

Caregiver-Child Symptom Agreement on DMS-5 PTSD Severity and Clusters: Influence of Trauma Type

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INTRODUCTION

Interpersonal violence (IPV) is a broad term that encompasses both direct violence exposure (DVE, i.e. sexual abuse and physical abuse) and exposure to inter-parental violence (IV, i.e. domestic violence). However, IV is a distinct trauma category, consisting of its own taxonomy of exposure types (Holden, 2003), and thus requires individual examination. Although much research and clinical attention has been directed to DVE victims, witnesses to inter-parental violence have been called "invisible victims" (Osofsky, 1995) because it is difficult to know the extent to which children are exposed to this violence. Millions of children witness both verbal and physical spousal abuse yearly, yet caregivers may be unaware (Jaffe, et.al., 1990), may underestimate (Rosenberg, 1987), or may deny their child's direct experience with IV or their knowledge of it (Holden, 2003). Further, definitional confusion has led to lack of consensus on what constitutes IV. Recently, researchers have agreed that exposure to inter-parental violence includes witnessing or hearing verbal or physical abuse, experiencing the aftermath of abusive interactions (i.e., injuries, parental distress), or hearing about abuse from another source (Evans, et.al. 2008; Holden, 2003). However, there continues to be poor child-caregiver interrater agreement regarding exposure to domestic violence. Children rate higher levels of exposure to IV in both frequency and severity (Osofsky, 1995). Research suggests that caregivers may minimize the potential impacts of IV on children who are not physically present during verbally or physically abusive interactions, or assume their children were unaware of these incidents (Jaffe, et.al., 1990; Rosenberg, 1987). Smith, Berthelsen & O'Conner (1997) found that forty-eight percent of mothers believed their children were unaware of a majority of the violence that occurred between their self and their partner.

The misperception and lack of knowledge regarding the extent of a child's exposure to IV, in turn, impacts caregiver ratings of a child's symptomatology, particularly as the distinct IV exposure types are perceived as differentially traumatizing (e.g., witnessing abuse first-hand versus hearing it from another room, Margolin, 1998). Caregivers' reports of their child's PTSS symptoms may also be affected by the caregiver's direct involvement in their child's IV exposure or by their own matched trauma (i.e., caregiver childhood IV exposure; Cohodes, et.al., 2016). Overall, strong relationships exist between IV exposure in youth and accompanying internalizing, externalizing, and trauma-related symptoms, adjustment problems, increased psychopathology, and decreased social competence and self-esteem (Evans, Davies, & DiLinno, 2008; Ktizmann, et.al., 2003; Jaffe, et.al., 1986; Fantuzzo, et.al., 1991). Since caregiver-child symptom agreement, particularly across DSM-5 Posttraumatic Stress Disorder (PTSD) clusters, is known to be inconsistent and variable (Rischar, et.al. 2016), exploration of interrater agreement in the context of IV as a distinct trauma type is warranted.

PURPOSE

- This study aimed to explore how caregiver-child dyads compare in their traumatic stress ratings across clinical severity levels of posttraumatic stress symptoms (PTSS), criteria met for DSM-5 Posttraumatic Stress Disorder (PTSD), and the following DSM 5 PTSD symptom clusters: re-experiencing, avoidance, negative mood/cognitions, and hyper-arousal.
- Further, this study aimed to determine how trauma exposure type, caregiver characteristics (e.g., caregiver type), and individual characteristics (i.e., age, gender, race) impact these discrepancies.

HYPOTHESES

- We predict higher symptom agreement in children with only DV exposure, compared to children with only IV or both IV and DVE combined, considering research findings indicating a minimization of impacts of IV exposure on children (Osofsky, 1995; Jaffe, 1987).
- We predict higher symptom agreement within adoptive parent and child dyads compared to both biological and foster parents, considering previously gathered findings from by Rischar, et.al. (2016).

METHODS

Participants

- 107 caregiver-child dyads
- 81 School-age youth (7-12 years old)
- 26 Adolescent youth (13-17 years old)
- Mean age of child in years = 9.9 (SD 2.81)
- 51% Male; 49% female
- 49% Caucasian, 18% multi-racial, 18% African American,
- Caregivers: 38% Biological; 23% Adoptive; 36% Foster/Legal Guardian; 1% DHS caseworker
- 39% both DVE & IV, 30% DVE only, 21% IV only

Procedure

- Children were referred to the OUHSC Child Trauma Services Program (CTSP) to evaluate for mental health treatment needs related to trauma exposure. Participants attended CTSP intake assessments between December of 2014 and October of 2016.
- Assessments consisted of a semi-structured clinical interview and administration of a battery of caregiver and child measures.
- All data was collected as part of routine clinical care and retrospectively analyzed for purposes of this investigation.
- This study was approved by the OUHSC Institutional Review Board (# 7394).

Measure

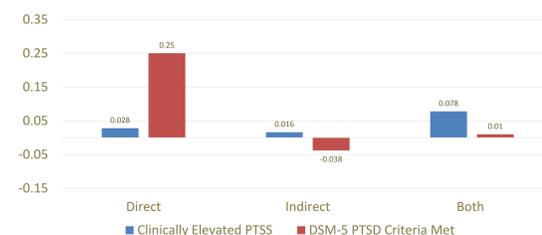
- Child and Adolescent Trauma Screen (CATS): A 20-item self-report and caregiver-report checklist of a child's PTSD symptoms. The informant rates each item for frequency on a 0-3 Likert scale. Ratings of a 2 or 3 denote symptomology. The range of possible severity scores (i.e., sum of ratings) is 0 to 60, with a clinical cut-off score of 21.

Analyses

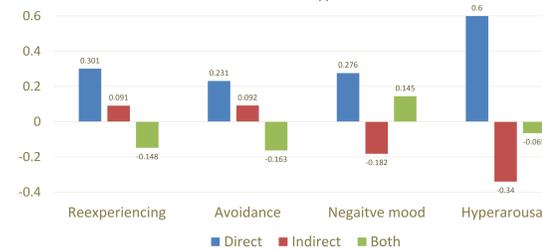
- Cohen's kappa (Cohen, 1960) was used to assess agreement between youth and caregiver reports of PTSD. PTSD was defined and explored in two ways: 1) a CATS severity score at or above 21 or 2) requisite number of DSM-5 symptoms endorsed on the CATS within each PTSD cluster. Paired sample t-tests were used to examine mean differences in average number of PTSD symptoms.

RESULTS

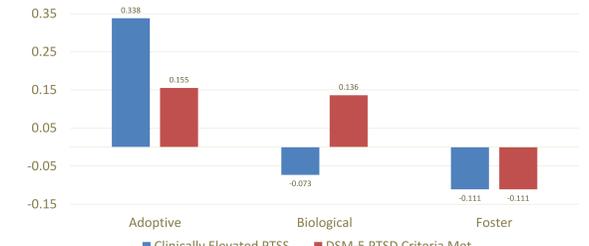
Clinically Elevated PTSS and DSM-5 PTSD Criteria Met Agreement by Trauma Type



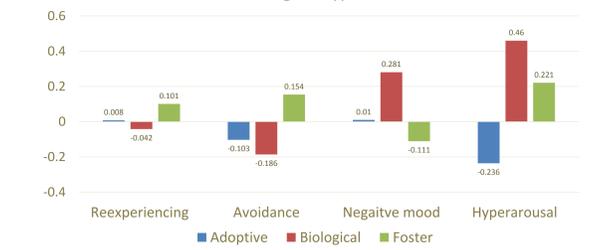
Agreement within DSM-5 PTSD Symptom Clusters by Trauma Type



Clinically Elevated PTSS and DSM-5 PTSD Criteria Met by Caregiver Type



Agreement within DSM-5 PTSD Symptom Clusters by Caregiver Type



DISCUSSION

- Overall, results indicated poor agreement between youth and caregiver report of both clinically elevated posttraumatic stress symptoms (PTSS) and DSM-5 criteria met.
- Despite low agreement scores, results indicate that 62% of youth and caregivers agreed on whether there was a clinically elevated PTSD scores and 44% agreed as to whether DSM-5 PTSD criteria was met. Indicating that families recognize there are concerning symptoms, but disagree with regard to specific pattern of symptoms.
- In line with our prediction, children with DVE only (i.e., physical or sexual abuse) showed the highest agreement on DSM-5 criteria met compared to those with IV only. DVE youth also displayed fair to good agreement across each DSM-5 symptom cluster. IV exposed youth showed poor agreement with their caregivers across all categories, in line with our prediction. These results are supported by research in which caregivers underreport both the extent of their child's IV exposure and their child's symptomatology (Osofsky, 1995; Holden, 2003).
- In line with our prediction, adoptive parents displayed the highest agreement of all caregiver types in regards to their agreement of clinically elevated PTSS (k=.338) and DSM-5 PTSD criteria met (k=.155). Results from Rischar, et.al. (2016) support these findings. As a result of the adoption process, adoptive parents may have received trauma-focused parenting training and have an intimate knowledge of their child's trauma exposure history due to access to reports from the Department of Human Services. Thus, they are perhaps more aware of trauma-related symptomatology and more attune with their child's current emotional and behavioral status.
- Biological caregivers displayed overall low agreement with youth with regard to PTSS severity and DSM-5 PTSD criteria met. Biological parents did show fair to good agreement for both the Negative Mood and Hyperarousal DSM-5 PTSD clusters. Based on attachment formation research (Bowlby, 1980), biological caregivers are perhaps more attune to their children's cognitions, changes in behavior and mood over time, and current emotional difficulties in these respective areas.
- Although meaningful statistical analysis could not be run due to small sample sizes, it is important to note that 50% of biological caregivers of children with IV exposure were directly involved in their child's trauma (i.e., victims or participants). This involvement could have impacted caregiver reporting as noted by Osofsky (1995), Holden (2003), and Cohodes, et.al. (2016).
- Agreement patterns across youth and caregivers were also dependent on demographic variables. Notably, adolescents reported fair agreement with their caregivers in regards to PTSS severity, compared to poor agreement with school age children. This may be due to adolescents elevated capacity for self-awareness and accurate reporting. African American children and caregivers displayed moderate agreement on DSM-5 criteria met (k=.400) compared to poor agreement for Caucasian children. No gender differences were found.

LIMITATIONS AND FUTURE RESEARCH

- The small sample size, particularly within caregiver and trauma types, likely decreased power to detect differences and limits the generalizability of these findings.
- Data was not initially collected for the purpose of research projects, thus administration methods varied (i.e., measures completed independently vs. with provider facilitation). Standardized measure administration processes will improve the significance of results in future research studies.
- Data on caregiver trauma-exposure, symptomatology, and other characteristics was not consistently or systematically gathered during normal clinical practice within this site. Additional research incorporating caregiver factors as variables could provide insight into discrepancies between child-caregiver symptom reports.
- Future research should collect data on child and caregiver reports of children's exposure to IV along Holden's (2003) 10 category taxonomy (i.e., Exposed prenatally, intervenes, victimized, participates, eyewitness, overhears, observes initial effects, experiences the aftermath, hears about it, ostensibly unaware). Comparing discrete categories within the realm of IV should be explored. In a similar vein, bi-directional or mutual inter-parental violence is an understudied subset of direct violence exposure for children (Fantuzzo & Fusco, 2007). This information should be gathered systematically during normal clinical practice and taken into consideration for future exploration.
- Fantuzzo and Fusco (2007) found children ages three to six are typically exposed to IV at far greater rates than older children. However, the CATS assessment measure is not validated for the self-report of children under the age of seven, thus excluding this demographic. Future studies should continue to explore the extent to which young children are exposed to differing types of IV and the psychological impact of this exposure.
- Lastly, research should examine how symptom agreement changes as a result of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), particularly after initial psychoeducational sessions on PTSD and common trauma-related reactions in children. These therapy components may increase both caregiver and children's ability to identify trauma-related responses and perhaps lead to increased interrater symptom-agreement.