

JOURNAL OF CHILD AND ADOLESCENT PSYCHOPHARMACOLOGY
Volume 21, Number 5, 2011
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Pp. 1–2
DOI: 10.1089/cap.2011.2159

Guest Editorial

Two Opinions About One Child—What’s the Clinician To Do?

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HOW DOES A CLINICIAN proceed when she or he gets conflicting information from parent, child, and school? The special section in this issue entitled, “Information Variance and Its Diagnostic Implications,” tackles a conundrum that confounds evaluations in youth (Achenbach, et al. 1987, Youngstrom, et al. 2003) and adults (Achenbach, et al. 2005) alike. After years of wrestling with the reality that any two information sources correlate only moderately with each other, and often disagree, there has been a concerted effort to move beyond solutions like counting symptoms only if there is agreement, or counting everything for lack of a better plan (De Los Reyes & Kazdin 2005).

The five articles in this section address basically two different but related aspects of informant relationship—that between parent and teacher and that between parent and offspring.

Studies by Rettew et al. and Carlson and Blader examine parent/teacher agreement and disagreement. The former uses a community sample in the Netherlands ($N=1,730$ children, mean age 11 years) and asks how often parents report clinical levels of problems when teachers do not and vice versa. Further analyzed is whether parent personality, parental stress, number of children in the household, child gender, socio-economic status (SES), intelligence quotient (IQ), and an aspect of child temperament called “effortful control” (the ability to inhibit something you want to do in favor of something you should do) contribute to our understanding of the agreement versus site specific differences. The authors found that disagreement between informants was more the rule than the exception, but with only a few of these variables distinguishing between symptoms reported only at home or only at school. Using a multivariate analysis, they concluded that parental stress predicts greater symptomatology in all the symptom domains studied (i.e., aggression, rule breaking behavior, attention symptoms, and attention-deficit/hyperactivity disorder (ADHD) behaviors). They also reported that effortful control (or its absence) was associated more with parent-reported (with or without teacher agreement) symptoms than teacher reported symptoms. Gender played a somewhat different role depending on the type of behavior studied. Female gender was most predictive of inattentive and hyperactive symptoms reported only at home, while for rule breaking behavior, the home specific group was primarily boys. Children with cross-situational problems had lower IQ and lower SES along with greater parental stress and poorer effortful control, though for statistical reasons, these variables did not contribute to the final model.

The Carlson and Blader study uses a large outpatient clinic sample ($N=911$, mean age about 12 years), rather than a community sample, to examine parent/teacher agreement and disagreement specifically on manic symptoms. They found the usual modest correlation between parent and teacher scores to be $r=0.27$ ($p<0.000$), this time

on the Child Mania Rating Scale (Pavuluri et al., 2006). This is similar to what others have found between parent and teacher ratings using other scales. The article, though, is more focused on the question of the diagnostic implications of informant agreement and disagreement about manic symptoms. Using $\geq 75\%$ ile of scores on the Child Mania Rating Scale (Pavuluri et al., 2006) to determine most symptomatic and $\leq 25\%$ ile for the least symptomatic children, the study hypothesizes that bipolar disorder, where it occurs, will be most associated with cross situational endorsement of high mania symptom scores. The study also examines what diagnoses are most prominent where there is parent/teacher agreement, and where a parent only reports symptoms but the child is completely asymptomatic in school. In this report, logistic regression revealed a 10-fold greater odds of an externalizing disorder (ADHD with or without oppositional defiant disorder/compulsive disorder being present) where there was high parent/teacher concordance on the presence of manic symptoms. Although bipolar disorder did occur more often where the child was significantly symptomatic at home and at school, the overall low base rate of bipolar disorder made it a less useful explanatory diagnosis for parent/teacher concordance. Perhaps more importantly, in situations where parents only reported significant manic symptoms, and the child was fine in school both academically and behaviorally, anxiety disorders, and not ultradian cycling bipolar disorder was the diagnosis observed.

The next three articles focus on parents and youths seeking services from a large outpatient mental health sample. Keep in mind that the question of what to do with disparate information between parents and others has usually been solved by combining positive symptoms from both informants. The article by Youngstrom et al. instead examines interviewer ratings of the “credibility” of the caregiver or youth to decide how to combine information. At the end of the diagnostic interview, the interviewer noted whether the credibility of information seemed “good,” “fair” or “poor” for the caregiver and for the youth. Credibility is a clinical decision about how much to credit or discount the information provided by an individual and differs from reliability in that reporters can be consistent in their information but not necessarily credible. Youngstrom and colleagues found that informants with “good” or “fair” credibility groups tended to perform similarly, with a more pronounced drop in validity for the “poor” group measured against criteria such as consensus diagnoses (based on all information) or observational ratings.

What makes a person more credible during a clinical interview? On average, caregiver (i.e., the adult most involved in the child’s life, regardless of who it was) credibility was higher in better functioning families with higher levels of education, and when youths were younger versus adolescent. Youth credibility was strongly connected to increasing age, cognitive ability, caregiver credibility, and

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independent observations of youth behavior (less credibility was associated with more observed disruptive behavior, even by an independent observer). Overall, these results suggest that rather than combining information willy-nilly, or simply using any positive information from either parent or child, credibility judgments can provide some guidance about how to integrate information into a case formulation. It is also worth remembering, of course, that more information is obtained from the youth than simply how she or he answers questions so that evidence of physical hyperactivity, thought disorder, sad **facies** etc., captured in behavioral ratings if they are thorough, also provide additive information.

In the next article, De Los Reyes and colleagues focused on the part of the outpatient sample which had available norms on youth rating scales and used latent class analysis to identify groups defined by profiles of agreement across a wide range of symptom domains. Even though caregivers and youths each reported about more than eight different aspects of clinical presentation, these sorted themselves into 3 main groups: one common profile in which both the caregiver and youth reported high levels of concerns, a second common pattern in which caregiver was concerned, but the youth reported low scores on the same dimensions, and a final, less common pattern in which the youth was more concerned than the caregiver. De Los Reyes et al. then examined whether credibility ratings—generated by the interviewer while still blind to the youth and caregiver checklist scores—varied systematically across these profiles. It turned out that the informant reporting the most problems had been given higher credibility ratings. When caregivers had high levels of concern and youths endorsed few problems, youth credibility had been low based on the interviewer ratings. This would be consistent with “lack of insight,” minimization, denial or of an unmotivated patient, potentially harder to engage in treatment with a high degree of adherence.

Finally, Freeman and colleagues examine caregiver and youth (ages 11–17) perceptions of manic symptoms in the youth using the Mood Disorder Questionnaire (Hirschfeld, et al. 2000). Interestingly, it appears that some mood symptoms appear to be reported at relatively low levels of mania and are thus highly sensitive to bipolar disorder, meaning that almost all cases with bipolar disorder would show the symptom. Other symptoms are unlikely to manifest until the mania becomes relatively severe, and these are often more specific to bipolar disorder – and thus unlikely to be evident in cases without bipolar disorder. Which symptoms are noted at what may be relatively mild levels of hypomania or mania appears to depend on who is asked. Irritable mood is likely to be a concern to the caregiver at relatively low levels of manic symptom endorsement, whereas money problems or hypersexuality only were endorsed at very severe levels in youths. Conversely, adolescents endorse symptoms like increases in energy and activity at lower levels of mania than required for caregivers to comment on the same symptoms. One implication of these results is that youths and caregivers will often focus on different constellations of symptoms when presenting for an outpatient evaluation. That parents will focus first on irritability comes as no surprise to practitioners working with families, but concentrating on changes in energy may frame things in a way that help the adolescent recognize changes in mood. The findings paint a more nuanced picture than simply stating that caregivers and youths disagree.

The clinical implications of these findings taken together are important. Agreement across informants, especially from different settings, is not high. Rather than rending garments and despairing, however, this disagreement may be looked upon as additional information. Rather than automatically using the highest rated symptoms from all reporters, clinicians could integrate information

into judgment about credibility of each informant’s report, which can help make sense of divergent perspectives and also has implications for treatment engagement, adherence, and ultimately outcomes. Although parent report usually is the one on which most clinicians rely, parental stress predicts greater symptomatology. When talking about groups of families, this leads to a “chicken and egg” problem: are the parents reporting more problems because they are stressed? Or are they stressed because there are more problems at home? The degree to which informants agree (be they parent and teacher or parent and child) increases the likelihood that the same phenomenon is being described. Youths and caregivers may not disagree so much as they focus on different details while still having similar global perceptions of the presenting problem. The presence of different disorders may explain situations where phenomenology differ across situations (e.g., home and school). For instance, when the parent endorsed manic symptoms and the child was asymptomatic in school, anxiety disorders were more commonly diagnosed when all information as considered together. High scores on a parent symptom scale for manic symptoms, especially when corroborated by teacher report, were most often indicative of common externalizing disorders.

Finally, it is important to keep in mind that the aforementioned studies that addressed manic symptoms were describing just that. Bipolar spectrum disorder was much less common than manic symptom endorsement. Nevertheless, if a clinician cannot make sense of how parents, teachers and youths delineate manic symptoms, it will be nigh impossible to determine whether an episode of mania or hypomania has occurred.

References

- Achenbach TM, Krukowski RA, Dumenci L and Ivanova MY. Assessment of adult psychopathology: Meta-analyses and implications of cross-informant correlations. *Psychol Bull* 131:361–382, 2005.
- Achenbach TM, McConaughy SH and Howell CT. Child/Adolescent behavioral and emotional problems: Implication of cross-informant correlations for situational specificity. *Psychol Bull* 101:213–232, 1987.
- De Los Reyes A and Kazdin AE. Informant discrepancies in the assessment of childhood psychopathology: A critical review, theoretical framework, and recommendations for further study. *Psychol Bull* 131:483–509, 2005.
- Hirschfeld RM, Williams JBW, Spitzer RL, Calabrese JR, Flynn L, Keck PEJ, Lewis L, McElroy SL, Post RM, Rappaport DJ, Russell JM, Sachs GS and Zajecka J. Development and validation of a screening instrument for bipolar spectrum disorder: The mood disorder questionnaire. *Am J Psychiatry* 157:1873–1875, 2000.
- Pavuluri MN, Henry DB, Devineni B, Carbray JA, Birmaher B. Child mania rating scale: Development, reliability, and validity. *J Am Acad Child Adolesc Psychiatry*.45:5505–60, 2006
- Youngstrom EA, Findling RL, Calabrese JR. Who are the comorbid adolescents? Agreement between psychiatric diagnosis, parent, teacher, and youth report. *J Abnorm Child Psychol* 31:231–245, 2003.

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