2018-08-01

Informant Discrepancy in Y-OQ Reporting and Inferences Regarding Youth and Primary Caregiver Functioning

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A thesis submitted to the faculty of
Brigham Young University
in partial fulfillment of the requirements for the degree of

Master of Science

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ABSTRACT

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Discrepancy in reporting is a frequent phenomenon in psychotherapy research and its presence indicates added information to take into account when assessing youth functioning (De Los Reyes, 2011; Hawley & Weisz, 2003). There is a need to further understand patterns in youth psychotherapy to protect from risk of treatment failure or deterioration. Our study aimed to explore informant discrepancy and its relation to key therapeutic constructs as well as youth functionality over time within youth outpatient mental health populations who use the Y-OQ and TSM in routine outcome monitoring and as clinical support measures. Using an outpatient mental health sample, regular Y-OQ and TSM data from n=157 youth ages 12-18 and their primary caregivers was assessed. Informant discrepancy was measured using initial total Y-OQ scores from both the youth and primary caregiver. Therapeutic constructs were measured using the TSM domains of primary caregiver distress, therapeutic alliance, and youth motivation. Change in functioning throughout the course of treatment was measured by the primary caregiver and youth Y-OQ total scores at each session. Results indicated that informant discrepancy predicted primary caregiver distress as well as change in youth functioning over time as perceived by the primary caregiver. Consistent with previous research, higher discrepancy between was associated with higher primary caregiver distress and predicted poorer youth functioning throughout the course of treatment. Implications and conclusions are discussed.

Keywords: discrepancies, multiple informants, outcome, youth psychotherapy, distress

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Many measures that assess psychological functioning show high validity and reliability, yet the use of these measures by two informants to assess the same construct often produce discrepant reports. This disparity seen when multiple informants use parallel measures has been shown to indicate that additional inferences from these discrepancies can be drawn about psychopathological functioning (De Los Reyes, 2011). The additional inferences resulting from informant discrepancies have been a topic of interest for many years and results often conclude that discrepancies provide important information about the constructs being assessed and predict outcomes better than the use of only one report (Achenbach & McConaughy, 1997; De Los Reyes, 2011; Weisz, Weiss, & Donenberg, 1992; Weisz, Donenberg, Han, & Weiss, 1995; Yeh & Weisz, 2001). In particular, informant discrepancy between a parent's report of their child's functioning and their child's self-report is prevalent (De Los Reyes, 2011; Duchnowski, Johnson, Hall, Kutash, & Friedman, 1993). Unfortunately, a large percentage of past discrepancy research, including youth discrepancy research, has used outdated methods of analyzing informant discrepancy, leaving inconclusive findings and further examination needed (Hawley & Weisz, 2003; Laird & De Los Reyes, 2012). Examining informant discrepancies in youth treatment settings is important and the need for updated research informing youth treatment is due to youth functioning being a crucial predictor for later life functioning and treatment failure (De Haan, Duckworth, Birch & Jones, 2013). Given the prevalence of informant discrepancy and concern that professionals have towards youth treatment outcomes, empirical work examining the patterns of informant discrepancies in youth treatment outcome is warranted. The

purpose of this study is to examine patterns of youth and primary caregiver functioning associated with informant discrepancy in outpatient mental health settings.

Informant Discrepancy

Informant discrepancy is the term that describes a difference in scores between two or more informants (e.g. parent & child) reporting on the same construct (e.g. child behavior) (Hawley & Weisz, 2003). It is commonly seen in many areas of psychological measurement and presents a tantalizing question that has initiated its own line of research inquiry: If informants are providing disparate information about the same construct, how are we to correctly evaluate that construct? Thus, informant discrepancy research has attempted to answer questions such as what patterns exist in relation to informant discrepancy, why they exist and how to intervene while being informed by the answers. For this study, we will limit our exploration to patterns of informant discrepancy. As an aside, most studies have reported a majority of their primary caregivers as being mothers of the client. Therefore, most but not all, results are discussed in terms of maternal and child discrepancy. In the past, researchers have demonstrated associations between levels of informant discrepancy and areas of functioning crucial to the therapeutic process in youth psychological services. Some of these areas include parental distress, parent- and youth-reported therapeutic alliance, and youth motivation for treatment.

Informant Discrepancy and Crucial Therapeutic Constructs

Primary caregiver distress. Multiple studies have identified parent distress levels as being linked to parent-child discrepancy (Chi & Hinshaw, 2002; Fergusson, Lynskey & Horwood, 1993; Youngstrom, Loeber & Stouthamer-Loeber, 2000). Definitions of distress vary based on the measurement used, however, they commonly consist of parent self-reports of depressive, anxiety and general “stress” symptoms. Results repeatedly find a positive

relationship between high levels of discrepancy and high levels of maternal distress, with between 2% and 16% of the variance in discrepancies being explained by maternal distress (Fergusson et al., 1993; Youngstrom et al., 2000). These results have been demonstrated in youth presenting with both externalizing and internalizing problems (Chi & Hinshaw, 2002). Thus, there appears to be a clear link between informant discrepancy and parental distress using several psychopathology measures.

Therapeutic alliance. A similarly crucial area influencing the youth's treatment outcome is that of therapeutic alliance. Securing a strong parent-therapeutic alliance and child-therapeutic alliance is predictive of positive treatment outcomes for youth with internalizing and externalizing problems (Kazdin, Whitley & Marciano, 2006; McLeod & Weisz, 2005). This relationship between the therapist and the client has been shown to be linked to informant discrepancy. Similar to parental distress, we find many studies suggesting that increased informant discrepancy is associated with lower therapeutic alliance for clients (Hawley & Weisz, 2003; Yeh & Weisz, 2001). In fact, measurement and therapeutic manuals describe the therapeutic alliance as a construct that may be strengthened by increasing the amount of agreement between therapist and clients (Safran, Muran, Samstag & Stevens, 2002; Warren & Lambert, 2013). With these findings, it is not surprising that other areas related to therapeutic alliance, such as the client's motivation for treatment, are also connected to disagreements between informants.

Youth motivation for treatment. Commitment and success of treatment interventions are also partially contingent upon a client's willingness to engage in treatment (Garcia & Weisz, 2002). The extent to which a client is motivated to engage in treatment may be influenced by several factors, but one such factor has been the degree to which the primary caregiver and child

agree or disagree on the presenting problem (Horvath & Luborsky, 1993; Liddle, 1995; Weisz et al., 1995). This lack of consensus resulting in discrepant reports has been associated with low motivation towards treatment for the child as well as the parent, with high discrepancy relating to lower motivation (Liddle, 1995). Altogether, it is clear that informant discrepancy is associated with therapeutic constructs shown to be crucial to the treatment outcome of youth receiving psychological services.

Informant Discrepancy and Changes Throughout the Course of Treatment

Studies have also examined the link between informant discrepancy and the changes in psychological functioning that youths make throughout the course of treatment. Research has shown informant discrepancies in youth treatment as predicting later treatment outcomes (Ferdinand, van der Ende & Verhulst, 2004; Guion, Mrug & Windle, 2009; Laird & De Los Reyes 2012). This is seen in higher discrepancies predicting negative responses to treatment such as increases in emotional distress and behavioral problems. Using longitudinal data, Ferdinand et al. (2004) found that initial discrepancy between youth and primary caregivers in a general population sample significantly predicted increased psychological distress four years later. It is frequently portrayed that certain scores on measures that assess psychological functioning are predictive of poor treatment outcomes. Psychopathology in youth may also be validly predicted by not only the scores on those measures but the discrepancy found among scores from multiple informants.

There remains work to be done in understanding and solidifying current informant discrepancy findings. Though many studies have shown intriguing results related to specific areas of functioning as well as overall treatment outcomes, previous studies have typically not used appropriately sophisticated analyses and rarely explore informant congruence (in addition

to discrepancy). Additionally, there is no research documenting informant discrepancy patterns in the Youth Outcome Questionnaire (Y-OQ) and Treatment Support Measure (TSM), which are widely-used treatment measures. Due to the high utility of these measures and the inconsistency of past findings because of differing measures and samples, it is important to explore informant discrepancy in relation to these measures and the population that they target (De Los Reyes & Kazdin, 2005).

Current Study

The purpose of the present study was to examine associations between youth and primary caregiver report patterns and functioning in order to further understand patterns in youth mental health treatment thus informing treatment intervention. More specifically, we aim to identify initial discrepancy and congruence in relation to specific crucial therapeutic constructs (parent distress, therapeutic alliance and youth motivation for treatment) as well as treatment outcomes. In order to examine these questions we tested the relationships between discrepancies on youth and primary caregiver initial total Y-OQ scores and initial TSM scales including parent distress, therapeutic alliance and youth motivation. We also tested the relationship between discrepancies on youth and primary caregiver initial total Y-OQ scores and youth and primary caregiver Y-OQ change scores (change in psychological functioning over the course of treatment).

Using polynomial regression models, we tested four discrepancy hypotheses. In line with past research, we hypothesized that greater reporter discrepancy on the Y-OQ will be associated with high levels of primary caregiver distress (H1), low levels of therapeutic alliance for both primary caregiver (H2a) and youth (H2b), and low levels of youth motivation for treatment (H3). We also hypothesized that informant report discrepancy levels would significantly predict primary caregiver (H4a) and youth (H4b) perceived treatment outcome as a function of the other

informant report. In order to inform and improve youth mental health treatment, further understanding of informant discrepancy patterns is essential.

Method

We utilized data from three local community mental health outpatient clinics in the intermountain west.

Participants

Our sample consisted of 157 clients who were participating in therapy and their primary caregivers. Youth client ages ranged from 12-18 (m=14.3, sd=2.96) and of the entire sample, 48% were female. Among the sample, 87.5% were Caucasian, 2.2% were African American, 2% were American Indian, 2% were Pacific Islander, and 6.3% were categorized as other. Approximately 75% of the primary caregivers were mothers with 12% being fathers and the remaining being aunts/uncles, foster parents and "others." The community mental health clients primarily consisted of low-middle income families, many of whom receive government assisted funding.

Procedure

After IRB approval was given, youth seeking therapy and their parent/primary caregivers were recruited during routine intake at large outpatient community mental health clinics in the Intermountain West. Potential participants were recruited by research personnel and families were given forms giving an overview of study purpose and procedures. Following informed consent/assent, longitudinal data collection tracking youth functioning commenced.

At intake, TSM and Y-OQ data were collected, with the exception of the therapeutic alliance domain on the TSM because clients had not yet started treatment. The following five

sessions consisted of youth and primary caregiver participants completing the TSM-Y and TSM-P, respectively. Youth clients additionally completed the Y-OQ for each of the first five sessions over the course of therapy. After the initial five sessions of data collection, subsequent TSMs and Y-OQs were completed approximately every 3 weeks for 6 months, or until termination (whichever came first).

Measures

Youth outcome questionnaire. The Youth Outcome Questionnaire (Y-OQ) assesses total youth distress using multi-informant methods having both a self-report for the youth to complete and a parent report for the primary caregiver to complete. The Y-OQ is made up of 64 items and contains the following six domains: intrapersonal distress, somatic complaints, interpersonal relations, social problems, behavioral dysfunction, and critical items assessing concerns frequently found in youth receiving inpatient treatment (Ridge, Warren, Burlingame, Wells, & Tumblin, 2009). Higher total scores indicate increased levels of total psychological distress (Burlingame et al., 2003). The Y-OQ is able to routinely monitor outcomes with high sensitivity, showing a 63-77% accuracy in predicting risk for treatment failure (Cannon, Warren, Nelson & Burlingame, 2010; Warren, Nelson, & Burlingame, 2009; Warren, Nelson, Burlingame & Mondragon, 2012). It has demonstrated strong psychometrics with an internal consistency of .97, specificity of .79, sensitivity of .81 and strong convergent and divergent validities (Burlingame et al., 2003). The Y-OQs are typically administered to the youth and primary caregiver prior to the therapy session. Once answers to questions are entered into the OQ-Analyst system (software system supporting the Y-OQ and TSM), feedback regarding the youth's progress is immediately generated for the therapist's use.

Treatment support measure. The Treatment Support Measure (TSM) assesses specific areas of functioning in the youth and their primary caregiver that have been empirically identified as constructs crucial to symptom improvement (Warren & Lambert, 2013). It too contains a self and parent report for the youth to answer about his/herself and the primary caregiver to answer about his/herself. The TSM youth-report assesses the constructs of youth self-efficacy, youth perception of social support, motivation for treatment, and youth perspective of therapeutic alliance. The TSM parent-report assess the constructs of parenting self-efficacy, parent's perception of social support, parenting skills, parental distress, and parent's perception of therapeutic alliance. This 40-item clinical support tool is typically used by the therapist to create treatment plans and re-evaluate treatment throughout the youth's mental health services. Preliminary results examining TSM psychometric properties have shown strong 4-week test-retest reliability estimates of .91 to .92, moderate to strong subscale alpha estimates ranging from .77 to .89 and sensitivity to change (Warren & Lambert, 2013). The TSM is typically administered with the Y-OQ at intake as well as whenever additional information is needed about the youth's situation (e.g. when the Y-OQ shows that the client is at risk for treatment failure).

Variables

Informant discrepancy variable. Informant discrepancy was included in the model as the predictor variables by including the 64 item total youth and primary caregiver Y-OQ scores. The Y-OQs scores were obtained from the youth's initial therapy session. In order to represent level of discrepancy we modeled total scores of both informants as well as a discrepancy variable. This discrepancy variable was the difference between primary caregiver and youth initial Y-OQ total scores.

Therapeutic constructs. Certain TSM subscales were used as outcome variables. These subscales were chosen due to their relevance in past literature to both treatment outcome and informant discrepancy. Subscales included primary caregiver distress, primary caregiver perceived therapeutic alliance from the TSM parent measure and youth perceived therapeutic alliance and youth motivation for treatment from the TSM youth measure. Lower scores in primary caregiver distress indicate increased levels of the parent's psychological distress and higher primary caregiver perceived therapeutic alliance scores indicate increased levels of a good therapeutic relationship between the primary caregiver and the youth's therapist (Warren & Lambert, 2013). Higher scores in youth perceived therapeutic alliance indicate a good therapeutic relationship between the youth client and their therapist and high scores in youth motivation for treatment indicate higher levels of awareness and willingness toward engaging in therapeutic interventions (Warren & Lambert, 2013).

First session TSM scores on all subscales were utilized except for therapeutic alliance, which was first assessed at the second session due to the fact that clients were unlikely to have a therapeutic alliance before meeting with the therapist. We then dichotomized subscale scores to reflect the levels of severity specified in the TSM manual (Warren & Lambert 2013). Because a score of 25 or less has been statistically determined as abnormally high primary caregiver distress, we dichotomized the distress score as either high distress (less than or equal to 25) or low distress (greater than 25). Similarly, we created dichotomized scores with therapeutic alliance and motivation subscales.

Change in functioning over time. Lastly, in order to indicate change throughout the course of therapy, total Y-OQ scores at each session were cumulatively used in order to adequately represent trajectory of change for clients. Total functioning scores were created by

summing the score of all Y-OQ subscales. By doing this we were able to test informant discrepancy's impact on patterns of change in total primary caregiver and youth perceived functioning throughout the course of treatment.

Analysis

Using Stata 14.0 we conducted four ANOVAs and two Hierarchical Linear Models to test our six hypotheses. The ANOVAs were used to show patterns of congruence/discrepancy among informant reports and its association with the severity of our therapeutic constructs (H1, H2a, H2b, & H3). HLM was used to test informant discrepancy's impact on change in youth functioning throughout the course of treatment as perceived by both the primary caregiver (H4a) and the youth (H4b). We used HLM due to its robust examination of longitudinal data, providing directional and magnitude of change trajectory information. HLM is able to examine flexible trajectories while including most data points across the span of the youth's treatment services (as opposed to the frequent omitting of important data points that is regularly seen in less robust models). Additionally, the use of HLM allows for analyses to account for individual and environmental aspects and is appropriate in exploring patterns of change over time and individual differences in change over time (Laurenceau, Hayes & Feldman, 2007). These analyses were helpful in the aim to examine informant discrepancy as an influential variable in psychotherapy.

Results

We used two phases of analyses, the first to explore congruence patterns between youth and primary caregiver reports and therapeutic constructs such as parent distress, youth and caregiver therapeutic alliance and youth motivation for treatment. The second phase of analyses

explored informant discrepancy predictability of treatment outcome using hierarchical linear modeling. Prior to initiating analyses, we conducted multiple imputation for item-missing values as well as dropping 26 data points due to questionable entries.

Patterns of Discrepancy Among Therapeutic Constructs

During the first phase of analyses, discrepancy was shown to be weakly correlated to therapeutic constructs. More specifically the degree to which the youth and primary caregiver disagreed on reports of youth functionality was negatively correlated with primary caregiver distress (r = -.08), youth therapeutic alliance (r = -.07), primary caregiver therapeutic alliance (r = -.02), and youth motivation for treatment (r = -.03). Higher discrepancy between informants was associated with higher primary caregiver distress scores. Also, lower discrepancy between informants was associated with higher therapeutic alliance between primary caregivers and therapists and youth and therapists. Lastly, lower discrepancy between informants was associated with higher scores in youth motivation for treatment.

Table 1
Informant Discrepancy According To Therapeutic Construct Severity Level

	Informant Discrepancy	
	Mean	SD
High PC Distress	32.92	22.19
Low PC Distress	28.54	22.94
High PC Therapeutic Alliance	29.20	22.91
Low PC Therapeutic Alliance	35.34	12.23
High Y Therapeutic Alliance	29.13	23.04
Low Y Therapeutic Alliance	33.56	14.47
High Y Motivation	29.30	23.29
Low Y Motivation	28.67	18.60

Note: PC = primary caregiver, Y = youth

In further assessing these patterns we ran descriptive statistics and illustrative analyses. It appeared that there were differences in discrepancy between the two severity levels of constructs (see Table 1). To illustrate these differences, we created box plots of the degree of informant discrepancy across severity levels of specified constructs (see fig. 1). The figure shows that on average, the degree to which the primary caregiver and youth disagree is higher when constructs are more poor/severe. Next we ran four t-tests to determine the significance of these differences. Of the four therapeutic constructs, parent distress demonstrated the only significant informant discrepancy difference ($F = 7.73(df1)$, $p < .01$). In other words, in support of our first hypothesis, in dyads where the primary caregiver reported abnormally high levels of personal distress, there were significantly higher levels of informant discrepancy than those dyads where the primary caregiver reported more typical levels of distress. Additionally, our second and third hypotheses were not supported; instead, those primary caregivers and youth who report good therapeutic relationships do not seem to differ in amount of informant discrepancy compared to those who report poor therapeutic relationships. Lastly, our fourth hypothesis was not supported, with our analyses showing that whether the youth seeking treatment has low or high motivation towards said treatment does not significantly show differences in amount of informant discrepancy.

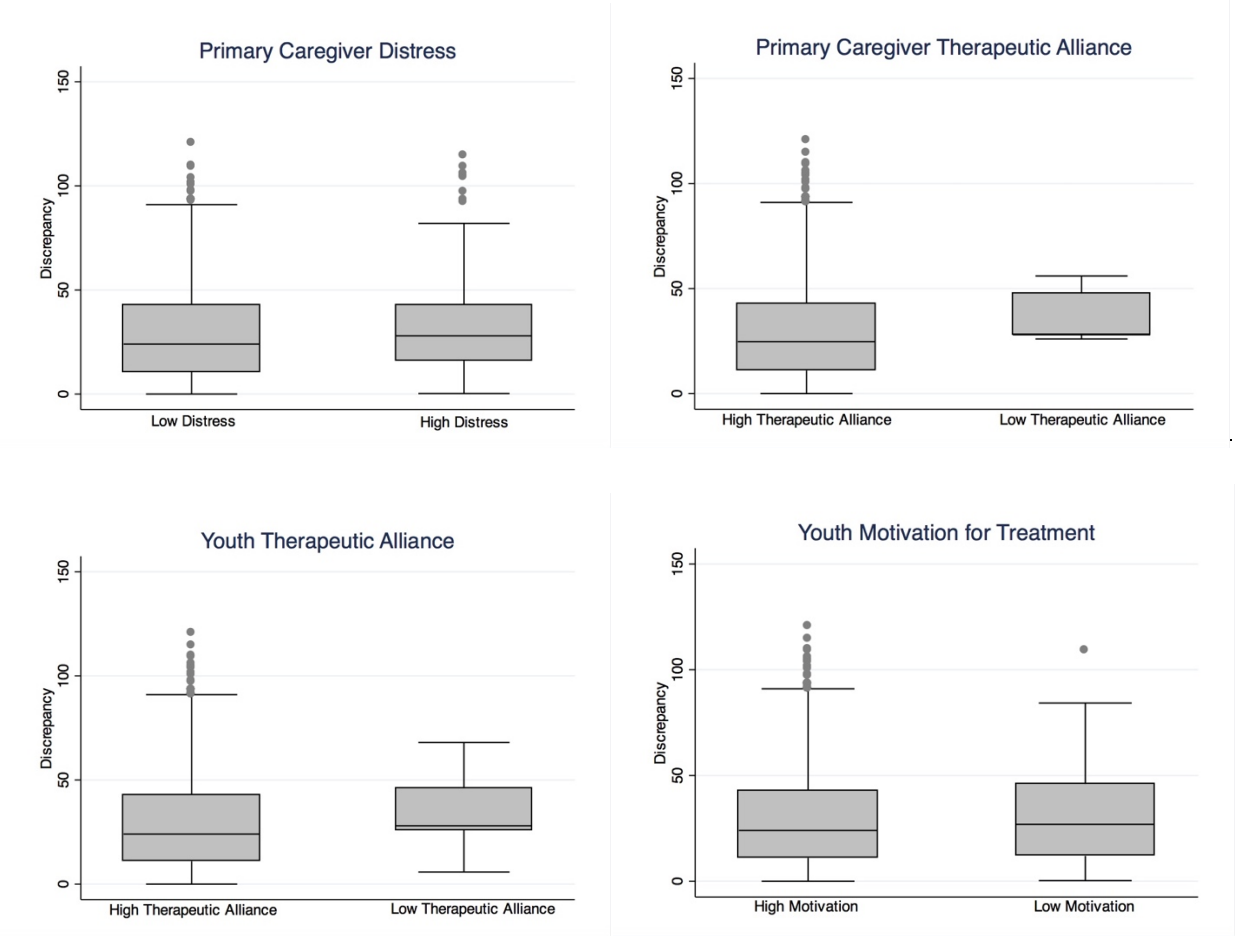


Figure 1.
Informant discrepancy across severity levels of therapeutic constructs.

Informant Discrepancy Predicting Change Over Time

For the second phase and in order to determine if informant discrepancy significantly predicted change in youth functioning throughout the course of treatment, we first identified which mathematical model would best fit our question. After mapping different models, we found that the use of the natural log (LNWKS) transformation of weeks the youth has been in treatment was the most appropriate model. This was determined due to the significant improvement of fit indices such as the -2 Log Likelihood, Bayesian Information Criterion (BIC) and Akaike's (1987) information criterion (AIC). The natural log model indicates that change

throughout the course of treatment is best represented by a logarithmic trajectory which includes accelerated changes in functioning at the beginning of treatment. This is frequently represented in the youth psychotherapy literature (Spielmans, Masters & Lambert, 2006).

Our first HLM analysis indicated that informant discrepancy was a significant predictor of change over time as perceived by the primary caregiver (see Table 2). This HLM analysis of fixed effects for Y-OQ total functionality scores confirmed our hypothesis (4a) and showed that for every one-point increase in Y-OQ total scores (higher scores indicate poorer functioning), a .250 point increase in discrepancy scores was observed. In other words, more disagreement between multiple informants predicted poorer youth functioning (as perceived by the primary caregiver) throughout the course of treatment.

Table 2
Informant Discrepancy Predicting Change Over Time

	Estimate	Std. Error	*p*
Primary Caregiver Perceived Youth Total Functioning			
Discrepancy	0.250	0.151	0.045
LNWKS	-6.504	2.511	0.010
Discrepancy*LNWKS	0.091	0.064	0.099
Intercept	59.454	5.502	0.000
Youth Self- Perceived Total Functioning			
Discrepancy	0.048	0.167	0.773
LNWKS	-10.919	1.987	0.000
Discrepancy*LNWKS	0.033	0.053	0.532
Intercept	62.420	6.036	0.000

Note: PC = primary caregiver, Y = youth, n = 157.

Our second HLM analysis exploring informant discrepancy as a possible predictor of change over time as perceived by the youth did not reach statistical significance. Although model

fit was increased with the addition of our informant discrepancy predictor, as evidenced by significant changes in -2 Log Likelihood, AIC and BIC, the predictor was not significant. Therefore, our last hypothesis (4b) was not supported and results are not interpreted.

Discussion

The purpose of this study was to explore informant discrepancy patterns within youth outpatient mental health populations who use the Y-OQ and TSM in routine outcome monitoring and as clinical support measures. These patterns were explored between informant discrepancy primary caregiver distress, primary caregiver and youth therapeutic alliance, and youth motivation for treatment. The significance of informant discrepancy predicting youth functioning throughout the course of treatment was also examined.

In exploring the extent to which informant discrepancy is linked to constructs that have been shown to be crucial to youth psychotherapy outcome, we found that the amount of reported distress that a primary caregiver has was associated with the level of disagreement between primary caregiver and youth reports of youth functioning. This is consistent with previous research and indicates that the pattern exists within the use of Y-OQ and TSM measures (Stokes, Pogge, Wecksell, & Zaccario, 2011; Youngstrom et al., 2000). We found that although there was a general pattern of higher discrepancy being linked to poorer functioning (lower therapeutic alliance and motivation), this pattern did not reach statistical significance. Much of the discrepancy literature is inconclusive in that some studies will find significant and non-significant results regarding discrepancies link to therapeutic alliance and motivation for treatment, nonetheless this finding was surprising and possibly implies a difference in measures or population from past research (De Los Reyes & Kazdin, 2005). Lastly, our findings also indicated that the primary caregiver's report of youth psychological functioning throughout the

course of therapy is significantly predicted by levels of informant discrepancy. However, youth self-reports of psychological functioning failed to reach statistical significance. This non-significant finding is not uncommon, as past related research appears to find inconsistent results in this area (De Los Reyes & Kazdin, 2005). Researchers have posited several possible theoretical explanations for discrepancy from a developmental standpoint that are noteworthy.

Contextual embeddedness. Discrepancy in adolescent and parent reporting have been hesitantly explained by several theories. One primary explanation is the concept of contextual embeddedness, where a phenomenon is interpreted by the individual inherently informed by their contextual surroundings (BrandtstAdter, 2006). When completing measures and answering questions about behaviors, youth tend to use unsupervised peer behavior as a reference point (Spithoven, Vanhalst, Lodder, Bijttebier & Goossens, 2017). However, this is different for the caregiver, who will usually reference supervised behavior of youth and/or their own behavior at that age. Ultimately, this leads to reporters pulling from different knowledge bases and ultimately explaining how closely related individuals completing parallel measures can still result in discordance (Carlston & Ogles, 2006).

Internalizing verses externalizing. One area of informant discrepancy that many studies have shown a difference in is externalizing and internalizing behaviors. A meta-analysis of 341 studies by De Los Reyes and colleagues (2015) found that correspondence between parent and child reports is higher for externalizing behaviors than for internalizing behaviors. This correspondence holds across ages with no significant effect based on age level. This is likely due to the fact that externalizing behaviors are easier to observe, and therefore parents are more likely to be aware that there is a problem. In contrast, internalizing behaviors are not easily observed by parents, and are correspondingly less reported by them. For instance, diagnostic

interviews based on parent reports and child reports exhibit greater correspondence when reports are about directly observable anxiety behaviors (e.g., behavioral avoidance displayed at home) relative to internal anxiety behaviors such as worry displayed (Comer & Kendall, 2004). Not surprisingly, then, studies find that parents report more discrepant cases on externalizing disorders (e.g. ADHD) and children report more discrepant cases of internalizing disorders (e.g. major depression). Some research shows children actually report higher levels of internalizing symptoms than parents, making child report critical in assessing for disorders such as depression and other internalizing symptoms in children than youths report themselves (Jensen et al., 1999).

Social desirability. Another factor that seems to play into informant discrepancy is social desirability. Children may refuse to acknowledge problems (e.g. separation anxiety in young children) or feel embarrassed by them (e.g. panic disorder in adolescents), leading children to under-report in their self-reports in an attempt to look better to peers or adults (Jensen et al., 1999). Social desirability becomes increasingly important in adolescence as children begin to be more aware of and concerned with their social status and how they are viewed by others, as well as beginning to be more connected to a peer group and more autonomous from parents. One study showed that adolescents under-report symptoms even when they are physiologically experiencing them. Adolescents self-reported lower levels of social anxiety relative to their parents' reports, and adolescents' self-reports exhibited little to no correspondence with objective measures of psychophysiology (i.e., during a baseline psychophysiological assessment; De Los Reyes et al., 2012). Thus, adolescents may deny the presence of pathological symptoms even in the presence of objective physiological distress.

Child verses adolescent. The age of the child who is the subject of the reports can also effect informant discrepancy and has been the subject of significant research. However, studies

show a wide range of results in whether parents agree more with older (age 11 and up) or younger (age 10 and down) children. In their meta-analysis of 341 studies, De Los Reyes and colleagues (2015) found no significant effect of the child age on magnitude of informant discrepancy. On one side of the debate are the studies that find that there is more correspondence between the reports of parents and younger children (age 10 and down). One of the theories as to why there is more agreement in these studies is that parents are more involved in the day to day life of young children than older children and are therefore more knowledgeable about their behavior and activities (Edelbrock, Costello, Dulcan, Kalas & Conover, 1985; Klein, Dougherty & Olino, 2005). Adolescents are beginning to gain increasing autonomy and spend more time away from parental supervision, and thus their behaviors often occur in situations where the parent is not present to observe it. Additionally, adolescents often intentionally withhold information from parents, or view parental questioning as intrusive. Parents also tend to have a more difficult time judging whether adolescent symptoms are normative or pathological (e.g., excess activity, anxiety, moodiness) as behavioral norms also become more fluid in adolescence and adolescence tends to be a time of behavioral change and increased emotional lability (Edelbrock et al., 1985). Thus, the increased supervision of young children as well as understanding of their behaviors and moods may lead to higher correspondence in parent and child reports of the child's psychological distress.

On the other side of the debate are the studies that find more correspondence between the reports of parents and older children (age 11 and up). One of the theories as to why there is more agreement in these studies is that adolescents have increased insight into their symptoms and pathology due to improving cognitive, memory, and language skills (Smetana, Campione-Barr, & Metzger, 2006; Spear, 2000). Accuracy in a clinical interview require self-awareness,

perspective taking, recall, reasoning ability, and expressive skills that are strongly related to age and developmental level (Edelbrock et al., 1985). For example, recognizing cognitive impairments associated with depression requires significant self-awareness by an individual, which is typically limited in children. Research has also found that children tend to be less reliable in giving consistent reports of their pathology over time, likely due to developmental limitations in cognitive processes and language abilities. The consistency of child self-reports tend to be substantially lower than that of parent or adolescent report for both behavioral and cognitive symptoms. However, the reliability of the child symptom reports increased sharply with age, and by age 10 children are as nearly reliable as their parents in many areas (Edelbrock et al., 1985). Thus, the increasing cognitive development of older children may contribute to their ability to give valid reports of their psychological distress.

Implications

When planning and choosing interventions for youth treatment, it is important to attend to both parent and child characteristics (De Los Reyes & Kazdin, 2005). As De Los Reyes and Kazdin (2005) point out in their proposed attribution-bias-context (ABC) model, primary caregiver distress may signify the presence of a rater bias where the informant discrepancy is resulting from differences in the way informants make attributions about the functioning of the youth. The ABC describes the role of both the "actor" and "observer" as explaining the resulting report. Much of the recent literature exploring theoretical explanations behind discrepancy and parental distress has identified primary caregivers with high distress as possibly having different reactions and interpretations of the child's behavior than those who are experiencing less psychological distress. Although our results are unable to test this hypothesis, this seems to be a likely explanation given the depression-distortion hypothesis and other biases correlated with

heightened psychological distress (Najman et al., 2000). Findings imply that primary caregiver distress may be an important area to address when treating a youth who's reports have shown high levels of discrepancy. In particular, it may be of added benefit to consider issues related to the informant's attributions and perceptions of youth behavior.

Findings indicating that higher discrepancy between informants predicts poorer perceived youth functioning throughout the course of treatment could imply that an adverse effect is resulting from certain aspects associated with high levels of disagreement in primary caregiver and youth dyads (Ferdinand et al., 2004; Sourander, Helstelae & Helenius, 1999). Past research has explained this phenomenon as most likely being related to the long-term consequence that result from factors commonly associated with disagreement, such as lack of awareness of the youth's activities, and one informant seeing the behavior as situational and the other as inherently within the child. Patterns of miscommunication and disagreement can create discord in other areas, possibly adding to over increases in distress and poor functioning (De Los Reyes & Kazdin, 2005). Nonetheless, our results indicate the discrepancy and concordance in information from multiple informants may be imperative when considering treatment approaches. Although this study did not test the underlying theoretical reasoning behind findings, past research concludes that when these patterns of discrepancy are present it may be beneficial for clinical interventions to explore areas of the informant dyad that might be feeding disagreement in reports of youth functioning (Ferdinand et al., 2004).

Limitations

One limitation of this study is the overrepresentation of mothers to fathers and other types of primary caregivers. Therefore, like much of the discrepancy research, our conclusions are mainly geared towards mother primary caregivers. The next step in Y-OQ informant discrepancy

research might be exploring the differences between type of primary caregiver and youth dyads (mother-child, father-child, etc.) and patterns of informant discrepancy and functionality. It would also be important to further examine the discrepancy between specific subscales within the Y-OQ as influencing functioning and change over time. This would increase our understanding of the underlying patterns that exist below general differences in reports of total functioning and possibly direct researchers towards target that effect greater change in youth psychotherapy outcomes.

Conclusion

The risks that threaten youth seeking mental health services can be informed by discrepancy in the reports of multiple informants. One area of treatment that should not be ignored by the clinician or researcher is that of discrepant reports between the youth seeking therapy and their primary caregiver. First, therapists and researchers should not rely on only one report of youth functioning and second, the level of disagreement between multiple reports should be taken into account when conducting research or providing services for youth. In particular, when high levels of discrepancy are observed, researchers and therapists should consider the level of distress of the primary caregiver as one potential leverage point through which to intervene. Lastly, when considering the risks threatening youth outcomes, levels of discrepancy should be evaluated for increased understanding of the likelihood of negative outcomes.

References

Achenbach, T. M., & McConaughy, S. H. (1997). *Developmental clinical psychology and psychiatry, Vol. 13. Empirically based assessment of child and adolescent psychopathology: Practical applications (2nd ed.).* Thousand Oaks, CA, US: Sage Publications, Inc.

Akaike, H. (1987). Factor analysis and AIC. *Psychometrika, 52*(3), 317–332.

BrandtstAdter, J. (2006). Action perspectives on human development. In R. M. Lerner, & W. Damon, (Eds.), *Handbook of child psychology* (pp. 516-568). doi:10.1002/9780470147658

Burlingame, G. M., Wells, M. G., Hoag, M. J., Hope, C. A., Nebeker, K. K., McCollam, P., Peterson, G., & Lambert, M. J. (2003). *Administration and scoring manual for the youth outcome questionnaire 2.0.* American Professional Credentialing Services LLC.

Cannon, J. N., Warren, J. S., Nelson, P. L., & Burlingame, G. M. (2010). Change trajectories for the youth outcome questionnaire self-report: Identifying youth at risk for treatment failure. *Journal of Clinical Child and Adolescent Psychology, 39*(3), 289–301.

Carlston, D., & Ogles, B. (2006). The impact of items and anchors on parent–child reports of problem behavior. *Child and Adolescent Social Work Journal, 23,* 24–37.

Chi, T. C., & Hinshaw, S. P. (2002). Mother–child relationships of children with ADHD: The role of maternal depressive symptoms and depression-related distortions. *Journal of Abnormal Child Psychology, 30,* 387–400.

Comer, J. S., & Kendall, P. C. (2004). A symptom-level examination of parent-child agreement in the diagnosis of anxious youth. *Journal of the American Academy of Child and Adolescent Psychiatry. 43*, 878–886.

De Haan, E., Duckworth, A., Birch, D., & Jones, C. (2013). Executive coaching outcome research: The predictive value of common factors such as relationship, personality match and self-efficacy. *Consulting Psychology Journal: Practice and Research, 65*(1), 40–57.

De Los Reyes, A. (2011). Introduction to the special section: More than measurement error: Discovering meaning behind informant discrepancies in clinical assessments of children and adolescents. *Journal of Clinical Child and Adolescent Psychology*, *40*(1), 1–9.

De Los Reyes, A., Augenstein, T. M., Wang, M., Thomas, S. A., Drabick, D. A., Burgers, D. E., & Rabinowitz, J. (2015). The validity of the multi-informant approach to assessing child and adolescent mental health. *Psychological Bulletin, 141*(4), 858-900.

De Los Reyes, A., Aldao, A., Thomas, S. A., Daruwala, S. E., Swan, A. J., Van Wie, M., & Lechner, W. V. (2012). Adolescent self-reports of social anxiety: Can they disagree with objective psychophysiological measures and still be valid? *Journal of Psychopathology and Behavioral Assessment*, *34*, 308–322.

De Los Reyes, A., & Kazdin, A. E. (2005). Informant discrepancies in the assessment of childhood psychopathology: A critical review, theoretical framework, and recommendations for further study. *Psychological Bulletin*, *131*(4), 483–509.

Duchnowski, A. J., Johnson, M. K., Hall, K. S., Kutash, K., & Friedman, R. M. (1993). The alternatives to residential treatment study: Initial findings. *Journal of Emotional and Behavioral Disorders*, *1*, 17–26.

Edelbrock, C., Costello, A. J., Dulcan, M. K., Kalas, R., & Conover, N. C. (1985). Age differences in the reliability of the psychiatric interview of the child. *Child Development*, *56*(1), 265–275.

Ferdinand, R. F., van der Ende, J., & Verhulst, F. C. (2004). Parent-adolescent disagreement regarding psychopathology in adolescents from the general population as a risk factor for adverse outcome. *Journal of Abnormal Psychology*, *113*, 198–206.

Fergusson, D. M., Lynskey, M. T., & Horwood, L. J. (1993). The effect of maternal depression on maternal ratings of child behavior. *Journal of Abnormal Child Psychology*, *21*(3), 245–269.

Garcia, J. A., & Weisz, J. R. (2002). When youth mental health care stops: Therapeutic relationship problems and other reasons for ending youth outpatient treatment. *Journal of Consulting and Clinical Psychology*, *70*(2), 439–443.

Guion, K., Mrug, S., & Windle, M. (2009). Predictive value of informant discrepancies in reports of parenting: Relations to early adolescents' adjustment. *Journal of Abnormal Child Psychology*, *37*, 17–30.

Hawley, K. M., & Weisz, J. R. (2003). Child, parent and therapist (dis)agreement on target problems in outpatient therapy: The therapist's dilemma and its implications. *Journal of Consulting and Clinical Psychology*, *71*(1), 62–70.

Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology*, *61*, 561–573.

Jensen, P. S., Rubio-Stipec, M., Canino, G., Bird, H. R., Dulcan, M. K., Schwab-Stone, M. E., & Lahey, B. B. (1999). Parent and child contributions to diagnosis of mental disorder: Are both informants always necessary? *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(12), 1569–1579.

Kazdin, A. E., Whitley, M. & Marciano, P. L. (2006). Child-therapist and parent-therapist alliance and therapeutic change in the treatment of children referred for oppositional,

aggressive, and antisocial behavior. *Journal of Child Psychology and Psychiatry*, *47*(5), 436–445.

Klein, D. N., Dougherty, L. R., & Olino, T. M. (2005). Toward guidelines for evidence-based assessment of depression in children and adolescents. *Journal of Clinical Child and Adolescent Psychology*. *34*, 412–432.

Laird, R. D., & De Los Reyes, A. (2012). Testing informant discrepancies as predictors of early adolescent psychopathology: Why difference scores cannot tell you what you want to know and how polynomial regression may. *Journal of Abnormal Child Psychology, 41*, 1–14.

Laurenceau, J. P., Hayes, A. M., & Feldman, G. C. (2007). Some methodological and statistical issues in the study of change processes in psychotherapy. *Clinical Psychology Review, 27*(6), 682-695.

Liddle, H. A. (1995). Conceptual and clinical dimensions of a multidimensional, multi-systems engagement strategy in family-based adolescent treatment. *Psychotherapy*, *33,* 39–58.

McLeod, B. D., & Weisz, J. R. (2005). The therapy process observational coding system-alliance scale: Measure characteristics and prediction of outcome in usual clinical practice. *Journal of Consulting and Clinical Psychology*, *73*(2), 323–333.

Najman, J. M., Williams, G. M., Nikles, J., Spence, S., Bor, W., O'Callaghan, M., … Anderson, M. J. (2000). Mothers' mental illness and child behavior problems: Cause–effect association or observation bias? *Journal of the American Academy of Child and Adolescent Psychiatry, 39,* 592– 602.

Ridge, N. W., Warren, J. S., Burlingame, G. M., Wells, M. G., & Tumblin, K. M. (2009). Reliability and validity of youth outcome questionnaire self-report. *Journal of Clinical Psychology, 65*(10), 1115–1126.

Safran, J. D., Muran, J. C., Samstag, L. W., & Stevens, C. (2002). Repairing alliance ruptures. In J. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 235–254). New York, NY: Oxford University Press.

Smetana, J. G., Campione-Barr, N., & Metzger, A. (2006). Adolescent development in interpersonal and societal contexts. *Annual Review of Psychology*, *57*, 255–284.

Sourander, A., Helstelae, L., & Helenius, H. (1999). Parent-adolescent agreement on emotional and behavioral problems. *Social Psychiatry and Psychiatric Epidemiology*, *34*, 657–663.

Spear, L. P. (2000). The adolescent brain and age-related behavioral manifestations. *Neuroscience and Behavioral Reviews, 24*(4), 417–463.

Spielmans, G. I., Masters, K. S., & Lambert, M. J. (2006). A comparison of rational versus empirical methods in prediction of negative psychotherapy outcome. *Clinical Psychology and Psychotherapy, 13,* 202–214.

Spithoven, A. W. M., Vanhalst, J., Lodder, G., Bijttebier, P., & Goossens, L. (2017). Parent-adolescent discrepancies regarding adolescents' peer-related loneliness: Associations with adolescent adjustment. *Journal of Youth and Adolescence, 65*(5), 1104-1116.

Stokes, J., Pogge, D., Wecksell, B., & Zaccario, M. (2011). Parent-child discrepancies in report of psychopathology: The contributions of response bias and parenting stress. *Journal of Personality Assessment, 93*(5), 527–536.

Warren, J. S., Nelson, P. L., & Burlingame, G. M. (2009). Identifying youth at risk for treatment failure in outpatient community mental health services. *Journal of Child and Family Studies*, *18*, 690 –701.

Warren, J. S., Nelson, P. L., Burlingame, G. M., & Mondragon, S. A. (2012). Predicting patient deterioration in youth mental health services: Community mental health vs. managed care settings. *Journal of Clinical Psychology, 68*(1), 24–40.

Warren, J. S., & Lambert, M. J. (2013). *Youth clinical support tools manual, treatment support measure: Parent and youth forms.* Salt Lake City, UT: OQ Measures LLC.

Weisz, J. R., Donenberg, G. R., Han, S. S. & Weiss, B. (1995). Bridging the gap between laboratory and clinic in child and adolescent psychotherapy. *Journal of Consulting and Clinical Psychology, 63*(5), 688–701.

Weisz, J. R., Weiss, B., & Donenberg, G. (1992). The lab versus the clinic: Effects of child and adolescent psychotherapy. *American Psychologist*, *47*, 1578–1585.

Yeh, M., & Weisz, J. R. (2001). Why are we here at the clinic? Parent-child (dis)agreement on referral problems. *Journal of Consulting and Clinical Psychology*, *69,* 1018–1025.

Youngstrom, E., Loeber, R., & Stouthamer-Loeber, M. (2000). Patterns and correlates of agreement between parent, teacher, and male adolescent ratings of externalizing and internalizing problems. *Journal of Consulting and Clinical Psychology, 68,* 1038–1050.

Appendix

TSM – PARENT

ID #: _____

Today's Date: _____ Child's Birthdate: _____

Child's sex: ○ Male ○ Female Child's Race/Ethnicity: _____

Person completing form: ○ Mother ○ Father ○ Guardian ○ Other: _____

INSTRUCTIONS (#1-7): Please rate how confident you are that you can do each of the parenting tasks described below. Circle the answer that best describes how you have felt about these things over the past week.

	Strongly Disagree	Slightly Disagree	Neutral	Slightly Agree	Strongly Agree
1) I can help my child feel loved and cared for.	1	2	3	4	5
2) I can help my child develop good self-esteem.	1	2	3	4	5
3) I can help my child feel needed and wanted.	1	2	3	4	5
4) I can appropriately discipline my child when he/she does something wrong.	1	2	3	4	5
5) I can help my child to develop a healthy sense of independence.	1	2	3	4	5
6) I can avoid criticizing my child or blaming him/her too much.	1	2	3	4	5
7) I can respect my child's feelings and ideas.	1	2	3	4	5

INSTRUCTIONS (#8-14): These questions are about your relationships with your family, friends, and significant others. Circle the answer that best describes how you have felt about these things over the past week.

8) My family really tries to help me.	1	2	3	4	5
9) I get the emotional help and support I need from my family.	1	2	3	4	5
10) I can talk about my problems with my family.	1	2	3	4	5
11) My family is willing to help me make decisions.	1	2	3	4	5
12) There is a special person who is around when I need help.	1	2	3	4	5
13) There is a special person in my life who cares about my feelings.	1	2	3	4	5
14) I have friends with whom I can share my joys and problems.	1	2	3	4	5

INSTRUCTIONS (#15-26): These questions ask about parenting situations that are challenging for some parents. Circle the answer that best describes you over the past week.

15) I often get into long arguments with my child.	1	2	3	4	5
16) I often show affection for my child through words, hugs, or other warm gestures.	1	2	3	4	5
17) When my child misbehaves I keep the discussion short and to the point.	1	2	3	4	5
18) I look for opportunities to compliment my child.	1	2	3	4	5

	Strongly Disagree	Slightly Disagree	Neutral	Slightly Agree	Strongly Agree
19) When there is a problem with my child I can usually keep the situation from escalating.	1	2	3	4	5
20) If my child talks back or complains when I handle a problem, I ignore the complaining and stick to what I said.	1	2	3	4	5
21) I regularly spend quality time with my child.	1	2	3	4	5
22) When I give my child a warning I follow through with what I said.	1	2	3	4	5
23) When there is a problem with my child, things build up and I do things I don't mean to do.	1	2	3	4	5
24) When my child misbehaves I handle it without getting upset.	1	2	3	4	5
25) When my child is out of sight or away with friends, I have a good idea what my child is doing.	1	2	3	4	5
26) I frequently praise my child for his/her good behavior.	1	2	3	4	5

INSTRUCTIONS (#27-36): Answer the following questions based on how you have felt during the past week. Questions about work refer to employment, housework, school, or volunteer work.

27) I feel I am able to handle all my responsibilities very well.	1	2	3	4	5
28) I am able to handle the challenges of parenting without many problems.	1	2	3	4	5
29) My child creates a lot of stress for me.	1	2	3	4	5
30) Being a parent takes up almost all my energy.	1	2	3	4	5
31) I often feel overwhelmed as a parent.	1	2	3	4	5
32) I feel irritated.	1	2	3	4	5
33) I find my work satisfying.	1	2	3	4	5
34) I have frequent arguments.	1	2	3	4	5
35) I like myself.	1	2	3	4	5
36) I feel that I am not doing well at work.	1	2	3	4	5

INSTRUCTIONS (#37-40): These questions are about working with your child's therapist. Circle the answer that best describes how you have felt about these things over the past week. It's ok to say how you really feel about these things - your honest answers will help ensure your child receives the services he/she needs.

37) I look forward to meeting with my child's therapist.	1	2	3	4	5
38) I don't feel like my child is making much progress with his/her therapist.	1	2	3	4	5
39) I feel like my child's therapist knows how to help my child.	1	2	3	4	5
40) My child's therapist really listens to me.	1	2	3	4	5

TSM – YOUTH

ID #: _____

Today's Date: _____

Your Age: _____ Male ○ Female ○ Your Race/Ethnicity: _____

INSTRUCTIONS (#1-15): Please rate how confident you are that you can do each of the things described below. Circle the answer that best describes how you have felt about these things over the ***past week***.

	Strongly Disagree	Slightly Disagree	Neutral	Slightly Agree	Strongly Agree
1) I can make and keep good friends.	1	2	3	4	5
2) I can get along well with most people.	1	2	3	4	5
3) When I have problems with friends, I can work things out.	1	2	3	4	5
4) I can work well in a group.	1	2	3	4	5
5) I can achieve my goals in life.	1	2	3	4	5
6) I can live up to what my parents expect of me.	1	2	3	4	5
7) I can live up to what I expect of myself.	1	2	3	4	5
8) I can control my temper.	1	2	3	4	5
9) When I have a problem, I can find ways to solve it.	1	2	3	4	5
10) If I make a mistake, I can fix it.	1	2	3	4	5
11) When there are problems in my family, I can do things to improve the situation.	1	2	3	4	5
12) I can get good grades in school.	1	2	3	4	5
13) I can get teachers to help me when I get stuck on schoolwork.	1	2	3	4	5
14) I can get another student to help me when I get stuck on schoolwork.	1	2	3	4	5
15) I can motivate myself to do schoolwork.	1	2	3	4	5

INSTRUCTIONS (#16-30): These questions are about your relationships with your ***immediate*** family (e.g., father, mother, step-parent or guardian, brother, sister), your ***extended*** family (grandparents, aunts, uncles, cousins) and your friends. Circle the answer that best describes how you have felt about these things over the *past week*.

16) I have an *immediate* family member (father, mother, brother, or sister) who I can turn to for good advice.	1	2	3	4	5
17) I feel like I "fit in" and belong with the members of my immediate family.	1	2	3	4	5
18) My immediate family appreciates my abilities and helps me to believe in myself.	1	2	3	4	5

	Strongly Disagree	Slightly Disagree	Neutral	Slightly Agree	Strongly Agree
19) I feel like my immediate family needs me.	1	2	3	4	5
20) I feel emotionally connected to the members of my immediate family (we care about each other).	1	2	3	4	5
21) I have an *extended* family member (grandparent, uncle, aunt, or cousin) who I can turn to for good advice.	1	2	3	4	5
22) I can count on members of my extended family if I need help.	1	2	3	4	5
23) My extended family appreciates my abilities and helps me to believe in myself.	1	2	3	4	5
24) I feel like my extended family needs me.	1	2	3	4	5
25) I feel emotionally connected to the members of my extended family (we care about each other).	1	2	3	4	5
26) I have family members or friends who can help me in material ways, like providing me with food, clothing, or money.	1	2	3	4	5
27) I feel like I "fit in" and belong with friends my age.	1	2	3	4	5
28) I have a friend who I can turn to for good advice.	1	2	3	4	5
29) My friends appreciate my abilities and help me to believe in myself.	1	2	3	4	5
30) I feel emotionally connected to at least one friend my age (we care about each other).	1	2	3	4	5

INSTRUCTIONS (#31-36): These questions ask how you feel about being in therapy. Circle the answer that best describes how you have felt about these things over the *past week*.

31) I'm glad I'm participating in therapy.	1	2	3	4	5
32) The things I work on in therapy will help me in the future.	1	2	3	4	5
33) Being in therapy is a waste of time for me.	1	2	3	4	5
34) I'm only in therapy because my parent (or someone else) thinks I need help.	1	2	3	4	5
35) I am willing to do my part in therapy to make things better.	1	2	3	4	5
36) I'm participating in therapy to get the help I need.	1	2	3	4	5

INSTRUCTIONS (#37-40): These questions are about working with your therapist. Circle the answer that best describes how you have felt about these things over the *past week*. It's ok to say how you really feel about these things - your honest answers will help ensure you receive the services you need.

37) I feel like my therapist is on my side and tries to help me.	1	2	3	4	5
38) I look forward to meeting with my therapist.	1	2	3	4	5
39) I feel like my therapist knows how to help me.	1	2	3	4	5
40) My therapist really listens to me.	1	2	3	4	5

Youth Outcome Questionnaire (Y-OQ®2.01)

ID# _____ Today's Date: _____

Person completing this form: Mother ❍ Father ❍ Other ❍ (describe): _____

PURPOSE: The Y-OQ2.01 is designed to describe a wide range of troublesome situations, behaviors, and moods that are common in children and adolescents. You may discover that some of the items do not apply to your child's current situation. If so, please do not leave these items blank but check the "Never or almost never" category. When you begin to complete the Y-OQ®2.01 you will see that you can easily make your child look as healthy or unhealthy as you wish. Please do not do that. If you are as accurate as possible it is more likely that you will be able to receive the help that you are seeking for your child.

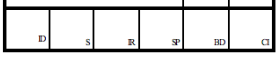
DIRECTIONS: - Read each statement carefully. - Check the box that most accurately describes your child during the past week.
- Decide how true this statement is for your child during the past **7 days**. - Check only one answer for each statement and erase unwanted marks clearly.

PLEASE COMPLETE BOTH SIDES

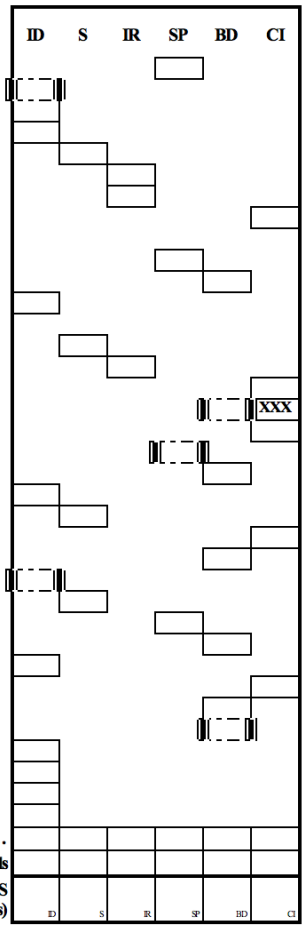
My Child:	Never or Almost Never	Rarely	Sometimes	Frequently	Often or Always
1. Wants to be alone more than other children of the same age	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2. Complains of dizziness or headaches……..	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3. Doesn't participate in activities that were previously enjoyable	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4. Argues or is verbally disrespectful……..	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5. Is more fearful than other children of the same age	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6. Cuts school or is truant……	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7. Cooperates with rules and expectations	☐ 2	☐ 1	☐ 0	☐ -1	☐ -2
8. Has difficulty completing assignments, or completes them carelessly……..	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9. Complains or whines about things being unfair	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10. Experiences trouble with her/his bowels, such as constipation or diarrhea……	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
11. Gets into physical fights with peers or family members	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
12. Worries and can't get certain ideas off his/her mind……	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
13. Steals or lies	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
14. Is fidgety, restless, or hyperactive……	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
15. Seems anxious or nervous	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
16. Communicates in a pleasant and appropriate manner……..	☐ 2	☐ 1	☐ 0	☐ -1	☐ -2
17. Seems tense, easily startled	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
18. Soils or wets self……	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
19. Is aggressive toward adults	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
20. Sees, hears, or believes things that are not real……	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
21. Has participated in self-harm (e.g. cutting or scratching self, attempting suicide)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
22. Uses alcohol or drugs……	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
23. Seems unable to get organized	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
24. Enjoys relationships with family and friends……..	☐ 2	☐ 1	☐ 0	☐ -1	☐ -2
25. Appears sad or unhappy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
26. Experiences pain or weakness in muscles or joints……	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
27. Has a negative, distrustful attitude toward friends, family members, or other adults	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
28. Believes that others are trying to hurt him/her even when they are not……	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
29. Threatens to, or has run away from home	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
30. Experiences rapidly changing and strong emotions……..	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
(continue on the other side of this page)					
SUBTOTALS					

For Office Use Only

ID	S	IR	SP	BD	CI
XXX					



My Child:	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
31. Deliberately breaks rules, laws, or expectations	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
32. Appears happy with her/himself	☐ 2	☐ 1	☐ 0	☐ -1	☐ -2
33. Sulks, pouts, or cries more than other children of the same age	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
34. Pulls away from family or friends	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
35. Complains of stomach pain or feeling sick more than other children of the same age	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
36. Doesn't have or keep friends	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
37. Has friends of whom I don't approve	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
38. Believes that others can hear her/his thoughts, or that s/he can hear the thoughts of others	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
39. Engages in inappropriate sexual behavior (e.g. sexually active, exhibits self, sexual abuse towards family members or others)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
40. Has difficulty waiting his/her turn in activities or conversations	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
41. Thinks about suicide, says s/he would be better off if s/he were dead	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
42. Complains of nightmares, difficulty getting to sleep, oversleeping, or waking up from sleep too early	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
43. Complains about or challenges rules, expectations, or responsibilities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
44. Has times of unusual happiness or excessive energy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
45. Handles frustration or boredom appropriately	☐ 2	☐ 1	☐ 0	☐ -1	☐ -2
46. Has fears of going crazy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
47. Feels appropriate guilt for wrongdoing	☐ 2	☐ 1	☐ 0	☐ -1	☐ -2
48. Is unusually demanding	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
49. Is irritable	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
50. Vomits or is nauseous more than other children of the same age	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
51. Becomes angry enough to be threatening to others	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
52. Seems to stir up trouble when bored	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
53. Is appropriately hopeful and optimistic	☐ 2	☐ 1	☐ 0	☐ -1	☐ -2
54. Experiences twitching muscles or jerking movement in face, arms, or body	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
55. Has deliberately destroyed property	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
56. Has difficulty concentrating, thinking clearly, or attending to tasks	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
57. Talks negatively, as though bad things are all his/her fault	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
58. Has lost significant amounts of weight without medical reason	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
59. Acts impulsively, without thinking of the consequences	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
60. Is usually calm	☐ 2	☐ 1	☐ 0	☐ -1	☐ -2
61. Will not forgive her/himself for past mistakes	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
62. Lacks energy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
63. Feels that he/she doesn't have any friends, or that no one likes him/her	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
64. Gets frustrated and gives up, or gets upset easily	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
				This Page Subtotals…	
				Side 1 Subtotals	
TOTAL =				SUBSCALE TOTALS (Sum of Subtotals)	



Youth Outcome Questionnaire-Self Report (Y-OQ®-SR 2.0)

Name _____ ID# _____ Today's Date _____

Date of Birth _____ Sex: Male ___ Female ___ Parent/Guardian _____

PURPOSE: The Y-OQ®-SR 2.0 is designed to describe a wide range of troublesome situations, behaviors, and moods that are common to adolescents. You may discover that some of the items do not apply to your current situation. If so, please do not leave these items blank but check the "Never or almost never" category. When you begin to complete the Y-OQ®-SR 2.0 you will see that you can easily make yourself look as healthy or unhealthy as you wish. Please do not do that. If you are as accurate as possible it is more likely that you will be able to receive the help that you are seeking.

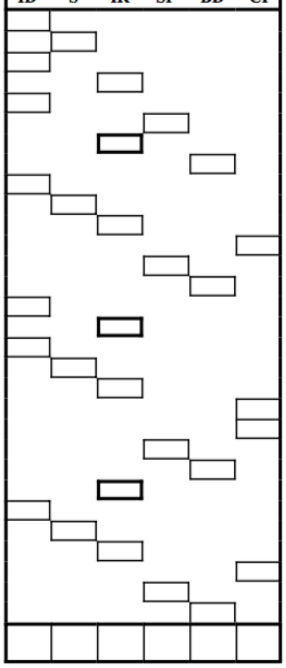
DIRECTIONS:
- Read each statement carefully.
- Decide how true this statement is during the past **7 days**.
- Check the box that most accurately describes the past week.
- Check only one answer for each statement and erase unwanted marks clearly.

PLEASE COMPLETE BOTH SIDES

	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
1. I want to be alone more than others my same age.	☐0	☐1	☐2	☐3	☐4
2. I have headaches or feel dizzy.	☐0	☐1	☐2	☐3	☐4
3. I don't participate in activities that used to be fun.	☐0	☐1	☐2	☐3	☐4
4. I argue or speak rudely to others.	☐0	☐1	☐2	☐3	☐4
5. I have more fears than others my same age.	☐0	☐1	☐2	☐3	☐4
6. I cut classes or skip school altogether.	☐0	☐1	☐2	☐3	☐4
7. I cooperate with rules and expectations of adults.	☐2	☐1	☐0	☐-1	☐-2
8. I have a hard time finishing my assignments or I do them carelessly.	☐0	☐1	☐2	☐3	☐4
9. I complain about things that are unfair.	☐0	☐1	☐2	☐3	☐4
10. I have trouble with constipation or diarrhea	☐0	☐1	☐2	☐3	☐4
11. I have physical fights (hitting, kicking, biting, or scratching) with my family or others my age.	☐0	☐1	☐2	☐3	☐4
12. I worry and can't get thoughts out of my mind.	☐0	☐1	☐2	☐3	☐4
13. I steal or lie.	☐0	☐1	☐2	☐3	☐4
14. I have a hard time sitting still (or I have too much energy).	☐0	☐1	☐2	☐3	☐4
15. I feel anxious or nervous	☐0	☐1	☐2	☐3	☐4
16. I talk with others in a friendly way.	☐2	☐1	☐0	☐-1	☐-2
17. I am tense and easily startled (jumpy).	☐0	☐1	☐2	☐3	☐4
18. I have trouble with wetting or messing my pants or bed.	☐0	☐1	☐2	☐3	☐4
19. I physically fight with adults.	☐0	☐1	☐2	☐3	☐4
20. I see, hear, or believe in things that are not real.	☐0	☐1	☐2	☐3	☐4
21. I have hurt myself on purpose (for example, cut, scratched, or attempted suicide).	☐0	☐1	☐2	☐3	☐4
22. I use alcohol or drugs.	☐0	☐1	☐2	☐3	☐4
23. I am disorganized (or I can't seem to get organized).	☐0	☐1	☐2	☐3	☐4
24. I enjoy my relationships with family and friends.	☐2	☐1	☐0	☐-1	☐-2
25. I am sad or unhappy.	☐0	☐1	☐2	☐3	☐4
26. I have pain or weakness in muscles or joints.	☐0	☐1	☐2	☐3	☐4
27. I have a hard time trusting friends, family members, or other adults.	☐0	☐1	☐2	☐3	☐4
28. I think that others are trying to hurt me even when they are not.	☐0	☐1	☐2	☐3	☐4
29. I have threatened to, or have run away from home.	☐0	☐1	☐2	☐3	☐4
30. My emotions are strong and change quickly	☐0	☐1	☐2	☐3	☐4
SUBTOTALS					

For Office Use Only

ID	S	IR	SP	BD	CI



	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
31. I break rules, laws, or don't meet others' expectations on purpose.+	☐0	☐1	☐2	☐3	☐4
32. I am happy with myself.	☐2	☐1	☐0	☐-1	☐-2
33. I pout, cry, or feel sorry for myself more than others my age.	☐0	☐1	☐2	☐3	☐4
34. I withdraw from my family and friends	☐0	☐1	☐2	☐3	☐4
35. My stomach hurts or I feel sick more than others my same age.	☐0	☐1	☐2	☐3	☐4
36. I don't have friends or I don't keep friends very long.	☐0	☐1	☐2	☐3	☐4
37. My parents or guardians don't approve of my friends.	☐0	☐1	☐2	☐3	☐4
38. I think I can hear other people's thoughts or that they can hear mine.	☐0	☐1	☐2	☐3	☐4
39. I am involved in sexual behavior that my friends or family would not approve of.	☐0	☐1	☐2	☐3	☐4
40. I have a hard time waiting for my turn in activities or conversations.	☐0	☐1	☐2	☐3	☐4
41. I think about suicide or feel I would be better off dead.	☐0	☐1	☐2	☐3	☐4
42. I have nightmares, trouble getting to sleep, oversleeping, or waking up too early	☐0	☐1	☐2	☐3	☐4
43. I complain about or question rules, expectations, or responsibilities	☐0	☐1	☐2	☐3	☐4
44. I have times of unusual happiness or excessive energy	☐0	☐1	☐2	☐3	☐4
45. I'm generally okay with frustration or boredom.	☐2	☐1	☐0	☐-1	☐-2
46. I am afraid I am going crazy.	☐0	☐1	☐2	☐3	☐4
47. I feel guilty when I do something wrong.	☐2	☐1	☐0	☐-1	☐-2
48. I demand a lot from others or I am pushy.	☐0	☐1	☐2	☐3	☐4
49. I feel irritated.	☐0	☐1	☐2	☐3	☐4
50. I throw-up or feel sick to my stomach more than others my age.	☐0	☐1	☐2	☐3	☐4
51. I get angry enough to threaten others.	☐0	☐1	☐2	☐3	☐4
52. I get into trouble when I'm bored.	☐0	☐1	☐2	☐3	☐4
53. I'm hopeful and positive.	☐2	☐1	☐0	☐-1	☐-2
54. Muscles in my face, arms, or body twitch or jerk.	☐0	☐1	☐2	☐3	☐4
55. I destroy property on purpose.	☐0	☐1	☐2	☐3	☐4
56. I have a hard time concentrating, thinking clearly, or sticking to tasks.	☐0	☐1	☐2	☐3	☐4
57. I get down on myself and blame myself for things that go wrong.	☐0	☐1	☐2	☐3	☐4
58. I have lost a lot of weight without being sick.	☐0	☐1	☐2	☐3	☐4
59. I act without thinking and don't worry about what will happen.	☐0	☐1	☐2	☐3	☐4
60. I am calm	☐2	☐1	☐0	☐-1	☐-2
61. I don't forgive myself for things I've done wrong.	☐0	☐1	☐2	☐3	☐4
62. I don't have much energy.	☐0	☐1	☐2	☐3	☐4
63. I feel like I don't have any friends or that no one likes me.	☐0	☐1	☐2	☐3	☐4
64. I get frustrated or upset easily, and give up.	☐0	☐1	☐2	☐3	☐4
					This Page Subtotals
					Side 1 Subtotals
TOTAL =					**SUBSCALE TOTALS (Sum of Subtotals)**