

Medicine Use Among 11- and 13-Year-Olds: Agreement Between Parents' Reports and Children's Self-Reports

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A number of studies have reported that adolescents' medicine use for common symptoms, especially aches, is prevalent in many countries in Europe, as well as in North and South America.¹⁻⁴ Data on the use of such medication must necessarily be obtained from surveys, unlike information on the use of antibiotics, for example, which is available from prescription records.

Surveys on the use of medicines among children have addressed children themselves and elucidated their use through self-reports,¹⁻⁷ but they have also addressed caregivers, primarily parents.⁸ We studied medicine use as a risk behavior.⁹ Studies from other aspects of young people's behavior have documented that children aged 10 years and older can report valid answers on food intake,^{10,11} smoking,^{12,13} physical exercise,^{14,15} and alcohol use.^{16,17} However, according to our literature searches, as of March 7, 2007, the validity of children's reports on medicine use behavior and the agreement between parents' and children's reports has not yet been reported.

The goal of this study was to determine the agreement between parents' and children's reports of medicine use for 5 common complaints among 11- and 13-year-old children and to analyze predictors for disagreement between children's and parents' reports of medicine use.

BACKGROUND: The validity of children's self-reports on medicine use has not been reported.

OBJECTIVE: To determine the agreement between parents' and children's reports of medicine use for 5 common complaints and to analyze predictors for disagreement.

METHODS: We used the child-parent validation survey from the research project Health Behaviour in School-Aged Children. Three hundred ninety-three 11- and 13-year-old Danish children and their parents responded to identical questionnaires. The main outcome measures were self-reported medicine use during the previous month for headache, stomachache, difficulties in falling asleep, nervousness, and asthma.

RESULTS: The percent agreement was lowest with medicine use for headache (64.6%), but was very high for the other 4 complaints (85.3–91.8%). The simple κ coefficients were moderate to good for medicine use for headaches, stomachache, and asthma (0.31–0.58) but poor for difficulties in falling asleep and nervousness. Children who had the specific complaint during the previous month were more likely than their parents to report more frequent medicine use.

CONCLUSIONS: We have some confidence in young adolescents' self-reports of medicine use, as the results of this study are in keeping with other studies on the validity of children's reports of health-related behaviors. Furthermore, the findings suggest that such data can be used in epidemiologic studies that aim to categorize children into groups with and without medicine use.

KEY WORDS: children, medicine use, parents, pharmacoepidemiology, validation study.

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Methods

DESIGN

We used data from the Health Behaviour in School-Aged Children (HBSC) Child-Parent Validation Study 2005. This study was designed to validate selected items from the internationally standardized questionnaire of the HBSC research project, a World Health Organization collaborative study.¹⁸ The HBSC includes 11-, 13-, and 15-year-old children. The aim of the HBSC Child-Parent Validation Study 2005 was to validate children's responses

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against responses from their parents on identical items. As some studies show that validity of self-reports increases with age,¹⁴ we included the 2 youngest age groups to ensure confidence in our results.

DATA COLLECTION

The Danish part of the HBSC Child–Parent Validation Study included all 11- and 13-year-old children from 8 schools in Denmark, which represented areas of wide sociodemographic diversity: metropolitan, urban, and rural districts, and districts with high and low average income. There is no formal agency for ethical approval of school surveys in Denmark. Therefore, we asked the board of parents in each of the participating schools for assessment and approval of the study. All schools agreed to participate. The children completed a questionnaire in the classroom after standardized instruction from their homeroom teacher. Furthermore, they were instructed to bring home an envelope for their parents containing a sheet of information, a questionnaire for the parents, and a pre-stamped return envelope for the parent’s questionnaire. Although the study was anonymous, the questionnaires were numbered to match parents and children. After 2 weeks, the school received a letter for each child to bring home to parents, reminding them to answer and return the questionnaire to the research group.

POPULATION

A total of 708 children were enrolled in the classes we approached, 627 (88.6%) of which were present on the day of data collection. Five hundred ninety-five children (84.0% of those enrolled and 94.9% of those present) and 393 parents (62.8% of children who were present) completed the questionnaires. The final data file included 393 matched child–parent pairs. Table 1 shows the complete set of data on medicine use for each of the 5 complaints, stratified by sex and age.

MEASUREMENTS

The items were selected from the HBSC 2002 study. The children and parents answered 1 question with 5 items about the child’s medicine use: “During the past month, did you/your child take any pills or medicine for (a) headache, (b) stomachache, (c) difficulties in getting to sleep, (d) nervousness, and (e) asthma?” The response key was “no,” “yes, once,” and “yes, several times.” We dichotomized the answers into yes and no for the prevalence analyses.

The predictor analyses included 5 child-reported items: sex, age group, family socioeconomic position (SEP), ethnicity, and prevalence of the relevant complaint. Family SEP was measured by 2 items about the father’s and mother’s occupation and coded according to the standards of the Danish National Institute of Social Research¹⁹ into 6 groups: social class I (high) to V (low); group VI included parents living on social welfare benefits. The participants were categorized according to the highest-ranking parent into 2 groups, family SEP I–IV and V–VI. Ethnicity was measured by the open-ended question: “Which language do you usually speak at home?” The answers were dichotomized into national language (Danish) versus all other languages. Complaint prevalence was measured by the question: “In the past 6 months, how often have you (a) had a headache, (b) had a stomachache, (c) had difficulties in getting to sleep, (d) been nervous?” The response key was “almost every day,” “more than once a week,” “about every week,” “about every month,” and “rarely or never.” We dichotomized the responses into “daily + once a week + weekly + monthly” vs “rarely or never” had the complaint within the past 6 months. Asthma was measured by the question: “Has the doctor ever told you that you have asthma?” The response key was “yes” and “no.”

STATISTICAL ANALYSES

The statistical analyses involved 3 steps. The first was a comparison of the children with and without a matching parent questionnaire in relation to all included variables, testing for homogeneity by the χ^2 test. The second step was evaluating agreement by percent agreement and κ and γ statistics. The third step was predictor analyses calculated by means of logistic regression analyses. We focused on the cases in which the children reported more use of medicine than the parents did ($C > P$), as this was the situation most frequently observed. We treated $C > P$ as the dependent variable (binary variable: $C > P$ vs complete agreement + parents reporting more use of medicine than the children [$P > C$]) and sex, age group, family SEP, ethnicity, and prevalence of complaints as independent variables. We conducted analyses of sensitivity for family SEP and ethnicity by using different cut-off points (data not

Table 1. Number of Participants and Complete Data

Parameter	11-Year-Olds		13-Year-Olds		Total
	Boys	Girls	Boys	Girls	
Completed child questionnaires (n)	127	151	151	166	595
Matched pairs of children and parents (n)	81	105	94	113	393
Complete matched data on medicine use (n)					
headache	80	104	94	112	390
stomachache	79	101	91	109	380
difficulties in getting to sleep	80	99	91	106	376
nervousness	81	99	91	106	377
asthma	80	99	92	107	378

shown). These analyses demonstrated that choices of cut-off points did not change the direction of the associations between the predictor variables and the outcome variable.

Results

The comparison of the children with ($n = 393$) and without ($n = 202$) matching parent questionnaires showed no difference in relation to sex; age; medicine use for headache, difficulties falling asleep, nervousness, and asthma; and frequency of the 5 complaints ($p > 0.13$ for all). The children without matching parent questionnaires included a higher proportion from lower socioeconomic backgrounds (15.3% vs 27.2%, respectively; $p = 0.002$), a higher proportion who did not speak Danish at home (5.5% vs 9.8%, respectively; $p = 0.057$), and a higher proportion who reported medicine use for stomachache (14.0% vs 19.3%, respectively; $p = 0.096$).

Table 2 shows the prevalence of medicine use for the 5 complaints. More children than parents reported use of medicine, especially for difficulties in getting to sleep (10.6% vs 1.3%, respectively) and nervousness (7.2% vs 1.1%, respectively).

Table 3 displays the results of the agreement analyses by percent agreement, percent C > P, percent P > C, and simple κ and γ statistics. The percent agreement for boys and girls of both ages, was lowest for medicine use for headache (64.6%), whereas the percent agreements for medicine use for the other 4 complaints were very high (between 85.3% and 91.8%). The proportion of C > P and P > C are highest for medicine use for headache (22.1% and 13.3%, respectively).

Complaint	11-Year-Olds (%)		13-Year-Olds (%)		Total (%)
	Boys	Girls	Boys	Girls	
Headache					
child-reported	41.3	35.6	37.2	50.9	41.5
parent-reported	37.5	28.9	41.5	39.3	36.7
Stomachache					
child-reported	15.2	8.9	8.8	21.1	13.7
parent-reported	3.8	7.9	2.2	16.5	8.2
Difficulties in getting to sleep					
child-reported	17.5	10.1	6.6	9.4	10.6
parent-reported	1.3	0	1.1	2.8	1.3
Nervousness					
child-reported	14.8	6.1	4.4	4.7	7.2
parent-reported	1.2	0	1.1	1.9	1.1
Asthma					
child-reported	11.3	7.1	14.1	11.2	10.9
parent-reported	3.8	9.1	12.0	7.5	8.2

^aMatched data; $n = 393$.

The percent agreement for the dichotomized items (yes vs no) was higher for medicine use for headache (73.6%), stomachache (88.2%), and asthma (93.1%), but unchanged for medicine use for difficulties in getting to sleep and nervousness. The proportion of C > P and P > C was still highest for medicine use for headache, at 15.6% and 10.8%, respectively (results not shown).

In contrast to the percent agreement, the κ statistic takes into account the agreements expected by chance. According to Fleiss,²⁰ κ coefficients in the interval 0.75–1.00 are excellent, 0.40–0.74 good, and below 0.40 moderate or poor. The weighed κ coefficients were moderate to good in all sex and age subgroups (except 11-year-old boys) for medicine use for aches and asthma, but poor for difficulties in getting to sleep and nervousness. The combination of high percent agreement and low κ reflects that the few cases of disagreement were systematic; in this case, the instances of disagreement were almost exclusively children reporting more use of medicines than did parents. The γ coefficient measures the association between 2 ordered categorical variables. According to Kreiner,²¹ associations above 0.30 are strong, between 0.15 and 0.30 are moderate, and below 0.15 are weak. The γ coefficients were very high and significant for headache, stomachache (except among the 11-year-old boys), and asthma (between 0.57 ± 0.13 and 1.00 ± 0.00 , mean \pm ASE).

Table 4 shows predictors for C > P for headache. In the mutually adjusted analyses, the odds ratios for children reporting more use of medicine than did their parents were very high, although not all were significant, among ethnic Danish children (OR 3.39; 95% CI 0.43 to 26.65), children from higher SEP (OR 1.71; 95% CI 0.68 to 4.31), and among children who reported having had a headache the past month (OR 1.84; 95% CI 1.03 to 3.31). In the mutually adjusted analyses for the 3 other complaints, only the complaint itself was predictive of C > P.

Discussion

This article has 3 important findings. First, the agreement between children's and parents' responses about the children's medicine use for headache, stomachache, and asthma was high. Second, most cases of disagreement reflected that children reported more use of medicine than parents did. Third, children who had experienced the specific complaint during the past month were more likely to report more medicine use than were their parents. In many ways, the results of this study are in accordance with other studies of the validity of children's reports of health-related behaviors^{10–17}; these studies show fair to high validity and test–retest reliability, as well as some misclassification that should be taken into consideration in the interpretation and use of the results. We have not been able to find other stud-

ies that examined the validity of self-reported answers on medicine use among children and adolescents.

This study has some limitations. Although the sample included very different schools, it was not nationally representative. However, when we compared the prevalence of medicine use to that in the nationally representative HBSC study from 2002, the prevalence in comparable sex- and age-composed subgroups was quite similar: the proportion in the nationally representative study who had used medicine for 4 of 5 complaints during the prior month was 40.4% for headache, 15.0% for stomachache, 4.2% for difficulties in getting to sleep, and 3.7% for nervousness. There is a risk of selection bias because of the nonresponse of 16% and because we can use only matched data, that is, only 55.6% of the children enrolled in the participating classes. Comparison between the children whose parents did answer and did not answer the questionnaire showed similar frequencies of medicine use, except for stomachache, but a higher prevalence of non-Danish children

and children from lower socioeconomic positions. Furthermore, this study might miss children with a high use of medicine, as non-Danish children have a greater tendency to use medicine than do ethnic Danish children.²² It is difficult to assess how this influences our findings, but we have no reason to believe that the child–parent agreement is different among included and not-included children. The non-Danish children who are excluded because of lack of parent match might also be the children with high child–parent disagreement. The finding that children report more medicine use than their parents do is more common among ethnic Danes; this might be biased by the exclusion of non-Danish children. Finally, this study is based on self-reported medicine use. We do not ask the children to report on specific medications, as this might be impossible for this age group to answer^{23,24}; rather, our study concerns specific behaviors, namely, medicine use for a specific complaint. Studies that assess use of medicines in this age group approach both parents⁸ as well as the children themselves¹:

Table 3. Percent Agreement and Simple κ and γ Coefficients for the Agreement Between Parents' and Children's Responses

Parameter	11-Year-Olds		13-Year-Olds		Total
	Boys	Girls	Boys	Girls	
Percent agreement for medicine use for					
headache	58.8	72.1	61.7	64.3	64.6
C > P	26.3	17.3	21.3	24.1	22.1
P > C	15.0	10.6	17.0	11.6	13.3
stomachache	82.3	90.1	91.2	78.0	85.3
C > P	13.9	5.9	7.7	13.8	10.3
P > C	3.8	4.0	1.1	8.3	4.5
difficulties in getting to sleep	81.3	89.9	92.3	88.7	88.3
C > P	17.5	10.1	6.6	9.4	10.6
P > C	1.3	0	1.1	1.9	1.1
nervousness	84.0	93.9	94.5	93.4	91.8
C > P	14.8	6.1	4.4	4.7	7.2
P > C	1.2	0	1.1	1.9	1.1
asthma	88.8	94.9	88.0	89.7	91.3
C > P	11.3	1.0	7.6	7.5	5.8
P > C	0	4.0	4.3	2.8	2.9
Weighed κ coefficients (95% CI) for medicine use for					
headache	0.31 (0.13 to 0.49)	0.45 (0.29 to 0.62)	0.40 (0.25 to 0.55)	0.43 (0.29 to 0.58)	0.41 (0.33 to 0.49)
stomachache	0.04 (-0.11 to 0.19)	0.41 (0.18 to 0.65)	0.26 (0.01 to 0.52)	0.37 (0.22 to 0.64)	0.31 (0.19 to 0.43)
difficulties in getting to sleep ^a				0.06 (-0.11 to 0.24)	0.009 (-0.05 to 0.06)
nervousness ^a					
asthma ^a		0.74 (0.51 to 0.97)	0.61 (0.39 to 0.83)	0.41 (0.16 to 0.66)	0.58 (0.44 to 0.71)
γ Coefficients (mean \pm ASE) for medicine use for					
headache	0.57 \pm 0.13	0.74 \pm 0.09	0.70 \pm 0.09	0.67 \pm 0.09	0.67 \pm 0.05
stomachache	0.42 \pm 0.43	0.91 \pm 0.05	0.97 \pm 0.02	0.76 \pm 0.10	0.82 \pm 0.05
difficulties in getting to sleep ^a				0.66 \pm 0.33	0.38 \pm 0.48
nervousness ^a					
asthma	1.00 \pm 0.00	0.99 \pm 0.02	0.93 \pm 0.04	0.89 \pm 0.06	0.94 \pm 0.02
ASE = asymptomatic standard error; C > P = children reporting more medicine use than parents; P > C = parents reporting more medicine use than children.					
^a Blank spaces indicate that data were not calculated due to few observations or mathematical conditions not met.					

therefore, it is important to know the agreement between these groups of respondents.

Disagreement between children's and their parents' responses to items about medicine use can be interpreted in several ways. One possibility is differences in memory, conscious or nonconscious, about the episodes in which the children used medicine; perhaps the parents do not want to admit their children's use of medicines. Another reason for the discrepancies may be different perceptions of health complaints between children and parents. The children's reports can, however, be more valid than those of their parents, especially if the children have free access to medicines from other sources without their parents' knowledge. It may well be that the parents do not know the children's sources of drugs. This problem raises the need for further studies about the supply of medicine to children.

Despite these limitations, we have some confidence in young adolescents' self-reports of medicine use because the findings are in line with those of studies on other kinds of health-related behaviors among adolescents. The high proportion of child–parent agreement in our study suggests that such data can be used in epidemiological studies that aim to categorize children into groups with and without medicine use.

Conclusions

Validation of children's self-reports of medicine use is a very important contribution to the research of children's medicine use behavior. This study examined the agreement between parents' and children's reports on medicine use for 5 common complaints: headache, stomachache, difficulties in getting to sleep, nervousness, and asthma. The agreement for 3 of the complaints was high, which gives us confidence about young adolescents' self-reports on medicine use for headache, stomachache, and asthma. For this age group, it seems relevant to ask the children themselves about medicine use for common complaints.

Predictor	OR (95% CI)	
	Crude	Mutually Adjusted
Sex (girl vs boy)	0.85 (0.53 to 1.38)	0.75 (0.42 to 1.34)
Age group (13 vs 11 y)	1.10 (0.68 to 1.78)	1.07 (0.60 to 1.90)
Ethnicity (Danish vs minority)	5.48 (0.72 to 41.58)	3.39 (0.43 to 26.65)
Family SEP (high vs low)	1.50 (0.67 to 3.36)	1.71 (0.68 to 4.31)
Headache past month (yes vs no)	1.58 (0.97 to 2.55)	1.84 (1.03 to 3.31)

SEP = socioeconomic position.

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EXTRACTO

OBJETIVO: Determinar como concuerdan los reportes de padres y niños sobre el uso de fármacos para 5 dolencia comunes y analizar pronosticadores de desacuerdo.

MÉTODOS: Los investigadores usaron la encuesta de validación niño-padre del proyecto de investigación "Comportamiento de Salud en Niños de Edad Escolar." Trescientos noventa y tres niños daneses de 11 y 13 años y sus padres respondieron a cuestionarios idénticos. Las medidas de resultados principales fueron el uso de fármacos para dolor de cabeza, dolor de estómago, dificultades para conseguir el sueño, nerviosismo, y asma durante el último mes.

RESULTADOS: El porcentaje de concordancia fue menor para el uso de medicinas para el dolor de cabeza (64.6%) pero muy alto para las otras 4 dolencia (85.3%–91.8%). Los coeficientes κ simples fueron de moderados a buenos para el uso de fármacos para los 2 tipos de dolor y asma (0.31–0.58), pero pobre para dificultades para conseguir el sueño y nerviosismo. Los niños que tuvieron la dolencia específica durante el último mes era mas probable que reportaran un uso de fármacos mas frecuente que sus padres.

CONCLUSIONES: Los autores concluyen que tienen confianza en los reportes sobre el uso de fármacos de adolescentes jóvenes porque los resultados de este estudio concuerdan con otros estudios sobre la validez de reportes de niños sobre comportamientos relacionados a la salud. Además, los hallazgos sugieren que estos datos pueden ser usados en estudios epidemiológicos dirigidos a categorizar niños en grupos con o sin uso de fármacos.

Juan F Feliú

RÉSUMÉ

MISE EN CONTEXTE: La validité des auto-questionnaires sur l'emploi des médicaments chez les enfants n'a pas été mesurée.

OBJECTIF: Déterminer la concordance entre les parents et les enfants sur l'utilisation de médicaments dans 5 conditions cliniques déterminées et identifier les facteurs pouvant prédire un désaccord.

MÉTHODES: Nous avons utilisé le questionnaire parent-enfant validé pour le projet de recherche Health Behavior in School-Aged Children. Trois cents quatre-vingt-dix trois enfants danois âgés entre 11 et 13 ans, de même que leurs parents ont répondu au même questionnaire. Les questions portaient sur l'utilisation de médicaments pour traiter les maux de tête, maux d'estomac, insomnie, nervosité, et asthme durant le mois précédent.

RÉSULTATS: La concordance était la plus basse pour les maux de tête (64.6%) mais très élevée pour les 4 autres conditions (85.3–91.8%). Les coefficients de κ simple étaient de modéré à bon pour les maux de tête et d'estomac et l'asthme, mais faible pour l'insomnie et la nervosité. Les enfants ayant présenté 2 épisodes d'une condition au cours du dernier mois avaient tendance à rapporter un usage plus fréquent que leurs parents.

CONCLUSIONS: Nous avons confiance dans l'usage de médicaments tel que rapporté par les adolescents, puisque ces résultats sont en conformité avec ceux rapportés dans d'autres études. De plus, ces résultats suggèrent que ces données peuvent être utilisées dans des études épidémiologiques visant à catégoriser les enfants qui utilisent ou non des médicaments.

Nicolas Paquette-Lamontagne