Assessing anxiety symptoms in children:
Agreement between parents and children

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Assessment of anxiety disorders in children is a difficult process and requires the use of multiple resources of information. Such resources may come from children, parents, and educators and they also require the use of multiple types of diagnostic tools, like structured and semi-structured clinical interviews, as well as self-report questionnaires. Previous research shows that anxiety symptoms ratings of different informants are to some degree correlated (low to moderate agreement) but nonetheless also often show clear discrepancies. Important variables may affect the degree of child-parent agreement. The present study focused on child's gender and age possible impact. The aim of the present study was to examine the agreement between children's and parents' reports on self-reported questionnaires for anxiety symptoms. 431 children from 4th to 6th grade of elementary school and their parents participated in the study. 190 were boys and 241 were girls. Both children and their parents responded to Spence Children's Anxiety Scale (SCAS) (child's and parent's version correspondingly). Relations between children's and parents' reports concerning anxiety symptoms were examined by calculation Pearson's correlation coefficients. The results showed that there was a medium but statistically important positive correlation between children's and parents' reports on SCAS total score (r=0.50, p<0.01). Concerning SCAS subscales results supported that higher correlations were those reported for Separation Anxiety (r=0.53, p<0.01) and Fear of Physical Injury (r=0.55, p<0.01). Concerning gender differences the present study found that correlation coefficients for girls were higher than for boys in SCAS total score (r=0.57 and r=0.39 correspondingly, p<0.01). Correlations according to age showed that the highest correlation coefficients were found in comparatively older children (r=0.34, r=0.54 και r=0.63, p<0.01 for 4th, 5th and 6th Grade). The latter underlies that in the process of assessing and diagnosing anxiety disorders in children, it is both necessary and important to gather information from multiple sources, especially in cases of younger children.

Key words: Anxiety, child, parents, assessment, interrater agreement.

Introduction

Assessment of anxiety disorders in children is a difficult task and requires the use of multiple resources of information. Such resources may come from children, parents, and educators and they also require the use of multiple types of diagnostic tools, like structured and semi-structured clinical interviews, and self-report questionaires.[1,2] However, such process faces significant problems. One of the most important issues is the agreement or disagreement between children's and parents' reports on observed emotional difficulties.

Many studies have shown that children and parents perceive and respond in a different way to questions about the frequency and severity of anxiety symptoms in children. More specifically, Rapee et al[3] and Edelbrock et al[4] found that there is poor agreement between the reports of parents and those of children about the symptoms of different types of anxiety disorders. Poor child-parent agreement has been found by other researchers too.[5–7] Pereira et al[8] found low to moderate correlations between mother's and child's report of children's anxiety. The strongest correlations were found between child's and mother's report of specific phobia and school phobia symptoms, while the lowest agreement was found for symptoms of obsessive-compulsive disorder (OCD), traumatic stress disorder, generalized anxiety (GA), and panic disorder.

Consistent with the above findings, Canavera et al[7] found that there is a poor parent-child agreement in the assessment of OCD at the diagnostic level, as well as symptom level in general. Nevertheless, at the symptom level, there was an acceptable agreement in some aggressive and religious thoughts and cleaning/washing compulsions. Rapoport et al[9] confirmed the poor parent-child congruence in OCD, and speculate that this agreement is due to the child's intention to "hide his illness" from his parents. Comer et al[10] explored parent–child agreement at the symptom level, within the diagnostic model, in the assessment of separation anxiety (SA), social phobia (SP), and GA, and found that for all three disorders, parent–child agreement at the symptom level was stronger than parent–child agreement at the diagnostic level. Boyle and colleagues[11] assessed parent-child con-

gruence in 251 pairs, in two age groups of anxious children (6–11 years and 12–16 years) twice (two week interval). Results showed that there was a poor parent-child agreement, except for SA where degree of parent-child agreement was satisfactory. More specifically, in the first interview, the assessment of degree was greater for the older children. The degree of agreement was slightly increased in the group of younger children during the second interview two weeks later.

Several studies have also replicated this poor parent-child agreement in the assessment of anxiety symptoms and disorders in school children[1,9,12–16] confirming findings from earlier studies.[4,17] Nauta et al[18] and Li et al[19] applied the Spence Anxiety Scale, both the parent and child version, in the group of parents and their children and found that there was a moderate to satisfying parent-child agreement, but nevertheless statistically significant, in all anxiety subscales. On the contrary, Wren et al[20] found that the levels of parent–child agreement as to anxiety score, in a non clinical sample, was moderate to high.

A very interesting study examined parent-child congruence reports in three conditions, GA, SA, and SP, during three different time points, one prior to the implementation of a specific Cognitive Behavioural anxiety treatment program, two after its end, and three seven years later.[21] Their findings supported the notion that there is a rather poor to moderate agreement in a diagnostic level, since this agreement remained relatively stable at post-treatment and the seven years follow-up. Authors conclude that neither therapy nor age affected the degree of agreement. It is interesting that Safford's initial hypothesis was that treatment would increase the degree of parent-child agreement due to a better mutual understanding of anxiety symptoms. What these authors also found was that younger children had a better agreement with their parents in all three assessments compared with older children.

Another consistent finding is that of better parent-child agreement for externalizing symptoms, than for the internalizing symptoms – children tend to report more frequently internalizing problems than their parents, like depression and anxiety.[1,4,9,15,22] On the other hand, parents usually notice and consequently report more externalizing, thus, more observable, symptoms.[3,4,6,9,11,14,22,23]

Important variables that affect the degree of child-parent agreement

Degree of parents-child agreement seems to be influenced by several variables (like child age, child gender, child social desirability, type/severity of disorder, lack of communication, family conflict, etc.).[5,24] For the sake of our report we will focus on the child gender and age.

Concerning the role of child gender, Rapee found that the degree of agreement tended to be greater in boys for most anxiety disorders (overanxious disorder, SP and a general diagnosis of anxiety disorder) while for girls parent-child agreement was higher in SP.[3] A similar study showed that girls and their parents evidenced higher agreement for GA and specific phobia, while parent-child agreement was higher in boys with social anxiety and SA.[5] Also, it was found that mothers reported fewer symptoms than their male children in terms of worries and anxieties and SA.[16] Taking into consideration that some other studies found no significant differences,[4,7,8,12,13] one can conclude that parent-child agreement is not consistently influenced by gender and unfortunately we do not have a coherent theoretical explanation for this.[1]

Child age seem to play an important role in the way children respond to either clinical interviews or self-report questionnaires,[25] therefore age may influence the agreement between a child's and his/her parents' reports. It seems that there are important developmental differences in the way children perceive and interpret given instructions or specific words and concepts that are used in some diagnostic tools.[26] A common finding is that older children (>11 years) have a better agreement with their parents compared with younger children (<10 years).[3–6] This finding may reflect the possibility that older children give more reliable answers and information than younger ones.[3,26,27] Thompson et al[16] studied mother-child agreement on the Child Assessment Schedule with nonreferred children and found that mothers reported fewer symptoms than their older children (8–12-year old compared to 6–7-year old) reported in terms of worries and anxieties and SA. On the other hand, many studies evidence no consistent relationship between child age and parent child reporting discrepancy[7,8,12,13,15,28] while other studies evidenced poor to moderate parent-child agreement for older adolescents.[29–32]

The above discrepancies seem to have different theoretical explanations. On one hand, it has been supported that age interferes with a child's ability to respond to diagnostic questions in a reliable way,[5,33] while on the other hand, it is common for many children and adolescents to tend to hide information about their emotional state and difficulties.[34] However, apart from child's cognitive ability and his desire to avoid expressing his anxiety symptoms, Niditch et al[35] found that children's self-report of anxiety were affected by their mothers' apparent anxiety. Younger children self-reported significantly higher anxiety than anxious mothers reported for them while older children self-reported significantly lower anxiety than their anxious mothers.

Primary aim of the present study is to examine the agreement between children's and parents' reports on self-reported questionnaires for anxiety symptoms while secondary aim is to examine whether the degree of agreement differs by gender and age.

According to the Nauta's and Li's[18,19] findings we hypothesized children's and parents' reports will present a medium congruence something that could be different in different anxiety symptoms. Furthermore, we expected that there will be gender-specific differences in parent-child agreement, as well as age-specific differences in this agreement. What we expected is that older children have better agreements with their parents in almost all anxiety scales than younger ones.[3,5,6]

Material and method

Study setting, subjects and procedure

The present study is a part of a wider research that took place in Thessaloniki, from April 2021 through November 2014 from the Department of Educational and Social Policy of the University of Macedonia, with the approval of the corresponding Section of Pedagogical Institute/ Greek Ministry of Education, Research and Religious Affairs. Of the 1128 4th to 6th grade school children approached, 431 children completed and returned the questionnaires. Children were from 18 randomly selected elementary schools of Thessaloniki. The participants' descriptive characteristics are presented in table 1.

Table 1. Demographic Characteristics of participants.

Children				
Age/Sex	**4th class**	**5th class**	**6th class**	**Total**
Boys	60	65	65	190
Girls	77	75	89	241
Total	137	140	154	431
	Fathers		**Mothers**	
	Mean	**SD**	**Mean**	**SD**
Age (in years)	45.44	21.91	41.00	5.55
	Fathers	**Mothers**	**Both**	
Responder	10.6 (44)	79.2 (328)	9.9 (41)	
Number of children in family				
1	17.0 (71)			
2	61.6 (257)			
3	13.9 (58)			
>4	7.0 (29)			

In the first phase of the study a set of questionnaires was distributed to each 4–6th grade child attending one of those eighteen elementary schools. Children were asked to deliver it to their parents. Parents' package included (a) an informative letter about the nature and aim of the present study, (b) a written consent form for the parent and their permission for the participation of their child in the study, and (c) self-report questionnaires for parents. Consenting parents had to sign the written consent form, to fill in their questionnaires and return them to the researchers in a sealed envelope. At the second visit in each school, the researchers collected parents' envelopes and administered the appropriate questionnaires to those children whose parents had agreed on their participation in the present study. Questionnaires were filled in during an academic hour and researchers were present for guidance, clarification and support.

Measures

Anxiety

Participating children responded to Spence Children's Anxiety Scale – SCAS-C,[36] (Mellon et al for the Greek version[37]), while parents responded to Spence Anxiety Scale for Parents (SCAS-P).[38] Spence – Children's Anxiety Scale assesses severity of anxiety symptoms according to those included in the DSM-IV diagnostic criteria for anxiety disorders. SCAS-C focuses on six domains of anxiety including Generalized Anxiety (GA), Panic/Agoraphobia (P/A), Social Phobia (SP), Separation Anxiety (SA), Obsessive Compulsive (OC), and Physical Injury Fears (PIF). SCAS-C is a 45-item questionnaire where a child indicates the frequency (never, sometimes, often, always) he experiences anxiety and fear in a variety of situations. In order to reduce negative response bias, SCAS-C also embeds six positive behaviour items. Greek version of SCAS has also an additional item about the fear of elevators, an item that was not included in the original one.

The items of the SCAS-P were formulated as closely as possible to the corresponding item of the child version of the SCAS. Items referring to an internal state (e.g. item 4, I feel afraid) were rephrased into observable behavior for parents (e.g. My child complains of feeling afraid). The positive filler items were not included in the SCAS-P, leaving 39 items in the scale on the same 0 (never) to 3 (always) scale.

Data analysis

Descriptive statistics were examined for all variables. Relations between children's and parents'

reports concerning anxiety symptoms were examined by calculating Pearson's correlation coefficients.

Results

Demographic characteristics of the participating children and their mothers and/or fathers, according to parents' reports, are presented in table 1. Most common participating parent was mother (72.9%), corresponding percentage for fathers was 10.6%, while the involvement of both parents was 16.5%.

Descriptive characteristics of anxiety scales for children and parents separately are presented in table 2. Children's reports on SCAS total score, as well as in subscale scores were higher than related parents' scores. Children's score on the fears of physical injury subscale were significantly lower than those of parents. Statistically significant differences were those related to SCAS total score, SP, OC, P/A, PIF, and GA subscale scores. Scores on the SA Subscale were not significantly different.

Correlations between children's and parents' scores in all anxiety subscales and SCAS total score in our sample, as well as, in the Nauta[18] and Li[19] samples are presented in table 3. We preferred to compare our data with the corresponding data from Nauta's and Li's studies because they used the same anxiety scale as well as a similar age group. Correlations were statistically significant (p<0.01). Higher correlations

were those reported for SA, PIF, and the SCAS total score, while OC had the lowest correlation.

Correlations between children's and parents' scores in SCAS-C and SCAS-P subscales and total score according to gender and age are presented in tables 4 and 5 respectively. Correlation coefficients for girls were higher than for boys. Higher correlations were those of SA, PIF, and SCAS total score. On the other hand, boys presented statistically significant correlations but nevertheless correlation coefficients were rather low. In order to test the difference between the above correlation coefficients, r values were transformed into z scores. In a 2-tailed test, z values greater than |1.96| are considered significant.[39] Consequently, girls' correlation coefficients in SA, SP, PIF, GA and SCAS total score differed statistically significant from boys' coefficients.

Correlations between children's and parents' scores in SCAS-C and SCAS-P subscales and total score according to age, showed that the highest correlation coefficients were found in comparatively older children (6th Grade). Children in the 4th Grade tend to have lower correlations compared with children in 5th and 6th Grade. Correlations in the younger children group were not significant for SP, OC and P/A, while parents' and children's scores significantly related for SA, PIF, GA and SCAS total score. Z scores showed that only the 4th Grade children's correlation in SCAS total score was significantly lower than 6th Grade children's r-value.

Table 2. Mean & Standard Deviation of anxiety symptoms for children and parents. T-test between children's and parents' reports.

	Children		Parents			
	Mean	SD	Mean	SD	t-test	p
SA	3.34	3.30	3.20	3.04	t(407)=0.590	0.555
SP	4.94	3.84	4.38	3.15	t(409)=3.25	0.000
OC	5.31	3.92	2.11	2.39	t(388)=15.69	0.000
P/A	3.20	3.95	1.35	2.27	t(403)=9.73	0.021
PIF	3.79	2.95	4.16	2.71	t(411)=−2.315	0.000
GA	4.12	3.43	3.54	2.58	t(410)=3.66	0.000
SCAS	24.16	16.23	18.73	11.79	t(362)=7.23	0.000

**p<0.01, SA: Separation Anxiety, SP: Social Phobia, OC: Obsessive-Complulsive, P/A: Panic/Agoraphobia, PIF: Physical Injury Fears, GA: Generalized Anxiety

Table 3. Correlations between children's-parents' scores in total sample. Data from Li and Nauta studies.

Parents/Children	1	2	3
SA	0.53**	0.42**	0.60**
SP	0.42**	0.36**	0.55**
OC	0.27**	0.30**	0.27**
P/A	0.37**	0.25**	0.33**
PIF	0.55**	0.34**	0.23**
GA	0.37**	0.24**	0.28**
SCAS	0.50**	–	0.49**

**p<0.01, 1: present study, 2: Li et al, 2011 (n=207), 3: Nauta et al, 2004, (N=260), SA: Separation Anxiety, SP: Social Phobia, OC: Obsessive-Compulsive, P/A: Panic/Agoraphobia, PIF: Physical Injury Fears, GA: Generalized Anxiety

Discussion

Previous research has shown that the relationship between the way parents assess anxiety symptoms of their child and a child self-assess his anxiety are to some degree correlated (low to moderate agreement). Nonetheless research has also shown some clear discrepancies. These findings emphasize the need for further studies that take into consideration specific kinds of anxiety and the characteristics of a given sample (eg. community versus clinical samples).

It is well grounded that parental reports are viewed as essential to a satisfactory psychiatric assessment of children, so that it is standard clinical practice to obtain information from parents to assess children's functioning. Assessment of anxiety symptomatology is rather complicated because of the diversity of its behavioral consequences. The present study aimed to examine the agreement between children and parents on the severity and frequency of anxiety symptoms and to examine whether age and gender may influence this agreement.

Our results showed that, in line with other findings,[1,4,15,22] children tend to report more frequent anxiety symptoms than their parents. This finding is probably due to the conviction that parents are not always completely aware of the presence of anxiety in their child's life.[40]

Using Pearson's correlation analyses, this study found significant correlations between children's and parents' reports for the total anxiety score and for the majority of the anxiety subscales. In general correlations were within the predicted range. Higher correlations were found for total anxiety score, SA and PIF, followed by SP. These findings agree with the corresponding findings from Nauta's and Li's studies.[18–19] Comparison of our findings with these of Li's study in Hong Kong, showed that our degree of correlation was higher for the total anxiety score and all the subscales score. Such a finding may be explained by the way parental roles and the ways of communication are construed in

Table 4. Correlations and z scores between children's-parents' reports by gender.

Children/Parents	B/P	G/P		
	r	r	z-scores	p
SA	0.41**	0.59**	−2.48	0.007
SP	0.30**	0.49**	−2.34	0.010
OCD	0.29**	0.26**	0.40	0.345
P/A	0.40**	0.35**	0.65	0.259
PIF	0.39**	0.61**	−3.06	0.001
GA	0.26**	0.43**	−1.98	0.024
SCAS	0.39**	0.57**	−2.22	0.013

**p<0.01, B/P: Boys/Parents, G/P: Girls/Parents, SA: Separation Anxiety, SP: Social Phobia, OC: Obsessive-Compulsive, P/A: Panic/Agoraphobia, PIF: Physical Injury Fears, GA: Generalized Anxiety

Table 5. Correlations and Z scores between children's-parents' reports by grade.

Children/ Parents	4th Grade/P	5th Grade/P	6th Grade/P	4th Vs 5th Grade		5th Vs 6th Grade		4th Vs 6th Grade	
	r	r	r	z	p	z	p	z	p
SA	0.49**	0.47**	0.60**	0.13	0.45	−1.48	0.07	−1.34	0.09
SP	0.21*	0.45**	0.53**	−2.23	0.01	−0.87	0.19	−3.14	0.00
OCD	0.16	0.31**	0.34**	−1.23	0.11	−0.29	0.39	−1.55	0.06
P/A	0.19*	0.41**	0.55**	−1.93	0.02	−1.50	0.07	−3.49	0.00
PIF	0.52**	0.51**	0.63**	0.12	0.45	−1.42	0.08	−1.28	0.1
GA	0.29**	0.37**	0.45**	−0.76	0.22	−0.74	0.23	−1.51	0.06
SCAS	0.34**	0.54**	0.63**	−1.92	0.02	−1.09	0.14	−3.09	0.00

**p<0.01, *p<0.05, SA: Separation Anxiety, SP: Social Phobia, OC: Obsessive-Compulsive, P/A: Panic/Agoraphobia, PIF: Physical Injury Fears, GA: Generalized Anxiety

families. It is known that in Greek contemporary society, members of a family have usually a strong emotional attachment,[41] allowing us to hypothesize that higher correlation coefficients in our study may be related to the closest relationship between parents and children in Greece. Furthermore, the reported relatively high levels of agreement are more common in nonclinical compared with clinical populations.[24] Mixed results are presented comparing data from the present study with the study of Nauta.[18] We found that the Greek sample had better agreement in PIF, P/A and GA subscales and lower/worst agreement in SA and SP.

Child's gender seems to play a role in the way that children as well as their parents perceive frequency of childhood anxiety symptoms. The study of the way both boys and girls report anxiety symptoms and how this agrees with the way parents perceive it, shows a higher agreement in girls than in boys. This finding underlies the fact that there are gender differences in emotion expression in children that fluctuate depending on age and context.[42] In line with other findings, degree of parent-child agreement was higher for girls.[16,21] However, this finding does not agree with other studies that found no gender differences[23,28] or no statistically significant differences.[7,40]

Studies so far[3–6,15,24] have found that younger children's reports of their anxiety symptoms do not quite agree with their parents reports. Our study confirmed this – correlations between children's and parents' scores in SCAS-C and SCAS-P subscales and total score showed that the highest correlation coefficients were found in comparatively older children, i.e., early adolescents (6th Grade). Factors related to children's ability to understand their feelings and the way they express feelings of anxiety and nervousness may explain the above finding.[33] Moreover, although anxiety symptoms in younger children are usually expressed by more overt behaviors (e.g. crying, irritability) and parents are more reliable observers and informants about the child's emotional state, younger children do not reliably express them when asked for.[3] Our findings do not agree with other studies that found no significant influence of age in child-parent congruence[23,28] and studies where younger children were found to have better agreement with their parents.[16]

Conclusion and limitations

Our results indicate that there is a medium and predicted agreement between children's (9–11 years old) and their parents' reports on the way both assess given children's anxiety symptoms. This finding underlies that in the process of assessing and diagnosing an anxiety disorders in children, it is both necessary and important to gather information from multiple sources. Any discrepant information should be considered as an additional diagnostic clue.[11]

One important limitation of the present study is the use of one only anxiety scale for the assessment of childhood anxiety symptoms and consequently

child-parent congruence when assessing anxiety symptoms. However SCAS has been found to possess good psychometric properties in a Greek elementary school-aged population.[37] Furthermore, this study did not include a gold standard determination of psychiatric diagnoses or functional impairment associated with symptoms. Hence, it cannot answer the questions raised as to the true clinical significance of these findings. Finally, the age distribution of our sample (9–11 years old) was rather narrow. A broader age range in our sample could have given more significant and conceptually valued age differences. Our sample size was quite small, but it was randomly selected; that means that our results could be generalized in the general population. Finally, mothers were the main respondent to our questionnaires so we do not have enough evidence on the way that fathers respond at the same task.

What we have found is only an aspect of the agreement or disagreement between parent and child ratings of a child's anxiety symptoms. Ways of family communication, parental psychopathology, child's tendency to respond in a socially desirable way, as well as other possible related variables, should also be incorporated in the realm of research questions. Finally, the role of teachers as informants for a child's emotional difficulties should also be examined, given that information from multiple resources leads to more reliable conclusion about a child's emotionally difficulties and his level of functioning in different settings.

Αξιολόγηση των συμπτωμάτων άγχους στα παιδιά:
Συμφωνία μεταξύ των γονέων και των παιδιών

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Η αξιόπιστη αναγνώριση και αξιολόγηση των διαταραχών του άγχους στα παιδιά είναι μια δύσκολη διαδικασία η οποία απαιτεί τη χρήση πολλαπλών πηγών. Οι πληροφορίες μπορεί να προέρχονται από τα παιδιά, τους γονείς και τους εκπαιδευτικούς καθώς και από τη χρήση πολλαπλών διαγνωστικών μεθόδων και εργαλείων όπως οι δομημένες και ημιδομημένες συνεντεύξεις και τα ερωτηματολόγια αναφοράς, κ.λπ. Οι έρευνες δείχνουν ότι οι αναφορές των παιδιών και των γονέων σχετικά με τα συμπτώματα του άγχους παρουσιάζουν μικρή έως και μέτρια συμφωνία, ενώ εμφανίζουν και σημαντικές διαφοροποιήσεις. Σημαντικές παράμετροι μπορούν να επηρεάσουν το μέγεθος της συμφωνίας. Στην παρούσα μελέτη δόθηκε έμφαση στην επίδραση του φύλου και της ηλικίας του παιδιού. Στόχος της ήταν να εξετάσει τη συμφωνία που υπάρχει ανάμεσα στις αναφορές των παιδιών και των γονέων σχετικά με τα συμπτώματα άγχους των πρώτων. Στην έρευνα συμμετείχαν 431 παιδιά (190 αγόρια και 241 κορίτσια) Δ΄, Ε΄ και ΣΤ΄ Δημοτικού. Τόσο στα παιδιά όσο και στους γονείς χορηγήθηκε η κλίμακα του Άγχους των Παιδιών της Spence (SCAS). Οι συσχετίσεις ανάμεσα στις αναφορές των παιδιών και των γονέων εξετάστηκαν με τον υπολογισμό του συντελεστή συσχέτισης Pearson. Τα αποτελέσματα έδειξαν ότι υπήρχε μία μέτρια αλλά στατιστικά σημαντική θετική συσχέτιση ανάμεσα στις αναφορές των παιδιών και των γονέων για τα συμπτώματα του άγχους συνολικά (r=0,50, p<0,01). Αναφορικά με τις υποκλίμακες του SCAS βρέθηκε ότι η μεγαλύτερη συσχέτιση μεταξύ παιδιών και γονέων υπήρχε για το άγχος αποχωρι-

σμού (r=0,53, p<0,01) και για τον φόβο τραυματισμού (r=0,55, p<0,01). Λαμβάνοντας υπόψη τις διαφορές φύλου οι αναφορές των κοριτσιών παρουσίασαν μεγαλύτερη συσχέτιση με αυτές των γονιών τους συγκριτικά με τα αγόρια (r=0,57 και r=0,39 αντίστοιχα, p<0,01). Αναφορικά με την ηλικία παρατηρήθηκε ότι οι αναφορές των μεγαλύτερων παιδιών παρουσίασαν μεγαλύτερο βαθ-μό συσχέτισης με τις αντίστοιχες αναφορές των γονιών τους (r=0,34, r=0,54 και r=0,63, p<0,01 για τα παιδιά της Δ΄, Ε΄ και ΣΤ΄ αντίστοιχα). Τα ευρήματα δείχνουν τη σημασία της χρήσης τόσο των αναφορών των γονέων όσο και των παιδιών για την αξιόπιστη αξιολόγηση των συμπτωμά-των του άγχους, ιδιαίτερα για τα παιδιά μικρότερης ηλικίας.

Λέξεις ευρετηρίου: Άγχος, παιδί, γονείς, μέτρηση, συμφωνία αυτοαναφορών.

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