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Target problem (mis) matching: Predictors and consequences of parent–youth agreement in a sample of anxious youth

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ABSTRACT

Parents and youth often report discrepant target problems upon seeking treatment for youth psychopathology, which can have important impact on therapy processes (e.g., dropout) and treatment outcomes, as entry-level attitudes have been found to be influential in ultimate use and benefit of treatment. The current study examined parent–youth agreement within an anxiety disordered sample by assessing demographic and diagnostic factors that may predict matching, as well as the impact of matching on attrition, treatment outcome, and parental satisfaction. Ninety-five youth with principal anxiety disorders received cognitive–behavioral treatment for anxiety at a university outpatient clinic. Youth and parents independently identified target problems during the pretreatment assessment. Target problems were coded into 25 qualitative categories representing diagnostic, symptom, and functional impairment domains, including diffuse anxiety, social anxiety, academic achievement, oppositional/behavior problems, sleep problems, suicidal ideation, and family functioning. The majority of parent–youth dyads (67.4%) agreed on at least one target problem. Although problems related to diffuse anxiety and social anxiety were reported most frequently, relatively low rates of agreement were found in these domains. Kappa values demonstrated higher levels of agreement for problems with specific fears, school attendance, and panic and lower levels of agreement for difficulties with worry, shame, and self-esteem. Further, youth diagnosed with comorbid externalizing disorders were less likely to agree with their parents on at least one target problem. No effects were found for gender, age, or number of diagnoses in predicting agreement. Target problem agreement did not significantly impact rates of attrition or diagnostic remission, but did predict some measures of parental satisfaction. Results suggest that disagreement on treatment goals exists even within a narrow treatment population and may predict important consumer variables such as satisfaction. Findings emphasize that initial goals disagreement warrants careful assessment and monitoring.

Anxiety disorders are the most commonly identified psychological disorders in children and adolescents (hereafter referred to as youth), exceeding both depression and disruptive behavior disorders in frequency (Catwright-Hatton, McNicol, & Doubleday, 2006). While research supports the use of cognitive–behavioral therapy (CBT) for youth with anxiety (e.g., Barrett, Dadds, & Rapee, 1996; Kendall et al., 1997; Manassis et al., 2002), efficacy is not guaranteed. Issues of treatment engagement and involvement are important to successful CBT treatment, as CBT relies on active learning of coping skills and participation in in vivo exposure (Chu, Suveg, Creed, & Kendall, 2010). However, active engagement in treatment is far from guaranteed as youth rarely self-refer to treatment. As a result, treatment often focuses on the problems and goals reported by parents or other adults (e.g., teachers, counselors) by default. Therapy may go smoothly when parents and youth agree on the goals for treatment. However, conventional wisdom suggests that parents and youth disagree on many important elements of the psychotherapy process (e.g., Achenbach, McConaughy, & Howell, 1987; De Los Reyes & Kazdin, 2004; Youngstrom, Loeber, & Stouthamer-Loeber, 2000). Research has shown that parents and youth provide discrepant ratings on which emotional and behavioral problems exist (Achenbach et al., 1987; Rey, Schrader, & Morris-Yates; 1992), in rating how distressing those problems are (e.g., Weisz & Weiss, 1991), and in responses to diagnostic interviews (Herjanic & Reich, 1997). Parents and youth also tend to attend to different aspects of the therapy when evaluating satisfaction with treatment (Aarons et al., 2010).

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In addition, Yeh and Weisz (2001) and Hawley and Weisz (2003) reported significant parent–youth disagreement on reported target problems, or treatment goals. Yeh and Weisz (2001) examined 381 parent–youth dyads and found that greater than one-third of these dyads failed to agree on even one broad target problem category (e.g., Anxious/Depressed, Delinquent Behavior symptoms). Hawley and Weisz's (2003) follow-up study on parent–youth–therapist triads found that approximately 30% of parent–youth dyads and 45% of parent–youth–therapist triads failed to agree on even one broad target problem. Parent–youth disagreement on treatment goals is of particular interest to the current study because mismatch between the goals of youth clients and their parents can lead to early disagreement, lower initial treatment motivation, and lesser treatment engagement throughout therapy (Hawley & Weisz, 2003; Yeh & Weisz, 2001). Thus, it is important to investigate the nature, occurrence, and consequences of parent–youth disagreement on target problems as it may serve as an early indicator of subsequent treatment failures, such as drop-out and poor outcomes (DiGuiseppe, Linscott, & Jilton, 1996; Hawley & Weisz, 2003).

Research studies have proposed interesting theoretical models to explain informant discrepancies. In particular, many studies (e.g., Yeh & Weisz, 2001) apply a social and cognitive psychology phenomenon, the actor–observer bias (e.g., Anderson, Krull, & Weiner, 1996), to explain parent–youth disagreement. The actor–observer bias suggests that there is a tendency for those who complete a behavior (i.e., youth/actors) to attribute their actions to situational factors. In contrast, those who observe the behavior of another person (i.e., parents/observer) tend to attribute this behavior to the person's individual characteristics or disposition. Thus, youth and parents have different interpretations of the same action, which can lead to discrepancies in their perceptions and ultimate reporting of those actions. In therapy, perceptional differences like these could lead to disagreements about treatment goals, who is most responsible for change, and differential levels of engagement in session activities. Couched in this broader theoretical framework, the current study evaluates if parent–youth disagreement impacts service use and treatment outcomes, as entry-level attitudes have been found to be influential in ultimate use and benefit of treatment (e.g., Brookman-Frazee, Haine, & Garland, 2008; Crane, Griffin, & Hill, 1986; DiGuiseppe et al., 1996; Weisz et al., 2011).

Therapy outcomes that may be impacted by parent–youth disagreement on treatment goals include, early treatment drop out, diagnostic and symptom outcomes, and parental satisfaction with treatment. Families who disagree on target problems may be more likely to drop out as motivation, engagement, or therapeutic alliance are impacted (Liddle, 1995; Shirk & Saiz, 1992; Sommers-Flanagan & Sommers-Flanagan, 1995). Garcia and Weisz (2002) found that in community mental health centers, one-third of parents reported that they stopped bringing their youth to therapy in part because "the therapist talked about the wrong problems." Further, a study of two outpatient community clinics found that parent–youth agreement on at least one treatment goal significantly predicted number of therapy visits (Brookman-Frazee, Haine, & Garland, 2008). Clinician–youth goal agreement, on the other hand, did not predict treatment outcomes, suggesting the specific importance of parent–youth agreement for predicting therapy visits.

Parent–youth disagreement may also impede successful treatment outcomes. Israel, Thomsen, Langeveld, and Stormark (2007) found that greater differences in measures of youth psychopathology predicted lower parental involvement in the youth's therapy. Parental involvement, subsequently, has been associated with more positive clinical outcomes, as parents are needed to help youth expand upon and apply the skills and insights used in therapy (Siqueland & Diamond, 1998). Further, a study by Panichelli-Mindel, Flannery-Schroeder, Kendall, and Angelosante (2005) found that parent–youth disagreement on anxiety symptoms not only predicted poorer treatment outcomes, but was also associated with slower rates of improvement. In addition, discrepancies between parent and youth reported psychopathology were found to predict disciplinary problems at school, judicial problems, and increased drug use 4 years following initial assessment (Ferdinand, van der Ende, & Verhulst, 2006). Such research has focused on parent–youth agreement for the presence of broad symptom clusters. Less research has focused on target problems agreement, which arguably provides a more concrete measure of goals agreement between parent and youth (Yeh & Weisz, 2001).

Initial goals disagreement may also impact parental satisfaction ratings. Disagreement may decrease ease of collaboration, reduce positive feelings of hope and validation, and interfere with enjoyment of the overall treatment process. These factors, among others related to the course of treatment, are ultimately reflected in satisfaction ratings (Huang, Woolverton, & Hepburn, 2002). Further, parental satisfaction ratings are often related to clinical outcomes (Fontana, Ford, & Rosenheck, 2003), although the research is mixed (Garland, Aarons, Hawley, & Hough, 2003). As one example, Garland, Haine, and Lewczyk-Boxmeyer (2007) found a significant correlation between changes in youth functional impairment (i.e., social, academic, family functioning) and parent satisfaction ratings, suggesting that satisfaction ratings capture important changes that may not be detected in diagnostic and symptom ratings.

Regarding predictors of parent–youth agreement, little research exists to pinpoint the factors that predict agreement on target problems. A broader literature has identified several factors that predict agreement/disagreement on symptom clusters in general, though the research is mixed. Some studies provide evidence that parents are more likely to agree with older than younger youth (Grills & Ollendick, 2002; Jensen et al., 1999), but others have not found support for an age effect (Briggs-Gowan, Carter, & Schwab-Stone, 1996; Grills & Ollendick, 2002). Still, others have found increased agreement among older parent–youth pairs for some disorders (e.g., social phobia), but no effect for others (Rapee, Barrett, Dadds, & Evans, 1994). Research is also mixed for youth gender. Some have found higher agreement on symptom reports between parents and sons (Angold et al., 1987), others have reported no significant gender differences (Briggs-Gowan et al., 1996; Grills & Ollendick, 2002), and others reported mixed gender effects in that girls and boys were each more likely to agree with their parents on symptom clusters in different diagnostic categories (Thompson, Merritt, Keith, Murphy, & Johndrow, 1993). In terms of target problem agreement, Yeh and Weisz's (2001) study found no effect of gender or age on parent–youth agreement.

It is also unclear if parent–youth agreement comes easier in some clinical populations than others. Some studies suggest that parent–youth agreement does not vary with type of diagnosis (Ferdinand et al., 2006; Jensen et al., 1999), but many others contend that parents and youth are more likely to agree on externalizing problems than on internalizing problems (Achenbach et al., 1987; Forehand, Frame, Wierson, Armistead, & Kempton, 1991; Kolko & Kazdin, 1993; Sourander, Helstela, & Helenius, 1999; Yeh & Weisz, 2001). Researchers argue that parents and youth may be more likely to agree on the presence of externalizing problems because they tend to be more concrete, observable, and disruptive than internalizing symptoms (e.g., worry or sadness) which are more difficult to observe (Salbach-Andrae, Klinkowski, Lenz, & Lehmkuhl, 2009). These patterns may be true for general clinical populations, but results may differ in a sample of primarily anxious youth whose parents noticed anxiety symptoms significant enough to warrant specialty treatment. For example, in one sample of primarily anxious youth, Barbosa, Manassis, and Tannock (2002) found lower parent–youth agreement on symptom reports