

Why Are We Here at the Clinic? Parent–Child (Dis)Agreement on Referral Problems at Outpatient Treatment Entry

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Do clinic-referred children and their parents agree on the problems for which treatment is undertaken? The authors asked 381 outpatient-clinic-referred children and their parents to list, independently, the child's target problems. Of the parent–child pairs, 63% failed to agree on even a single problem. When problems were grouped into broad categories (e.g., delinquent, withdrawn), more than a third of the pairs still failed to agree on a single broad problem area. Parent–child agreement was higher for externalizing than for internalizing problem categories (though poor for both). Low parent–child agreement may help explain the poor outcomes often reported for clinic-based child therapy.

Most episodes of child mental health care are initiated by a parent, who identifies problems for which the child needs help (Kazdin, 1989; Stanger & Lewis, 1993; Weisz et al., 1988). The agenda for the therapy that follows tends to be shaped to a significant degree by the parent's report and focused on problems the parent has identified. In cases in which parent and child perceive the same problems, the process may work well, with parent and child working toward common therapy goals. However, when parent and child disagree about the problems for which help is needed, their ability to work toward common treatment goals may be undermined. Which of these two scenarios is more common: parent–child agreement or disagreement regarding referral problems? To our knowledge, the question has not been addressed in research published to date.

Although little is known about parent–child agreement on treatment referral problems (i.e., the problems for which treatment is

sought), there have been studies on two partially related topics: (a) parent–child agreement as to whether particular emotions, behaviors, and problems simply *exist*, and (b) parent and child *distress* over child emotions, behaviors, and problems. On the first topic, findings have documented poor parent–child agreement on structured diagnostic interviews (Herjanic & Reich, 1997; Tarullo, Richardson, Radke-Yarrow, & Martinez, 1995; Weissman et al., 1987) and only modest correspondence between adult and youth reports on emotion and behavior checklists (Achenbach, McConaughy, & Howell, 1987; Phares, Compas, & Howell, 1989; Stanger & Lewis, 1993). Notably, in a meta-analysis of 119 studies investigating cross-informant correspondence, Achenbach, McConaughy, and Howell (1987) found a mean correlation of .25 between parents and children.

Turning to the topic of distress, it is important to note that even when both parent and child acknowledge that a particular behavior exists, one may be troubled by the behavior while the other is not. Phares and Compas (1990) investigated adolescent subjective distress over emotional and behavioral problems in a nonclinical sample and found that 34% of the items acknowledged by respondents on the Youth Self-Report (YSR; Achenbach & Edelbrock, 1987) were not associated with youth distress. When Phares and Danforth (1994) assessed adolescent and adult reports of distress over clinically referred youths' problems, they found that parents were more bothered than were adolescents by both internalizing and externalizing behaviors. Although parent and adolescent distress were significantly correlated for internalizing problems ($r = .52, p = .039$), they were not correlated for externalizing problems. These findings suggest that problem acknowledgment does not necessitate distress among general population and referred youth and that parents and their referred children may not agree about the severity of certain problems.

The findings reviewed here point to some areas in which parent–child agreement is weak, but none of these findings address the question of interest in the present study: parent–child agreement on the problems for which referred children need help in therapy. This question is especially intriguing in light of the nature of child referral and treatment. At clinic entry, the child's problems have reached a threshold of severity sufficient to persuade an adult that treatment is needed. At this threshold, one might think that the

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problems should be clear to both parent and child. However, note that parent-child agreement on a referral problem requires (a) agreement that the behavior/emotion *exists*, (b) further agreement that the behavior/emotion is problematic or distressing, and (c) still further agreement that that particular behavior/emotion is *among the specific problems for which the child most needs help*. This three-part requirement may undermine prospects for agreement on the problems that led to referral. Agreement may also be undermined by the fact that referral problems are nearly always reported in an entirely open-ended manner, unlike checklist procedures, which present parent and child with a finite, common list of problems to be either endorsed or not. Finally, there is a rich literature in social and cognitive psychology on the actor-observer bias (e.g., Anderson, Krull, & Weiner, 1996; Jones & Nisbett, 1972), the tendency of those who observe others' actions (analogous to parents here) to make different judgments about those actions than do the "actors" who perform them (analogous to referred children here). Thus, there are several reasons, both clinical and social-cognitive, to suspect that parent-child agreement on the problems for which referred children most need help may not be strong.

In the present study, we explored this possibility in a large outpatient clinic sample in a major metropolitan area. Parents and children, interviewed separately, were asked to identify the problems for which the child most needed help. In addition to assessing overall agreement, we investigated whether demographic variables, problem-endorsement agreement (i.e., on standardized checklists), and referral-problem type were associated with higher agreement. Three questions guided the research. (a) To what extent do parents and children agree on referral problems at clinic entry? We anticipated low levels of agreement. (b) Does parent-child referral-problem agreement differ as a function of problem type (i.e., internalizing vs. externalizing)? We anticipated better agreement for externalizing problems, which are more observable. (c) What factors other than problem type are associated with higher parent-child agreement on referral problems? We focused on a number of potential demographic and clinical predictors of agreement. One question of special interest was whether children were more likely than parents were to identify problems that parents and children agreed on. The answer to this question could help shed light on the intriguing issue of which informant—parent or child—may be a better source of information on concerns *shared* by parent and child.

Method

Participants

Study participants were 381 parent-child pairs. The children had all been referred by a parent or guardian for treatment to one of nine community mental health clinics in central and southern California. All the clinics served a broad variety of children and families, and all employed sliding fee scales to ensure access to families at all economic levels. Intake clinicians read a short description of the study to all families, and families interested in learning more about the study were then contacted by research project staff. Human subjects' procedures prevented collection of data on nonparticipants, but more than 80% of those invited to participate agreed to do so. Parental consent and child assent were obtained for all participant pairs. The sample of 381 included children aged 7-18 years ($M = 12.04$; $SD = 2.51$)—237 (62.2%) boys and 144 (37.8%) girls; 166 (43.6%) were

Caucasian, 63 (16.5%) were African American, 54 (14.2%) were Hispanic, 6 (1.6%) were Asian/Pacific Islander, 68 (17.8%) were of other (including mixed) racial/ethnic background, and 24 (6.3%) were missing information. The mean Hollingshead (1975) index of socioeconomic status (SES) based on highest parent occupation was 4.41 ($SD = 2.88$; range = 0-9, with 9 being the highest SES), corresponding to occupations such as skilled manual workers and solo business owners (e.g., shoe repair, taxi driver). Average gross monthly income of the families was \$1,693 ($SD = \$1,328$), and families averaged 3.58 dependents ($SD = 1.36$). Adult respondents included 329 (86.4%) mothers, 26 (6.8%) fathers, 10 (2.6%) nonparent relatives, 2 (.5%) female nonrelatives, and 14 (3.7%) others. All the adult respondents were the children's legal guardians, and the nonparents had lived with the child for an average of 7.56 years ($SD = 5.18$). Adults' mean age was 39.57 ($SD = 7.97$). Child Behavior Checklist (CBCL; Achenbach, 1991a) *T*-score means were 66.42 ($SD = 9.51$) for Total Problems, 63.73 ($SD = 10.33$) for Internalizing, and 65.23 ($SD = 10.73$) for Externalizing. Youth Self-Report (YSR; Achenbach, 1991b) *T*-score means were 60.66 ($SD = 11.32$) for Total Problems, 58.09 ($SD = 11.65$) for Internalizing, and 58.58 ($SD = 11.71$) for Externalizing.

Procedures and Measures

The children and their parents were interviewed separately with multiple measures, including youth and parent reports of youth behavior and problems. Separate parent and child interviews were essential to ensure that neither party's responses could influence the other's responses. The study interview averaged 27 days after the first clinic intake session (67% of intakes involved one session, 33% involved two or more sessions). Intakes were conducted through normal clinic procedures, completely independent of the study, and by clinic staff not associated with the study in any way; 19% of the staff were doctoral/master's level, 47% were master's level, and 35% were bachelor's level. Because multiple staff in multiple clinics were involved and considerable clinical judgment was involved, specific procedures differed across intakes but all procedures included inquiry into the problems that needed clinical attention, the assignment of specific diagnoses, and the completion of routine clinic paperwork. The intake therapist later became the ongoing therapist in 38% of the cases.

Measures in the study interview included the parent report CBCL (Achenbach, 1991a) and the youth report YSR (Achenbach, 1991b), widely used measures of child problems. The CBCL and YSR have heavily overlapping item content, yield very similar factors in principal-components analyses (see information to follow), and are supported by extensive reliability and validity evidence (see Achenbach, 1991a, 1991b).¹ Both measures yield scores on narrowband problem scales (e.g., Aggressive Behavior, Withdrawn) and broadband scales (i.e., Internalizing, Externalizing).

In another aspect of the interview, each child was asked to identify "the major problems for which you feel you need help." Similarly, each parent

¹ To evaluate the appropriateness of including YSR data for children in our study who were below the age for which the YSR is normed (i.e., below age 11), we compared our older (ages 11 and up) and younger (ages 7-10) participants with respect to (a) syndrome scale coefficient alpha, and (b) scale test-retest reliability. Alphas computed for the 11 YSR scales (8 narrowband, 2 broadband, 1 total problems score) averaged .76 ($SD = .15$) for the younger group ($n = 145$) and .79 ($SD = .10$) for the older group ($n = 235$). Test-retest reliability correlations were computed for the YSR raw scores of a subsample for whom 6-month retest scores had been obtained. The resulting 6-month test-retest coefficients averaged .54 ($SD = .06$) for the younger group ($n = 97$) and .62 ($SD = .05$) for the older group ($n = 135$). Because internal consistency alphas and test-retest reliability coefficients were quite similar for the two age groups, it appeared appropriate to use YSR data from our younger participants.

was asked to identify "the major problems for which your child needs help." The problem lists were then coded for content (see below).

Coding the Problem Lists

A coding system for the responses was developed on the basis of the items of the CBCL. Each CBCL item constituted a code for classifying problems. Thus, a response of "hot temper" would be coded as 95 to match CBCL Item 95, "Temper tantrums or hot temper." This system was used reliably in previous studies (Eastman, 1997; Weiss, Jackson, & Susser, 1997; Weisz, Suwanlert, Chaiyasit, & Walter, 1987; Weisz & Weiss, 1991); our reliability report follows. To maximize use of the data, we added 39 codes (including one to designate "uncodable") to capture responses that did not fit CBCL items. Decisions to add codes were made sparingly and by agreement between two coders (a postdoctoral fellow and an advanced clinical psychology graduate student) who had great familiarity with the data.²

To provide a conservative estimate of interrater agreement on assignment of the 151 codes, we calculated reliability among six trained coders by using percentage agreement for the exact code assigned to a problem. (Because of the rarity of some codes, it was not feasible to compute kappas.) Average interrater agreement for child-reported problems was 75.2% (range = 68.9%–82.9%); for parent-reported problems, it was 87.5% (range = 84.2%–93.4%). The average number of codes given to respondents in this study was 2.64 for children and 3.11 for parents.

Category coding. In developing the coding system, we noted that some parent-child pairs disagreed on specific problems (e.g., "steals" vs. "uses drugs") but agreed on the general category of the child's problems (i.e., stealing and using drugs both represent delinquent behavior). To reflect agreement at this broader level, we developed a complementary set of categories based on the narrowband syndrome scales of the CBCL and YSR, as derived through principal-components analyses by Achenbach (1991a, 1991b). Responses were assigned by computer to the appropriate Achenbach narrowband syndrome (Aggressive Behavior, Anxious/Depressed, Attention Problems, Delinquent Behavior, Sex Problems,³ Social Problems, Somatic Complaints, Thought Problems, and Withdrawn).

For items that did not belong to the Achenbach narrowband syndromes, six additional categories were developed through consensus among a senior clinical psychologist, a postdoctoral fellow, and an advanced clinical psychology graduate student: Apathy (5 codes; e.g., laziness), Daily Living Problems (24 codes; e.g., problems with cleanliness), Interpersonal Issues (13 codes; e.g., overly sensitive), Phobias⁴ (2 codes; e.g., afraid to go to school), Stressors (8 codes; e.g., loss or death of a friend or loved one), Treatment-Related Issues (5 codes; e.g., medication-related concerns). Six of the specific responses by parents or children were designated as uncodable (e.g., positive statements made by the respondent, denying the existence of problems). Ultimately, all but 2 of the remaining 145 specific problem codes (98.6%) were assigned to categories, and 98.2% of the total 2,190 responses fell into these categories.

We computed kappa coefficients to determine coder agreement for assignment of categories to each respondent (e.g., whether coders agreed that a respondent gave an answer that was in the Aggressive Behavior category). The average category κ for youth respondents across the six coders was .77 (κ range = .71–.84), which represents "substantial" strength of agreement as per Landis and Koch (1977); the average category κ for adult respondents was .87 (κ range = .84–.90), which reflects "almost perfect" agreement (Landis & Koch, 1977).

Operational definitions of match. Two types of parent-child match were possible: *specific problem match* (e.g., both child and parent identified a problem that was coded as Item 3: Argues a lot) and *category match* (e.g., child said "I'm lonely" and parent said the child "cries too much" constituted a category match because both specific problems are in the Anxious/Depressed category⁵). Specific problem matches were important because they dealt with parent-child agreement on the exact problems for

which treatment was needed. Category match provided information on whether parent and child problems at least fell into the same general problem areas. Matches were identified regardless of the rank of the problem on the respondent's list (e.g., a problem listed first on a child's list and third on a parent's list would constitute a match).

Results

Analyses were organized by the three study questions. First, we addressed overall referral-problem agreement by calculating percentages of match between parents and children. Second, we examined agreement for different types of problems through kappa coefficients reflecting parent-child agreement and test-of-proportion comparisons. Third, we explored factors associated with parent-child agreement, using logistic regression equations.

Overall Problem Match

First we investigated parent-child agreement about specific problems. When we assessed the number of parent-child pairs that had achieved one or more matches, we found that only 37% of the pairs showed any specific problem match. That is, asked to identify the child's major problems, 63% of the parents and children did not agree about even one problem (see Figure 1). Turning next to category matches, we found that 66% of the parent-child pairs had at least one match (see Figure 1.) Thus, more than a third of the parent-child pairs could not agree on even a single general area in which the child had problems.⁶

Agreement by Problem Type

Next we investigated parent-child agreement for different types of problems, by computing kappas for each of the 15 categories. These kappas ranged from $-.03$ to $.14$, with a mean of $.04$ (which represents a "slight" strength of agreement, as per Landis & Koch, 1977). Three categories showed significant though very modest agreement: Attention Problems ($\kappa = .12$, $p < .05$), Delinquent

² Because of difficulties differentiating between disobedience at home and disobedience at school in some of the responses, these two CBCL items were combined into a single General Disobedience item.

³ Although the Sex Problems syndrome did not meet the CBCL's analytic criteria for inclusion as a core syndrome, it was identified for some Age \times Gender groups (Achenbach, 1991a), and so we included it here.

⁴ A separate category was created for phobias, to include the specific fears that were not on the Anxious/Depressed syndrome in Achenbach's (1991a, 1991b) original principal-components analysis.

⁵ As mentioned earlier, two of the problem codes were not assigned to categories. Because a category match represented a broader match than did specific problem match, specific problem matches for these two codes were also classified as category matches.

⁶ These findings appear to reflect agreement in a representative clinical sample, given the unconstrained report of problems in an open-ended format. However, it was possible that a greater number of problems listed by respondents increased the probability of match (e.g., if the child lists one problem, an adult who lists five has a higher probability of some match than an adult who lists two.) To investigate this effect, we identified half of the sample that fell at or above the median in total number of parent and child responses. The effect was evident but not dramatic: Of this group, 40% showed a specific problem match (vs. 37% for the full sample), and 71% showed a category match (vs. 66% for the full sample).

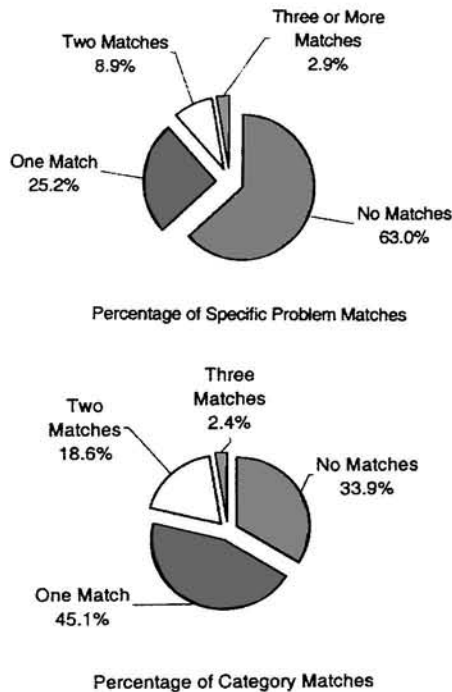


Figure 1. Overall percentage of parent-child specific problem matches and category matches.

Behavior ($\kappa = .14, p < .01$), and Social Problems ($\kappa = .12; p < .05$). The kappas for the remaining categories were as follows: Aggressive Behavior, $\kappa = .07$; Anxious/Depressed, $\kappa = .02$; Apathetic, $\kappa = -.03$; Daily Living Problems, $\kappa = .07$; Interpersonal Issues, $\kappa = .06$; Phobias, $\kappa = -.02$; Sex Problems, $\kappa = -.009$; Somatic Complaints, $\kappa = -.008$; Stressors, $\kappa = .05$; Thought Problems, $\kappa = -.02$; Treatment-Related Issues, $\kappa = -.01$; and Withdrawn, $\kappa = .07$.

We then tested our prediction that agreement would be better for externalizing than for internalizing problems. If a category match existed for Anxious/Depressed, Somatic Complaints, or Withdrawn (i.e., the three narrowband scales loading on the CBCL Internalizing broadband scale), this constituted a match for internalizing problems. Similarly, a category match for Aggressive Behaviors or Delinquent Behaviors constituted an externalizing problem match.

We calculated matches for internalizing problems and externalizing problems using three different baselines. First, we assessed parent-child agreement when either the parent or child identified the category (i.e., parent-child as baseline). This allowed us to investigate the degree to which clinicians might expect parent and child to agree, given that either parent or child identified problems within the internalizing or externalizing category. Second, we assessed children's agreement with problems identified by their parents (i.e., parent as baseline). Because parents are likely to initiate service entry, it is useful to know the degree to which children agree with what their parents say regarding internalizing versus externalizing problems for which parents have sought services. Third, we investigated parents' agreement with problems identified by their children (i.e., child as baseline). This provided

assessment of whether internalizing or externalizing problems salient to the child were also noted by the parent. We used tests of proportions in these analyses, comparing the proportion of "matched" externalizing problems with the proportion of "matched" internalizing problems for each of the three baselines. For all three baselines, externalizing problem match was significantly better than internalizing problem match at the $p < .05$ level: for combined parent and child as baseline, $z = 7.93, p < .05$ (externalizing proportion = .45, internalizing proportion = .12); for parent as baseline, $z = 7.76, p < .05$ (externalizing proportion = .51, internalizing proportion = .14); and for child as baseline, $z = 5.04, p < .05$ (externalizing proportion = .72, internalizing proportion = .37).

We also compared match between all pairs of categories. Tests of proportions were computed between the 15 categories for parent and child as baseline, parent as baseline, and child as baseline. A Bonferroni-corrected p value of .00048 ($p = .05/105$) was used in the analyses for each baseline. Twelve comparisons were significant for the parent and child baseline, 9 for the parent baseline, and 15 for the child baseline (see Table 1). The proportion for Aggressive Behavior problems was significantly greater than that for 12 of the 14 other categories for at least one baseline. The proportion for Attention Problems was significantly greater than that for 5 of the 14 other categories for one or more baselines. For child-as-baseline data, the proportion of Stressors that matched was significantly lower than were those for Aggressive Behavior, Anxious/Depressed, Attention Problems, and Delinquent Behavior. In general, the comparisons showed that agreement was best (though poor in an absolute sense) for problem categories that are arguably the most outwardly observable (Aggressive Behavior and Attention Problems) and worst for problems that involved life stressors (see Table 1).

Factors Other Than Problem Type Associated With Match

Last, we explored factors other than problem type that might be associated with parent-child match and mismatch. Two sets of hierarchical logistic regressions were computed. The first included specific problem match as the dependent variable (one or more specific problem matches = 1), and the second included category match as the dependent variable (one or more category matches = 1). The models for the two regression equations entered variables in four steps, moving from quantitative control to demographic factors and then to parent and child internalizing and externalizing problem reports. Given our special interest in the latter factors, we wanted to ensure that tests focused on them were as fully controlled as feasible. In Step 1, we entered variables to control for the number of parent and child responses; because a higher number of problems listed increased the probability of some agreement, it was important to control for this effect before examining other factors. In Step 2, we controlled for demographic variables found to predict various kinds of child-adult agreement in previous research (e.g., Jensen et al., 1999; Tarullo et al., 1995): gender (female = 1), age (continuous), ethnic minority status (ethnic minority = 1), and respondent relationship (mother = 1, all others = 0). A continuous score for point difference between parent and child on the CBCL and the YSR was entered in Step 3. This CBCL-YSR similarity score involved calculating the difference between CBCL and YSR T scores separately for each Achenbach

Table 1
Between-Category Tests of Proportions for Three Baselines

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. Aggressive Behavior		> ^{abc}	> ^{abc}	> ^c	> ^{abc}	> ^{abc}	> ^{ac}	> ^c	=	> ^{ac}	=	> ^{ac}	> ^c	> ^c	> ^{abc}
2. Anxious/Depressed			=	< ^{ab}	=	=	=	=	=	=	=	> ^c	=	=	=
3. Apathy				< ^{ab}	=	=	=	=	.	.	.
4. Attention Problems					=	> ^b	=	=	=	=	=	> ^{ac}	=	=	> ^{ab}
5. Daily Living						=	=	=	=	=	=	=	=	=	=
6. Delinquent Behavior							=	=	=	=	=	> ^c	=	=	=
7. Interpersonal Issues								=	=	=	=	=	=	=	=
8. Phobias									.	=	.	=	.	.	=
9. Sex Problems										=	.	=	.	.	=
10. Social Problems											=	=	=	=	=
11. Somatic Complaints											=	=	.	.	=
12. Stressors												=	.	.	=
13. Thought Problems														.	=
14. Treatment Issues															=
15. Withdrawn															=
Proportion of matches with parent and child as baseline	.44	.12	.00	.30	.09	.15	.16	.00	.00	.16	.00	.05	.00	.00	.08

Note. Parent-child matches were compared across all 15 categories. An equals sign means that there was no significant difference in extent of parent-child match between the categories in the column heading and the row heading. A > symbol means that there was a significantly larger parent-child match for the row heading category. A < symbol means that there was a significantly smaller parent-child match for the row heading category. A . symbol means that there was a comparison between zero values.

^a Both parent and child as baseline. ^b Parent as baseline. ^c Child as baseline.

narrowband scale and then summing this difference across the scales. The score allowed us to explore whether increased agreement between parent and child as to the existence of child behavior and emotional problems was associated with a greater likelihood of referral-problem match. In Step 4, dichotomous variables for parent-reported internalizing referral problem (yes = 1), parent-reported externalizing referral problem (yes = 1), child-reported internalizing referral problem (yes = 1), and child-reported externalizing referral problem (yes = 1) were entered into four separate logistic regression equations. These four variables allowed us to investigate which informant (i.e., parent or child) may be a better source of information on what type of problem (i.e., internalizing or externalizing) for concerns shared by both parent and child.

Neither the demographic variables nor the CBCL-YSR difference score was significantly associated with either specific problem or category match. When the child's age was entered as a categorical variable comparing adolescents to children (children aged 7-12 = 0, adolescents aged 13-17 = 1) instead of a continuous variable, the age results remained the same. However, the presence of a parent-reported internalizing referral problem was associated with a reduced likelihood of specific problem match (odds ratio [OR] = .55), whereas the existence of a child-reported externalizing referral problem was associated with a greater likelihood of specific problem match (OR = 2.57). Child-reported externalizing referral problem (OR = 6.69) was also associated with a greater likelihood of category match, and there was a trend for child-reported internalizing problem to have a positive relationship (OR = 2.00, *p* = .054; see Tables 2 and 3 for logistic regression models).

Discussion

Perhaps the most striking finding of this study was one of the simplest: More than 60% of the parent-child pairs failed to agree on even a single problem for which the child needed help. Even when given greater latitude, with agreement based on broad category match, more than a third of the parent-child pairs failed to agree on even one general area in which the child needed help.

At the time of our interview, the children were at the beginning of treatment. Given the low level of agreement between parents and children as to the problems for which the child needed help, one wonders what the treatment would have been for. Therapists who shaped their treatment agenda on the basis of parent input may have missed problems that were most significant from the child's perspective, and therapists who focused more on child-identified problems would have risked missing significant parent concerns. Regardless of what course therapists might choose, a high level of parent-child discord on such a basic issue as target problems would seem to undermine parent-child collaboration in therapy and certainly could not be good for the treatment process. The findings suggest that clinicians who interview parents and children separately, even with structured diagnostic interviews and even when the goal is a composite diagnosis, may face a key problem highlighted by this study—that is, that parents and children see “the problems” in very different ways. We return to this issue at the end of the Discussion.

Although the findings point to substantial mismatch in the views of parents and their children as to reasons for treatment, the data do not tell us why agreement is so poor. Perhaps parents and children

Table 2
Hierarchical Logistic Regression Analysis Predicting Specific Problem Match

Step and independent variable	<i>B</i>	<i>SE</i>	OR	$\Delta\chi^2$
Step 1				
No. of parent responses	.21	.18	1.23	5.55
No. of child responses	.24	.12	1.27*	
Step 2				
Gender (female = 1)	-.22	.23	.80	3.60
Age (continuous)	.02	.05	1.02	
Ethnic minority (minority = 1)	.33	.23	1.39	
Parent relationship (mother = 1)	.24	.35	1.27	
Step 3				
CBCL–YSR difference score	-.004	.003	1.00	1.94
Step 4				
Parent: Internalizing referral problem	-.60	.23	.55*	6.69**
Parent: Externalizing referral problem	.17	.28	1.18	
Child: Internalizing referral problem	.23	.30	1.26	
Child: Externalizing referral problem	.94	.25	2.57***	

Note. *N* = 356 because of missing demographic variables. Beta weights (*B*), standard errors (*SE*), and odds ratios (OR) reflect values for the step of the equation at which they were first entered. Each item in Step 4 represents a separate regression equation. CBCL = Child Behavior Checklist; YSR = Youth Self-Report.
 * *p* < .05. ** *p* < .01. *** *p* < .001.

are not communicating effectively about why the child is in treatment. The child may have a vague notion derived from the parent, of “having a problem,” but the specifics may not have been defined. Alternatively, the problems may have been discussed but communication may have been hampered by poor communication skills or poor receptive ability. Or parent and child may both be aware of what the other thinks but remain unpersuaded. Indeed, the actor–observer literature noted in the introduction (also see, e.g., Anderson et al., 1996; Jones & Nisbett, 1972) suggests that individuals whose actions are scrutinized by observers will have markedly different perceptions and interpretations of their actions than will the observers. A common finding is that observers tend to attribute actions to internal characteristics of the actors, whereas

actors make more situational attributions. If we think of children as the actors in the family drama that leads to clinic referral and parents as the observers, it is not difficult to imagine that the two may differ substantially in their perspectives and interpretations (see relevant findings in Compas, Friedland-Bandes, Bastien, & Adelman, 1981). In this connection, it is intriguing to note that our most situational category, Stressors (which includes, e.g., loss or death of a loved one, parents’ divorce, monetary/financial concern), was identified as one of the most important problems by 11.5% of the children in our sample but by only 3.9% of the parents. Such findings raise the possibility that actor–observer differences may color parent and child judgments about the very nature of the problem that needs to be addressed in clinical care.

Table 3
Hierarchical Logistic Regression Analysis Predicting Problem Category Match

Step and independent variable	<i>B</i>	<i>SE</i>	OR	$\Delta\chi^2$
Step 1				
No. of parent responses	.26	.20	1.30	19.19***
No. of child responses	.53	.13	1.69***	
Step 2				
Gender (female = 1)	-.45	.24	.64	10.89*
Age (continuous)	.08	.05	1.08	
Ethnic minority (minority = 1)	.44	.24	1.56	
Parent relationship (mother = 1)	.43	.35	1.54	
Step 3				
CBCL–YSR difference score	-.002	.003	1.00	.52
Step 4				
Parent: Internalizing referral problem	-.43	.24	.65	3.30
Parent: Externalizing referral problem	.52	.28	1.68	
Child: Internalizing referral problem	.69	.36	2.00 ^a	
Child: Externalizing referral problem	1.90	.27	6.69***	

Note. *N* = 356 because of missing demographic variables. Beta weights (*B*), standard errors (*SE*), and odds ratios (OR) reflect values for the step of the equation at which they were first entered. Each item in Step 4 represents a separate regression equation. CBCL = Child Behavior Checklist; YSR = Youth Self-Report.

^a *p* = .054.

* *p* < .05. ** *p* < .01. *** *p* < .001.

Research addressing these and other possible reasons for parent-child disparity would clearly be a useful next step.

Although specific problem match and category match were both very low overall, we did identify some variations, and several interesting correlates of category match were observed. First, category match occurred more often for externalizing problems than for internalizing problems (as defined by the CBCL and YSR) overall. Aggressive Behavior problem matches were also generally proportionally greater than those of the other categories investigated. These findings on problem identification are consistent with the literature on symptom endorsement (i.e., from a fixed list; see e.g., Hodges, Gordon & Lennon, 1990) in showing moderate to low levels of agreement on internalizing problems in clinic populations. One plausible interpretation is that our findings reflect the relatively observable nature of delinquency, social problems, and attention problems, including the disruption that such problems can cause in the family, school, or peer group. Agreement may also be enhanced by the ready availability of linguistic labels for such externalizing and mixed problems (e.g., stealing, fighting, can't sit still) relative to internalizing problems, which can be rather subtle and more linguistically challenging for children. Although there were no age-related differences in parent-child agreement found in this study, future research may explore specific developmental characteristics (e.g., cognitive developmental level) that might relate to level of agreement. Although demographic variables were not associated with category match, respondent contributions appeared to be important. Parental report of an internalizing problem decreased the probability of a specific problem match by approximately one half. However, child report of an externalizing problem was associated with higher rates of both specific problem match and category match. In addition, parent-child pairs in which children reported an internalizing problem showed a trend ($p = .054$) toward more category matches. Stated simply, the problems that bothered children were more likely to show parent-child agreement than were the problems that bothered parents. It is interesting that these findings suggest that consulting with the child may yield a better sense of shared parent-child goals for treatment than would asking the parent. This finding is reminiscent of findings on behavior/emotion endorsement, where children have been viewed as better informants than parents (Herjanic & Reich, 1997; Weissman et al., 1987).

Potential limitations of the study warrant attention as we look to future research. First, the majority of parents in this study were mothers. Although this high percentage may be ecologically valid in reflecting which parent is usually more likely to seek and be involved in a child's mental health care, it is possible that mothers might differ from fathers and other informants in their level of agreement with children about major problems. Given that our informants were the adults who had brought their child to the clinic for treatment, it seems possible that using any other informants could have resulted in even lower levels of parent-child agreement than what we found here. Second, our procedure called for separate adult and child research interviews, to ensure that responses of one would not influence responses of the other. We might well have had different findings had we interviewed the adult-child pairs together; however, it might also have been difficult to interpret such findings, given uncertainty about the independence of the two sets of responses. A related issue concerns the clinic intake procedures that preceded our research interview. Given that mul-

tiplex clinic staff members in multiple clinics conducted the intakes, and that the procedures involved considerable clinical judgment (and no control by the study), the intake procedures and the extent to which children and parents were together in the sessions varied across cases. In future research, if such procedural variations could be well documented, it would be useful and clinically relevant to determine whether adult-child agreement is better following joint parent-child intake procedures than following other approaches. It would also be meaningful to understand how parents and children respond to problems reported by the other in separate interviews. Third, this study focused on outpatient clinic clients and voluntary entry into services. Agreement findings might differ for inpatient children or involuntary service entry (e.g., court mandated), and this bears further investigation. And finally, the study focused on child problems; in the future, an important complement to such a focus would be research on family problems, which are often treated within a family therapy context and which might conceivably generate a different picture of agreement than what our results have shown. Future research may examine the role of parental psychopathology in parent-child agreement, particularly given reported relationships between parental anxiety/depressive symptomatology and parental report of child symptoms (Frick, Silverthorn, & Evans, 1994; Krain & Kendall, 2000).

The extent to which parents and children agree on the problems for which they want help may affect their ability to work together in pursuit of therapy goals. In support of this notion, one investigative team found that parent-child agreement on anxiety symptoms (assessed by structured diagnostic interview) was associated with a steeper slope of improvement in children treated for anxiety disorders (Panichelli-Mindel, Flannery-Schroeder, Callahan, & Kendall, 1995, as cited in Kendall, Panichelli-Mindel, Sugarman, & Callahan, 1997). And conversely, parent-child disagreement may be one factor that contributes to the poor outcomes often associated with conventional clinic-based treatment for children (see e.g., Weisz, Donenberg, Han, & Weiss, 1995; Weisz & Jensen, 1999; Weisz, Weiss, & Donenberg, 1992).

One could envision a number of clinic and therapist responses to the apparent tendency of parents and children to perceive different target problems. These might range from working to include at least some of the parent's concerns and some of the child's in the treatment agenda to structuring the intake to focus parent-child discussion on identification of common problems that both parties view as treatment targets, before beginning treatment. It may be wise for clinicians to assess parent and child concerns independently in separate intake sessions and then bring parent and child together to formulate joint goals. In support of this notion, Compas, Adelman, Freundl, Nelson, and Taylor (1982) found parent-child differences in causal attributions for child problems when parents and children were interviewed separately but not when they were interviewed together. However, in regard to problem identification, the focus of the present study, it is important to note that getting parents and children into the same room and getting them to "agree" on problems may not reflect true agreement as much as persuasion by one and a decision by the other to just "go along." Still, a joint interview following separate interviews may be a useful step toward encouraging shared therapy goals. Whatever the response of therapists and clinics, our findings do suggest that parent-child discrepancies in perceived problems can be so

pronounced at the beginning of clinic care that it would be unwise to leave them unassessed and unaddressed.

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