Parent–Child Agreement Regarding Children's Acute Stress: The Role of Parent Acute Stress Reactions

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ABSTRACT

Objective: We examined parent–child agreement regarding child acute stress disorder (ASD) and the relationship between parent ASD symptoms and parent ratings of child ASD. **Method:** Parent–child dyads ($N = 219$; child age 8–17 years) were assessed within 1 month of child injury. Parent–child agreement was examined regarding child ASD presence, severity, and specific symptoms. Relationships among parent ASD and parent- and child-reported child ASD were examined using regression analysis and generalized estimating equations (GEE). **Results:** Parent–child agreement was low for presence of child ASD ($\kappa = 0.22$) and for individual symptoms. Parent and child ratings of child ASD severity were moderately correlated ($r = 0.35$). Parent ASD was independently associated with parent-rated child ASD, after accounting for child self-rating ($\beta = .65$). Generalized estimating equations indicated that parents with ASD overestimated child ASD and parents without ASD underestimated child ASD, compared to the child's self-rating. **Conclusions:** Parents' own responses to a potentially traumatic event appear to influence their assessment of child symptoms. Clinicians should obtain child self-report of ASD whenever possible and take parent symptoms into account when interpreting parent reports. Helping parents to assess a child's needs following a potentially traumatic event may be a relevant target for clinical attention. *J. Am. Acad. Child Adolesc. Psychiatry,* 2006;45(12):1485–1493. **Key Words:** acute stress disorder, parent–child discrepancy, pediatric injury.

Acute stress reactions are common in children and parents in the aftermath of pediatric injury, with the vast majority experiencing at least one moderate to severe acute stress symptom within the first month postinjury (Winston et al., 2002). Acute stress disorder (ASD) and posttraumatic stress disorder (PTSD) affect a significant minority of children after such events, and acute stress is one predictor of later PTSD severity (Kassam-Adams and Winston, 2004). Assessment of child acute stress within the first few weeks following a potentially traumatic event may be clinically useful for the identification of children in distress who need immediate assistance or follow-up services. Self-report is important in assessing internalizing disorders because of the private and subjective nature of the symptoms (Velting et al., 2004). However, clinicians may need or choose to rely on parent reports to understand a child's reactions to a potentially traumatic event (e.g., when an injured child is engaged in medical treatment, parents are reluctant to allow a child to be interviewed). The extent to which it is appropriate to rely on parent report of a child's acute stress symptoms is unknown.

Parents are often affected when a child experiences a potentially traumatic event, regardless of whether the parent directly shares that experience (Balluffi et al., 2004; DeVries et al., 1999; Hall et al., 2006; Jones et al., 2002; Kazak et al., 1998; Winston et al., 2002). A parent may have difficulty discerning that a child has reactions that differ from his or her own and could assume that the child is responding similarly to the parent. Alternatively,

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a parent's own distress may cloud his or her ability to perceive a child's reactions, such that a symptomatic parent could simply be more prone to error in either direction (e.g., either underreporting or overreporting their child's symptoms). Either of these scenarios may have important implications for a child's recovery after a potentially traumatic event. When a parent and child do not share the same assessment of the child's symptoms, it may be more difficult for the parent to identify his or her child's specific needs and provide the support and coping assistance that will promote psychological recovery following a potentially traumatic event.

Prior research suggests that parent–child agreement with respect to behavioral or emotional problems is low across a variety of diagnostic categories (Jensen et al., 1999). Parent–child agreement appears to be particularly low for internalizing symptoms such as anxiety or depression (Achenbach et al., 1987; Yeh and Weisz, 2001), perhaps because of the difficulty of rating the internal experiences of another person. Among clinic-referred children with anxiety disorders, prior research has demonstrated that parent–child agreement is stronger for specific observable symptoms than for symptoms that are difficult to observe (Comer and Kendall, 2004). However, there are mixed findings regarding the impact of parental anxiety on the parent's reporting of child symptoms (Frick et al., 1994; Krain and Kendall, 2000). A limitation of this literature for the present purposes is that findings regarding clinic-referred anxious children may not generalize to the broader group of children who face potentially traumatic events.

Fewer studies have explored parent–child agreement regarding traumatic stress reactions. To our knowledge, none of these studies have examined parent– child agreement regarding ASD presence and severity or the possible influence of parent ASD symptoms on parent report of child ASD soon after a potentially traumatic event. Several studies with small samples of children (sample numbers range from 16 to 47) exposed to a terrorist attack (Koplewicz, 2002; Phillips et al., 2004) or involved in a public transportation crash (Dyb et al., 2003) have found that parents report fewer or less severe child PTSD symptoms compared with child self-report. One school-based study assessed the perspectives of 250 Israeli mothers, fathers, and 11- to 12-year-old children concerning their own and each others' anxiety (rated with a single item) at multiple time points during a period of SCUD missile attacks (Rosenbaum and Ronen, 1997). Results indicated that parent ratings of child anxiety were associated with the spouse's anxiety and the spouse's evaluation of the child and not with the child's self-reported anxiety. Even increased physical proximity (i.e., ratings for periods of time when all were together in a sealed room) did not change this pattern. Several investigators (Daviss et al., 2000a; Koplewicz, 2002) have reported that parents' own traumatic stress symptoms and their reports of their children's traumatic stress are associated, but these analyses did not control for child self-reported symptoms. Shemesh et al. (2005), in a study of PTSD symptoms among 76 children with a variety of traumatic experiences related to medical illness, found that parents' own distress was independently associated with parent report of child PTSD severity, after taking into account child self-reported PTSD. They also found that child self-report, but not parent report, was significantly associated with independent diagnostic assessment of the child by a clinical team.

Research Questions and Hypotheses

The present study assessed parent and child acute stress symptoms within 1 month after the child sustained an injury in a crash. The assessment included measures of child acute stress severity by both self-report and parent report and of parent self-reported acute stress severity. This study addressed the following research questions and hypotheses:

Research question 1: To what extent do parents and children agree in their report of the child's ASD symptom severity (1a), the presence of child ASD or subsyndromal ASD (1b), and the presence of specific symptoms (1c)? We hypothesized that parent–child agreement with respect to each of these would be low to moderate, based on prior research on parent–child discrepancies in ratings of internalizing symptoms.

Research question 2: How does severity of parent acute stress influence parent ratings of child acute stress symptoms? We examined two hypotheses regarding the possible relationship between parents' acute stress symptoms and parent report of child symptoms. The first (hypothesis 2a) was that parents would overestimate the similarity between their own and their children's responses, or, in other words, that parent ASD symptom severity would be positively and independently associated with parent report of child ASD symptoms, after accounting for the child's self-rated symptom severity.