SOURCE MATTERS

CHALLENGES IN OBTAINING OBJECTIVE INFORMATION IN MENTAL HEALTH ABOUT CHILDREN AND ADOLESCENTS

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CAMH CLINICAL PRACTICE

Still largely based on "talking"

- Interviews
- Questionnaires

Observation does not reveal several symptoms required for a diagnosis

Significant efforts to create objective tools

INFORMANT DISCREPANCIES

Exist all over health care

Diabetes management (Sood et al., 2012)

- discrepancy between mother and father predict poorer glycemic control

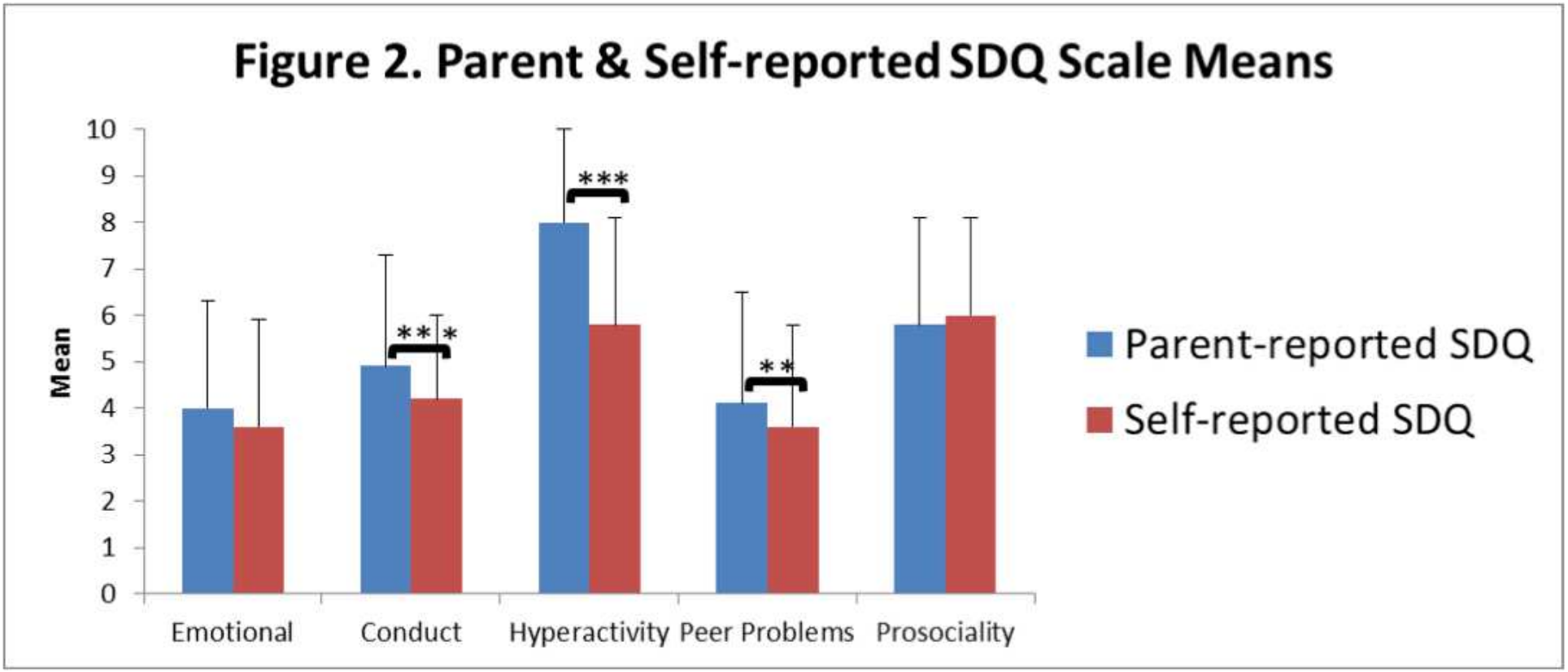
Asthma (Ungar et al., 2012)

Quality of life

- In general (Dey et al., 2013)
- In children with cancer (Parsons et al., 2012)

Headaches (Nakamura et al., 2012)

Physical activity (Rebholz et al, 2014)



Nagy et al., 2013: Behavioral symptoms and callous unemotional traits in adolescent boys with ADHD

AFFECTED FIELDS

- Prevalence of disorders
- Risk factors, protective factors
- Treatment efficacy
- Clinical decisions

DISAGREEMENT IS CONSISTENT

- Even if shown that only valid measures are used
- Parent-child
- Parent-teacher
- Parent-parent

EXAMPLES

EXTERNALIZING/INTERNALIZING SYMPTOMS

larger discrepancy for internalizing

- children tend to endorse subjective states more (Klein, 1991)
- parents tend to endorse conduct problems more

clinicians tend to agree with parents on both

- but child-reported anxiety predicted observed anxiety levels better than parents' report (DiBartolo, Grills, 2005)

better parent/child agreement at symptom level than diagnosis level (Comer, Kendall, 2004)

BEHAVIORAL PROBLEMS

parent/teacher disagreement is significant

discrepancy predicts lab behavior! (De Los Reyes, 2009)

AGE

usually, better parent-child agreement as child gets older

but several studies dispute this, including one LTFU (Seiffge-Krenke, I., & Kollmar, F.,1998)

- parent/child agreement did *not* improve with age

cross-informant agreement is not better for adults (Achenbach, Krukowski, Dumenci, & Ivanova, 2005)

even if better agreement is demonstrated, it is still low

AGE

clinicians agree more with older children for GAD, MDD, ADHD (Grills and Ollendick, 2003)

worse agreement for non-observable phenomena (Collins and Laursen 2004)

- parents rely on voluntary disclosure more in later ages

TREATMENT

Parenting training

- efficacy can be demonstrated based on parent report, but not on teacher report (De Los Reyes and Kazdin, 2009)

CBT for anxiety

- efficacy based on child report
  - only child-rated measures actually predicted post-treatment anxiety (Crawford, Manassis, 2001)
- discrepancy predicts poor outcome
  - outcome better, if agreement on at least 1 diagnosis (Weisz et al., 2005)

PARENTING

larger disagreement predicts worse outcome

lower warmth, acceptance

need to suppress feelings/experiences – less probability to cope (e.g. Ozer and Weinstein 2004)

PARENTAL PSYCHOPATHOLOGY

The effect is not as robust as presumed (Klein, 1991)

Other factors account for this apparent effect (De Los Reyes et al., 2011)

- family functioning
- clinical severity

If present, the effect is very small (Youngstrom et al., 1999)

TABLE 1

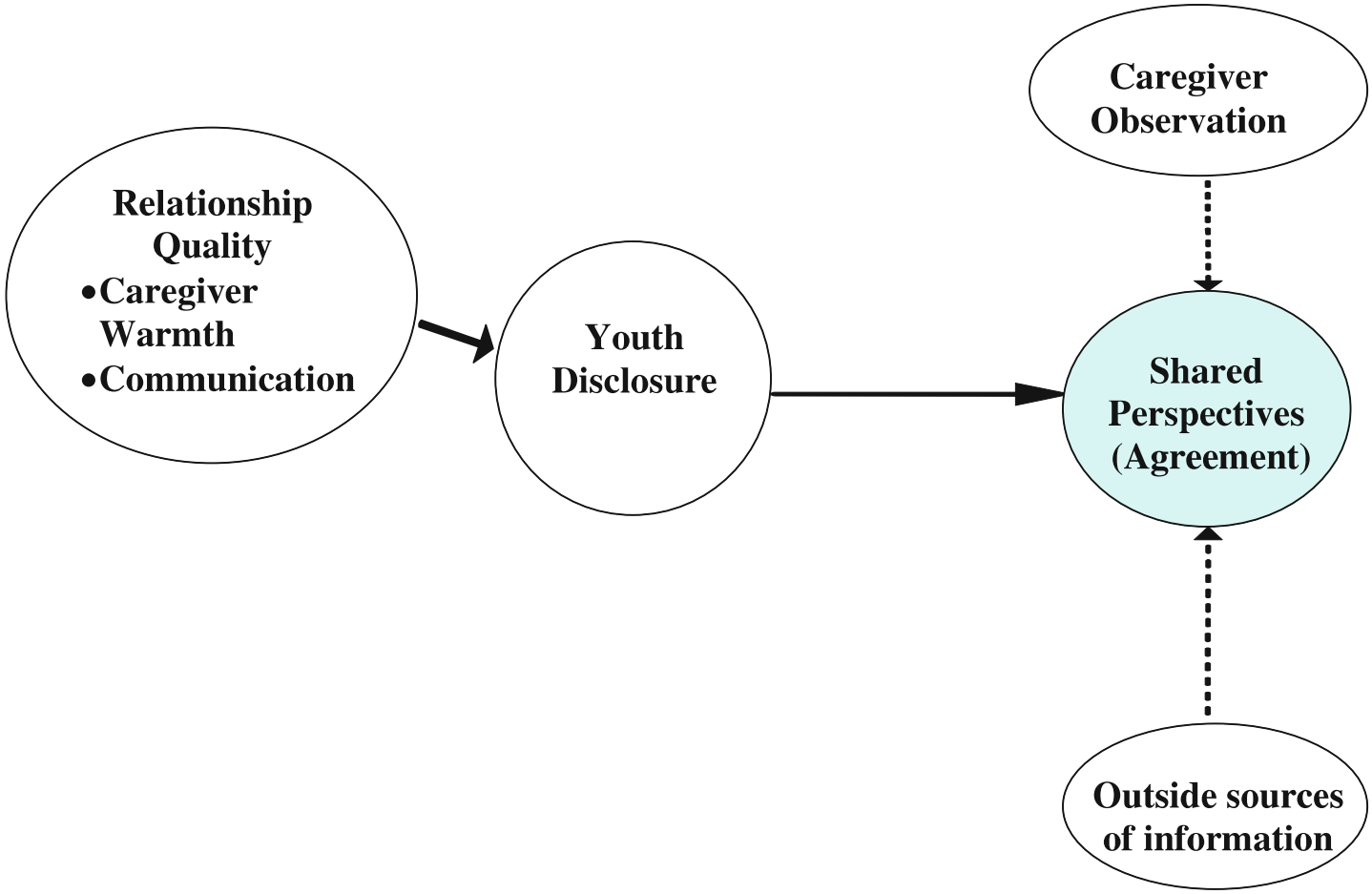
Examples of Studies (NonExhaustive) Demonstrating a Predictive Relation Between Informant Discrepancies and Poor Outcomes

Study	*Pair*	*Sample Type*	*Discrepancies Assessed*	*Outcome(s) Assessed*	*Predictive Effect*	*Time Period*
Beck et al. (2006)	P-Ch	Randomized trial of teen driving education program	Teen driving restrictions	Risky teen driving	Greater absolute discrepancies predict greater risky teen driving	9 months
Brookman-Frazee et al. (2008)	P-Ch	2 outpatient community mental health clinics	Treatment goals	Treatment attendance	Parent–child agreement on at least one treatment goal (relative to no agreement) predicts greater number of therapy visits	6 months
De Los Reyes, Goodman et al. (2010)	P-Ch	Community	Parental monitoring behaviors	Child delinquency	Parents reporting more positive parental monitoring behaviors than their child have children who reported greater child delinquency	2 years
Ferdinand et al. (2004)	P-Ch	Epidemiological	Child psychopathology	Poor young adult outcomes	Greater directional discrepancies (parent > child, vice versa) predict poorer outcomes	4 years
Ferdinand et al. (2006)	P-Ch	Referred psychiatry clinic outpatients	Child psychopathology	Child treatment outcomes	Greater directional discrepancies (parent > child, vice versa) predict poorer outcomes	$M = 4.3$ years
Guion et al. (2009)	P-Ch	School (5th graders recruited through probability sampling)	Negative parenting behaviors	Child psychopathology	Greater directional discrepancies predict greater internalizing (child > parent) and social competence (parent > child)	1 year
Israel et al. (2007)	P-Ch	University hospital outpatients	Child psychopathology	Parental involvement in child's therapy	Greater discrepancies (unspecified direction) predict lower parental involvement in the child's therapy	$M = 13.57$ months
Jensen Doss & Weisz (2008)	Cl-P	5 outpatient community mental health clinics	Pretreatment child diagnoses	Treatment processes and child outcomes	Diagnostic agreement (relative to disagreement) predicts greater therapy engagement and reduced internalizing	2 years
Panichelli-Mindel et al. (2005)	P-Ch	Clinic-referred outpatients receiving child anxiety treatment	Pretreatment child anxiety disorder diagnosis	Pre–post treatment gains in therapy for child anxiety	Agreement on presence of a pre-treatment child anxiety disorder diagnosis (relative to parent-reported presence and not child) predicts greater pre-post treatment gains	Approx. 16 weeks[a]
Pelton & Forehand (2001)	P-Ch	Community	Relationship quality	Child psychopathology	Greater absolute discrepancies predict greater internalizing and externalizing	1 year
Pelton, Steele, et al. (2001)	P-Ch	Community	Relationship quality	Child psychopathology	Greater absolute discrepancies predict greater externalizing	1 year

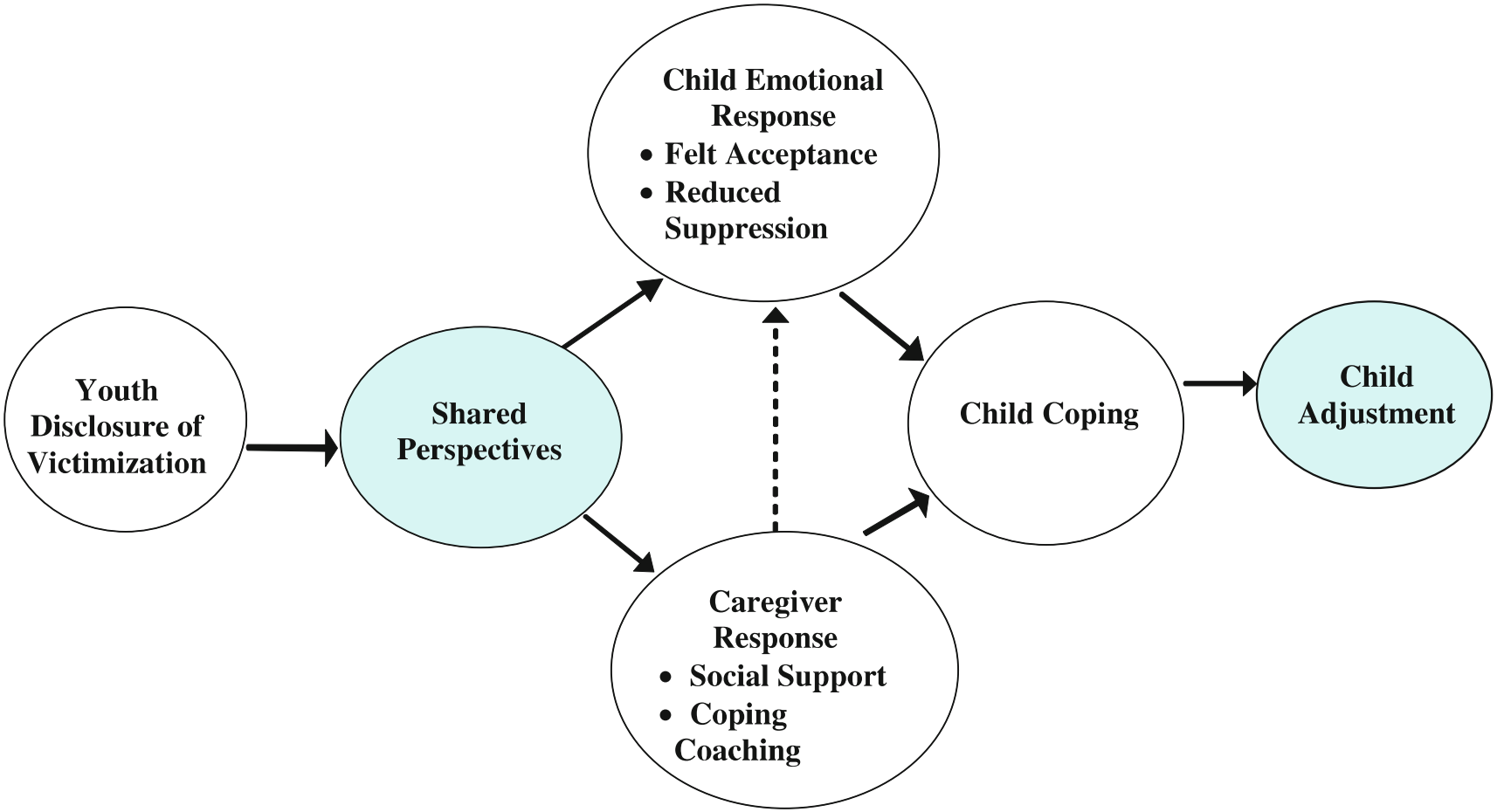
Note: P-Ch = parent–child; Cl-P = clinician–parent.

[a]Predictive period estimated based on Kendall (1994) and Kendall et al. (1997).

De Los Reyes, 2011

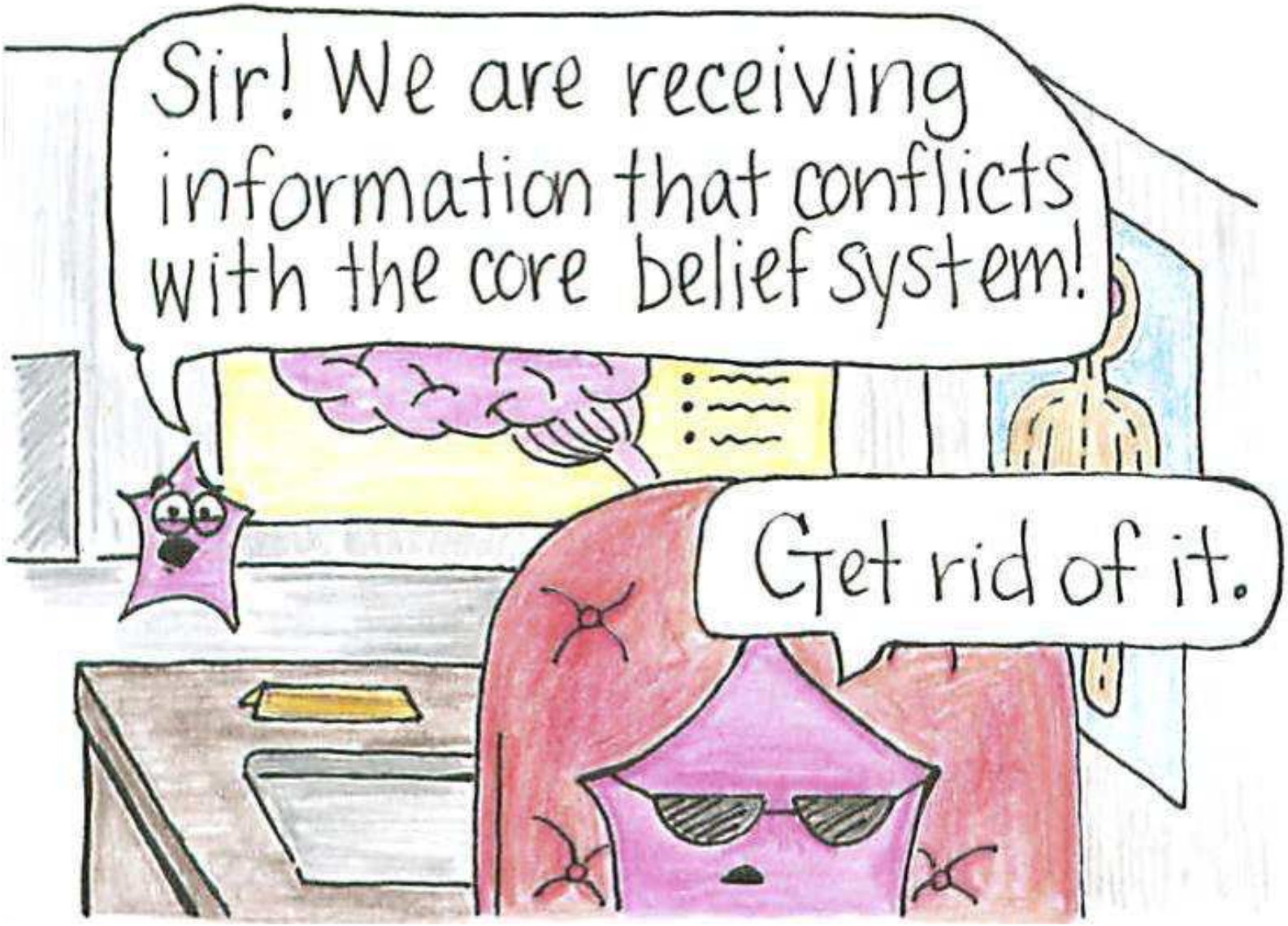


Goodman et al., 2010



Goodman et al., 2010

Unfortunately, this is how the brain works:



REACTION

Researchers – error – get rid of it somehow

Clinicians – only one can be valid

- tend to agree with parents (DiBartolo, Albano, Barlow, & Heimberg, 1998; Grills & Ollendick, 2003; Rapee, Barrett, Dadds, & Evans, 1994; Verhulst & Akkerhuis, 1989)

BUT disagreement carries useful information

CONCLUSIONS

The population in transition from childhood to adulthood is at risk

- we may not have good enough data about prevalence, risk factors etc
- everyday clinical decisions may not be based on good enough foundations

Discrepancies between parents/children never mean anything good

- treatment works less
- outcome is poorer

Agreement can be improved by promoting children's (esp. adolescents') selective disclosure

- better parenting means better outcome, better efficacy, more reliable data etc.

ULTIMATE CONCLUSIONS

Always use multiple sources of information

Never assume any single source to be more reliable than the other

Invest in parenting programs from an early age, possibly at the community level