

RESEARCH ARTICLE

# Contrasting the Treatment-Related Perceptions of Parents and Their Children: Using Data from Child and Adolescent Brief Mental Health Services Recipients in Canada

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## Introduction

When employing a medicalized model, the initial step in mental health therapy would be to complete a full assessment using standardized instruments to determine the presence or absence of clinical conditions. For Child and Adolescent Mental Health Services (CAMHS), researchers consider a combination of parent and child reports as best practice as it provides more complete assessments (De Los Reyes & Kazdin, 2005; Kuhn

**Introduction:** Discrepancies between parental and child perceptions of problems and their therapeutic expectations can negatively impact mental health treatment efficacy.

**Aims:** We sought to explore concordance and discrepancy in families receiving brief, client-centered, and strengths-based mental health services, specifically by contrasting parents' and children's perceptions of the child's presenting issues; treatment expectations; and levels of concern pre- and post-treatment. We also examined the psychometric properties of a therapeutic scaling question on the level of concern, by examining associations with scores from the Strengths and Difficulties Questionnaire.

**Methods:** Using a mixed-methods approach, we examined data from open- and closed-ended questions, some used as part of the treatment. This included brief descriptions of perceived presenting issues and treatment expectations, and levels of concern on a scale of 1 to 10.

**Results:** Parent and child descriptions of issues were judged generally congruent 66% of the time. Respectively, minor and major non-congruence was observed 25% and 9% of the time. In terms of treatment expectations, parents were more likely to express a desire to understand the issues and improve communication in the family. Children were more likely to express no expectancies or respond with simple statements (e.g., feel better). Parents initially rated their children's problems as more severe than did their children. We found that the scaling question demonstrated a modest association with the level of concern from the Strength and Difficulties Questionnaire (SDQ).

**Conclusions:** Even though most parents and their children broadly agree on presenting mental health issues for which they seek counseling, important differences manifest in how they perceive them and what they want accomplished during sessions. Practitioners need to consider, assess, and accommodate such discrepancies.

**Keywords:** child and adolescent mental health services, parent-child agreement, informant discrepancy, brief therapy, mixed methods

et al., 2017). However, a robust research base shows that children and parents often provide discrepant views related to the child's functioning (Bajeux et al., 2018; Edelbrock et al., 1986) and that child and parent ratings are often discrepant from clinicians' diagnoses (van der Meer et al., 1986). A low agreement exists on clinical diagnoses and desired treatment goals, and parents report greater severity of clinical issues (Achenbach et al., 1987; De Los Reyes et al., 2022; Goolsby et al., 2018; Yeh & Weisz, 2001). One can view this discrepancy as a complication that negatively impacts treatment. For instance, concordant dyads attend a higher number of appointments than non-concordant dyads (Williams et al., 2011), and parent-child discrepancy at the beginning of CAMHS is positively associated with a poorer treatment response (Goolsby et al., 2018). An initial treatment objective in CAMHS, therefore, should be the reduction of parent-child disagreement, when it exists. However, this could engender disagreement among family members and delays in dispensing therapy, thereby adding to the frustration of help-seekers and increasing the likelihood that they will discontinue treatment (Barrett et al., 2008).

Recently, scholars and clinicians have questioned whether informant discrepancy truly represents a treatment complication, arguing that different interpretations of the presenting problem often provide valuable assessment information, the investigation of which could allow for more nuanced and effective therapeutic strategies (De Los Reyes et al., 2011, 2022, 2023; Fitzpatrick et al., 2023). De Los Reyes and colleagues argue that some disagreements in perceptions of child functioning (e.g., whether a child is depressed, anxious, aggressive, etc.) are attributable to the observers' social locations, and thus provide insight into differences in adjustment at school, at home, and among peers. These insights can help determine the need for targeted or global treatment plans and even identify issues that are largely environmental rather than psychological. Some treatment models accommodate informant discrepancies. Shared Decision-Making, which seeks to foster understanding and collaboration between multiple stakeholders, is gaining currency in youth psychotherapy (Fitzpatrick et al., 2023; Langer & Jensen-Doss, 2018).

Based on research regarding parent and child expectations from participating in CAMHS, the areas of greatest agreement are in desiring to reduce emotional and behavioral problems, and accomplish school-related goals (Garland et al., 2004; Jacob et al., 2016; Krause et al., 2021; Ronzoni & Dogra, 2012). In terms of discrepancies, Garland and colleagues found that parents are more likely to desire that their children talk about their feelings, obey parents, and improve self-esteem. Children are more likely to desire improved concentration. Jacob and colleagues concluded that parent goals focus more on the management of child behaviors, and child goals relate more to internalizing/personal difficulties and coping with specific issues. Krause and colleagues studied depression therapy goals, finding that parents prioritized academic functioning, whereas children gave precedence to coping. Thus, one could speculate that parent goals focus more on child capacity for control and fitting in, whereas child goals seem to revolve more around coping and internal adjustment.

### Brief Client-Centered and Strengths-Based Therapy

Proponents of brief, client-centered and strengths-based (BCCSB) therapeutic models advocate for less medicalized CAMHS (Bannink, 2007; Lethem, 2002). Rather than employing standardized diagnostic instruments to guide interventions and monitor treatments, BCCSB therapists work with clients in a collaborative and co-constructive manner, guiding them in developing solutions to their problems and drawing upon inner resources, strengths, and resiliencies (Franklin, 2015; Kim, 2008; Perkins, 2006). To facilitate the process, uncomplicated questions are asked, like, "What do you want to talk about today? What concerns you the most?"; and client progress is monitored through scaling questions, such as, "On a ten-point scale, how close are you to achieving your goal? How much do these issues concern you today?"

There is growing evidence that BCCSB therapies can effectively treat an array of mental health problems, delivering services through flexible networks that adapt well to diversity and young people's needs (Barwick et al., 2013; Bond et al., 2013; Ellenbogen et al., 2019; Gingerich & Peterson, 2013; Kim & Franklin, 2009). BCCSB models are also suggested to be less stigmatizing. Because diagnoses are not a focus, service users do not feel labeled as mentally unfit. Likewise, parents are less liable to express culpability for contributing to their children's diagnosis, or as has been noted in prior research, blame both themselves and the child (Goldberg & Campbell, 1997; Lethem, 2002; Partridge et al., 1999; Wheeler, 2001). Through self-directed inquiries, BCCSB therapies help families seek understanding and devise treatment plans. These processes encourage families to believe that their problems are no different than anyone else's and that help-seeking is only required because on this occasion they face an overwhelming confluence of factors.

Service outlets offering BCCSB are an increasingly common feature in public CAMHS systems. Their brief nature ensures that help-seekers access services quickly, experience less psychic discomfort, and gain control of their situation in a timely manner (Hair et al., 2013; Kim, 2008; Miller & Slive, 2004; Stallard & Sayers, 1998). Although parent–child discrepancy might also impede BCCSB treatments, these models are theoretically suited to dealing with such issues because they focus on working toward a shared understanding of the children’s problems and co-constructing solutions.

### Change Clinic Counseling Service

In response to a need for innovation to reduce CAMHS waiting times and client attrition in the province of Newfoundland & Labrador Canada, a community-university participatory partnership was established in 2009 to develop a BCCSB mental health service for children, youth, and families (Government of Newfoundland & Labrador, 2005). Blending principles from solution-focused, narrative, single session and other approaches to counseling, the Change Clinic (CC) model presented a timely response. Using a collaborative process, the treatment is organized with a mindset of addressing the whole of families’ current needs in one session. Clients can choose to extend the treatment for one or two additional sessions (Ellenbogen et al., 2019; Hair et al., 2013); however, in a few cases, the clinician agreed to fourth and fifth sessions.

The first clinic in Newfoundland & Labrador to offer BCCSB therapy to families seeking mental health services, CC operated out of the Janeway Family Centre. The Janeway receives approximately 850 referrals each year for children and adolescents dealing with emotional, social, behavioral, and psychiatric problems. Licensed social workers and psychologists offer a variety of services, including traditional individual and family counseling, and psycho-educational group therapies. The service came about through consultations between the faculty in the School of Social Work at Memorial University and the Janeway program. It should be noted that since the time of data collection, CC services have been transitioned into a walk-in service called Doorways and are offered province-wide.

### Study Aims and Research Questions

Our current study represents an exploration of concordance and discrepancy between perspectives of parent and child clients of a BCCSB service called CC. Specifically, we conducted a concurrent mixed methods study (Creswell & Plano Clark, 2011) of client reports, contrasting children’s and parents’ descriptions of presenting issues, treatment expectations, and pre- and post-treatment levels of concern. We also tested the validity of a single-item scaling question on the level of concern with child issues, by examining correlations with items from a standardized mental health questionnaire. To our knowledge, no one has examined discrepancies in families availing of BCCSB services; extant research has focused on associations between diagnostic scores of different raters in the context of traditional therapies. Additionally, this research adds to the limited qualitative research base on discrepancy. The research questions were:

1. How do parents and their children describe the issues for which they are attending CC, and is there congruence and discrepancy between their descriptions?
2. What do parents and their children expect from CC, and is there congruence and discrepancy between their descriptions?
3. Are there parent-child and pre-post treatment differences in scores from a single item rating regarding the level of concern with child presenting issues?
4. How do single-item ratings correlate with scores from clinical diagnostic tests?

## Methods

### Participants and Procedure

The Interdisciplinary Committee on Ethics in Human Research approved the research (Ref. No. 20130817-SW). The data was gathered from a convenience sample of families who sought CAMHS from CC between June 2013 and April 2014. The clinic had been operating one day per week for three years prior to the start of data collection. Upon their first arrival to the clinic, a male graduate student acting as research assistant approached all families and read a script inviting them to participate in the study, explaining that their participation is voluntary

and confidential, and that refusal will not affect the quality of services received. Service users over 16 who agreed to participate completed an informed consent form. Parental consent was obtained for children under 16 who agreed to participate.

Of 68 families that were approached to participate, 55 agreed. However, attrition was high for follow-up data and children were not involved in some data collection. This affected the feasibility of some quantitative analyses. Twenty-five child/adolescent participants identified as male and thirty as female. Eighteen were adolescents (12–17 years) and thirty-seven were children (4–11 years). Forty-five parent participants identified as the child's mother and ten as the father. Participants reported they were attending CC services for a range of internalizing behaviors (e.g., anxiety, sadness), externalizing behaviors (e.g., acting aggressively towards others, self-harming), and other psychological issues (e.g., obsessive-compulsive behaviors, eating-related issues).

## Data Collection

Prior to receiving services, participants completed the Pre-Interview Questionnaire (PIQ) and Strength and Difficulties Questionnaire (SDQ) in an empty room before their first CC session. If children drew pictures reacting to the PIQ questions, a research assistant asked the child to describe the pictures and took note of their responses. After each session, the participants answered a questionnaire containing the scaling questions. If completed, service providers viewed and discussed the completed PIQ forms as part of the therapeutic sessions, but they did not see the post-treatment responses.

## Measurements

### *Pre- and Post-Treatment Concerns and Expectations of Change Clinic*

The self-report PIQ is a clinical form that clinicians designed to help service users choose a priority concern and identify their expectations for the first meeting with their service provider. Clinicians across various mental health service agencies in Canada developed it to gather information that is therapeutically congruent with brief therapy. The PIQ contains non-intrusive, present-focused, and future-oriented questions that allow the clinician to guide the therapeutic conversation toward an outcome that is manageable in a single session (Miller & Slive, 2004). This instrument proved useful to our study objectives because it gathers clinical information that is specifically relevant to BCCSB treatment and thus helps assess the degree to agreement between family members as to what should be the focus of the session. To our knowledge, no one has ever tested the psychometric properties of the PIQ.

The questionnaire consists of seven items. Six are open-ended questions, three of which were employed to gather background information about the service users' mental health concerns (e.g., "What concern do you want to talk about today?", "How does it affect you and other people in your family?", "What do you need us to know today about the concern?"); two of which concerned their expectations from CC (e.g., "What would be the best thing that could happen in our meeting today?"); and one question asked "What have you tried to do to help with the problem and what has worked?" The seventh item is a scaling question; it asks participants to rank their level of concern regarding the problem on a scale of 0–10 (*not at all to a lot*). Adults and adolescents completed the full version. Children at 6–11 years of age completed an adapted and abridged version. Forty-three parents (36 mothers; 7 fathers), 27 children (10 females; 17 males), and 12 adolescents (11 females; 1 male) completed the pre-treatment questions. The scaling question was asked again at the end of the first session and following subsequent sessions. The scores from the final meeting were selected as post-treatment ratings, which were completed by 28 parents (25 mothers; 3 fathers), 13 children (7 females; 6 males), and 8 adolescents (6 females; 2 males).

Introduced by de Shazer and colleagues (1986), the scaling question represents an important facet of Solution-Focused Therapy, among other brief therapeutic models. Although the validity and reliability of single items cannot be fully assessed and they fail to capture the dimensionality of constructs, they remain appropriate in therapy. Some have argued that scaling questions provide accurate and stable measurements of overall wellness (e.g., Abdel-Khalek, 2006; Fischer, 2004; West et al., 2009; Willits et al., 2016).

### *Strengths and Difficulties Questionnaire*

Developed by Goodman and colleagues (1998), this widely used child and adolescent mental health diagnostic tool contains four subscales: emotional difficulties, conduct problems, hyperactivity/inattention, peer relationship problems (parental perceptions: Cronbach's  $\alpha = .79, .65, .75, .61$ , respectively). The 34-item measure is normed

and possesses satisfactory validity and reliability (Goodman, 2001). We examined associations with two parent- and child-rated global assessments: total score of the four mental health dimensions (Range 0–40) and Question 26, “Overall, do you think your child has [you have] difficulties in one or more of the following areas: emotions, concentration, behavior, or being able to get on with other people?” (answered on a four-point scale: *no, yes minor difficulties, yes definite difficulties, and yes severe difficulties*). Analyses of changes in mental health prior to and after CC, using this questionnaire, are reported elsewhere (Ellenbogen et al., 2019).

## Data Analysis

Thematic analysis was used on qualitative data, drawing from Braun and Clark’s (2006) six-step framework. First, Ellenbogen and Power familiarized themselves with the data through repeated contrasting of parent and child reports while searching for examples of congruence, non-congruence, and therapeutic expectations. Second, initial codes were generated based on semantic and latent meanings and then grouped into meaningful units. Third, the codes were used to generate broad categories of: (1) congruence and non-congruence in family members’ understanding of the issues for which they are seeking CAMHS and (2) what they expect from treatment. Fourth, the themes were reviewed to ensure coherent patterns existed and that the themes accurately reflected the meanings evident in the dataset as a whole. At this stage, Ellenbogen and Hynes Brothers separately coded the responses of nine dyads and met to compare results and make refinements to the themes and coding process. The process was repeated using the responses of another nine dyads, and then the remaining data was coded. Fifth, the themes were named and defined to reflect the essence of the theme. Sixth, Ellenbogen and Hynes Brothers searched the qualitative data for exemplary quotes, and deepened the descriptions of themes. MAXQDA software was used to code and organize the data.

Due to small sample sizes, we did not attempt advanced statistics. The main comparisons were examined through paired t-tests as these are found to be robust and produce acceptable analyses of data with minor non-normality (Boneau, 1960; Snijders, 2011). Normality was assessed using Shapiro-Wilk’s tests. To examine the psychometric properties of the scaling question, Pearson’s  $r$  was used. We examined inter-rater agreement by using weighted Kappa.

## Results

Almost half (49.1%;  $n = 27$ ) of the 55 families who participated attended only one session; 23.6% ( $n = 13$ ); 16.4% ( $n = 9$ ), 9.1% ( $n = 5$ ), and 1.8% ( $n = 1$ ) of the families attended two to five sessions, respectively. Of the 21 parents who completed both the pre- and post-measures, 47.6% ( $n = 10$ ), 33.3% ( $n = 7$ ), 9.5% ( $n = 2$ ), 4.7% ( $n = 1$ ), and 4.7% ( $n = 1$ ) attended one to five sessions, respectively. Of the 16 children and adolescents who completed both pre- and post-measures, six (37.5%) attended one session. 37.5% ( $n = 6$ ), 18.7% ( $n = 3$ ), and 6.3% ( $n = 1$ ) attended two, three, and four sessions, respectively.

## Qualitative Analysis

A total of 44 families entered qualitative information on the PIQ. However, only one family member completed some of the questionnaires; other surveys were only partially completed. Details on attrition were provided for each analysis. It should be noted that adolescents’ descriptions exhibited greater depth as compared to those of children. Also, the analysis of all the answers on the PIQ revealed that families present a broad range of presenting issues, often describing complex challenges and extenuating circumstances. To ensure coding is informed by these nuances, we considered the entirety of responses in rating the level of concordance between parent and child responses, and treatment expectations. Finally, initial examination of the data revealed that insufficient information, in terms of quantity and depth of child responses, existed to permit contrasts between parents’ and children’s expected outcome from CC. Therefore, we analyzed and categorized their responses separately.

## Parent and Child Perceptions of Presenting Issues

It was impossible to compare the perceptions of 12 parent/child dyads due to missing child forms (6), missing parent form (1), and missing/uncodable child responses to questions on the presenting problems (5). Thus, a

comparison of the data of 32 dyads was undertaken. The analysis of parent and child perceptions regarding the presenting problem resulted in four categories (see Table 1). The efforts of two coders to categorize the data according to this schema produced a moderate level of interrater reliability ( $\kappa = .71$ ), see McHugh (2012).

#### *Generally Congruent Perceptions of Presenting Issues*

In 21 (65.6%) dyads, parent and child descriptions of the presenting problems at pretreatment were considered to be generally congruent, despite minor differences in how parents and children described the issues. For example, one parent reported, “[child] anxiety, fears e.g., elevators. Currently doesn’t want to leave me, panic attacks, won’t leave house... .” In contrast the child wrote, “I’m afraid that my mom won’t be there for me ‘cause she’s been there so much even though she always is... I can’t live my life without my mom. I don’t wanna go to my friends’ houses.” Other congruent responses pertained to: not sleeping in one’s own bed, cutting/self-harming, dealing with abuse, dealing with parental break-ups, eating problems, aggression, and disliking school.

#### *Similar Presenting Issues – Differences in Severity*

In two cases (6% of dyads), we judged that the topics of the presenting issues were generally congruent; however, we considered the parents’ and their children’ descriptions to be different with respect to the seriousness of the issues. In one case, the adolescent wrote, “I want to talk about how I get frustrated and feel bad when I don’t have to” and “because there are only a few things that frustrate me...it’s not like 10 things.” In contrast, the parents wrote, “[child] becoming over-anxious with various daily issues and simple tasks” and “how [child] is going to ‘react’ is always a concern.” The contrasting descriptions could reflect exaggeration on the part of the parent or the child underappreciating the severity of the issues.

#### *Minor Differences in Descriptions of Presenting Issues*

In six dyads (18.8%), we noted minor but clinically relevant differences in descriptions of the presenting issue. In one example, a mother-daughter conflict was identified by both respondents as a key issue; however, the adolescent also noted having anger issues that “affects my day, sometimes schoolwork, sometimes my social skills, and often my sleep.” She added, “I don’t think [my family notices], I’m good at hiding my feelings.” In contrast, the father commented, “Perhaps it’s deeper than that, but I think that is the biggest thing”, adding, “it doesn’t affect [the family] and she is generally a happy child.” In another example, both respondents specifically mentioned the child’s anxiety and frustration as the central issue, but expressed markedly different interpretations of how family dynamics are impacting this issue. The mother wrote, “very open conversations, stressing [she can] talk to me about anything”, in response to a question on what was done to help with the problem. In contrast, the adolescent child wrote, “My mom doesn’t understand how she makes me feel and often gets angry if I tell her I am feeling angry because of her ... I tried talking to her, didn’t work.” Thus, the parent thought that she and her daughter had good lines of communication; however, the daughter felt communication constituted a key issue.

**Table 1.** Distribution Across Categories of Congruence Between Parent and Child Perceptions of the Issues and Therapeutic Expectation

Coding Categories	<i>n</i>	%
Congruence in Presenting Issues ( <i>N</i> = 32)		
Generally congruent	21	65.6
Similar issue-difference in severity	2	6.3
Minor difference in presenting issue	6	18.8
Substantial disparity	3	9.4
Parent Expected Outcomes of Therapy* ( <i>N</i> = 41)		
Help for the child	27	65.9
Improved communication	10	22.4
Parent can better understand and help child	20	48.8
Self-help for parent	4	9.8
Child Expected Outcomes of Therapy* ( <i>N</i> = 24)		
Resolve the issue and feel better	19	79.2
Learning what do to improve things	15	62.5
Facilitate communication	3	12.5

*Note.* \* Percentage does not total 100 because respondents can express multiple categories of expectations.

### *Substantial Disparity in Descriptions of Presenting Issues*

In three dyads (9.4%), substantial disparities were identified. Even if some overlap in parents' and children's description was noted, cases were coded as disparate when parents and children focused on largely distinct issues. For example, a child wrote, "Life, I just don't understand a lot of things and why people do certain things and act a certain way." In answer to a question on how it was affecting self and family, they wrote, "not handling things well; have changed a lot; family members dislike it. Mostly mom." In comparison, the parent wrote, "[child] seems sad, confused-anxiety-depressed? Really want to see what I can do to help improve emotional health and stability... Unhealthy friend group/risky behaviors (drinking)/problems at school... [child]'s self-confidence is low." In answer to a question on how it was affecting self and family, they wrote, "I probably am not dealing with it as well as I should be; very hard to see her so confused and upset ... Increased conflict in the household." In this case, there may be elements of congruence between family members' descriptions of presenting issues (e.g., a stressful child crisis, characterized by confusion and anxiety, and family conflict). However, coders agreed that there was substantial disparity in their descriptions because the child's central concern pertains to confusion over changes she is experiencing, whereas the parent alludes to extrinsic (problematic friendships, substance use) and self-confidence issues.

In another example, a child expressed a need to talk about her nerves, panicking in elevators, and dad who is "sometime ... mean to me." According to the parent, the key issue is that the child is anxious and having difficulty dealing with the parents' separation. In this case, the child does not mention the parents' separation and the parent does not mention the child's panic attacks, both relevant topics for counseling.

### Expected Outcomes from CC for Parents

Questions from the PIQ were used to determine expectations; these are described in the subsection entitled Pre- and Post- Treatment Concerns and Expectations of CC. The 41 parents who provided responses to questions about expected outcomes reflected four categories of expectations (see Table 1). A comparison of the two coder's response categorizations yielded a moderate interrater reliability score ( $\kappa = .71$ ). The four main categories were:

(1) *Help for the child in dealing with their issues.* Twenty-one parent responses indicated a desire to gain access to guidance and coping strategies that could help their children. One parent wrote, "Just giving us some steps to proceed with will help me." Others wanted, "info and suggestions to help [her daughter] fight the thoughts and behaviors" and for their child to "find a way to deal with their anger."

(2) *Improved communication.* The answers of ten parents pertained to improving communication with their children and having their children speak more openly about their problems. In response to the question on how they will know the meeting was helpful, one parent wrote his daughter, "opens up and articulates her real frustrations." Other responses include, "if the child talks about what is bothering her" and, "to get him to open up and start talking."

(3) *Parent can better understand and help child.* Twenty parent answers indicated a desire to better understand their child's struggles and be part of a process that improves the situation. For example, one wanted help "to better understand his issues" and "find the issue causing the problem." Another parent explained, "[We] cannot help her to deal with what is bothering her as we are unable to find the root of the issue." Finally, one parent stated the best thing that could happen out of today's session would be if they "had a better understanding of how [child] feels."

(4) *Seeking guidance, reassurance, and coping strategies for their own issues and general wellness.* Four parents indicated that they were having a difficult time coping and wanted help for themselves. Two parents in this category recently separated from their partners and were seeking reassurance. One parent indicated she "can't sleep, no appetite", and in answer to the question on how they know the meeting was helpful, wrote, "hopefully I will feel a little more relieved that I made a good decision in leaving and also bring [child] to a new community." One parent, who was struggling with their child's behavior, admitted needing help in dealing with their own anger and sought "coping strategies for us", adding that the meeting would be helpful "If I can keep a cool head while he has his tantrums and not want to pull my hair out and cry."

### Expected Outcomes from CC for Children

Child responses aligned with three categories of expectations (see Table 1). We noted that children were less able to express expected outcomes. Of the 38 children who were administered the PIQ, 12 did not answer questions related to their expectations, two provided uncodable answers, and one stated that they did not know, leaving 23 codable responses. A comparison of the two coder's response categorizations yielded a moderate level of interrater reliability ( $\kappa = .62$ ). The three categories of expectations were:

(1) *Resolving issues and feeling better.* This was the most common expectation, aligning with 19 respondents (82.6%). Children often expressed this expectation through brief statements like, “make me feel better” and “get it to stop.” Other respondents expressed expectations that were specific to their concerns. For example, one child hoped to stop fighting with their sibling. In answer to the question about the best thing that could happen today, one adolescent wrote “bullying and rumors would stop”, and in answer to how they will know that CC is helpful “I would know how to handle the bullying.”

(2) *Learning what I can do to improve things.* Fourteen children wanted advice and strategies to help them deal with their issues. For example, one child wanted the therapist to “teach me to sleep alone.” An adolescent wanted to learn “how to control my anger and stuff to help depression.” Another adolescent wanted the therapist to “help me understand why I’m doing this [behavior]” and one other wanted to ask the therapist “a few questions and figure things out.”

(3) *Facilitating communication.* Three children expressed a desire to address the issues through communication. This was expected to take place during the session. An eight-year-old expressed concern with “how my dad treats me and how my mom treats me” and started crying; when asked to explain what was the best thing that could happen today, the child indicated “that we would talk about it.” Another wrote, “For me to ask a few questions and try to figure stuff out.” It should be noted that ten children mentioned having already tried talking to their parents or a health professional in answer to a question about what they have done to deal with the problem, two adding that it did not help.

## Quantitative Analysis

Normality analyses using boxplots and Shapiro-Wilk’s test revealed univariate normality in all analyses, and multivariate nonnormality in one analysis, namely a pre-treatment comparison of parent and child/adolescent levels of concern ( $W = 0.93$ ;  $p = .037$ ). Inspection of a box plot of difference scores (child-parent) revealed a single outlier (i.e., more than three box-lengths above the edge of the box). The analysis with the outlier excluded did not change the results. The outlier is included in the t-tests presented.

### *Changes in Level of Concern*

Analyses of paired t-tests revealed significant improvements in the level of concern (described in Pre- and Post-Treatment Concerns and Expectations section). Mean levels of parent concern pre-CC ( $M = 8.14$ ,  $SD = 1.86$ ) were significantly higher than post-treatment levels ( $M = 4.71$ ,  $SD = 2.87$ ;  $t(20) = 5.30$ ,  $p < .001$  [2.02, 4.78],  $d = 1.41$ ). A similar effect was found for child/adolescent reports (pre  $M = 6.53$ ,  $SD = 3.17$ ; post  $M = 2.94$ ,  $SD = 2.57$ ;  $t(15) = 4.51$ ,  $p < .001$  [.89, 5.29],  $d = 1.24$ ). We examined whether families who attended only one session reported less change than those attending multiple sessions, as dosage is a plausible moderating factor. We saw no evidence of this in parent reports. The mean change from pre- to post-CC was 3.6 and 3.2 for single- and multiple-session clients, respectively. The mean changes were greater for children receiving higher dosage; the change was 2.2 and 4.4 for single- and multiple-session clients, respectively. However, the sample size is too small to permit statistical testing.

### *Validity of Single-Item Measure of the Level of Concern*

We conducted analyses to better understand this scaling question as a construct. An association was found between the child and parent level of concerns pre-CC,  $r(36) = .42$ ,  $p = .014$ . The level of agreement between child and parent is somewhat stronger for SDQ Total Score,  $r(16) = .59$ ,  $p = .016$ . Sample sizes were sufficient to contrast the different parent report measures at pre-treatment. Interestingly, the single item level of concern was not associated with SDQ Total Score,  $r(43) = .24$ , ns. However, it was associated with item 26 of the SDQ, “overall, I think [child] has difficulties in investigated areas,”  $r(43) = .46$ ,  $p = .002$ .

### *Comparison of Parent and Child Levels of Concern*

Pre-treatment, parents reported significantly higher levels of concern ( $M = 8.23$ ,  $SD = 1.74$ ) than did their children ( $M = 7.13$ ,  $SD = 2.83$ ;  $t(34) = -2.47$ ,  $p = .019$  [-2.01, -0.19],  $d = 0.47$ ; the measure is described in the Pre- and Post-Treatment Concerns and Expectations section). No post-treatment differences were found, (parent  $M = 4.24$ ,  $SD = 2.66$ ; child  $M = 3.24$ ,  $SD = 2.49$ ;  $t(16) = -1.18$ ,  $p = .254$  [-2.79, 0.79]). Given concerns with the



heterogeneity of variance for this analysis, a Wilcoxon signed-rank test was also used to examine differences. The same results were found using the nonparametric test: prior to treatment ( $z = 2.14, p = .032$ ); and after treatment ( $z = -1.37, p = .170$ ). Given that the mean difference between parent and child ratings remained roughly the same pre- and post-treatment, about one point, and the sample size was small, we determined that the results are inconclusive with regard to comparing changes in parent and child ratings.

## Discussion

This study adds to the considerable literature on informant discrepancy in CAMHS, by using mixed methods to examine reports from parent and child recipients of BCCSB treatment. Examining qualitative data, we found moderate congruence between parents and children in their perspectives on what were the presenting issues; how these issues were impacting respondents and their families; the importance of finding solutions to these issues; and the need to gain coping strategies. According to our analyses, only 9.4% of dyads reported substantively different versions of the presenting problems. However, we regularly noticed minor discrepancies, suggesting divergent interpretations of the presenting problems (e.g., how it came about, the severity of the child's issues) and treatment expectations. Similar to prior discrepancy research, these differences reflected their social locations (De Los Reyes et al., 2022, 2023; Fitzpatrick et al., 2023). Parents tended to focus on external influences on the child's presenting issue, and expectations included wanting to improve parenting capacity and other references to caregiving. Children tended to focus on internal struggles and sometimes qualified family dynamics differently than parents (e.g., greater conflicts). Their expectations centered on feeling better and having their concerns subside; many reported having no expectations.

A minority of parents (22.4%) and children (12.5%) indicated communication as treatment expectations; however, these were expressed differently. Parents wanted their children to "open up more", whereas children indicated a desire to have others contribute to the conversation. Given that 34.4% of dyads express some level of non-concordance in their perceptions concerning the presenting issues, and that minor differences were noted in all dyads, using treatment time to explore and reconcile family members' perspectives on presenting issues and treatment expectations could be beneficial. As noted, treatment success was positively associated with concordant perceptions between family members (Goolsby et al., 2018). Moreover, having family members come to an agreement could help build trust, encouraging a shared belief that they can work through future differences.

In prior research, family members opined that participation in CC inspired hope for change and facilitated communication between parents and children, leading to greater understanding between them (Hair et al., 2013). As such, the perceptions of participating families appear to support an assertion that the treatment reduces informant discrepancy, thereby contributing to increased motivation. However, it should be noted that the treatment model is not focused on getting family members to agree on the presenting problem. Designed from a social constructivist perspective, it allows for multiple interpretations of the presenting problem, without one necessarily being more correct than another. Thus, when working with clients who seek to better understand things, Hair and colleagues (2013) suggest "that practitioners first explore any expected outcomes ... further questions about the problem need to be avoided until all participants agree to the focus of the meeting." (p. 22)

It is notable that many parents experienced difficulties in dealing with their children's problems and with parenting in general. Even though the intent is to seek treatment for the child, parents also want guidance and strategies to help them cope with their own situation. Parents of children with mental health problems are known to experience high levels of distress; report being depressed, worried, and tired; doubt their parenting competence; and view their children's problems as causing difficulties in their spousal and family relationships (Angold et al., 1998; Azzi-Lessing, 2013; Farmer et al., 1997; Friesen & Huff, 1996). As Leon (2014) points out, service providers need to look beyond the child's individual mental health challenges and remember that "children do not live in a vacuum." (p. 587) De Los Reyes and Kazdin (2006) found that mother-child discrepancies in perceived child behavior problems were associated with mother-child conflict and that maternal stress mediated this relationship. Thus, discrepancies between child and parent reports might be a sign that there is more to attend to than just the child's wellbeing. Some family situations might require that clinicians work directly with parents or refer them to appropriate resources for adults.

Quantitatively, parent ratings of their children's foremost issue were significantly higher than those of their children; this result is consistent with prior research (Achenbach et al., 1987; Goolsby et al., 2018). Multiple explanations for this difference can exist. Parents might be predisposed to have greater concern (e.g., because they feel they are failing as parents). Children might lack the maturity to accurately assess their problems or underestimate them due to a self-preservation bias (Janoff-Bulman, 1989). Alternatively, the differences in the level of concern might be a consequence of perceiving different presenting problems, with parents tending to report issues of greater severity.

The validation tests revealed that one-item scaling questions used to assess the level of concern have some validity. The scores on the scaling question were correlated with the SDQ question regarding the level of concern, and parent and child reports were also correlated. The low to moderate effect sizes for these correlations are notable, highlighting considerable non-concordance between child and parent reports. Also of note, no association was found between the scaling question and the SDQ total score at pretest, demonstrating that the concerns assessed through this scaling question are not analogous to the gravity of clinical problems.

Used in solution-focused and other therapies, clinicians administer scaling questions to help clients acquire awareness of personal gains. They provide a broad assessment of how far clients feel they have progressed in their efforts to drive change. For example, a reduced level of concern might indicate a successful effort to negotiate periods of instability and crisis, stem negative thoughts and emotions, and re-establish family and individual functioning. The intention of brief therapies, such as CC, is not to diagnose and treat clinical problems. Therefore, the lack of association between the scaling question and the SDQ total score should not be viewed as a validity issue. Also, improvements in wellness might be a precursor to clinical improvements. In earlier research, we found that CC was associated with reductions in clinical mental health issues (Ellenbogen et al., 2019). Nevertheless, all clinicians who employ this scaling question should be mindful that it measures wellness, which is associated with but conceptually distinct from the absence of clinical issues; they also need to ensure that clients understand this distinction.

## Strengths and Limitations

Most research on informant discrepancy involves quantitative comparisons of parent- and child-reported scores on standardized mental health instruments. A strength of this study lies in its representing an initial attempt to employ qualitative techniques to develop a schema for researching the perceptions of BCCSB service users in regard to what they think are the presenting issues and what outcomes they expect from treatment. The results of this study can serve to refine clinical and research tools, thereby improving these services' effectiveness.

As is common in community-engaged research, data collection was negatively affected by a lack of on-site data collection experience, scheduling challenges, infrastructure limitations and client challenges (e.g., lack of time, in crisis). Also, our region's ethics protocols require data collection to take place in a different location than the therapy room. In combination, these challenges resulted in a small sample size and high attrition, particularly at post-test. This is a problem in two ways: it reduces statistical power and might have inflated the effect size for post analyses; i.e., study participants might be less inclined to take the time to complete the questionnaire if they do not feel the treatment is helping. The quantitative analyses were also limited by the fact that each participant was instructed to identify the presenting problem and rate how much this problem concerns them. This constitutes a methodological limitation because it cannot be determined whether parents and children were rating the same issue. Another limitation of the study is that it did not collect post-treatment qualitative data or include a comparison group. This would have enabled an examination of whether CC encourages convergence between family members on perceptions of presenting problems and treatment expectations. Finally, we emphasize that this remains a preliminary attempt to gather and analyze BCCSB service user perceptions. Further research is needed to assess the usefulness of the coding schema and the consistency of the results.

## Conclusion, Implications, and Future Directions

Using mixed methods to understand and evaluate informant discrepancies, our study found that parents and their children tended to have moderately similar views when asked to describe presenting issues. Parents rated issues as more severe. As in prior research, we found therapeutically relevant discrepancies in a minority of cases, highlighting the value of relying on multiple informants to assess child and adolescent mental health. Treatment expectations were also revealing, with parents seeking ways to be better parents and the children most often wanting to feel better or reporting no expectations.

The findings reinforce the need for CAMHS to provide opportunities for children and parents to express their views of the presenting issues and their therapeutic expectations, and for clinicians to help families work through discrepant perceptions and investigate parent needs for mental health and other help. Even when parents and children express generally concordant perceptions, we noted subtle differences of opinion. The initial success in resolving discrepancy might initiate the motivation for change.

Further research is needed to better understand the meaning of discrepancies and how they impact treatment, and to devise strategies for addressing them. These would need to be adapted to different levels and qualities of discrepancies, and to the possibility that some circumstances might require a deferring of conversations about discrepancy. Also, further examination of the applicability of social constructivist treatment models for helping families with discrepant perceptions merits attention.

Before conducting research on BCCSB services, it will be important to first develop and validate methodologies for researching informant discrepancies. There is a need for strategies that go beyond assessing informant perceptions as being either conforming or non-conforming. These strategies could enable the evaluation of the theoretical underpinnings of BCCSB therapies and make possible treatment refinements and broader improvements to CAMHS. Researchers should consider devising tools that are accessible and conducive to providing in-depth answers, like audio recording. Although the PIQ is a widely used clinical tool that permits acceptable preliminary research, several written answers were brief and ambiguous. Finally, to enable valid comparisons between raters, researchers and clinicians are advised to use scaling questions that assess the overall level of concern.

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### Declaration of interest statement

The authors declare no conflict of interest.

### Ethical statement

This manuscript is the authors' original work.

All participants engaged in the research voluntarily and anonymously.

Their data are stored in coded materials and databases without personal data.

The studies involving human participants were reviewed and approved by the Interdisciplinary Committee on Ethics in Human Research (Ref. No. 20130817-SW).

### Data Availability Statement

Datasets presented in this article are not readily available because we only received participant consent to conduct research on the data, not to make the data publicly available.

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