables, and none have done so in a treatment setting for adolescents with acute suicidality. This study examined how parent–adolescent discrepancies in familial dysfunction and depression impact adolescent treatment response in an intensive outpatient program for suicidality.

Methods: Adolescents ($N = 315$) were assessed at treatment entry and exit for familial dysfunction, depression, and suicidal ideation. Parents received parallel assessments of familial dysfunction and adolescent depression at each time point. A polynomial regression was conducted to determine whether parent–adolescent discrepancies in reports of familial dysfunction and depression at entry related to the treatment outcome of adolescent-reported depression and suicide ideation at exit.

Results: Significant discrepancies were present with on average adolescents reporting more depression and familial dysfunction than parents. Entry discrepancy in familial dysfunction (but not depression) predicted suicide ideation at exit.

Conclusions: Our results suggest that parent–adolescent discrepancies in perception of familial dysfunction is a risk factor for poor outcomes in suicidal youth and might be a fruitful target in treatment programs.

KEYWORDS

adolescents, depression, familial dysfunction, informant discrepancy, risk factors, suicide

INTRODUCTION

Every year, around 22% of adolescents seriously consider attempting suicide (Center for Disease Control and Prevention, 2021), and suicide has become the second leading cause of death among people aged 10–24 (Center for Disease Control and Prevention, 2021). Assessing who is at greatest risk for increased suicidal ideation is critical to adolescents, their families, and the clinicians charged with their care. Presently, the best practice method for assessing adolescents features the use of multiple informants, most often including parent reports (De Los Reyes et al., 2013). Though informant discrepancies within the parent–adolescent dyad have previously been discounted as measurement error or poor reporting capabilities, they are now understood as an independently valid parameter in adolescent psychopathology (De Los Reyes & Epkins, 2023; De Los Reyes & Kazdin, 2005). The current study examines how parent–adolescent discrepancies in perceptions of familial dysfunction and adolescent's depression impact adolescent psychopathology and treatment response in an intensive outpatient program for the treatment of suicidal thoughts and behaviors.

Approaches to discrepant reports

Parent–adolescent agreement on adolescent symptomatology is historically low (Achenbach et al., 1987; De Los Reyes et al., 2015) found that parent–youth internalizing symptom correlation value was only $r = 0.26$. In the past, scientists have used the degree of informant convergence (agreement between reporters) on a phenomenon as an index of support for that report (De Los Reyes et al., 2013, 2019). This means that where informants disagree, the phenomenon's existence and clinical relevance may be dismissed (De Los Reyes et al., 2013). Several studies have revealed that informant discrepancies are not simply a reflection of inconsistent reporting or measurement error but are indicative of differing perceptions of severity between parent and adolescent, and intrinsically valuable in predicting clinical outcomes independently from the source reports (Achenbach, 2006; Achenbach et al., 1987; De Los Reyes et al., 2009; De Los Reyes & Kazdin, 2005).

The meaning and consequence of discrepancies between parents and offspring might differ in children versus adolescents. Adolescents seeking emotional autonomy are likely to disclose less to their parents than do children (Finkenauer et al., 2002). Consequently, parents might typically be less aware of the adolescent's experience and perceptions. Lower disclosure in children on the other hand might be less normative and broadly indicative of other problems in the parent–child relationships, with greater negative consequences. For this reason, we will describe the findings of the relevant literature with a specification of age group.

Adolescent and parent-reported depression

Though depression eclipses all other adolescent mental health disorders in terms of prevalence (Center for Disease Control and Prevention, 2017), parent–adolescent agreement on depressive symptoms is significantly lower than other disorders and symptoms (Abate et al., 2018; Lauth et al., 2010). Literature suggests adolescents report experiencing more depression than their parents report about them (Angold et al., 1987; Csorba et al., 2003; Orchard et al., 2019). Many parents may be unaware of the severity of their adolescent's depression, or even of the existence of the depression; Logan and King (2002) found that only 21% of parents of depressed adolescents in a clinical sample endorsed at least one depressive symptom in their adolescent. Because adolescents often depend on their parents for access to treatment, discrepancies in perception of the adolescent's symptomatology may contribute to difficulty identifying and treating those who are in critical need of care. Indeed, over 60% of depressed adolescents never receive treatment, possibly due to parents who do not believe them to be in need (Center for Disease Control and Prevention, 2017). If a parent invalidates an adolescent's depression experience by failing to sufficiently acknowledge it, the adolescent may infer lower levels of support, which is a serious risk factor for suicidality in addition to the depression itself. The combination of high depression and low emotional trust with family members is a strong risk factor for suicidal behavior (Venta et al., 2017).

Limited research (Augenstein et al., 2022; Makol et al., 2019) has examined how convergent versus divergent patterns of reporting adolescent depression among parents and adolescents may be associated with adolescent suicidality. Though this analytic approach differs from directly examining discrepancy as a predictor, Latent Class Analysis results offer support for reporting patterns in which adolescents who rate higher depression than parents as presenting higher risk for suicidality. Research concerning the impact of parent–youth discrepancy in reports of depression on suicidality is also extremely limited. Ferdinand et al. (2004) examined the effects of parent–adolescent disagreement regarding psychopathology and found no significant relationship between depression score discrepancy and future suicidality. However, this community study used difference scores in their discrepancy analyses, a method which has been demonstrated to generate results of limited credibility (Laird, 2020). Thus, the prognostic capacity of informant discrepancies in depression reports for adolescent suicidality remains unclear.

Familial dysfunction and trouble within the parent–adolescent dyad

Alongside depression, self-reported problems within the family system (high familial dysfunction, low closeness, and high conflict) have long been an established risk factor for suicide ideation and behaviors in adolescents (Garber et al., 1997; Garrison et al., 1991; Lewinsohn et al., 1993; McKeown et al., 1998. For a review, see Wagner et al., 2003). Self-reported familial dysfunction is also predictive of adolescent psychopathology, including depression (Nomura et al., 2002; Rognli et al., 2021; Sander & McCarty, 2005; Sheeber & Sorensen, 1998; Wang et al., 2020; Wisotsky et al., 2006). Similarly, high amounts of conflict within the parent–adolescent dyad are related to more risk-taking behaviors and depression in the adolescent (Hollenstein & Lougheed, 2013; Kane & Garber, 2004; Marmorstein & Iacono, 2004).

Adolescents perceive the family significantly more negatively than do their parents; they report lower levels of communication, satisfaction, disclosure, support, and family cohesion, all characteristics of dysfunction (Fung & Lau, 2010; Gaylord et al., 2003; Ohannessian et al., 1995, 2000; Shek, 2007). These findings are particularly critical to adolescents struggling with suicidal ideation, as a perceived lack of familial support is a well-established risk factor for suicidal thoughts and behaviors (Czyz et al., 2012; Kang et al., 2017; Sharaf et al., 2009).

Discrepancies in parent and adolescent reports of family function are associated with negative outcomes such as internalizing symptoms, externalizing symptoms, substance abuse, and emotional adjustment (De Los Reyes, 2011; De Los Reyes et al., 2009; De Los Reyes & Ohannessian, 2016; Nelemans et al., 2016; Ohannessian et al., 1995, 2016; Ohannessian & De Los Reyes, 2014; Shek, 1998). Most of these studies have used community samples; explorations of the relationship between parent–adolescent discrepancies in perceived familial dysfunction and suicidal ideation in clinical samples are limited to a single cross-sectional study, which found no significant association (Chang et al., 2020). The predictive value of parent–adolescent discrepancies in familial dysfunction for suicidal ideation, particularly in a youth suicidality treatment setting, remains unknown.

Discrepancies and treatment

Very little research has explored the impact of parent–adolescent discrepancies on psychotherapeutic intervention outcomes. However, the following studies with children may shed light on the relationship between parent–youth discrepancies and treatment outcomes. Humphreys et al. (2015) found that youth (ages 7–8) diagnosed with PTSD responded better to treatment when entry parent–youth symptom agreement was higher. Panichelli-Mindel et al. (2005) demonstrated that children (ages 8–14) with lower parent–youth agreement on anxiety disorder-related distress exhibited worse treatment outcomes than those who were more likely to agree with their parents on distress severity. Similarly, Becker-Haimes et al. (2017) found children (ages 7–17) in treatment for anxiety were more likely to remit when agreement was higher pretreatment. Most relevantly, Goolsby et al. (2018) found that greater informant discrepancies in depression predicted poorer treatment outcomes, such as resiliency, anger control, and negative emotionality. However, the study participants were children (ages 7–12) rather than adolescents, and suicidality was not assessed. No studies of which we are aware have examined how parent–adolescent discrepancies in familial dysfunction and depression at admission may predict suicidality treatment outcomes. If discrepancies in reports of familial dysfunction and depression do predict symptomatology and impede treatment efficacy, more clinical focus during treatment on closing knowledge and empathy gaps between adolescents and their parents may be warranted.

The current study addressed the following questions: (1) Do parents and adolescents in a clinical sample of youth receiving treatment for suicidal ideation and behavior report differently on measures of familial dysfunction and depression? (2) Do parent–adolescent discrepancies in reports of familial dysfunction and depression at entry into treatment predict worse symptomatology at discharge from treatment? Reflecting relevant literature, we predicted that there would be discrepancies between parent and adolescent reports of familial dysfunction and depression. We further hypothesized that pretreatment parent–adolescent discrepancies would predict greater suicidal ideation and depression at exit, based on the theory that strong parental support and validation is a protective factor against suicidal ideation and depression (Czyz et al., 2012; Kang et al., 2017; Sharaf et al., 2009; Stice et al., 2004).

METHODS

Participants

The data analyzed for this study were maintained by the Suicide Prevention and Resilience at Children's Intensive Outpatient Program (SPARC IOP) for adolescents with active suicidal ideation or a recent suicide attempt. Each adolescent was evaluated by a program clinician at treatment intake. The SPARC IOP intake centered on a

clinical risk assessment process, with emphasis placed on identifying adolescents who were most vulnerable to future attempts and suicidal ideation. It is common for adolescents to under-report their own suicidal ideation levels (McGillivray et al., 2022), so clinicians used a combination of clinical interviews with the adolescent and guardians, and the clinician-administered Columbia-Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011). Per the C-SSRS, active suicidal ideation refers to ongoing thoughts of wanting to end one's life, with or without thoughts of methods, intent to act, or a suicide plan. A suicide attempt is defined as a potentially self-injurious act committed with at least some wish to die as a result, and the occurrence of this behavior within the preceding month was considered "recent." Eligibility for program entry was determined on an individual basis with reference to these criteria. Participant data from October 2017 through November 2020 were drawn for use in this study. SPARC IOP patients attended 3 h of group therapy twice weekly for 4–8 weeks according to individual need, with an average treatment length of 6 weeks. Adolescents received medication management for the duration of the program, individual therapy once weekly, and multifamily therapy twice during treatment. Group therapy sessions focused on identifying reasons for living, mindfulness, positive affect, behavioral activation, problem-solving, interpersonal effectiveness, wellness/relapse prevention, socialization and support, distress tolerance, and emotional regulation. Individual therapy goals included safety planning, treatment adherence, and psychoeducation (Kennard et al., 2019).

All patients treated in the IOP during this time (and thereby included in this database) had a primary caregiver who participated in the study and treatment with them. The primary caregiver was self-identified as the individual who brought the child to the intake visit. If more than one caregiver attended the intake visit, they were asked to identify which individual was primary. Patients and the primary caregiver ("parent") were assessed at treatment entry and exit. To be included in the current study, participants ($N = 438$ dyads) had to have entered the IOP between October 2017, and November 2020. Exclusion criteria for the present study included factors that might impact the validity of the self-report questionnaires (intellectual disability, active psychosis, neurological disorders, held back more than 2 years from age-appropriate grade level), and inability of the primary caregiver to read English. All 438 adolescents were eligible for inclusion in the program, of which 315 dyads had entry and exit data relevant to the current study, constituting 72% of the eligible sample. There were no significant differences in depression, suicidality, or familial dysfunction ratings between the included and 123 excluded participant dyads at program entry.

Demographic and clinical characteristics of the sample are shown in Table 1. The majority of the adolescents were girls, White, and non-Hispanic, and the mean age was 14.71 (SD = 1.56 years) (age range = 11–18 years). The admitting diagnosis for the large majority of the participants was major depressive disorder.

Measures

Depression

The Quick Inventory of Depressive Symptomology – Adolescent Self-Report (QIDS-A-SR; Rush et al., 2003) was used to measure severity of depression in adolescents at both entry and exit. Participants rated each of the 17 times on a Likert scale from 0 to 3, where higher ratings indicated more severe depression. Total scores were broken into the following severity interpretations: 0–5 = not depressed (7.3% of adolescents at entry), 6–10 = mild depressive symptoms (19% of adolescents at entry), 11–15 = moderate depressive symptoms (28.9% of adolescents at entry), 16–20 = severe depressive symptoms (30.8% of adolescents at entry), and >21 = very severe depressive symptoms (14% of adolescents at entry). Cronbach's α for all measures administered in the present study were calculated from entry responses. Cronbach's α in the present adolescent sample was 0.82, demonstrating good internal reliability. Item 13 of the QIDS-A-SR, which addresses suicidal ideation, was removed in all analyses also addressing suicidal ideation to avoid overlap between the two measures.

The adolescent's parent reported adolescent depression using the QIDS-A-SR (Parent) (QIDS-A-SR[P]). This self-report measure is identical in content to the QIDS-A-SR, but adjusted to address the adolescent's depression from the parent's point of view (e.g., a rating of 3 = "your child feels really down, unhappy, sad, or miserable pretty much all the time"). Cronbach's α for the present parent sample was 0.73, which falls into the acceptable range.

Familial dysfunction

Parents and adolescents rated familial dysfunction at treatment entry and exit with the Family Assessment Device – General Functioning Scale (FAD-GF; Epstein et al., 1983). This 12-item measure is a subscale of the 60-item McMaster Family Assessment Device. Assessment items are identical for parents and adolescents. Items assessing dysfunction within the family are rated on a 4-point Likert scale from 1 (*strongly agree*) to 4 (*strongly disagree*), where higher scores indicate greater dysfunction within the family. The

TABLE 1 Demographic characteristics and mean (SD) of study variables ($N = 315$).

Variable	Demographics of entire sample $N = 315$ *n* (%) or mean (SD); range
Adolescent age	14.71 (1.56)
Adolescent sex (girls: boys)	238 (76%): 77 (24%)
Adolescent ethnicity (non-Hispanic: Hispanic)	229 (73%): 86 (27%)
Adolescent race (white: black: other)	243 (77%): 23 (7%): 49 (16%)
Adolescent admitting diagnosis (MDD: other)	292 (93%): 23 (7%)
Adolescent length of treatment (days)	41.18 (11.68)
Adolescent history of attempt at entry (yes: no)	196 (62%): 119 (38%)
Socioeconomic status indicator: insurance type (public: private: self-pay)	91 (28.9%): 200 (63.5%): 24 (7.6%)
Adolescent home environment (Parent in the home: no parent in the home)	301 (95.6%): 14 (4.4%)
Adolescent-reported familial dysfunction (entry: exit)	27.96 (6.45): 26.58 (6.70); 12–45: 12–48
Adolescent-reported depression (entry: exit)	14.32 (5.65): 9.45 (5.30); 1–26; 0–24
Adolescent-reported suicidal ideation (entry: exit)	5.15 (3.45): 2.54 (2.81); 0–12; 0–12
Parent-reported familial dysfunction (entry: exit)	24.32 (5.42): 22.63 (5.16); 12–37; 12–37
Parent-reported depression (entry: exit)	13.27 (4.75): 8.00 (4.48); 3–27; 0–24

Note: Familial dysfunction was assessed using the FAD-GF. Depression was assessed using the QIDS-A-SR and QIDS-A-SR[P]. Suicidal ideation was assessed using the CHRT-SR.

measure includes items such as "In times of crisis we can turn to each other for support," and "We feel accepted for what we are." The highest possible score is 48, with problematic functioning designated as a score of 24 or above. Cronbach's α for both the adolescent and parent samples were good (Cronbach's $\alpha = 0.89$; Cronbach's $\alpha = 0.80$).

Suicidal ideation

Adolescent participants were assessed for self-reported suicidal ideation at treatment entry and exit by three items from the Concise Health Risk Tracking Self-Report Scale (CHRT-SR; Trivedi et al., 2011). Participants rated statements of increasing severity ("I have been having thoughts about killing myself," "I have thoughts about how I might kill myself," and "I have a plan to kill myself") on a Likert scale. Items were rated from 0 (*strongly disagree*) to 4 (*strongly agree*), and the three item ratings were summed to create a total "risk" score for each participant. These items had good internal reliability (Cronbach's $\alpha = 0.89$).

Statistical analysis

Multiple imputation for missing values

Missing values, observed only for the QIDS-A-SR[P] at entry and QIDS-A-SR at exit occurred in no more than about 9% and 1% of the sample, respectively, and were imputed. Missing values (with an assumed arbitrary missing pattern) were imputed via 500 burn-in iterations (samples) using fully conditional specification along with the discriminant method of the PROC MI procedures in SAS software, version 9.4. Little's chi-squared test (1988) supported the MCAR assumption ($\chi^2 = 5.78$, $p = 0.328$).

Descriptive statistics

Demographic and clinical characteristics of the sample of youth were described using the sample mean and standard deviation for continuous variables and the frequency and percentage for categorical variables. Paired samples *t*-tests compared parent and adolescent family dysfunction and depression scores at entry and exit, respectively.

Polynomial regression

General linear models (GLM), polynomial regression, were used to examine the relationship between parent–adolescent familial dysfunction discrepancy at entry and suicidal ideation at exit and depression severity at exit. We also examined the relationship between parent–adolescent depression discrepancy (with item 13 removed) at entry and suicidal ideation at exit. The GLM contained fixed effects terms for parent report, adolescent report, parent report squared, adolescent report squared, and the parent × adolescent report interaction. Higher order terms (e.g., cubic)

were also examined and reported only if significant and if model fit was improved. Age, sex, and respective entry value of suicidal ideation and depression were included as covariates in the model. All variables in the model were mean-centered and thus the regression coefficients were estimated at the mean level of the covariates. The interaction term tested the discrepancy hypothesis that conditional associations between the outcomes at exit (suicidal ideation and depression severity) and reports provided by one informant (adolescents) at entry vary as a function of the other informants' (parents') reports at entry. Post hoc probing of interaction terms was also examined via simple slopes and response surface contour plotting.

Statistical analyses were carried out using SAS software, version 9.4 (SAS Institute, Inc., Cary, NC). The level of significance was set at $\alpha = 0.05$ (two-tailed) and we implemented the false discovery rate (FDR) procedure to control false-positives over the multiple tests (Benjamini & Hochberg, 1995). Cohen's d was calculated and interpreted as the effect size estimator for the between- and within-subjects group effect (adolescents vs. parents and entry vs. exit on depression and familial dysfunction). Cohen's f^2 was calculated and interpreted as the effect size estimator for the predictor's effect on the outcome within the context of the multiple linear regression model. The magnitude of Cohen's effect size (f^2 and d) can be interpreted using Cohen's (1988) convention as "small effect ($f^2 = 0.02$; $d = 0.20$)," "medium effect ($f^2 = 0.15$; $d = 0.50$)," and "large effect ($f^2 = 0.35$; $d = 0.80$)," with the caveat that this conventional frame of reference (or *rules of thumb* regarding the size of the effect) is relative not only to each other but also to its substantive context, its operational definition, or even more particularly to the specific content and research method being employed in any given investigation (Cohen, 1988).

RESULTS

Participant characteristics

Study variable values at entry and exit are shown in Table 1. Both the mean adolescent-reported QIDS and the mean parent-reported QIDS entry score indicated moderate depression at treatment entry. The mean entry adolescent report of familial dysfunction fell into the "problematic" range. The mean entry parent report of familial dysfunction was several points below the adolescent score, but still narrowly fell into the clinically problematic range. Finally, the mean entry adolescent suicide risk score was below expected for a sample of suicidal youth. However, variability around the mean was large, and this score was only one piece of information used by the clinicians to admit an adolescent into intensive treatment.

Bivariate correlations of study variables are presented in Tables 2 and 3.

Adolescent versus parent depression and familial dysfunction ratings

Parent- and adolescent-reported mean scores for depression severity and familial dysfunction at entry and exit are reported in Table 1. Paired samples t-tests revealed

TABLE 2 Descriptive statistics and bivariate correlations for key variables of interest at entry.

Variable	1.	2.	3.	4.
1. Adolescent-reported depression				
2. Parent-reported depression	0.36**			
3. Adolescent-reported dysfunction	0.37**	0.16**		
4. Parent-reported dysfunction	0.04	0.16**	0.27**	
5. Adolescent-reported suicidal ideation	0.65**	0.26**	0.23**	0.01

Note: Familial dysfunction was assessed using the FAD-GF. Depression was assessed using the QIDS-A-SR and QIDS-A-SR[P]. Suicidal ideation was assessed using the CHRT-SR. $^{**}p < 0.01$.

TABLE 3 Descriptive statistics and bivariate correlations for key variables of interest at exit.

Variable	1.	2.	3.	4.
1. Adolescent-reported depression				
2. Parent-reported depression	0.43**			
3. Adolescent-reported dysfunction	0.43**	0.29***		
4. Parent-reported dysfunction	0.07	0.17**	0.26***	
5. Adolescent-reported suicidal ideation	0.56***	0.41***	0.33***	0.09

Note: Familial dysfunction was assessed using the FAD-GF. Depression was assessed using the QIDS-A-SR and QIDS-A-SR[P]. Suicidal ideation was assessed using the CHRT-SR. $^{**}p < .01$; $^{***}p < .001$.

adolescents reported significantly more depression than their parents at entry [$t(314) = 3.13$, $p = 0.002$; $d = 0.20$] and at exit [$t(314) = 4.87$, $p < 0.001$; $d = 0.29$], although the effect sizes were small. Paired samples *t*-tests also revealed adolescents reported significantly higher familial dysfunction than their parents at entry [$t(314) = 8.95$, $p < 0.001$; $d = 0.61$] and exit [$t(314) = 9.60$, $p < 0.001$; $d = 0.66$]; these differences reached a medium effect size. There was a significant improvement from entry to exit in adolescent-reported familial dysfunction (mean decrease = −1.38, SD = 6.09, $p < 0.001$, $d = 0.21$), depression severity (mean decrease = −4.87, SD = 5.66, $p < 0.001$, $d = 0.90$), and suicidal ideation (mean decrease = −2.61, SD = 3.47, $p < 0.001$, $d = 0.82$) as well as parent-reported familial dysfunction (mean decrease = −1.70, SD = 5.57, $p < 0.001$, $d = 0.32$) and depression severity (mean decrease = −5.27, SD = 5.10, $p < 0.001$, $d = 1.14$).

Discrepancy and treatment outcomes

The polynomial regression revealed a significant parent × adolescent familial dysfunction interaction effect at entry on suicidal ideation at exit ($\widehat{b} = -0.01$, SE = 0.00, 95% CI: −0.02 to −0.00, $p = 0.007$, $R^2 = 0.21$), indicating that the discrepancy of low parent-reported familial dysfunction and high adolescent-reported familial dysfunction at treatment entry was associated with higher levels of predicted suicidal ideation at exit and that the magnitude of this effect decreased as levels of parent-reported familial dysfunction increased (Figure 1). The polynomial regression, however, also revealed that the relationship between parent × adolescent familial dysfunction discrepancy at entry and adolescent depression severity at exit ($\widehat{b} = -0.00$, SE = 0.01, 95% CI: −0.01 to 0.02, $p = 0.75$, $R^2 = 0.22$) and the relationship between parent × adolescent depression discrepancy at entry and suicidal ideation at exit ($\widehat{b} = -0.00$, SE = 0.01, 95% CI: −0.02 to 0.02, $p = 0.945$, $R^2 = 0.18$; Table 4) were not statistically significant. No higher order terms emerged as being significant across any of the polynomial models (results not reported).

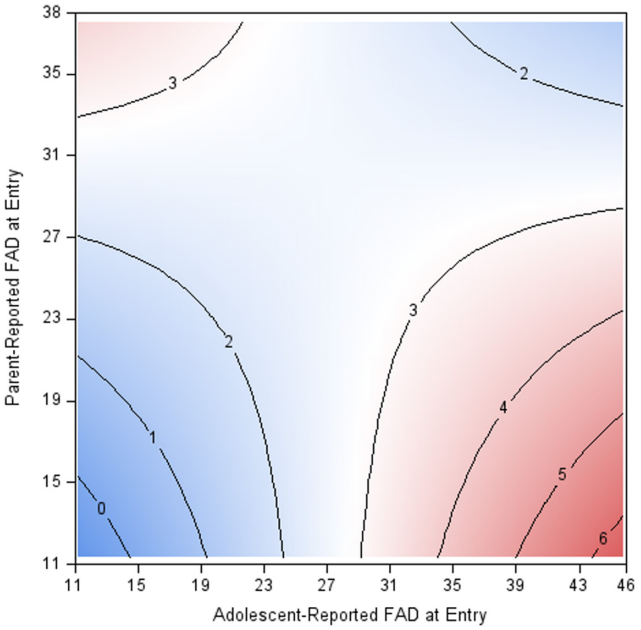

FIGURE 1 Predicted values of suicidal ideation (CHRT-SR) at exit as a function of observed adolescent-reported FAD and parent-reported FAD at entry. CHRT-SR, Concise Health Risk Tracking Self-Report Scale; FAD, family assessment device (familial dysfunction). The predicted values of suicidal ideation at exit, via the multiple linear regression, were adjusted for age, sex, and entry value of suicidal ideation.

DISCUSSION

This study explored the effects of parent–adolescent discrepancy in reports of familial dysfunction and depression on adolescent treatment outcomes in an intensive outpatient program for suicidality. As predicted, parent–adolescent discrepancies in ratings of both familial dysfunction and depression emerged. The nature of the discrepancies was consistent with previous literature, as well as our first hypothesis: adolescents reported experiencing more depression than their parents reported about them (Angold et al., 1987; Csorba et al., 2003; Orchard et al., 2019). Adolescents also reported more familial dysfunction relative to their parents (Angold et al., 1987; Ohannessian et al., 1995). Parent–adolescent discrepancy in reports of familial dysfunction at entry significantly predicted suicidal ideation at exit: the discrepancy of low parent-reported familial dysfunction and high adolescent-reported familial dysfunction at treatment entry was associated with higher levels of predicted suicidal ideation at exit. However, pretreatment parent/adolescent depression discrepancy and posttreatment suicidal ideation were unrelated.

Our results indicate that the direction of the discrepancy might be clinically relevant. There are several factors that may be impacting direction of discrepancy in parent and adolescent reports of familial dysfunction specifically. Parents have the responsibility to set the tone of support, conflict resolution, and understanding within a family, and consequently may be less likely to perceive the family environment in a negative light. Furthermore, parents of adolescents who have reached a level of distress that warrants intensive treatment for suicidality may experience guilt and/or perceive blame related to the adolescent's state, complicating the perception and endorsement of negative aspects of the family environment. It has been

TABLE 4 Polynomial regression testing the discrepancy hypothesis.

	Parameter estimate						
Treatment outcome at exit	$\hat{b}$	**SE**	**95% CI for $\hat{b}$**	***p-Value***	**FDR**	**Model R^2**	f^2
Suicidal ideation							
Adolescent-reported FAD (entry)	0.063	0.024	0.015 to 0.110	0.009	0.045	0.209	0.0219
Parent-reported FAD (entry)	−0.002	0.028	−0.059 to 0.053	0.921	0.945		0.0001
Adolescent-reported FAD squared (entry)	−0.0003	0.002	−0.005 to 0.004	0.894	0.945		0.0001
Parent-reported FAD squared (entry)	0.003	0.004	−0.004 to 0.012	0.378	0.673		0.0025
Adolescent FAD × parent FAD (entry)	−0.012	0.004	−0.021 to −0.003	0.007	0.045		0.0233
Suicidal ideation							
Adolescent-reported QIDS (entry)	0.058	0.038	−0.018 to 0.134	0.134	0.502	0.179	0.0073
Parent-reported QIDS (entry)	0.042	0.036	−0.029 to 0.114	0.245	0.612		0.0040
Adolescent-reported QIDS squared (Entry)	−0.001	0.006	−0.013 to 0.010	0.846	0.945		0.0001
Parent-reported QIDS squared (entry)	−0.003	0.006	−0.017 to 0.009	0.595	0.892		0.0009
Adolescent QIDS × parent QIDS (ENTRY)	−0.001	0.008	−0.016 to 0.015	0.945	0.945		0.0001
Depressive symptoms							
Adolescent-reported FAD (entry)	0.087	0.046	−0.005 to 0.179	0.063	0.315	0.233	0.0112
Parent-reported FAD (entry)	−0.051	0.053	−0.155 to 0.052	0.329	0.673		0.0031
Adolescent-reported FAD squared (entry)	−0.006	0.004	−0.015 to 0.003	0.187	0.561		0.0056
Parent-reported FAD squared (entry)	−0.006	0.007	−0.022 to 0.009	0.404	0.673		0.0023
Adolescent FAD × parent FAD (entry)	−0.002	0.008	−0.013 to 0.019	0.748	0.945		0.0003

Note: The polynomial regression was adjusted for age, sex, and respective entry value of suicidal ideation and QIDS. Length of treatment was investigated as it related to the polynomial regression analysis, and it neither improved the fit of the model nor made a difference in the model, so for the sake of parsimony it was excluded. All variables in the model were mean-centered.

Abbreviations: f^2 = Cohen's f^2 (effect size); FAD, Family Assessment Device (familial dysfunction); FDR, false discovery rate; QIDS, quick inventory of depressive symptomology (depression); SE, standard errors.

proposed that many parents of youth receiving treatment have untreated pathology (Engelhard et al., 2022) which may influence perceptions of the family environment. Further, depressed and suicidal youth may be prone to cognitive distortions, resulting in a pervasively negative view of their environment, including their family (Wolff et al., 2013).

The finding that parent/adolescent discrepancies in reports of depressive symptoms at entry were not predictive of suicidal ideation at exit stands apart from the limited literature examining the prognostic capabilities of discrepant depression reports on treatment outcomes (Goolsby et al., 2018). However, the study by Goolsby and colleagues included children only (aged 7–12 years), and examined different treatment outcomes. Possibly, discrepancies in adolescent/parent dyads are more normative than those during childhood. This finding illustrates that discrepancies in clinical symptoms arise and operate differently from discrepancies in interpersonal interactions, and carry different prognostic capability.

We note that we do not have the evidence to infer causality in the relationship between parent–adolescent discrepancies and treatment outcomes. The discrepancies seen in this sample may be produced by a common risk factor that also promotes suicidal ideation, such as parental pathology or poor family communication manifesting as discrepancies. Persistent or increased discrepancies might be an indicator of poor response to treatment, rather than a driver of response to treatment.

Clinical implications

The role of discrepancies in perceptions has not been a key formulation relevant to the treatment of suicidal adolescents. Our results raise the question of whether tailoring our program to increase family therapy for those with greater family dysfunction could optimize distress management and safety. Proactively identifying adolescent–parent dyads with greater discrepancies at treatment intake might identify patients disadvantaged from the outset, and thereby guide a more targeted and/or intensive treatment. These adolescents may benefit specifically from more frequent family therapy than parent–adolescent dyads who enter treatment with a shared understanding. Family therapy-based psychoeducation, as well

as support for open discussions of differing perceptions, may help resolve existing discrepancies.

We also believe that these results may have implications for prevention. Educating parents in non-clinical settings, such as schools and religious communities, on the importance of communication with adolescents may decrease discrepancies in perception and protect against suicidal ideation and depression. Parents may also need education on the theory that some discrepancy between parent and adolescent perceptions is developmentally normal, but has the potential to be problematic if communication is insufficient.

Though familial dysfunction, depression, and suicidal ideation ratings by adolescents and parents respectively all decreased significantly over treatment, results indicated larger effect sizes for improvements in depression and suicidal ideation than dysfunction. This may be attributable to the targeted treatment of depression and suicidality symptoms using cognitive behavioral therapy and dialectical behavior therapy informed interventions in primarily individual and peer group treatment modalities.

Finally, the possibility that the discrepancy might be attributed to parental depression or other pathology has implications. The link between untreated parental pathology and poor offspring treatment response outcomes has been noted by Engelhard et al. (2022) who propose routine screening of parents, and integrated treatment to improve outcomes.

Limitations and future directions

Our sample demographic is primarily white and female, and thereby our results may not be generalizable to a more diverse population. Further, this research was conducted in a high-risk population of adolescents struggling with acute suicidality and may not be generalizable to a less acute population. Third, there are limitations associated with using a self-report methodology. Because both predictor and outcome variables incorporated adolescent reports, we cannot rule out common method variance as an explanatory factor. Functional or behavioral outcomes independent of adolescent report would offer a more powerful methodology to assess similar hypotheses in future studies. An example of such would be suicide attempts after discharge. Furthermore, the adolescent-dependent reports mean the data could be characterized by over- or under- reporting of actual clinical symptoms at treatment exit. This study was also limited to two time points: treatment entry and treatment exit. There are no available data on parent–adolescent discrepancies following discharge, and the effects may differ posttreatment. Additionally, the CHRT-SR only assesses suicidal ideation within the past week, which may fail to account for ideation associated with recent attempts. Research indicates suicidality is temporally labile in adolescents, and can vary rapidly within those at high risk (Czyz et al., 2019). A measure of suicidality which accounts for the most severe ideation in a wider time range may allow more powerful prediction. Finally, we characterize these youth as being actively suicidal at entry into the program, but self-report results indicated that at time of entry, many were reporting low levels of ideation. These youth were admitted based on clinical judgment about their need for intensive treatment for suicidality. The circumstances that qualified them for treatment (e.g., difference in self-report on interview vs. rating scale, parent report of higher levels of suicidality, recent attempt, and expression of need by parent and/or child for safety in a less intensive setting) are not documented in the database. Thus, there is some subjectivity in classifying these youth as being at high risk for suicide-related behaviors. This study is also limited by a lack of reliable count on mothers versus fathers represented among the primary caregivers. We acknowledge that primary caregiver gender may moderate our findings. Finally, we do not have data regarding biological parents represented among the primary caregivers, though we included data in Table 1 reflecting the proportion of adolescents who live with a parent.

Our findings highlight the need for further attention directed toward the relationship between parent–adolescent familial discrepancies and suicidality in a treatment setting. We have made several hypotheses about the underlying basis for the discrepancies, such as parental pathology and adolescent cognitive distortions. Studies that elucidate the basis for the discrepancy might also suggest intervention strategies that target these factors. Future research should address the weight of parent–adolescent discrepancy on reduction of depression and suicidal ideation in a more diverse, less acute population. Further, interventions designed specifically to decrease discrepancies in perceptions of family function and measure resultant changes in treatment outcomes may clarify directional and bidirectional processes. Such interventions may include identifying dyads with high discrepancy using the FAD and mapping specific areas of discrepancies on to a treatment plan. Items where there are discrepancies might guide the content and strategies within family therapy such as parent psychoeducation, and communication skills with the parent and adolescent. Subsequent assessments of symptoms using the FAD, QIDS, and CHRT-SR could provide insight into subjective improvement in family function and in adolescent depressive symptoms and suicide ideation. The results determined by our analyses could be further improved upon by including objective, clinician-administered assessment

of discrepancies at regular intervals throughout the intervention. We acknowledge that there is a shortage in the field of validated brief measures that decrease the burden of repeat assessment and are sensitive to change, and hope that studies such as this one might stimulate the development of these measures. Qualitative studies that explore the mechanisms which create, promote, or decrease discrepancies in parent–adolescent perceptions would also be useful in guiding future clinical care and the development of assessment instruments.

CONCLUSION

These findings build upon research recommending informant discrepancy as a valid predictor of clinical outcomes (Achenbach, 2006; Achenbach et al., 1987; De Los Reyes et al., 2009; De Los Reyes & Kazdin, 2005). Our examination of discrepancy as an index for treatment outcome offers support for parent–adolescent familial dysfunction discrepancy as a disruptive mechanism in the treatment of adolescents with internalizing disorders (Guion et al., 2009). Future studies that determine the underlying bases for the discrepancy would inform models and guide clinical efforts to decrease risk for suicidal youth. Clinical interventions designed to bridge the gap in understanding reflected by parent–adolescent report discrepancies may improve outcomes in adolescents in treatment for suicidality. Interventions that seek to actively address familial dysfunction discrepancies are necessary to clarify whether such discrepancies are a causal factor in suicidality.

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DATA AVAILABILITY STATEMENT

The participants of this study did not give written consent for their data to be shared publicly, so due to the sensitive nature of the research supporting data are not available.

ETHICAL APPROVAL

Ethical approval to report this research was obtained from the University of Texas Southwestern Medical Center Institutional Review Board (STU032016-098), and all procedures in this study were conducted in accordance with this board's approved protocols.

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