

## YOUTH AND PARENTAL PERCEPTIONS OF PARENTAL MONITORING AND PARENT-ADOLESCENT COMMUNICATION, YOUTH DEPRESSION, AND YOUTH RISK BEHAVIORS

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Data from 752 Bahamian youth and their parents were analyzed to examine the relationship of youth depression with youth risk involvement, parental monitoring, and parent-youth communication. Depressed youth were older, more likely to engage in risk behaviors, and they perceived significantly lower levels of parental monitoring and higher levels of

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impaired communication than did nondepressed youth. Both depressed and nondepressed youth perceived significantly lower rates of parental monitoring and open communication and higher rates of problem communication than did their parents, but the differences in perceptions of open communication were significantly greater among depressed parent-youth dyads. Depressed youth, youth with past histories of risk behavior, youth reporting higher levels of impaired communication and lower levels of parental monitoring were more likely to anticipate future risk behavior.

*Keywords:* adolescents, depression, risk behaviors, intentions, parental monitoring, parent-youth communication, impaired communication, parent, self-destructive.

The increased participation in risk-taking behaviors is a robust characteristic of adolescence (He, Kramer, Houser, Chomitz, & Hacker, 2004). Although some risk-taking is a normal part of adolescent development (He et al.), certain subgroups engage in a higher incidence of self-destructive behaviors, including unprotected sexual intercourse, multiple partners, violent behaviors, and substance abuse (Dryfoos, 1998; Jessor, 1987). Depressed youth represent one subset of the adolescent population at risk for self-destructive behavior; the link between adolescent depression and risk-taking behaviors has been widely documented, both cross-sectionally and prospectively (DiClemente et al., 2005; Glied & Pine, 2002; Goodman & Huang, 2002; Newman et al., 1996; Ramrakha, Caspi, Dickson, Moffitt, & Paul, 2000). While the relationship is strong, the etiology of the association is uncertain. Possible intrapersonal characteristics of depressed youth have been suggested. For example, risk-taking behavior may give depressed youth the opportunity to develop an identity and foster independence, which in turn can help to improve a battered self-image (Le Breton, 2004, 2005). Interpersonal factors have also been described, such as the desire to seek acceptance from groups from whom the adolescent is mirroring risk behaviors (Ritt-Olsen et al., 2005).

Another interpersonal factor that may be of critical importance in the depression-risk behavior association is parental monitoring and communication. The inverse relationship between perceived parental monitoring/parent-child communication and adolescent risk involvement has been repeatedly documented across geographic and cultural niches (Borawski, Ievers-Landis, Lovegreen, & Trapl, 2003; Brown, Mounts, Lamborn, & Steinberg, 1993; DeVore & Ginsburg, 2005; Fletcher, Steinberg, & Williams-Wheeler, 2004; Li, Feigelman, & Stanton, 2000; Rai et al., 2003; Resnick et al., 1997; Romer et al., 1999; Steinberg, Lamborn, Dornbusch, & Darling, 1992). Likewise, the association of positive parental-child attachment and communication with increased child resiliency has been described (Dutra et al., 2000). In general the parent-child monitoring and communication literature has relied on youth perceptions of parental monitoring and/or communication (Cottrell et al., 2003; Crouter & Head, 2002). Studies

assessing perceptions of monitoring from the perspective of both youth and parents have typically found that parents perceive parent-adolescent relationships and adolescent behavior from a somewhat more optimistic perspective than do youth (Li et al., 2002; Stanton et al., 2000). Although lessening the gap between youth and parent perceptions of monitoring and communication is a logical target for interventions seeking to improve monitoring efforts (Crouter & Head, 2002; Li et al., 2002; Stanton et al., 2004; Stattin & Kerr, 2000), the implications of this discrepancy have not been investigated. That is, what is the critical dimension of parental monitoring and risk behavior: the absolute level, the level perceived by the adolescent, or a similar perspective on the "reality" shared by the parent and the child?

In potentially related work, it has been noted that adolescents scoring high on hopelessness (a proxy for depression) perceive decreased parental monitoring compared to their nondepressed peers (Cottrell, Stanton, Li, Harris, & Pack, 2006). Parental perceptions of monitoring were not reported and so it is not known if the parents also perceived impaired monitoring. It therefore remains unclear if the significant factor in the relationship between adolescent depression and perceptions of decreased parental monitoring occurs as a result of actual lower levels of parental monitoring, the perception of decreased monitoring, or the discrepancy between youth and parent perceptions of parental monitoring. This study was designed to address three primary questions:

- (a) Do depressed youth and their parents perceive decreased parental monitoring and problem communication compared to nondepressed youth?
- (b) Is the divergence in perceptions regarding parental monitoring and parent-adolescent communication greater between depressed youth and their parents compared to nondepressed youth and their parents?
- (c) What is the relationship of past risk behavior, parental monitoring, parent-youth communication, and youth depression to youth anticipated risk behavior?

## METHOD

### SETTING

An independent nation since 1973, The Bahamas remains one of the nations of the British Commonwealth. Approximately 85% of Bahamians are of African descent, while the minority Caucasian population controls much of the wealth of the island. Although the per capita GNP is approximately \$12,000 (Bahamas, Ministry of Health, Health Information Unit, 2005), wealth in the country is highly skewed. Ninety-nine percent of children attending public elementary school in Nassau are black.

English is widely understood and spoken, although there is a sizeable Haitian/Creole population and multiple dialects among the population living on the over

700 islands constituting The Bahamas. School is compulsory through to age 16, and thus illiteracy rates are low (2%).

### **SELECTION OF SUBJECTS**

The data used for the present study were obtained in the autumn of 2004 from Bahamian sixth-grade students and their parents as the baseline preparatory to a randomized, controlled evaluation of an HIV prevention intervention and an environmental promotion (control) intervention. In response to expression of interest from school principals, 9 of the 25 elementary schools on the island of New Providence participated in the first wave of a randomized trial and evaluation of two intervention programs, one addressing HIV/AIDS, and the other addressing ecology of the wetlands. The Ministry of Education had agreed that both programs would be considered to be part of the sixth-grade curriculum and thus all youth would receive one of the interventions. Participation in the evaluation required both parent and youth consent and assent; approximately two-thirds of eligible parents and youth in the nine elementary schools agreed to participate. Prior to the intervention assignment, the research team administered pencil and paper questionnaires to the students during class time and to the enrolled parents during the evening (either the mother or father). Questionnaires were read out loud by the researcher and each respondent completed his/her own questionnaire. Respondents were permitted to skip questions and to move at their own speed. Additional assistance was available for students who required individual help. Seven hundred and eighty-five young people and 678 parents were recruited in the baseline survey. This research was approved by the Institutional Review Boards at Wayne State University and Princess Margaret Hospital in Nassau, Bahamas.

### **MEASURE**

The group of young people completed The Bahamian Youth Health Risk Behavioral Inventory (BYHRBI), a cultural adaptation of the Youth Health Risk Behavioral Inventory (Stanton et al., 1995). The BYHRBI was developed through extensive ethnographic research and pilot testing. Included in the BYHRBI are questions assessing demographic information, basic knowledge, risk and protective behavioral history, and perceptions and intentions/expectations regarding risk and protective behaviors. Responses to the questions assessing demographics, past and anticipated behaviors and perceptions of parenting style are used in the study.

**Depression** The young people completed the Kovacs' Children's Depression Inventory (CDI) Short Form (consisting of 10 questions), which is used to screen for depression (Kovacs, 1982, 1991, 1992). Each item has three responses, with scores of 0 to 2 for a total possible composite score of 0 (*not depressed*) to 20

(*very high risk for depression*). For purposes of the present study a cut-off of above 8 was used to identify those likely to be depressed (“depressed”) and those with scores at 8 or below were categorized as “nondepressed”. A cut-off of 8 on the CDI Short Form is equivalent to a standardized *t*-score between 62 and 66, which corresponds to the full scale cut-off of 20 recommended for general screening (Kovacs, 1982, 1991, 1992).

***Parental monitoring and parent-adolescent communication*** Both the parents and the young people completed two measures to assess perceptions of parental monitoring and parent-adolescent communication from their respective perspectives.

Silverberg and Small’s Parental Monitoring Scale was administered to assess perception of parental monitoring (Silverberg & Small, 1991). Responses to the eight items (such as for youth “My parent knows where I am after school” or for parents, “I know where my child is after school”) were based on a 5-point Likert scale from (1) *Never* to (5) *Always*. Psychometric properties of the instruments among this population were assessed using estimates of internal consistency (Cronbach’s alpha). The Cronbach’s alpha for the parent versions of the Parental Monitoring Scale was 0.82, and that for the youth versions was 0.85 (0.86 for males, 0.82 for females).

McCubbin’s Parent-Adolescent Communication Scale, consisting of two subscales (9 items “Open Family Communication”, such as “I can discuss my beliefs with my parent without feeling restrained or embarrassed”, and 10 items “Problem Family Communication”, such as “Sometimes I have trouble believing everything my parent tells me”) was administered to assess perceptions of communication (McCubbin & Thompson, 1987). Responses to these items were based on a 5-point Likert scale from (1) *strongly disagree* to (5) *strongly agree*. The Cronbach’s alpha for the parent versions of the Open Communication and Problem Communication subscales were 0.76 and 0.74, and those for the youth versions were 0.83 (0.84 for males, 0.83 for females) and 0.73 (0.73 for males, 0.73 for females).

***Impaired parent-youth communication*** After rescoring the response of open communication items in the reverse direction (such that a higher score indicated less open communication), the *z*-scores of the problem communication calculated and open communication subscales were recoded. The *z*-scores of these two scales were combined to form an impaired parent-youth communication scale for multivariate analyses.

***Past risk behavior*** A composite past risk behavior score was created by indexing those who had ever had sex, never used a condom during sex, consumed alcohol, smoked a cigarette, used marijuana, used cocaine, pushed or carried any drugs, used a needle or injected any illegal drug, been asked to sell drugs, carried a knife/screwdriver, carried a gun, and/or engaged in physical fighting in the last 6

months. The possible past risk behavior composite scores ranged from 0 to 12, with a higher score indicating a higher risk behavior engagement.

**Anticipated risk behavior** Nine risk behaviors (see Table 1, intentions during the next 6 months) were used to measure how likely that youth thought it was that he/she would engage in risk behaviors during the next 6 months. Responses to these items were based on a 5-point Likert scale from (1) *very unlikely* to (5) *very likely*. The Cronbach's alpha for this scale was 0.86 (0.84 for males, 0.86 for females). Responses to the nine items were averaged to create a composite index of anticipated risk behavior, with a higher score indicating a higher likelihood to engage in risk behaviors.

## ANALYSES

Overall demographic characteristics were examined using frequency distribution, means, and standard deviations. To determine if the associations reported in earlier studies conducted among adolescents in the United States (DiClemente et al., 2005; Glied & Pine, 2002; Goodman & Huang, 2002; Newman et al., 1996; Ramrakha et al., 2000) applied to this preadolescent population in the Bahamas, the association of youth depression with age was tested using the student's *t*-test. To assess the association of youth depression with intentions and risk behaviors, adjusted odds ratios were calculated using binary logistic regression analysis controlling for age.

The association of youth depression with parental monitoring, and parent-youth communication was examined using analysis of covariance with age as a covariate, and parental monitoring, and parent-youth communication as the dependent variables.

Multivariate logistic regression analysis was performed to identify factors associated with youth depression. The model included age, gender, past risk behavior, youth and parent perceptions of parental monitoring, and impaired parent-youth communication as independent variables. The association of these variables with youth anticipated risk behavior was examined using multiple linear regression analysis. The mean score of anticipated risk behavior was employed as the dependent variable. The interaction between past risk behavior and youth perceptions of impaired parent-youth communication was included as an additional independent variable in the model.

All statistical analyses were performed using the SPSS 11.5 for Windows. A significance level of 0.05 was adopted in the analysis.

## RESULTS

Among the original sample of 785 youth, 33 were excluded due to missing values of the depression variable, yielding a sample size of 752 including 343

(46%) males with a mean age of 10.5 years (Table 1; not shown in this table, among the 678 enrolled parents, 31 were excluded due to missing child, yielding a parental sample size of 647.) Overall, 43 youth (5.7%) scored above 8 on the CDI and thus are considered in this study to be depressed, including 21 (6%) of the males and 22 (5%) of the females ( $p>0.05$ , two-tailed). The mean age of nondepressed youth was 10.44 and that of depressed youth was 10.72 ( $p=0.014$ , two-tailed).

**TABLE 1**  
**CHARACTERISTICS OF BAHAMIAN SIXTH-GRADE YOUTH BY DEPRESSION**

| Characteristics of youth   | Overall      | Nondepressed | Depressed    | ORadj. <sup>a</sup>  |
|--|--------------|--------------|--------------|----------------------|
| <i>N</i> (%)   | 752          | 709 (94.28)  | 43 (5.72)    |                      |
| Age, mean ( <i>SD</i> )  | 10.46 (0.73) | 10.44 (0.72) | 10.72 (0.77) | 0.014 <sup>a,b</sup> |
| Gender, <i>N</i> (%)   |              |              |              |                      |
| Female   | 409 (54.39)  | 387 (94.62)  | 22 (5.38)    | 1.00                 |
| Male   | 343 (45.61)  | 322 (93.88)  | 21 (6.12)    | 1.03                 |
| <b>Intentions during the next six months:</b>                                    |              |              |              |                      |
| Mean ( <i>SD</i> ), range→1 ( <i>very unlikely</i> ) to 5 ( <i>very likely</i> ) |              |              |              |                      |
| Have sex   | 1.91 (1.14)  | 1.88 (1.12)  | 2.45 (1.36)  | 1.42**               |
| Use a condom if I have sex   | 3.11 (1.51)  | 3.10 (1.51)  | 3.35 (1.51)  | 1.10                 |
| Get pregnant/get a girl pregnant   | 1.92 (1.10)  | 1.89 (1.07)  | 2.49 (1.42)  | 1.50**               |
| Get an STD   | 1.77 (0.98)  | 1.74 (0.96)  | 2.26 (1.29)  | 1.56**               |
| Become infected with HIV   | 1.78 (1.02)  | 1.75 (1.00)  | 2.24 (1.22)  | 1.47**               |
| Drink alcohol  | 2.05 (1.18)  | 2.04 (1.18)  | 2.24 (1.16)  | 1.13                 |
| Use marijuana  | 1.79 (1.02)  | 1.76 (1.00)  | 2.31 (1.14)  | 1.53**               |
| Use cocaine  | 1.71 (0.97)  | 1.68 (0.94)  | 2.29 (1.20)  | 1.71***              |
| Push drugs   | 1.73 (0.99)  | 1.70 (0.97)  | 2.17 (1.25)  | 1.43*                |
| <b>Risk behaviors, <i>N</i> (%):</b>   |              |              |              |                      |
| Had ever had sex   | 29 (3.97)    | 26 (3.77)    | 3 (7.14)     | 1.48                 |
| Never used a condom in the last six months during sex                            | 3 (37.50)    | 1 (16.67)    | 2 (100.00)   | ---- <sup>c</sup>    |
| In the last six months:  |              |              |              |                      |
| Drank alcohol  | 179 (23.96)  | 167 (23.72)  | 12 (27.91)   | 1.19                 |
| Smoked a cigarette   | 18 (2.41)    | 18 (2.56)    | 0 (0.00)     | ---- <sup>c</sup>    |
| Used marijuana   | 5 (0.68)     | 4 (0.57)     | 1 (2.44)     | 4.65                 |
| Used cocaine   | 4 (0.54)     | 4 (0.57)     | 0 (0.00)     | ---- <sup>c</sup>    |
| Pushed or carried any drugs  | 9 (1.21)     | 8 (1.14)     | 1 (2.38)     | 1.77                 |
| Used a needle/shot up any illegal drug   | 3 (0.40)     | 1 (0.14)     | 2 (4.65)     | 38.98**              |
| Been asked to sell drugs   | 13 (1.74)    | 10 (1.42)    | 3 (6.98)     | 4.83*                |
| Carried a knife/screwdriver to use as a weapon                                   | 27 (3.61)    | 22 (3.12)    | 5 (11.63)    | 3.70*                |
| Carried a gun to use as a weapon   | 10 (1.34)    | 10 (1.42)    | 0 (0.00)     | ---- <sup>c</sup>    |
| Physical fighting with a friend  | 252 (33.60)  | 230 (32.53)  | 22 (51.16)   | 2.06*                |

Note: \*  $p < 0.05$ (two-tailed); \*\*  $p < 0.01$ (two-tailed); \*\*\*  $p < 0.001$  (two-tailed).

<sup>a</sup>: Odds ratios adjusted for youth’s age are presented for gender, intentions and risk behaviors;

<sup>b</sup>: Student’s *t*-test *p* value;

<sup>c</sup>: OR cannot be calculated due to empty cells

Also shown in Table 1 are both future expectations/intentions to engage in risk behaviors, and current risk behaviors. Although generally youths did not perceive themselves as likely to engage in risk behaviors, depressed youth were significantly more likely to anticipate involvement over the next 6 months in 7 of the 9 risk behaviors; there were no differences relative to drinking alcohol and not using a condom on the basis of depression. Rates of risk behavior were generally low, but depressed youth engaged in significantly higher rates of 4 of the 12 risk behaviors assessed, while nondepressed youth did not have significantly higher rates of any risk behaviors.

**TABLE 2**  
COMPARISON OF MEAN PARENT AND YOUTH PERCEPTIONS OF PARENTING STYLE BY YOUTH DEPRESSION

|                                    | Parent |      | Youth |         | Parent-youth<br>(mean difference) |         |                   |
|------------------------------------|--------|------|-------|---------|-----------------------------------|---------|-------------------|
|                                    | ND     | D    | ND    | D       | ND                                | D       | ND-D <sup>c</sup> |
| Parental monitoring <sup>a</sup>   | 4.75   | 4.70 | 4.26  | 3.91*   | 0.49***                           | 0.78*** | -0.30             |
| Open communication <sup>b</sup>    | 4.06   | 3.98 | 3.82  | 3.22*** | 0.24***                           | 0.75*** | -0.52***          |
| Problem communication <sup>b</sup> | 2.62   | 2.67 | 3.29  | 3.35    | -0.68***                          | -0.73** | 0.05              |

Note: \*  $p < 0.05$  (two-tailed); \*\*  $p < 0.01$  (two-tailed); \*\*\*  $p < 0.001$  (two-tailed); Statistical tests were conducted using ANCOVA adjusted for youth age.

<sup>a</sup>: score 1=*never*, 5=*always*; <sup>b</sup>: score 1=*strongly disagree*, 5=*strongly agree*;

<sup>c</sup>: ND-D=difference between nondepressed groups and depressed groups in terms of the parent-youth dyad perception discrepancy.

As shown in the first column of Table 2, parental perceptions of parental monitoring and communication did not differ between parents of depressed and parents of nondepressed youth. Parents of both depressed and nondepressed youth viewed themselves as exhibiting high degrees of monitoring, and generally agreed with depictions of their communication with their children as open, while tending to reject descriptions of this communication as problematic. By contrast, the depression status of youth was associated with differences in youth perceptions of parental monitoring and communication.

Depressed youth perceived significantly lower levels of parental monitoring than did nondepressed youth (3.91 and 4.26,  $p=0.032$ , two-tailed). Depressed youth were significantly more likely to disagree than were nondepressed youth with a characterization of their communication with their parents as "open" (3.22 versus 3.82,  $p<0.001$ , two-tailed). Youth perceptions of problem communication with their parents did not differ on the basis of adolescent depression.

Between depressed youth and their parents and between nondepressed youth and their parents, youth were significantly more likely to perceive

decreased parental monitoring, less open communication and more problems communication. All three comparisons within both parent-youth groups were significant, as shown in Table 2.

As shown in the far right column of Table 2, while the youth-parent discrepancies did not differ between the depressed/nondepressed youth-parent dyad with regards to perceptions of parental monitoring and problematic communication, discrepancies regarding open communications were highly significant (0.24 for nondepressed dyads versus 0.75 for depressed dyads,  $p=0.001$ , two-tailed).

**TABLE 3**  
**ODDS RATIOS FROM LOGISTIC REGRESSION ANALYSIS ASSESSING ASSOCIATIONS BETWEEN**  
**DEMOGRAPHIC INDICES, PAST RISK BEHAVIOR, PARENTAL MONITORING AND COMMUNICATION**  
**AND YOUTH DEPRESSION**

| Characteristics                     | Youth depression ( $N=596$ ) |            |
|-------------------------------------|------------------------------|------------|
|                                     | OR                           | 95%CI      |
| Age (years)                         | 1.63*                        | 1.07~2.48  |
| Gender                              |                              |            |
| Female (ref)                        | 1.00                         |            |
| Male                                | 0.62                         | 0.28~1.35  |
| Past risk behavior                  | 1.42*                        | 1.04~1.93  |
| Parent reports:                     |                              |            |
| Parental monitoring                 | 0.94                         | 0.46~1.91  |
| Impaired parent-youth communication | 0.82                         | 0.34~1.99  |
| Youth reports:                      |                              |            |
| Parental monitoring                 | 0.78                         | 0.54~1.11  |
| Impaired parent-youth communication | 11.06***                     | 3.28~37.32 |

Note: \*  $p < 0.05$  (two-tailed); \*\*\*  $p < 0.001$  (two-tailed)

Multivariate logistic regression analysis revealed that age, past risk behavior, and youth perceptions of impaired parent-youth communication were associated with youth depression. Older youth, young people with past histories of risk behavior, and young people reporting higher levels of impaired parent-youth communication were more likely to be depressed (Table 3). The variable strongly associated with youth depression was youth-perceived impaired parent-youth communication (OR=11). Also included were different interaction items when the logistic regression models were constructed, but none of the interactions were significant.

Multiple linear regression analysis found that youth depression, past risk behavior, youth perceptions of parental monitoring and impaired parent-youth communication were associated with anticipated risk behavior of young people during the next 6 months. Compared with nondepressed youth, depressed youth were more likely to anticipate involvement in risk behaviors in the future. Past

risk behavior was associated with increased anticipation of future risk behavior. Youth perceptions of a higher level of impaired parent-youth communication were more likely to anticipate future risk behavior. Youth perception of increased parental monitoring was negatively associated with anticipated risk behavior. The interaction between past risk behavior and youth perceptions of impaired parent-youth communication was significant ( $p=0.004$ ) (Table 4). A multiple linear regression model which included parent perceptions of impaired parent-youth communication without the youth perceptions revealed that the parent perceptions were significantly associated with anticipated risk behavior ( $\beta = 0.158, p = 0.028$ ). However, this effect did not persist after the youth perceptions were added into the model.

**TABLE 4**  
**RESULTS OF THE MULTIPLE LINEAR REGRESSION MODEL EXAMINING THE ASSOCIATIONS**  
**BETWEEN DEMOGRAPHIC INDICES, YOUTH DEPRESSION, PAST RISK BEHAVIOR, PARENTAL**  
**MONITORING AND COMMUNICATION AND YOUTH ANTICIPATED RISK BEHAVIOR**

| Independent variables   | $\beta$ Coefficients | Standard error | $p$       |
|---|----------------------|----------------|-----------|
| Constant  | 1.308                | 0.560          | 0.020     |
| Age   | 0.076                | 0.042          | 0.073     |
| Gender  | 0.042                | 0.062          | 0.496     |
| Youth depression  | 0.320                | 0.133          | 0.016**   |
| Past risk behavior  | 0.198                | 0.034          | <0.001*** |
| Parent reports:   |                      |                |           |
| Parental monitoring   | 0.001                | 0.062          | 0.997     |
| Impaired parent-youth communication   | 0.133                | 0.072          | 0.065     |
| Youth reports:  |                      |                |           |
| Parental monitoring   | -0.072               | 0.035          | 0.039*    |
| Impaired parent-youth communication   | 0.415                | 0.103          | <0.001*** |
| Past risk behavior $\times$ youth perception of impaired parent-youth communication | -0.260               | 0.089          | 0.004**   |

Note: \*  $p < 0.05$  (two-tailed); \*\*  $p < 0.01$  (two-tailed); \*\*\*  $p < 0.001$  (two-tailed);  
 The  $p$  value for the model was <0.001, with an adjusted  $R^2$  value of 0.149.

## DISCUSSION

These data confirm and expand the findings from earlier studies. Consistent with the previous literature, although preadolescent youth do have lower rates of risk participation compared to older youth (Stanton, Li, Cottrell, & Kaljee, 2001), even among these young people at the cusp of adolescence, rates of risk behaviors and risk intentions were higher among depressed compared to non-depressed youth. This finding is important because it suggests that when depression is present and when there is already a differential in risk participation despite the overall low levels of risky behavior, it may be a propitious moment for aggressive intervention.

These data confirm other studies that depressed youth are more likely than nondepressed youth to perceive lower levels of parental monitoring (Cottrell et al., 2006). Consistent with the broader literature describing a relationship between youth depression, anxiety or hopelessness, and poor parenting (Biggam & Power, 1998; Topol & Reznikoff, 1982), these findings also indicate that depressed youth are less likely to describe their communication with their parents as open or positive. In the regression analysis, advanced age, past risk experience and perceived impaired communication with parents were all associated with depression. These findings provide evidence for impaired perceptions of parental-adolescent monitoring and communication among depressed adolescents. Applied against the theoretical model of parenting proffered by Steinberg, Baumrind, and Dornbusch (Baumrind, 1991; Dornbusch, Ritter, Leiderman, Roberts, & Fraleigh, 1987; Steinberg, Lamborn, Dornbusch, & Darling, 1992), these young people may perceive their parents as being undemanding and neither warm nor democratic in their parenting style. Although multiple studies have identified the inverse relationship between perceptions of parental monitoring and adolescent risk behavior (Rai et al., 2003), studies have generally not found the association with decreased open communication/increased impaired communication and adolescent risk behavior that was apparent in these data among depressed youth (Stanton et al., 2000).

That parents of depressed and nondepressed young people did not differ in their view of their monitoring and communication but the depressed and nondepressed young people did differ raises a series of questions. Do the differences in youth impressions reflect a core feature of depression – a tendency to view the world differently rather than a true difference in monitoring? Are depressed and nondepressed youth judging their parents against different relative scales? Do they have different perspectives as to what would constitute good parenting?

The findings that, across all categories and in both sets of parent-adolescent dyads, youth perceive less monitoring and more problematic communication is consistent with the previous literature on studies conducted among a general youth population (Stanton et al., 2000). This difference in perspective is perplexing and was addressed a quarter of a century ago by Rutter who suggested that a person's perceptions of parents play a critical role in his/her subsequent psychological development (Rutter, 1981).

The finding that, even within this context of differing parent-adolescent perspective on the parenting style components, depressed youth and their parents disagree to a greater extent than nondepressed parents and youth regarding the degree to which there is open communication, is noteworthy. Arguably, depressed youth is in particular need of access to open communication; is this finding merely a manifestation of his/her perceived isolation and alienation or is

it identifying a possible source of the depression?

Finally, these data among Bahamian pre- and early adolescents confirm findings from among older adolescents in the United States (Huebner & Howell, 2003; Riesch, Anderson, & Krueger, 2006) that, along with youth depression and youth perceptions of impaired communication and decreased parental monitoring, prior risk-taking behavior is associated with anticipated risk taking. These findings imply that improving parent-youth communication and enhancing parental monitoring may prevent preadolescents from engaging in risky behaviors in the future. In particular, preadolescents with histories of risky behavior or symptoms of depression may be especially important target populations for adolescent risk reduction and prevention efforts.

### **POTENTIAL LIMITATIONS**

Causality cannot be inferred from this cross-sectional study. Although the study population was large, the subset of depressed youth was relatively small. It would have been of interest to assess parental perceptions of adolescent depression.

### **IMPLICATIONS OF THE FINDINGS**

Risk prevention interventions, whether in general or in the context of depressed youth, should include parents as well as youth, and should directly address monitoring and communication. Such efforts may be especially important among pre early adolescents and among youth at the beginning of their risk trajectories both because of the relatively enhanced position of parents with respect to youth behavior during this developmental phase, and because once a youth has begun engaging in risk behaviors breaking the behavioral patterns may require more intensive intervention. Adolescent risk reduction and prevention efforts should target preadolescents with past histories of risky behavior or symptoms of depression.

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