Parenting practices and depressive symptomatology in adolescents

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ABSTRACT

The objective of this study was to analyze the predictive power that parenting practices have in depressive symptomatology among adolescents, taking into account the gender of both the child and the parents. A nonrandom sample was used, consisting of 1,934 adolescents from three different cities in Mexico (26.5% from Mexico City; 26.7% from Poza Rica, Veracruz; and 46.8% from Culiacán, Sinaloa). 51.4% were males and 48.6% were females, with an age range from 11 to 17 years, and a mean age of 13.3 years. Nine dimensions of parenting practices were evaluated, five for the mother (Communication, Autonomy, Imposition, Psychological Control, and Behavioral Control) and four dimensions for the father (Communication/Behavioral Control, Autonomy, Imposition, and Psychological Control). To evaluate depressive symptomatology, a revised version (adapted for the Mexican population) of the Center for Epidemiologic Studies Depression Scale (CES-D) was used. The results showed that girls obtained higher scores for depressive symptomatology than boys. Depressive symptomatology had a positive association with psychological control and imposition among both parents, and a negative association with communication, autonomy and behavioral control, also among both parents. Linear regression analysis was performed to determine the effect of parenting practices on depressive symptomatology and was conducted by gender and by city. In general, the results showed that girls had a higher percentage of explained variance (from 26% to 31%) than boys (from 6% to 25%), and the dimension that explained the highest variance in most of the groups was maternal psychological control, except with boys in Mexico City and Culiacán.

Key words: Adolescents, depression, parenting practices.

INTRODUCTION

Depression in young people represents a health problem with effects on psychosocial development. While it may present as a temporary (and often common) problem, in some cases it can result in a more hazardous condition, generating self-destructive behaviors.1 There is evidence of the continuity of depression throughout adolescence and extension through adult life, while it is also associated with abuse of alcohol and drugs and other risk behaviors, involving both personal and social consequences.2

In Mexico, the first nationwide estimates for mental...
disorders were obtained from the National Survey of Psychiatric Epidemiology (ENEP, in Spanish) which was conducted in 2001-2002, with an adult population ranging from 18 to 65 years of age. The ENEP shows that women have a higher probability of presenting with affective and anxious disorders, while men have a higher probability of substance abuse. This survey also showed that the onset of disorders occurs at a very young age. The data available for the adolescent population come from the Mexican Survey of Adolescent Mental Health, conducted in 2005, which evaluated the prevalence and severity during the prior 12 months as well as the age of onset for 17 psychiatric disorders in adolescents aged 12 to 17 years, residing in Mexico City and the surrounding metropolitan area.

Diagnosis of a mental disorder was conducted with a computerized version of the Composite International Psychiatric Interview (WMD-CIDI-A), designed for the World Mental Health Survey initiative. Results from this survey show that the most common individual conditions among males and females were specific phobias and social phobia. In addition, the next most prevalent disorder among females is major depression, followed by oppositional defiant disorder, agoraphobia without panic disorder, and separation anxiety. Among males, the disorder following specific phobias was oppositional defiant disorder, followed by alcohol abuse and dissociative personality disorder. The most severe disorders were mood disorders, followed by anxiety disorders. The age of onset for anxiety disorders (M = 6 years), mood disorders (M = 11 years) and substance abuse (M = 14 years) was similar among males and females.

The foregoing data suggests the need to perform research with regard to the etiology of early-onset disorders. In this study, adolescent depressive symptomatology is studied, which represents a complex case, as there are many factors that contribute to its occurrence and continuity. These elements include family factors, which include genetic factors, parental psychopathology, and parenting styles and practices.

For several decades, parenting styles and practices, as well as conflicts between parents and children, have been the focus of development theorists to understanding the impact they have on the psychosocial development of children. There is empirical evidence that children and adolescents who grow up in democratic households are more socially competent and show fewer internalized and externalized problems than those who grow up in authoritarian environments. Specific studies on the impact of parenting practices on depressive symptomatology are inconclusive. In 2005, McLeod, Weisz and Wood conducted a meta-analysis of 45 studies regarding the relationship between parenting practices and depression in children and adolescents, concluding that parenting practices explain only a small proportion of the variance of depression in children, in contrast with other factors such as genetic influence. Thus, they suggested that it was probable that depression is the result of a group of interactions ranging from biological vulnerability and environmental influences. These same authors indicate that although parenting practices play a minor role, they could be a significant catalyst, especially among children who are vulnerable to depression.

More recent studies consider specific aspects of parenting practices, analyzing the support and control of parents and even considering the moderating effect of the individual characteristics of children, such as temperament and self-esteem. Parental support refers to the quality of the parent-child relationship and involves physically and emotionally affective behaviors, as well as approval for and care of children, communication and support in difficult situations. On the other hand, control includes demands and expectations that parents require of their children through discipline and supervision. In 1996, Barber proposed the distinction between psychological control and behavioral control, to differentiate clear and open supervision strategies (behavioral control) from intrusive strategies that undermine the autonomy of the adolescent (psychological control), such dimensions having been reconsidered in other studies.

Regarding the effect of parental support on the depressive symptomatology of adolescents, several studies indicate that adolescents who report higher levels of depressive symptoms perceive less quality in the relationship with their parents and greater rejection. It bears mention that different tools have been used to measure parental support, as well as different scales to measure depressive symptomatology, and while correlations are significant, they are often either weak or moderate.

Regarding the relationship between behavioral control and depression, some studies have shown that low levels of supervision impact depressive symptomatology. Hamza and Willoughby pointed out that it is important to analyze the way in which parents supervise or are aware of the activities of their children, as it is not the same if young people spontaneously share information with their parents, as opposed to the parent requesting or demanding such information. In this regard, the authors conducted a study in which they analyzed separately the knowledge of parents regarding the activities of their children (parental knowledge), information that the children share with their parents (disclosure of the adolescent), the information that parents request from their children (parental request) and the restrictions that the parents impose on their children (parental control) and their relationship with depressive symptomatology among children. Their results show that high levels of parental knowledge regarding the activities of their children predict low levels of depression in adolescents, while high levels of adolescent disclosure are associated indirectly with low...
levels of depression, through parental knowledge. Contrary to their expectations, parental control was not associated with depression. In general, the effects, while significant, were small.

Kakihara et al.29 made other considerations regarding behavioral control, as they believe that, under certain conditions, such control can be perceived as negative, because young people can feel that their parents are over-controlling or invading their privacy, rather than just showing concern for them. For this reason, the authors propose that the perception and feelings of the child regarding the supervision of their parents must be taken into consideration. In their study, they considered three dimensions of parental control: rules, restriction of freedom and rejection, and two dimensions of the feelings of young people: excessive control and connection. They found that the restriction of freedom and rejection increase depressive symptoms through an increase in feelings of excessive control. Their results were different between sexes and age groups.

The psychological control dimension has received special attention in recent years regarding depressive symptomatology in adolescents, as it includes practices that interfere with the autonomy and independence of children, such as devaluation, invalidation of feelings, inciting guilt, blackmail and physical and psychological aggression. The results of several studies show that parental psychological control is positively related to depressive symptomatology.19,29-32 In recent studies, a debate has emerged regarding the importance of this construct in different cultures, as some authors believe that a parenting practice can be perceived as more intrusive in individualistic cultures than in collectivist cultures. However, Soenens et al.33 showed that the relationship between psychological control and depression was similar in two culturally distinct samples (Belgium and Korea).

In Mexico there is a lack of literature on the relationship between parenting practices and depressive symptomatology. González-Forteza et al.33 reported significant correlations between everyday family stressors and depressive symptomatology in adolescents. In turn, Gil-Rivas et al.34 evaluated the contribution of individual and familial factors in depressive symptomatology among 262 adolescent females in Mexico, finding that the perception of support and acceptance from parents not only contributes to lower levels of depression, but also decreases the negative effects of ruminative coping style with depression. Other studies have confirmed relationships between familial factors and depressive symptomatology among women only.35,36 Andrade, Betancourt and Orozco37 found that children that present with minimal depression perceived greater behavioral control from both the mother and the father, as well as low levels of psychological control on the part of the mother, as compared to children that presented with more severe depression. These same authors conducted another study with a sample of adolescents and showed that young people with serious depression perceive that their mothers exert greater psychological control and less behavioral control as compared to young people that present with minimal depression. They did not find differences in the perception of the parenting of the father.38 More recently, Betancourt and Andrade39 found that maternal and paternal psychological control were the main predictors of depression in adolescents. These results suggest the importance of conducting studies that consider not only the sex of the child but also the sex of the parent, which has also been emphasized in international literature.15,20,23,40-43

The objective of this study is to analyze the predictive power of parenting practices in depressive symptomatology among adolescents in three Mexican states, considering the sex of the child and that of the parents.

**MATERIALS AND METHODS**

**Participants**

A nonrandom sample was selected that included 1,934 adolescents from three Mexican cities: 26.5% from Mexico City; 26.7% from Poza Rica, Veracruz; and 46.8% from Culiacán, Sinaloa. Table 1 shows the socio-demographic information for the participants by city.

**Tool**

The Andrade and Betancourt Parenting Practices Scale44 was used, which consists of nine dimensions, five for the mother (Communication, 9 items, $\alpha = .92$; Autonomy, 7 items, $\alpha = .86$; Imposition, 8 items, $\alpha = .81$; Psychological Control, 8 items, $\alpha = .80$; and Behavioral Control, 7 items, $\alpha = .84$), and four for the father (Communication/Behavioral Control, 16 items, $\alpha = .97$; Autonomy, 8 items, $\alpha = .94$; Imposition, 8 items, $\alpha = .90$; and Psychological Control, 8 items, $\alpha = .90$).

To evaluate depressive symptomatology, the revised version of the Center of Epidemiologic Studies Depression Scale45 (CES-D) was used, as adapted to the Mexican population by González-Forteza et al.46 It is a Likert style scale with 35 questions and five response options (from 0 days to 10-14 days).

**Procedure**

The instrument was self-administered. Permission was requested from school authorities to apply the instrument in classrooms, and students were asked to participate on a voluntary basis. Their anonymity was guaranteed, and any questions they had were answered.
It is important to indicate that all analysis was conducted separately for the three locations in which information was obtained (Mexico City, Poza Rica and Culiacán).

To examine the differences in depressive symptomatology by sex and city, univariate analysis of variance was conducted (Table 2). The results showed significant effects in the corrected model ($F=21.10, p < .001$), by sex ($F=92.97, p < .001$) and by city ($F=4.48, p < .05$), but no interaction ($F=0.17, p > .05$). As we can see in Table 2, women obtained higher scores in depressive symptomatology as compared to men, while adolescents from Culiacán obtained lower scores that those from the other two cities.

In order to analyze the relationship between the different dimensions of parenting practices and depressive symptomatology, analysis was conducted of the Pearson product-moment correlation. This analysis was performed by sex and by place of residence (Table 3).

In general, the results showed correlations in the expected direction: depressive symptomatology was positively associated with psychological control and imposition from both parents, and was negatively associated with communication, autonomy and behavioral control, both maternal and paternal.

In the case of the women from the three cities, moderate correlations were found between all dimensions of parenting practices and depressive symptomatology, which was unlike the case of men, in which slight to moderate correlations were found and no significant relations were found with all dimensions of parenting practices. Specifically, among males in Mexico City no significant relationships were found between depressive symptomatology and maternal and paternal communication and behavioral control.

In the case of male adolescents from Poza Rica, no significant correlations were found with the dimensions of autonomy and paternal imposition, and for males in Culiacán, no relation was found with paternal imposition.

To determine the effect of the maternal and paternal parenting practice dimensions on depressive symptomatology in adolescents, stepwise multiple regression analysis was conducted, in which the parenting practice dimensions were entered as independent variables and depressive symptomatology as the dependent variable. It bears mention that this analysis was performed separately for men and women, as the correlations showed different patterns.

Table 4 shows the results of the effects of parenting practices on depressive symptomatology for adolescents in Mexico City. In the case of women, the maternal psychological control dimension was entered in the first step of the analysis [$F(1,200) = 48.43, p < .001$], while the paternal communication/behavioral control dimension was added in the second step [incremental $F(2,199)= 33.21, p < .001$], and in the third step, maternal communication was added to the equation [incremental $F(3, 198) = 24.17, p < .001$]. These results indicate that high levels of maternal
psychological control, as well as low levels of communication with both parents, influence the occurrence of depressive symptomatology in adolescent women.

Regarding men, in the first step of analysis, the paternal psychological control dimension was entered as predictor of the equation \[F(1,213) = 23.80, p < .001\], followed by maternal psychological control \[\text{incremental } F(2,212) = 16.27, p < .001\], and finally, paternal autonomy was added to the equation \[\text{incremental } F(3,211) = 12.30, p < .001\]. The results indicate that a high perception of psychological control, both maternal and paternal, together with limited support for autonomy on the part of the father, affects the occurrence of depressive symptomatology in adolescent men.

Table 3 shows the results for adolescents from Poza Rica. With regard to women, in the first step maternal psychological control was entered \[F(1,194) = 55.36, p < .001\] while in the second step, paternal communication/behavioral control was entered \[\text{incremental } F(2,193) = 65.43, p < .001\]. These results indicate that high levels of maternal psychological control and high levels of paternal imposition, together with low levels of communication and supervision on the part of the mother, influence the occurrence of depressive symptomatology in adolescent men.

Regarding men, for the first step of the analysis, maternal psychological control was entered as predictor of the equation \[F(1,179) = 50.39, p < .001\] and in the second step, maternal behavioral control was added to the equation \[\text{incremental } F(2,178) = 31.57, p < .001\]. These results indicate that a high level of psychological control, together with low levels of behavioral control on the part of the mother, have an impact on the occurrence of depressive symptomatology in adolescent men.

Table 4 shows the results for adolescents from Culiacán. With regard to women, in the first step maternal psychological control was entered \[F(1,267) = 65.43, p < .001\]; in the second step, the dimension for maternal communication was added \[\text{incremental } F(2,266) = 65.43, p < .001\]; in the following step, paternal imposition was added \[\text{incremental } F(3,265) = 43.42, p < .001\], while in the final step, maternal behavioral control was added to the equation \[\text{incremental } F(2,264) = 28.39, p < .001\]. These findings indicate that high levels of maternal psychological control and high levels of paternal imposition, together with low levels of communication and supervision on the part of the mother, influences the occurrence of depressive symptomatology in adolescent women.

### Table 3. Analysis of correlation between parenting practices and depressive symptomatology by sex and city of residence

<table>
<thead>
<tr>
<th></th>
<th>Depressive symptomatology</th>
<th>Mexico City</th>
<th>Poza Rica</th>
<th>Culiacán</th>
</tr>
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<tr>
<td></td>
<td></td>
<td>Men</td>
<td>Women</td>
<td>Men</td>
</tr>
<tr>
<td>Maternal communication</td>
<td>-.12</td>
<td>-.41**</td>
<td>-.31**</td>
<td>-.19**</td>
</tr>
<tr>
<td>Maternal autonomy</td>
<td>-.22**</td>
<td>-.36**</td>
<td>-.23**</td>
<td>-.18**</td>
</tr>
<tr>
<td>Maternal imposition</td>
<td>.24**</td>
<td>.38**</td>
<td>.30**</td>
<td>.16**</td>
</tr>
<tr>
<td>Maternal psychological control</td>
<td>.34**</td>
<td>.44**</td>
<td>.44**</td>
<td>.23**</td>
</tr>
<tr>
<td>Maternal behavioral control</td>
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<td>-.32**</td>
<td>-.35**</td>
<td>-.17**</td>
</tr>
<tr>
<td>Communication/behavioral control</td>
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<td>-.34**</td>
<td>-.06</td>
<td>-.14**</td>
</tr>
<tr>
<td>Paternal autonomy</td>
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<td>-.21**</td>
<td>-.08</td>
<td>-.13**</td>
</tr>
<tr>
<td>Paternal imposition</td>
<td>.28**</td>
<td>.29**</td>
<td>.17*</td>
<td>.08</td>
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<tr>
<td>Paternal psych. control</td>
<td>.35**</td>
<td>.31**</td>
<td>.19**</td>
<td>.02**</td>
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</tbody>
</table>

*p < .05; ** p < .001.

### Table 4. Stepwise regression analysis to predict depressive symptomatology in adolescents in Mexico City

<table>
<thead>
<tr>
<th>Variable</th>
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<th>SE B</th>
<th>β</th>
<th>R²</th>
<th>Δ R²</th>
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<td>Women</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Step 1. Maternal psychological control</td>
<td>18.31</td>
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<td>.44**</td>
<td>.19**</td>
<td></td>
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<td>Step 2. Paternal communication/behavioral control</td>
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<td>2.17</td>
<td>-.24**</td>
<td>.24**</td>
<td>.05**</td>
</tr>
<tr>
<td>Step 3. Maternal communication</td>
<td>-5.51</td>
<td>2.51</td>
<td>-.17*</td>
<td>.26*</td>
<td>.02*</td>
</tr>
<tr>
<td>Men</td>
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<td></td>
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<td></td>
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<tr>
<td>Step 1. Paternal psychological control</td>
<td>11.98</td>
<td>2.46</td>
<td>.32**</td>
<td>.10**</td>
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<td>Step 2. Maternal psychological control</td>
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<td>3.05</td>
<td>.20*</td>
<td>.12*</td>
<td>.02*</td>
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<tr>
<td>Step 3. Paternal autonomy</td>
<td>-4.06</td>
<td>2.05</td>
<td>-.14*</td>
<td>.14*</td>
<td>.02*</td>
</tr>
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</table>

*p < .05; ** p < .001.
With regard to men, for the first step of the analysis, paternal psychological control was entered as predictor of the equation \[ F(1,205) = 11.81, p < .001 \] and in the second step, maternal communication was added [incremental \( F(2,204) = 7.99, p < .001 \)]. This indicates that a high level of psychological control on the part of the father, together with low levels of communication with the mother, influences the development of depressive symptomatology in adolescent men.

**DISCUSSION**

The objective of this study was to analyze the predictive power of parenting practices in depressive symptomatology among adolescents, considering both the sex of the children and that of the parents, as well as their city of residence. The results confirmed that depressive symptomatology in adolescent women is greater than in men, which suggests the need to study certain vulnerability factors that are specific to women. In comparing the information by city, it was found that adolescents in Culiacán had the lowest levels of depressive symptomatology, as compared to those from Poza Rica and Mexico City. This result is interesting, and it would be appropriate to study certain contextual factors that might explain this difference.

With regard to the relationship between parenting practices and depressive symptomatology, the expected relationships were confirmed; greater support and communication, autonomy and behavioral control perceived by the adolescent (both on the part of the father and the mother) result in fewer depressive symptoms. Likewise, greater imposition and psychological control result in more depressive symptoms.

It bears mention that the correlations were generally stronger in the case of women than in the case of men, and were also stronger with maternal practices than with paternal practices; such phenomenon has not been consistent across international literature, as there are studies that have not found these magnitudes and differences, and others that have found maternal practices only.

Regression analysis has clearly shown that the percentages of variance explained by parenting practices in depressive symptomatology are greater than those reported in international literature. This may be a result of the importance of family within Mexican culture, although this contradicts the results of Soenens et al., who found similar results in a sample with individualistic cultural tendencies, and another with collectivist cultural tendencies. Future studies would need to evaluate these cultural tendencies to determine whether the effect of parenting practices is in fact affected by cultural beliefs.

Another important piece of information which was confirmed is that maternal psychological control is the strongest indicator of symptomatology across all groups, except in the case of men in Mexico City and Culiacán, where the strongest indicator was paternal psychological control, albeit to a lesser extent. These results are in accordance with

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE</th>
<th>( \beta )</th>
<th>( R^2 )</th>
<th>( \Delta R^2 )</th>
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<td><strong>Women</strong></td>
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<td>Step 1. Maternal psychological control</td>
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<td>-.31**</td>
<td>.31**</td>
<td>.09**</td>
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<td><strong>Men</strong></td>
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<tr>
<td>Step 1. Maternal psychological control</td>
<td>22.17</td>
<td>3.12</td>
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<td></td>
</tr>
<tr>
<td>Step 2. Maternal behavioral control</td>
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<td>2.00</td>
<td>-.22**</td>
<td>.25*</td>
<td>.03*</td>
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</tbody>
</table>

* \( p<.05; ** p<.001 \).

**Table 5. Stepwise regression analysis to predict depressive symptomatology in adolescents in Poza Rica**

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE</th>
<th>( \beta )</th>
<th>( R^2 )</th>
<th>( \Delta R^2 )</th>
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<tr>
<td><strong>Women</strong></td>
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<td></td>
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<td>Step 1. Maternal psychological control</td>
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<td>.44**</td>
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<td>.05**</td>
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<td>.28**</td>
<td>.04**</td>
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<td>Step 4. Paternal imposition</td>
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<td>2.09</td>
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<td>Step 1. Paternal psychological control</td>
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<td>.06*</td>
<td>.01*</td>
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* \( p<.05; ** p<.001 \).
those of other authors, albeit to a lesser extent, while the effect may be direct or indirect, depending on the sex of the child. The behavioral control dimension (both maternal and paternal) also contributed to explaining symptomatology, although to a lesser extent, which supports to some degree the results of Hamza and Willoughby, who found a small effect from parental awareness of children’s activities, although this effect was not different between males and females. However, in this study, maternal behavioral control had effects on women in Mexico City and Culiacán, as well as men in Poza Rica, and paternal behavioral control influenced women in Poza Rica.

In comparing the results of the regression analysis by sex, it is clear that parenting practices have a greater effect on women than on men, which confirms the findings of other Mexican studies, although there is still controversy here among international researchers. Comparisons by city return data that require further research to confirm whether in other adolescent samples, especially men in Culiacán, parenting practices have a diminished effect, as compared to men in Poza Rica, for whom both maternal and paternal psychological control was significant.

In conclusion, it can be stated that parenting practices, specifically psychological control, perceived by children on the part of their mother, play an important role in depressive symptomatology, especially among women. For this reason, it is important to include parents in prevention programs, so as to help them avoid the use of control strategies that are intrusive for their children, such as devaluation, blackmail, inducing guilt, and physical and verbal aggression. These practices negatively affect the health of their children, and although among men such factors were not as significant, they may affect other aspects of their development.

One of the limitations for this study is the transversal nature of the research, as it reduces the possibility of explanation. As Loukas indicates, it is likely that the relationship between parenting practices and depression are bidirectional, thus requiring longitudinal studies. Another limitation was the use of self-reported data, although there is evidence that data reported by adolescents themselves are more predictive than those reported by parents. In this regard, we suggest the use of additional informants and a different observation methodology.

Lastly, given the complexity of depression, we suggest including other variables, such as the personality traits of parents and children, which may affect the onset and continuance of depression in adolescents.

REFERENCES