Informant Discrepancies on DSM 5 PTSD Cluster Ratings: The Influence of Child and Family Variables
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INTRODUCTION

- Discrepancies between child self-report and caregiver report of emotional and behavioral symptoms are highly common (e.g., Youngstrom et al., 2000). Some previous research has concluded that greater agreement emerges when comparing reports on externalizing symptoms to internalizing symptoms (Ladakakos, 2000; Perlstein, 2004).
- Although certain caregiver variables (i.e., stress and psychopathology) have been found to impact child-caregiver symptom agreement, evidence concerning the influence of child characteristics (i.e., age and gender) is mixed (De Los Reyes & Kazdin, 2005). Notably, no study has explored how the type of caregiver (i.e., biological parent, adoptive parent, foster parent) affects symptom concordance; however, attachment literature indicates that longer caregiver-child relationships are linked to greater attunement (Bowlby, 1980; Bretherton, 1985).
- Presently, the literature examining caregiver-child agreement of traumatic stress symptoms is limited in scope and quantity, although existing studies have suggested that overall caregiver-child PTSD symptom agreement is poor (Kassam-Adams et al., 2006) and that caregivers underestimate their children’s PTSD symptoms (Ladakakos, 2000).

METHODS

- Assessed PTSD symptom clusters: re-experiencing, avoidance, negative mood/cognitions, and hyperarousal.
- Consistent with the literature examining caregiver-youth attunement of internalizing and externalizing symptoms, we predict the highest youth-caregiver discordance will exist for the re-experiencing and avoidance clusters (internalizing symptoms), while the greatest agreement, possibly emerging for the hyperarousal cluster (externalizing symptoms; Perlstein, 2004; Schreier et al., 2005).
- Considering the research regarding attachment formation and its impact on caregiver-youth attunement (Bowlby, 1980; Bretherton, 1985), we expect biological parents to exhibit the highest agreement with their children, as their relationships are likely the most enduring.

RESULTS

- Overall, results indicated fair agreement between youth and caregiver report of clinically elevated symptoms but poor agreement for DSM-5 criteria met, suggesting that caregivers and youth both recognize there are some concerning symptoms but disagree with regard to the specific pattern of symptoms.
- Despite low agreement scores, results indicate that 66% of youth and caregivers agreed on whether there was a clinically elevated PTSD score, and 51% of youth and caregivers agreed as to whether DSM-5 criteria was met.
- Patterns of agreement across youth and their caregiver were dependent on the age and gender of the youth, such that adolescents and males exhibited fair agreement with their caregivers only for clinically elevated levels of symptoms. This may partially represent adolescents’ increased capacity for accurate self-reflection, increasing agreement with caregivers.
- Contrary to our prediction, adoptive caregivers had the highest rates of agreement for both clinically elevated PTSD (moderate agreement) and DSM-5 PTSD (fair agreement). Several factors may have influenced this finding. Biological parents may have the same trauma history as the child and be experiencing PTSD symptoms, which may obscure their perception of the child’s functioning. Further, as a result of the adoption process, adoptive parents may have obtained detailed knowledge of their child’s history, attended parenting classes, and invested significant time and energy into the parent-child relationship, thereby increasing their accuracy and agreement with their child.

DISCUSSION

- In line with our hypotheses, on average, caregivers and youth reported similar levels of hyperarousal symptoms but significantly different levels of re-experiencing symptoms. This provides further support for higher caregiver-child attunement in reporting externalizing rather than internalizing symptoms. Contrary to expectations, we found no differences between caregiver and youth report of avoidance symptoms. Further, caregivers reported significantly greater levels of negative mood/cognition symptoms than did youth.
- Results from these analyses are significant, as they provide initial insight into the common patterns of discrepancies providers can expect to emerge when administering a screening consistent with the new DSM 5 PTSD criteria. Specifically, given the most recent update to the DSM 5, the current study provides preliminary data on how the extensively revised, negative/mood cluster may be interpreted by children and caregivers.

LIMITATIONS & FUTURE DIRECTIONS

- The small sample size limited power to detect differences and limits the generalizability of the findings.
- Given that the data was not initially collected for research purposes, administration methods likely varied (i.e., measure completed independently vs. with provider facilitation), and may have introduced error. A standardized procedure for administering the measure would improve the significance of the results.
- Future research could explore how additional variables related to the caregiver (e.g., gender, ethnicity, psychopathology, trauma history, etc.), child (e.g., type of trauma exposure) and referral process (i.e., referral source) influence agreement in caregiver-youth ratings of posttraumatic stress symptoms.
- As significant discrepancies were found across two clusters, future studies that examine the the direction of the discordant ratings by individual items may be useful in providing a more comprehensive understanding of these cluster-level disagreements.
- Further, investigators could also examine how treatment initiation and progression affects the rate of agreement between youth and caregivers reports of PTSD symptomology. As key components of evidence based practices for youth PTSD (e.g., Trauma-Focused Cognitive-Behavioral Therapy [TF-CBT]) include psychoeducation on common traumatic stress responses, it follows that engagement in TF-CBT is likely to improve symptom caregiver-child agreement.
- Finally, future research could explore if there is a relationship between symptom rates of caregiver-youth PTSD symptom agreement and trauma-focused treatment outcomes. Findings of a positive relationship between symptom agreement and treatment outcome could provide support for the role of the caregiver-youth bond in treatment success.