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Child, Parent, and Therapist (Dis)Agreement on Target Problems in Outpatient Therapy: The Therapist's Dilemma and Its Implications

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A minimal requirement for success in child psychotherapy is arguably that child, parent, and therapist agree about which problems to address. How often is this the case? Following clinic intake, the authors asked 315 children, parents, and therapists, separately, to identify target problems. More than 3/4 of child–parent–therapist triads began treatment without consensus on a single problem; nearly half failed to agree on even 1 broad problem domain (e.g., aggression vs. anxiety/depression). Therapists agreed more with parents than children for most child problems, but for family and environmental problems the reverse was true. Findings highlight the therapist's dilemma in identifying treatment foci when clients disagree and may help explain the poor effects of clinic-based therapy reported in previous research.

Deciding which problems should be the focus of treatment may be among the most critical tasks facing clinicians (Haynes, 1993; Nezu & Nezu, 1993). Achieving mutual agreement on the key problems to address in treatment is an important first step toward planning the intervention, engaging the client, and developing a working alliance. However, achieving therapist-client agreement may also be among the most complex tasks facing clinicians, particularly child clinicians.

In much adult therapy, assessment and treatment focus largely or exclusively on the individual adult client. In child therapy, by contrast, there are at least two clients whose concerns may be legitimate and important: child and parent. Achieving consensus with both may be particularly difficult to the extent that they view the situation differently; we know from past research with both clinic-referred and nonreferred community samples that children and their parents (both mothers and fathers) show little agreement about which emotional and behavioral problems the child displays[1] (e.g., Achenbach, McConaughy, & Howell, 1987; Edelbrock, Costello, Dulcan, Conover, & Kalas, 1986; Forehand, Frame, Wierson, Armistead, & Kempton, 1991; Rey, Schrader, & Morris-Yates, 1992) or about how distressing those problems are (e.g., Dubow, Lovko, & Kausch, 1990; Phares & Danforth, 1994; Weisz & Weiss, 1991).

Recently, in a sample of clinic-referred children and their parents, Yeh and Weisz (2001) found that parent–child disagreement extended even to the referral problems for which treatment is sought. One might expect that by the time of clinic entry at least those problems that are severe and troubling enough to have prompted treatment seeking would be obvious to both parent and child. Certainly, after going through clinic intake, children and parents should have discussed at least the key problems and reached some consensus about which are most important to address in treatment. However, Yeh and Weisz found that fewer than half of parent–child pairs agreed on even a single problem in need of intervention.

This lack of parent–child agreement could complicate the therapist's problem-identification task and pose a dilemma: The therapist needs to identify target problems to plan treatment, but the clients do not agree on what those problems are. Faced with this dilemma, therapists may respond in quite different ways. Some may choose to focus on parent-reported problems. After all, the parent is typically the one who sought treatment and who provides much of the initial information about child problems. It is usually parents who ensure that the child comes to therapy, who are asked to structure the family environment in ways conducive to therapy recommendations, and who play a primary role in deciding whether and for how long to continue therapy (e.g., Armbruster & Kazdin, 1994; Cottrell, Hill, Walk, Dearnaley, & Ierotheou, 1988). Furthermore, there may be developmental limitations to the insight children can achieve about problems, their inclination to collaborate with an adult therapist to determine appropriate targets of treatment, and even their ability to express themselves verbally (Shirk & Saiz, 1992). For these reasons, the therapist and the

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[1] Although parent–child agreement may be somewhat better for the more outwardly visible, externalizing problems (e.g., hitting) than for the less visible, internalizing problems (e.g., sadness; Achenbach et al., 1987; Edelbrock et al., 1986; Forehand et al., 1991; Rey et al., 1992), agreement is still quite low for both categories.

therapy process may be best served by attending to those problems that the parent identifies as most important.

Other therapists may rely more heavily on the child's input. Parents may sometimes distort, and they may identify problems as the child's that are actually more systemic or even the result of parental behavior. Moreover, if therapists shape their treatment agenda on the basis of parent input alone, they may miss problems that matter most to the child and risk alienating the child or failing to engage the child's interest and motivation. Indeed, because treatment referrals are usually made by parents or other caretakers, without the child's active involvement in the decision-making process (Adelman, Kaser-Boyd, & Taylor, 1984; Armbruster & Kazdin, 1994; Ollendick & Vasey, 1999; Weisz, Huey, & Weersing, 1998), the child's motivation for treatment may already be low. Attending to the child's view of target problems may help overcome the involuntary nature of the process and bring the child on board.

A third perspective on the therapist's dilemma is that for therapy to proceed most smoothly and effectively, therapists need to attend to both child and parent perspectives. Therapists may attempt to maximize agreement with both child and parent by focusing on those concerns that are mutually shared (when they exist) or by including both child-reported and parent-reported problems in their agenda. This strategy recognizes that both child and parent play key roles in the treatment process; if either participant perceives that the therapist does not understand the true problems, that perception may undermine treatment motivation and participation. Of course, a potential disadvantage of efforts to encompass both child and parent concerns is that therapy might be overly diffuse, lack clear focus, or in the worst case, be aimed at incompatible goals.

In sum, there are at least three strategies that might be used by therapists who want to address client concerns in treatment: relying most on parent-report, relying most on child-report, or attending to both reports equally. Loeber, Green, and Lahey (1990) found that mental health professionals view parents as more accurate and useful informants about child emotional and behavioral problems than children. This suggests focusing on parent report may be the most likely response to the therapist's dilemma, but in truth, we have little empirical information on the question.

In the present study, we sought to extend the work of Yeh and Weisz (2001) by examining target-problem agreement among children, parents and therapists in outpatient community mental health centers. The primary goals of the investigation were to (a) report what problems were most often targeted by therapists, (b) determine the level of agreement among children, parents, and therapists about those target problems, (c) ascertain whether agreement was better for certain types of problems (e.g., externalizing) over others (e.g., internalizing), and (d) assess the degree to which therapists targeted the problems identified by parents versus their children.

We hypothesized that externalizing problems would be targeted more than internalizing problems, given past research indicating that externalizing problems are more likely the impetus for clinic referral than internalizing problems (Weisz & Weiss, 1991). We also anticipated finding low levels of child–parent–therapist agreement on target problems, given the poor parent–child agreement found in past research (e.g., Achenbach et al., 1987). However, we expected to find greater agreement for externalizing problems than for internalizing problems (e.g., Forehand et al., 1991), in part because externalizing problems are more outwardly observable and thus require less inference regarding internal processes. Finally, extrapolating from the Loeber et al. (1990) survey, we hypothesized that therapists would generally show greater agreement with parents than with children. However, we thought it possible that therapist agreement with parents versus children might depend on other factors: judgments about who is a better reporter of certain types of problems, child age, parental psychopathology, and therapist experience and training in child and family therapy. Thus, we also investigated those variables as potential moderators of the relationship between therapist report and parent–child report.

Method

Sample

Participants were families of children ages 7–17 years referred for therapy to one of eight community mental health centers in Los Angeles between 1991 and 1999.[2] During the intake, clinic staff presented parents with a brief description of the project and a form on which to provide their names and numbers if they wished to be contacted by project staff for an assessment.[3]

The sample of 315 included 199 (63.2%) boys and 116 (36.8%) girls ages 7–17 years (M = 11.54, SD = 2.46); ethnicity was 49.3% Caucasian, 15.6% African American, 14.6% Hispanic, 1.4% Asian/Pacific Islander, and 19.0% mixed or other. The caregivers interviewed were 90.5% mothers (biological, adoptive, or step-), 6.9% fathers (biological, adoptive, or step-), and 2.6% other (e.g., grandmother, foster mother). Only 22.9% of the children lived with both parents; 63.2% lived with their mothers (35.3% mother alone, 15.9% mother and her spouse or partner, 11.5% mother and other relatives); 5.2% lived with their father (2.0% father alone, 2.6% father and his spouse or partner, 0.6% father and other relatives); and 8.6% lived in other situations (e.g. foster care, grandparents). Average annual family income was $17,647 ($SD$ = $14,523) with 3.48 ($SD$ = 1.39) dependents. Mean Hollingshead's (1975) index of socioeconomic status (SES) based on highest parent occupation was 4.4 (SD = 2.9; from a 10-point scale ranging from 0 [*lowest SES*] to 9 [*highest SES*]), corresponding to small business owners, skilled manual workers, receptionists, and retail/sales clerks.

Clinic Intake Procedures

At the time of first clinic contact, the parent or guardian provided contact information, along with the child's age, gender, and presenting concerns. As soon as a therapist became available, she or he contacted the family to determine whether they were still interested in services and, if so, to schedule an intake. During the intake, the therapist gathered information about developmental history, academic progress, and presenting concerns and their duration in order to complete clinic paperwork and assign therapy goals.

Therapists were 21% male and 79% female; 25.6% were at the doctoral level (PhD, PsyD, EdD, MD), 59.5% were at the master's level (MSW, MFCC, MA), and 14.9% were at the bachelor's level (BA, BS). Some 31.4% were licensed professionals, 20.7% were postdegree but

[2] The sample is part of a larger project examining youth community mental health care, the same project within which Yeh & Weisz (2001) examined parent–child agreement.

[3] Clinic staff indicated that over 80% of those asked agreed to participate in the project.

unlicensed, and 47.9% were trainees (e.g., clinical psychology interns). Professional disciplines included psychology (56.5%); social work (33.6%); education (3.3%); marriage, family and child counseling (MFCC; 3.3%); paraprofessional clinician assistants (2.5%); and psychiatry (0.8%).

Interview Procedures and Measures

As soon as they could be scheduled following the clinic intake, and before the start of therapy ($M = 22.3$ days after intake), the child and the parent or guardian who attended the clinic intake were each individually interviewed by graduate-level research assistants. Parents provided written consent, whereas children gave written assent for participation. Families were paid $50 for their time, and children were given a small age-appropriate prize (e.g., movie passes).

Brief Symptom Inventory (BSI). The caregiver completed the BSI (Derogatis & Melisaratos, 1983), a 53-item (each rated on a 5-point scale) self-report inventory with nine primary symptom dimensions (e.g., depression, anxiety), three global indices of distress, and a global severity index designed to reflect psychological symptom patterns in adults. The BSI has shown convergent validity with the Symptom Checklist-90–Revised and the Minnesota Multiphasic Personality Inventory, good internal consistency with scale alphas ranging from .71 to .85, and stability over time with an overall test–retest reliability of .90 (Boulet & Boss, 1991; Broday & Mason, 1991; Derogatis & Melisaratos, 1983; Morlin & Tan, 1998).

Target problems. The caregiver was asked to identify "the major problems for which you feel your child needs help." The child was asked separately to identify "the major problems for which you feel you need help." Therapist report of the problems initially targeted in treatment were obtained from clinic records.[4]

Coding Procedures and Reliability

Each child-, parent-, and therapist-identified target problem was coded according to the Child Behavior Checklist (119 items; CBCL; Achenbach, 1991; Achenbach & Edelbrock, 1983) item that it matched most closely (e.g., "crying all the time" was coded 14 to match CBCL Item 14 "cries a lot"). Additional codes were developed for responses not represented on the CBCL (e.g., "my brother hits me") by agreement between two coders (a postdoctoral fellow and an advanced clinical psychology graduate student). Four trained coders blind to study hypotheses independently coded all child, parent, and therapist responses; responses from each source were coded separately, so that coding of child-identified problems, for example, was done without knowledge of the parent- or therapist-identified problems. Percentage agreement was calculated on randomly selected samples of 20% of child, parent, and therapist responses to determine interrater reliability (because of the rarity of many items, it was not feasible to compute kappas at the item level). They demonstrated an average 79.6% (range: 73.7%–85.3%) agreement for child-reported target problems, 86.9% (range: 83.7%–90.7%) agreement for parent-reported target problems, and 79.8% (range: 72.5%–88.7%) agreement for therapist-reported target problems.

Once responses received item codes, most automatically fell into 1 of 10 narrow-band scale syndromes or problem types based on current versions of the CBCL.[5] Those items not falling into preexisting problem types were grouped by content to form two new problem type scales: Daily Living Skills (25 codes; e.g., cleanliness, bedwetting, thumb sucking) and Family/Life Stress (9 codes; e.g., divorce, loss, getting along with family members). Cohen's kappa coefficients were computed to determine problem type agreement among the coders. They demonstrated an average kappa coefficient of .85 (range: .75–.94) on child responses, .92 (range: .85–.95) on parent responses, and .84 (range: .73–.94) on therapist responses. These values reflect substantial to almost perfect agreement among the coders for the assignment of problem type codes (Landis & Koch, 1977). This system allowed us to examine agreement among children, parents, and therapists about the general type of problem, even when there was disagreement about the specific item (e.g., "Item 25. Doesn't get along with other kids," "Item 38. Gets teased a lot," and "Item 48. Not liked by other kids" all fall within the social problems syndrome).

Results

What Problems Are Most Often Targeted for Treatment?

We sought to identify the specific problems, and general problem domains, most often targeted for treatment. The target problems most commonly reported by therapists largely overlapped with those reported by children and parents. Disobedience,[6] temper tantrums, poor schoolwork, and getting along with other kids were among the top specific target problems reported by children, parents, and therapists (see Table 1). Aggressive behavior (e.g., temper, disobedience) was, by far, the most frequently reported type of target problem according to children (52.7%), parents (75.2%), and therapists (80.0%; see Table 2).

According to McNemar's tests of correlated proportions, children, $\chi^2(1, N = 315) = 67.08$, $p < .01$, parents, $\chi^2(1, N = 315) = 61.80$, $p < .01$, and therapists, $\chi^2(1, N = 315) = 75.21$, $p < .01$, were each significantly more likely to report externalizing (i.e., Aggressive, Delinquent) than internalizing (i.e., Withdrawn, Somatic, Anxious/Depressed) scale target problems. This finding is consistent with past research (e.g., Weisz & Weiss, 1991) indicating that externalizing problems are more often the impetus for clinic referral than internalizing problems.

Of note is that parents were more likely to endorse both externalizing (Aggressive, Delinquent) and internalizing (Anxious/Depressed, Withdrawn) scale types of child problems than were children, $\chi^2(1, N = 315) = 39.61$, $p < .01$, and $\chi^2(1, N = 315) = 45.74$, $p < .01$, respectively. On the other hand, children were more likely than parents to endorse family and environmental problems (i.e., Family/Life Stress problem type; $\chi^2[1, N = 315] = 30.53$, $p < .01$). Thus, parents appeared to focus primarily on problems the child needed to work on, whereas children were more concerned than their parents about problems involving parent behavior (e.g., divorce, abuse) and family relationships (e.g., getting along with family members). Interestingly, therapists were also more likely to endorse externalizing and internalizing types of child problems than were children, $\chi^2(1, N = 315) = 46.37$, $p < .01$, and $\chi^2(1, N = 315) = 61.04$, $p < .01$, respectively, and more

[4] At the project assessment, we obtained consent from the parent or guardian to gather therapist demographic data and initial therapy goals from the child's clinic records.

[5] To maximize credit for agreement among respondents, if an item fell into a problem type according to either CBCL or Youth Self-Report scoring, we placed it within that problem type (e.g., although "talks about killing self" falls within the anxious/depressed problem type for the YSR but not the CBCL; we placed it within the anxious/depressed problem type for each of child, parent, and therapist responses). In addition, some items fall within more than one problem type (e.g., Item 103: "unhappy, sad, or depressed" falls within both withdrawn and anxious/depressed problem types on the CBCL); we placed such items within each applicable problem type.

[6] Because of the difficulty differentiating between disobedience at home and disobedience at school in many of the responses, the two CBCL items were combined into a single disobedience item.

Table 1
Top Five Specific Problems Reported by Children, Parents, and Therapists

Target problems	*n*	%
Reported by children		
Poor schoolwork	107	34.0
Disobedient at home or school	73	23.2
Trouble getting along with family members	68	21.6
Doesn't get along with other kids	56	17.8
Temper tantrums or hot temper	39	12.4
Reported by parents		
Disobedient at home or school	135	42.9
Temper tantrums or hot temper	90	28.6
Poor schoolwork	72	22.9
Feels worthless or inferior	59	18.7
Doesn't get along with other kids	32	10.2
Reported by therapists		
Disobedient at home or school	167	53.0
Temper tantrums or hot temper	127	40.3
Poor schoolwork	107	34.0
Doesn't get along with other kids	96	30.5
Unhappy, sad, or depressed	78	24.8

likely to endorse Family/Life Stress problems than were parents, $\chi^2(1, N = 315) = 55.10$, $p < .01$; see Table 2.

How Well Do Children, Parents, and Therapists Agree About the Focus of Treatment?

We first examined the extent to which children, parents, and therapists agreed about the specific problems for which treatment was needed. We found that only 23.2% of child–parent–therapist triads agreed on any target problems (22.2% agreed on one, 1.0% agreed on two problems). In other words, when asked to report the main problems in need of treatment, 76.8% did not agree on a single target problem. We also examined agreement at the level of problem type, because it is possible for agreement to be relatively poor at the item level but still good at the category level (e.g., one reports hitting, one reports yelling, and one reports temper tantrums; all are consistent with aggressive behavior). Yet, even at this broad level, we found that nearly half (44.4%) of the sample failed to agree on even one general area in need of treatment. The remainder agreed on one (45.7%), two (9.2%), or three (0.6%) broad types of target problems.[7]

Was Agreement Better for Some Types of Problems Than for Others?

A test of correlated proportions showed that agreement about externalizing types of problems was significantly greater than agreement about internalizing types of problems, $\chi^2(1, N = 206) = 44.3$, $p < .01$, although it was still poor in an absolute sense. Only 15 (6.7%) of the 223 times that one of the three identified an internalizing problem did the other two agree, whereas 123 (41.3%) of the 298 times that one of them identified an externalizing problem the other two agreed. We also examined child–parent–therapist agreement for each narrow-band scale problem type (see findings in Table 3). Using a series of McNemar's tests and a Bonferroni adjusted $p < .05/12$ or .004 value, we found that agreement on aggressive behavior was significantly greater than agreement on all other problem types (chi-squares ranged from 16.69 to 53.78, all $p < .01$); no other differences were significant at the adjusted p value.

With Whom Do Therapists Agree More: Parents Versus Children?

As in Yeh and Weisz (2001), we found limited agreement between children and parents (38.1% agreed on one or more specific problems; 69.5% agreed on one or more problem types). To determine whether therapists facing such disparate parent and child views were more likely to respond by tilting toward problems identified by parents, children, or both to an equal extent, we examined pairwise parent–therapist and child–therapist agreement on target problems. We found that 76.2% of parent–therapist pairs agreed on at least one specific target problem (50.5% agreed on one, 21.3% agreed on two, and 4.4% agreed on three problems; see Figure 1). Therapists and children agreed somewhat less often; 52.7% agreed on at least one specific target problem (43.2% agreed on one, 7.9% agreed on two, and 1.6% agreed on three problems; see Figure 1). At the level of problem type, we found 94.3% of therapists and parents agreed on at least one type of problem (44.1% agreed on one, 35.2% agreed on two, 12.7% agreed on three, and 2.2% agreed on four problem types), and 77.8% of therapists and children agreed on at least one type (43.3% agreed on one, 28.7% agreed on two, and 5.7% agreed on three problems). Thus, most therapists appeared to incorporate at least some of what parents reported and some of what children reported into their treatment goals, but with more emphasis on what parents reported.

To assess the significance of this apparent tilt toward parent report, we first calculated the level of item agreement between parents and therapists and between children and therapists as the number of problems both reported divided by the number of problems either reported (e.g., if parent reported anger and disobedience and therapist reported anger, disobedience, and getting along with other kids, item level agreement was 2/3 or 0.67). We then compared parent–therapist with child–therapist item-level agreement using a paired observations t test and found parent–therapist agreement greater than child–therapist agreement, $t(314) = 6.62$, $p < .01$. We also calculated level of problem type agreement between parents and therapists, and between children and therapists, in an analogous manner. At the problem type level as well, we found parent–therapist agreement greater than child–therapist agreement, $t(313) = 6.13$, $p < .01$.

Parents versus children: The influence of problem type. Although therapists aligned more with parent view than child view overall, we wondered whether the pattern might be different for certain types of problems. For example, children might be seen as important informants regarding their own internal states (e.g., Anxious/Depressed), delinquent acts that can be concealed from parents (e.g., Delinquent Behavior), or family problems that might

[7] Did agreement decrease the more time had passed between the clinic intake and our interview? To find out, we computed correlations between the number of days from clinic intake to our interview and both item and problem type agreement. We found no relationship ($r = .03$, $p = .59$ for item agreement; $r = .003$, $p = .96$ for problem type agreement).

Table 2
Target Problem Domains Reported by Children, Parents, and Therapists

	Parent report		Child report		Therapist report		
Target problem	*n*	%	*n*	%	*n*	%	Comparison[a]
Aggressive Behavior	237	75.2	166	52.7	252	80.0	t = p, t > c, p > c
Anxious/Depressed	110	34.9	51	16.2	131	41.6	t = p, t > c, p > c
Attention Problems	120	38.1	123	39.0	139	44.1	t = c = p
Daily Living Skills	27	8.6	36	11.4	28	8.9	c = t = p
Delinquent Behavior	70	22.2	33	10.5	69	21.9	p = t, p > c, t > c
Family/Life Stress	59	18.7	123	39.0	150	47.6	t = c, t > p, c > p
Identity Problems	89	28.3	29	9.2	95	30.2	t = p, t > c, p > c
Sex Problems	2	0.6	3	1.0	0	0.0	c = p = t
Social Problems	53	16.8	73	23.2	108	34.3	t > c, t > p, c = p
Somatic Complaints	2	0.6	3	1.0	5	1.6	t = c = p
Thought Problems	6	1.9	6	1.9	5	1.6	p = c = t
Withdrawn	67	21.3	25	7.9	106	33.7	t > p, t > c, p > c

[a] Parent (p), child (c), and therapist (t), response rates for each scale problem type were compared using tests of correlated proportions. > means the difference was significant at the adjusted $p < .05/12$ or .004; = means the difference was not significant at the adjusted *p* value.

be less readily acknowledged by parents. For each type of problem, we sought to determine whether therapist report was associated with parent report, child report, both, or neither. Thus, our data consisted of one 3-dimensional contingency table for each type of problem (0 = did not endorse that type of target problem, 1 = did endorse that type of target problem), with parent report, child report, and therapist report. We analyzed each $2 \times 2 \times 2$ contingency table using hierarchical log-linear modeling procedures to arrive at the simplest model that adequately explained or predicted the number of cases in each cell. As recommended by Benedetti and Brown (1978) and Wickens (1989), we began with a completely saturated model for each target problem (i.e., one allowing associations between all three reporters). We then examined the change in the likelihood ratio chi-square as we removed parameters for relationships between parent and child, between parent and therapist, and between child and therapist reports (e.g., to test for an association between parent and therapist reports, we compared the fit of a model that asserted conditional independence of parent and therapist reports to the fit of a model that allowed an association between parent and therapist reports; a significant difference indicates that there is an association between parent and therapist reports).

Table 3
Agreement Among Children, Parents, and Therapists on 12 Problem Types

Type of problem	% [a]	All/any
Aggressive Behavior	39.8	117/294
Attention Problems	14.2	33/233
Anxious/Depressed	7.3	14/193
Delinquent Behavior	6.7	8/120
Social Problems	6.4	11/173
Family/Life Stress	6.0	13/218
Daily Living Skills	5.5	4/73
Withdrawn	2.7	4/150
Self-Destructive/Identity Problems	2.5	4/159
Thought Problems	0.0	0/16
Somatic Complaints	0.0	0/9
Sex Problems	0.0	0/5

[a] Number of cases for which child, parent, and therapist all endorsed the target problem divided by the number of cases for which any of parent, child, and/or therapist endorsed the target problem (hence, each target problem has its own baseline)

For none of the problem types were therapist responses independent of both parent and child responses, indicating that the problems therapists reported focusing on in treatment were indeed related to those parents and children reported. For most problem types (Anxious/Depressed, Attention, Social, Self-Destructive/Identity, and Withdrawn), therapist determination of treatment target was significantly related to parent report but not child report, implying that therapists were following the strategy of focusing on parent report (see Table 4). However, for Daily Living Skills and Family/Life Stress problems, therapist determination of treatment target was significantly related to child report but not parent report. For Aggressive and Delinquent Behavior problems, therapist determination of treatment target was significantly related to both parent and child reports (see Table 4). We did not examine relationships for sex, somatic, and thought problems because of their low base rates.

Parents versus children: The influence of child age. It seemed possible that therapists might attend more to children's views (or less to parent's views) if the children were older and thus presumably better able to evaluate their own behavior than younger children. Thus, we computed Pearson's correlations between child age and both child–therapist and parent–therapist problem type agreement. Child age did not correlate significantly with either child–therapist agreement ($r = .06$, $p = .29$) or parent–therapist agreement ($r = -.10$, $p = .09$). Thus, we found no evidence that child age significantly influenced child–therapist or parent–therapist agreement, at least when assessed across all problem types.

However, because we found different relationships between therapist responses and those of parents and children depending upon the type of problem, we also examined the influence of child age separately for each problem type. To determine whether child age hampered parent–therapist agreement or improved child–

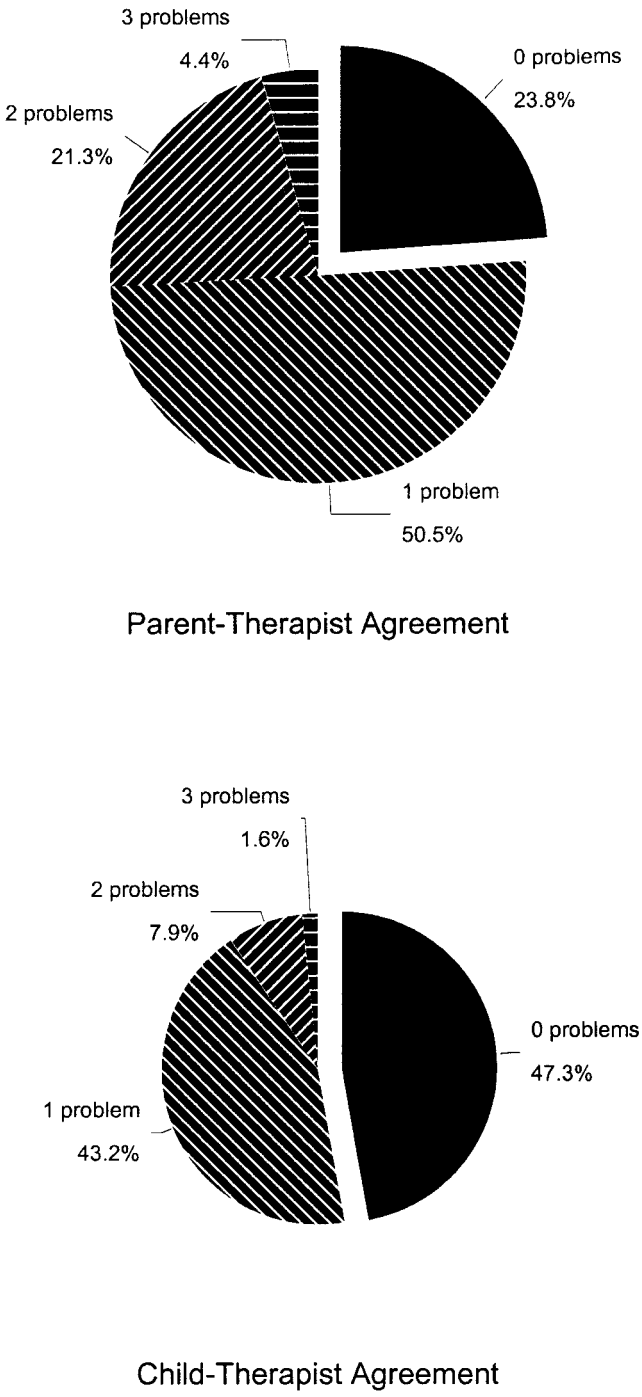

Figure 1. Number of target problems agreed on by parents and therapists (above) and children and therapists (below).

therapist agreement about any problem type, we examined the impact of child age (coded 0 for youths 12 years old and under, 1 for youths over 12 years old) in the log-linear models for each problem type described above. Specifically, we compared the fit of a model that allowed for all possible three-way associations among child age (A), child endorsement (C), parent endorsement (P), and therapist endorsement (T), with one that did not allow the [ACT] association (i.e., [CPT][ACP][ACT][APT] vs. [CPT][ACP][ACT]; and [CPT][ACP][ACT][APT] vs. [CPT][ACP][APT]) and with one that did not allow the [APT] association (i.e., [CPT][ACP][ACT][APT] vs. [CPT][ACP][ACT]). Child age did not influence the relation between therapist and parent or between therapist and child for Aggressive Behavior, Anxious/Depressed, Attention, Daily Living Skills, Family/Life Stress, Self-Destructive/Identity, Social or Withdrawn target problems (i.e., the associations shown in Table 4 held). Child age did influence the relation between therapist and parent endorsement of Delinquent Behavior, $\Delta\chi^2(1, N = 315) = 6.57$, $p < .05$; therapists were more likely to agree with parents of children than with parents of teens about delinquent behaviors; however, child age did not influence the relation between therapist and child endorsement of Delinquent Behavior.

Parents versus children: The influence of parental psychopathology. It seemed possible that therapists might give less credence to parents' views (or more credence to children's views) when the parent shows evidence of their own psychopathology. To determine, we computed Pearson's correlations between parents' Global Severity Index on the BSI, on the one hand, and child–therapist and parent–therapist problem type agreement, on the other hand. Parental psychopathology did not correlate significantly with either child–therapist ($r = .01$, $p = .87$) or parent–therapist ($r = -.06$, $p = .34$) agreement.

Again, because we found different relationships among therapist, parent, and child responses depending on the type of problem, we also tested for the influence of parental psychopathology separately for each problem type. To determine whether parental psychopathology decreased parent–therapist agreement or increased child–therapist agreement about any problem type, we examined the impact of parental psychopathology (0 for those below cutoff, 1 for those above cutoff) in the log-linear models for

Table 4
Therapist Strategy for Determining Target Problems on Clinic Entry

Therapist strategy	$\Delta\chi^2(1)$	$p <$
Align with parent		
Anxious/Depressed Problems	21.27	.01
Attention Problems[a]	9.29	.01
Self-Destructive/Identity Problems	7.43	.01
Social Problems	5.93	.05
Withdrawn Problems	10.70	.01
Align with child		
Family/Life Stress Problems	7.00	.01
Daily Living Skills Problems[b]	6.89	.01
Maximize agreement with both parent and child		
Aggressive Behavior Problems		
Therapist–parent	35.75	.01
Therapist–child	6.76	.01
Delinquent Behavior Problems		
Therapist–parent	36.81	.01
Therapist–child	5.83	.05

[a] Parent and child responses were also related in this model, $\Delta\chi^2(1, N = 315) = 5.79$, $p < .05$. [b] Parent and child responses were also related in this model, $\Delta\chi^2(1, N = 315) = 7.37$, $p < .01$.

each problem type described above. Specifically, we compared the fit of a model that allowed for three-way interactions between parental psychopathology (B), T, and either P or C with one that allowed for all possible three-way associations (i.e., [CPT][BCP][BCT] vs. [CPT][BCP][BPT][BCT]; and [CPT][BCP][BPT] vs. [CPT][BCP][BPT][BCT]). Parental psychopathology did not influence the relationship between therapist and parent or child reports for any problem types.

Parents versus children: The influence of therapist experience and training. We also wondered whether training or experience working with children and families might influence how therapists incorporate parent versus child views into the problems they target in treatment. We correlated years of postbaccalaureate training in child and family therapy with child–therapist and parent–therapist agreement but found no significant correlations ($r = .00$, $p = .96$, for child–therapist; $r = -.05$, $p = .51$ for parent–therapist). We also tested the influence of years of posttraining experience in child and family therapy but found no correlation with child–therapist ($r = .02$, $p = .76$) or parent–therapist ($r = .02$, $p = .81$) agreement.

We also tested for the influence of therapist training level separately for each problem type by examining the impact of training level (0 for unlicensed trainees, 1 for licensed staff member) in the log-linear models for each problem type described above. Specifically, we compared the fit of models that allowed for three-way associations between therapist training level (E), T, and either P or C with one that allowed for all possible three-way associations (i.e., [CPT][ECP][EPT] vs. [CPT][ECP][EPT][ECT]; and [CPT][ECP][ECT] vs. [CPT][ECP][EPT][ECT]). Therapist training did not influence the relationship between therapist report and parent or child reports for Aggressive Behavior, Anxious/Depressed, Attention, Daily Living Skills, Self-Destructive/Identity, Social, or Withdrawn target problems. Therapist training did influence the relationship between therapist and child endorsement of Delinquent Behavior, $\Delta\chi^2(1, N = 315) = 4.18$, $p < .05$, and Family/Life Stress, $\Delta\chi^2(1, N = 315) = 12.31$, $p < .01$; in both cases, unlicensed trainees were more likely to agree with children than were licensed staff members. Therapist training did not influence the relationship between therapist and parent endorsement of Delinquent Behavior or Family/Life Stress; therapists were still likely to agree with parents about Delinquent Behavior and unlikely to agree with parents about Family/Life Stress.

Discussion

The failure of parent and child to agree clearly presents the therapist with a dilemma. With parent and child views so different, few therapists would be able to achieve good agreement with both parent and child no matter how motivated they might be to do so (at least not without changing the parent's or the child's opinion). Indeed, we found strikingly low levels of child–parent–therapist agreement; more than three quarters began treatment without consensus on a single problem, and nearly half failed to agree about even the general area or broad problem domain on which treatment should focus.

Therapists did, however, show significantly greater agreement with parents than children on most target problems. There are numerous possible reasons for this tilt toward parents. Therapists may believe parents are more reliable reporters than children, may want to establish an immediate alliance with the parent to prevent drop out, or may unintentionally favor input from a fellow adult. Whatever the cause, our findings indicate that therapists may begin the treatment process more in tune with what parents want than what children want, raising the possibility that initial alliance may be stronger with the parent than the child. One notable exception to the tilt toward parents was evident for family and environmental problems, where therapists aligned more with child report than parent report. From the therapists' perspectives, children may have done a better job than their parents of accurately identifying family, systemic, and environmental problems needing attention, whereas parents may have been seen as more accurate in identifying the child problems needing therapeutic attention.

The overall pattern suggests that therapists were approaching the dilemma of parent–child disagreement in a mindful way, not simply accepting parent or child input. Over half of the therapists chose treatment goals that agreed with at least some of what the parent felt should be a focus of treatment and some of what the child felt should be a focus of treatment, and very few therapists (14.3% at the item level, 2.2% at the problem type level) disregarded every problem reported by parents and children. The fact, however, remains that many target problems endorsed by parents (63.0% at the item level, 39.5% at the problem type level) and by children (73.1% at the item level, 44.9% at the problem type level) were not identified as treatment targets by therapists. This brings us to the question of practical implications.

Such low agreement among the key therapy participants raises concern about whether there is sufficient concordance to foster optimum treatment planning and to maximize treatment benefit. After all, lack of agreement on target problems means lack of agreement on goals and desired outcomes. One wonders how therapy could be expected to go smoothly and lead to a positive outcome when children, parents, and therapists cannot agree on the problems they are trying to address or on the outcomes they are trying to produce. Many theorists and researchers have argued that obtaining agreement on therapy goals is a critical first step toward developing a working alliance, engaging the client in the treatment process, motivating the client for the sometimes difficult work of therapy, and, ultimately, reaching those therapy goals (Bordin, 1979; Haynes, 1993; Horvath & Luborsky, 1993; Karoly, 1993; Liddle, 1995; Nezu & Nezu, 1993). Lack of agreement may hamper essential rapport and working alliance, and clients who see their therapist as unwilling to collaborate on treatment goals may be unwilling to engage wholeheartedly in therapy (Horvath & Luborsky, 1993; Liddle, 1995). Certainly, from a consumer perspective, it could be argued that therapists have an obligation to treat the problems for which clients are seeking help and, where therapy participants have differing views, to work with them to reach consensus before beginning treatment.

Lack of consensus on target problems may well be one of the reasons why it has proven difficult to achieve beneficial effects in everyday clinical treatment (see Weisz, Donenberg, Han, & Weiss, 1995; Weisz, Weiss, & Donenberg, 1992). When therapy goals are inconsistent with the child's perceptions of the problems needing attention, the child's motivation for treatment may be undermined. Indeed, children can be difficult to engage in treatment as it is (Liddle, 1995; Sommers-Flanagan & Sommers-Flanagan, 1995), without adding the obstacle of therapy goals they have no desire to meet (Adelman et al., 1984; Shirk & Saiz, 1992). At least among

children treated for anxiety, Panichelli-Mindel, Flannery-Schroeder, Callahan, and Kendall (1995) have found evidence that children who disagree that they have an anxiety problem show significantly less improvement than those who agree. At the same time, if the therapist's treatment plan does not target those problems most concerning to the parent, parental motivation to participate in treatment, or even to have it continue, may be threatened. Garcia and Weisz (2002) found that nearly a third of parents whose children begin treatment in community mental health centers stop therapy in part because "the therapist talked about the wrong problems." The low levels of agreement we found seem to suggest a need for therapists to work harder to bring child, parent, and therapist goals into synchrony.

On the other hand, one could argue that the problems and goals identified by therapy clients are not always the most important foci for therapy, and therapists should do more than simply adopt the client's perspective. Perhaps what clients deserve, instead, is the therapist's best judgment about the critical issues in treatment. From this perspective, low levels of child–parent–therapist agreement may not be a problem. To some extent, the tension between these two positions represents an empirical question, and a very important one, that could be addressed in future research. Key to such research will be the question of whether low levels of agreement predict problems in alliance, engagement, and, ultimately, the outcomes experienced by children.

As outpatient care is one of the most common forms of child treatment, it seemed an appropriate starting point for research on child, parent, and therapist perspectives. However, levels of child–parent–therapist agreement may be rather different in other treatment settings, such as inpatient clinics, where opportunities to develop shared perspectives may be more ample. Future research should address agreement in other treatment contexts as well as the impact of agreement, or lack thereof, on the process and outcome of child treatment. If lack of agreement does undermine therapy process or outcome, it will be important to develop and test methods for improving agreement, or for conducting therapy in its absence.

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