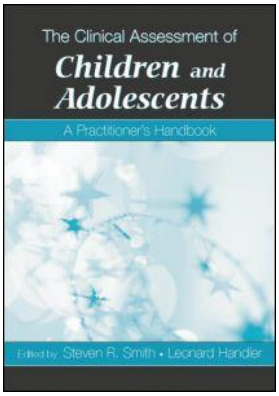

The Clinical Assessment of Children and Adolescents: A Practitioner's Handbook

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Applications of the Achenbach System of Empirically Based Assessment to Children, Adolescents, and Their Parents

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CHAPTER

19

APPLICATIONS OF THE ACHENBACH SYSTEM OF EMPIRICALLY BASED ASSESSMENT TO CHILDREN, ADOLESCENTS, AND THEIR PARENTS

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The Achenbach System of Empirically Based Assessment (ASEBA) comprises a family of assessment instruments for ages 1½ to 90+ years. The instruments are designed to assess a broad spectrum of problems and adaptive functioning, as reported by the people who are being assessed and by people who know them ("collaterals"), as well as by clinical interviewers, direct observers, and psychological examiners. Data are obtained on standardized rating forms that can be filled out in about 10 to 20 minutes. The forms include both structured items that are scored quantitatively and open-ended items that elicit clinically useful information in the respondent's own words. If a respondent cannot complete a form independently, the items can be read to the respondent by a receptionist or other nonclinician, who then writes the responses on the form.

Each form is tailored to the ages of the people being assessed and to the types of informants who complete the forms. The forms are scored on profiles of scales that enable users to compare the individual being assessed with scores obtained by normative samples of peers. Although this book focuses mainly on children and adolescents, the present chapter includes assessment of parents, because their problems and adaptive characteristics are often closely intertwined with those of their offspring. Clinical assessment of children and adolescents should therefore include assessment of their parents whenever possible. By having parents complete the ASEBA adult forms, clinicians can compare problems reported for parents with those reported for their children. The ASEBA adult forms can also be used to assess "identified patients" who have reached their 18th birthday and may be appropriate for assessing "emancipated minors" who are younger than 18 but live away from parent figures.

ASEBA forms and profiles are designed to help clinicians make direct comparisons between the problems reported for children by multiple informants, including parents, teachers, and the children themselves. Parallel self- and collateral-report forms for adults also

enable clinicians to compare parents' views of themselves with how they are viewed by spouses, partners, and other informants. The typical levels of agreement between most combinations of informants are modest, as shown by meta-analyses of cross-informant correlations between reports of both child and adult psychopathology (Achenbach, Krukowski, Dumenci, & Ivanova, 2005; Achenbach, McConaughy, & Howell, 1987; Duhig, Renk, Epstein, & Phares, 2000; Renk & Phares, 2004). This means that no single source of data, including self-reports, is likely to provide a gold standard for assessment. It also means that each informant may add clinically valuable information, both at initial assessments and at subsequent assessments to evaluate the progress and outcome of treatments. Table 19.1 lists ASEBA forms for ages 1½ to 59 years and indicates who completes each form. As referenced in Table 19.1, the manuals for the forms provide extensive reliability, validity, and normative data, as well as clinical and research applications.

DEVELOPMENT OF ASEBA FORMS AND SCALES

The development of the ASEBA began in the 1960s with efforts to determine whether more differentiated patterns of child and adolescent psychopathology could be identified than were evident in the official diagnostic system of the time, which was embodied in the first edition of the American Psychiatric Association's (1952) *Diagnostic and Statistical Manual* (DSM-I). By factor analyzing problems reported in child and adolescent psychiatric case records, Achenbach (1966) found considerably more patterns of problems than were identified in the DSM-I diagnostic categories for children and adolescents. Achenbach also found broad groupings of problems for which he coined the terms *Internalizing* and *Externalizing*. Internalizing problems include those that are primarily within the self, such as anxiety, depression, and somatic complaints without apparent physical causes. Externalizing problems, by

TABLE 19.1.
ASEBA Forms for Ages 1½ to 59 Years

Name of Form	*Filled Out By*
Child Behavior Checklist for Ages 1½–5 (CBCL/1½–5)	Parents; surrogates
Caregiver-Teacher Report Form for Ages 1½–5 (C-TRF)	Daycare providers; preschool teachers
Child Behavior Checklist for Ages 6–18 (CBCL/6–18)	Parents; surrogates
Teacher's Report Form for Ages 6–18 (TRF)	Teachers; school counselors
Youth Self-Report for Ages 11–18 (YSR)	Youths
Semistructured Clinical Interview for Children and Adolescents for Ages 6–18 (SCICA)	Clinical interviewers
Direct Observation Form for Ages 5–14 (DOF)	Observers
Test Observation Form for Ages 2–18 (TOF)	Psychological examiners
Adult Self-Report for Ages 18–59 (ASR)	Emancipated minors, adults
Adult Behavior Checklist for Ages 18–59 (ABCL)	Spouse, partner, grown children, relatives, friends, roommates, therapists

Note. The primary references for the forms are the Manuals, as follows: CBCL/1½–5 and C-TRF, Achenbach and Rescorla (2000); CBCL/6–18, TRF, YSR, and DOF, Achenbach and Rescorla (2001); SCICA, McConaughy and Achenbach (2001); TOF, McConaughy and Achenbach, (2004); ASR and ABCL, Achenbach and Rescorla (2003). The Manuals provide extensive reliability, validity, and normative data, plus illustrations of clinical and research applications and relations to other instruments.

contrast, include those that involve conflict with other people and with social mores, such as fighting, attacking people, lying, and stealing.

Empirically Based, Bottom-up Syndrome Scales

From the 1970s through the present, the approach embodied in Achenbach's (1966) study has been used to construct instruments for obtaining reports directly from different kinds of informants. The instruments have been developed through iterative stages in which draft items were tried out with samples of the intended informants who completed the items and provided feedback concerning the items and format. When the items were finalized, they were tested for their ability to discriminate between children who were referred for mental health services and demographically similar nonreferred children. Factor analytic procedures were used to identify *syndromes* (i.e., patterns) of problems that tended to co-occur. Syndromes that were found to be statistically robust in a variety of analyses were then used to construct scales of problem items. A syndrome scale consists of problem items that were found to co-occur in ratings by a particular kind of informant.

As an example, on the Child Behavior Checklist for Ages 6 to 18 (CBCL/6–18), factor analyses of ratings of children by their parents yielded eight syndromes (Achenbach, 1991; Achenbach & Rescorla, 2001). One of these syndromes is labeled *Aggressive Behavior*. This syndrome includes items such as *Gets in many fights; Cruelty, bullying, or meanness to others*; and *Physically attacks people.* Each item is rated 0 = *not true*, 1 = *somewhat or sometimes true*, and 2 = *very true or often true*, based on the preceding six months. A child's score on the Aggressive Behavior syndrome scale consists of the sum of the 1 and 2 ratings of the constituent items by the person who filled out the CBCL/6–18.

Profiles of Syndrome Scales

To enable clinicians to quickly see how a child compares with peers on the Aggressive Behavior syndrome and the other syndromes scored from the CBCL/6–18, the syndromes are displayed on a profile in relation to percentiles and standard scores (*T* scores), which are based on scores obtained by a national normative sample of the child's age and gender. Figure 19–1 illustrates a computer-scored CBCL/6–18 profile for 14-year-old Lonnie (not his real name) scored from the CBCL/6–18 completed by his mother. (Hand-scored profiles are also available.)

By looking at the bottom right side of Figure 19–1, you can see abbreviated versions of the problem items that make up the Aggressive Behavior scale. To the left of the items are the numbers the items bear on the CBCL/6–18, and to the left of each number is the 0, 1, or 2 rating given the item by Lonnie's mother. Lonnie's total score of 18 for the Aggressive Behavior syndrome is printed above the list of problem items. This score was obtained by summing the 1 and 2 ratings shown to the left of the items of the Aggressive Behavior syndrome. Beneath the 18, the number 72 is printed. This is the *T* score equivalent of the raw score of 18, based on a national normative sample of 12- to 18-year-old boys who had not received mental health services in the preceding 12 months. The *C* to the right of the *T* score indicates that it is in the clinical range, that is, above a *T* score of 69. Beneath the *T* score of 72, the >97 indicates that Lonnie's syndrome score is above the 97th percentile for the normative sample.

By looking to the left of the Aggressive Behavior scale, you can see Lonnie's scores on the other seven syndromes scored from the CBCL/6–18. The graphic display shows how

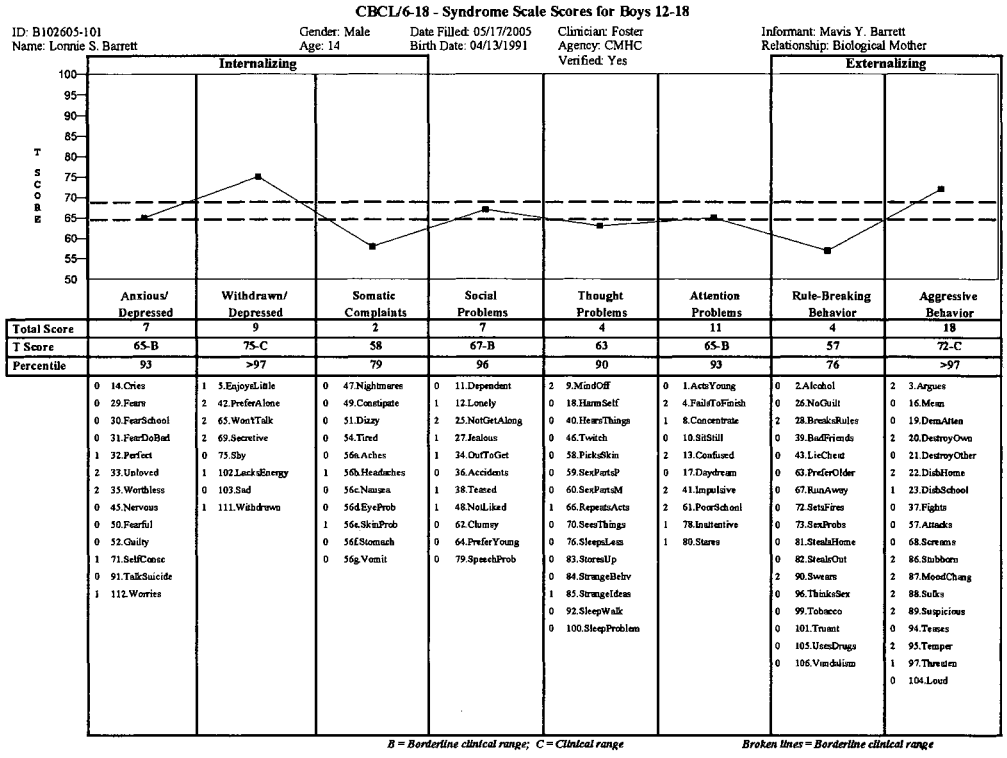


FIGURE 19–1. Computerized syndrome profile scored for 14-year-old Lonnie from CBCL/6–18, completed by his mother. (Hand-scored profiles are also available.)

Lonnie's score on each syndrome compares with the distribution of *T* scores (listed to the left of the profile) for the national normative sample of 12- to 18-year-old boys. Scores that are above the top broken line (above *T* 69) are in the clinical range, which exceeds the 97th percentile for the normative sample. Scores that are between the two broken lines are in the borderline clinical range (*T* 65 through *T* 69; 93rd through 97th percentiles). And scores that are below the bottom broken line are in the normal range (below *T* 65 and the 93rd percentile). In addition to the Aggressive Behavior syndrome, the other syndromes scored from the CBCL/6–18 are designated as *Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention Problems*, and *Rule-Breaking Behavior.* Counterparts of the eight syndromes scored from the CBCL/6–18 are also scored from the Teacher's Report Form for Ages 6 to 18 (TRF) and from the Youth Self-Report for Ages 11 to 18 (YSR). The syndromes scored from these three instruments and the other instruments for ages 1½ to 59 years are listed in Table 19.2.

The syndrome scales were derived by factor analyzing problem item ratings for thousands of individuals. The scales were designed to identify actual patterns of co-occurrence among problems, as seen by each type of informant. This approach to constructing scales is known as "empirically based" or "bottom up," because it starts with ratings of many problem items for many individuals and then statistically identifies patterns of co-occurrence among the items.

Ages 1½–5				
CBCL, C-TRF	Emotionally reactive Anxious/depressed Somatic complaints Withdrawn Sleep problems[a] Attention problems Aggressive behavior	Affective problems Anxiety problems Pervasive developmental problems Attention deficit/hyperactivity problems Oppositional defiant problems	*Language development Survey*[a] Length of phrases Vocabulary	none
Ages 5–14				
DOF	Withdrawn-inattentive Nervous-obsessive Depressed Hyperactive Attention demanding Aggressive	None	On-task behavior	None
Ages 6–18				
CBCL, TRF, YSR, SCICA	Anxious/depressed Withdrawn/depressed Somatic complaints Social problems[d] Thought problems[d] Attention problems[e] Rule-breaking behavior[f] Aggressive behavior[f] Anxious[g] Language/motor problems[g] Self-control problems[g]	Affective problems Anxiety problems Somatic problems Attention deficit/hyperactivity problems[e] Oppositional defiant problems Conduct problems	Activities[b] Social[b] School[b] Total competence[b] Academic[c] Adaptive functioning[c]	None

(*co*

TABLE 19.2. (*Continued*)

Forms	*Syndromes*	*DSM-Oriented Scales*	*Strengths*	*Substa*
Ages 2–18				
TOF	Withdrawn/depressed	Attention deficit/hyperactivity problems[e]	None	None
	Language/thought problems			
	Anxious			
	Oppositional			
	Attention problems			
Ages 18–59				
ASR,	Anxious/depressed	Depressive problems	Friends	Tobacco
ABCL	Withdrawn	Anxiety problems	Spouse/partner	Alcohol
	Somatic complaints	Somatic problems	Family[h]	Drugs
	Thought problems	Avoidant personality problems	Job[h]	Mean sub
	Attention problems	Attention deficit/hyperactivity problems	Education[h]	
	Aggressive behavior	Antisocial personality problems	Mean adaptive[h]	
	Rule-breaking behavior			
	Intrusive			

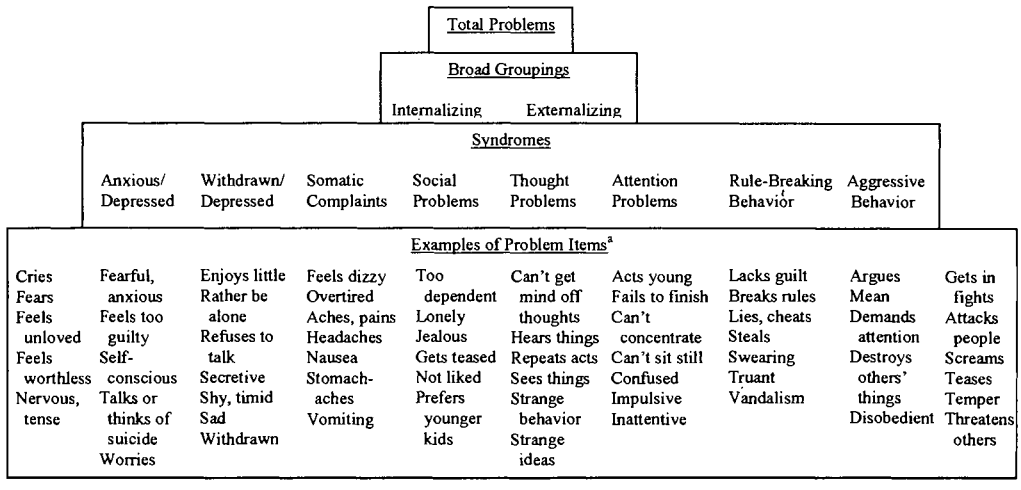
Note. Table 19.1 provides full names of forms. All forms are also scored in terms of the following groupings of problems: Internalizing, Externalizing, and Total
[a]CBCL/1½–5 only. [b]CBCL/6–18 and YSR only (on YSR the mean score for academic performance substitutes for the CBCL/6–18 School scale). [c]TRF only. [d]No
SCICA. [e]Attention Problems scales have subscales for Inattention and Hyperactivity-Impulsivity. [f]These two syndromes are combined on SCICA. [g]SCICA only. [h]ASR

Pyramid of Empirically Based Items and Scales

The empirically based, bottom-up approach can be viewed in terms of a pyramid of assessment levels, as illustrated in Figure 19–2. The base of the pyramid consists of many specific problem items, such as those that make up each of the syndromes shown in Figure 19–1. The next level of the pyramid consists of the syndromes that were derived by factor analyzing the correlations among ratings of the problem items for large samples of individuals.

Internalizing and Externalizing. The level immediately above the syndromes consists of groupings of syndromes that were found to be associated with each other in second-order factor analyses of correlations among the syndromes. ("Second-order" factor analyses are factor analyses of correlations among scores on scales, such as the syndromes, that were themselves derived from "first-order" factor analyses.) As an example, second-order factor analyses of the correlations among the eight CBCL/6–18 syndromes shown in Figure 19–1 yielded a grouping designated as *Internalizing*, which consists of the Anxious/Depressed, Withdrawn/Depressed, and Somatic Complaints syndromes. The second order-factor analyses of the CBCL/6–18 syndromes also yielded a grouping designated as *Externalizing*, which consists of the Rule-Breaking Behavior and Aggressive Behavior syndromes. A child's score for Internalizing is computed by summation of the child's scores for the three Internalizing syndromes. Similarly, the child's score for Externalizing is computed by summation of the child's scores for the two Externalizing syndromes. The Internalizing and Externalizing scores provide broad indices of the degree to which the reported problems are within the self, involve conflict with other people and with social mores, both, or neither. The remaining three syndromes were not found to be consistently associated with either the Internalizing or Externalizing groupings.

Total Problems. At the top of the pyramid, the Total Problems score consists of the sum of the 1 and 2 ratings of all problem items on a form such as the CBCL/6–18. The



[a]Abbreviated versions of CBCL/6-18, TRF, and YSR items.

FIGURE 19–2. Pyramid of empirically based assessment levels provided by the CBCL/6–18, TRF, and YSR.

problem items include all those that are on the eight syndromes, plus problem items that did not load significantly on any syndromes. Some of these other problem items are scored on the DSM-oriented scales that are presented in the following section. Others are not members of any scale except the Total Problems scale, but are intrinsically important in their own right, such as *Cruel to animals.*

DSM-Oriented Scales

In addition to the empirically based scales, the problem items of ASEBA forms are scored in terms of *DSM-oriented scales.* These scales enable clinicians to quickly identify areas in which relatively high problem levels suggest that an individual may qualify for particular DSM diagnoses. The DSM-oriented scales were constructed by enlisting international panels of expert psychiatrists and psychologists to identify ASEBA problem items that are very consistent with particular DSM-IV (American Psychiatric Association, 1994) diagnostic categories (Achenbach, Bernstein, & Dumenci, 2005; Achenbach, Dumenci, & Rescorla, 2003). Items that were identified by a large majority of the experts as being very consistent with a particular DSM-IV diagnostic category were used to construct scales analogous to the syndrome scales that were constructed by factor analysis of the same pools of items. For ages 6 to 18, the following six DSM-oriented scales were constructed from items of the CBCL/6–18, TRF, and YSR: *Affective Problems, Anxiety Problems, Somatic Problems, Attention Deficit Hyperactivity (ADH) Problems, Oppositional Defiant Problems,* and *Conduct Problems.* In addition, subscales for the Inattentive and Hyperactive-Impulsive types of ADH problems were constructed from the TRF. Table 19.2 lists the DSM-oriented scales scored from the ASEBA forms for ages 1½ to 59 years.

The DSM-oriented scales are displayed on profiles analogous to the profiles for the syndrome scales. Figure 19–3 illustrates the hand-scored profile of DSM-oriented scales scored from a TRF completed for 14-year-old Lonnie. (Computer-scored DSM-oriented profiles like those for the syndrome scales are also scored by the same program as the syndrome scales.) The score for a DSM-oriented scale is obtained by summation of the 1 and 2 ratings of its constituent items. The profile in Figure 19–3 indicates how Lonnie's score on each DSM-oriented scale compares with scores obtained by the national normative sample of 12- to 18-year-old boys rated by their teachers. Like the profiles for syndromes, the profiles for DSM-oriented scales display scores in relation to *T* scores and percentiles for the national normative sample. Scores above the top broken line are in the clinical range ($T > 69$; >97th percentile). Scores between the two broken lines are in the borderline clinical range (*T* 65 through 69; 93rd through 97th percentiles). And scores below the bottom broken line are in the normal range ($T < 65$; <93rd percentile). By looking at Figure 19–3, you can see that Lonnie's score on the ADH Problems scale was in the clinical range (above the top broken line), and his scores on the Anxiety Problems and Oppositional Defiant Problems scales were in the borderline clinical range.

Scales for Scoring Strengths

Comprehensive evaluations require assessment of strengths, as well as problems. To make it easy for clinicians to assess strengths with the same instruments that assess problems, most ASEBA self-report and other-report forms include sections for competence or adaptive functioning. Table 19.2 lists the names of the competence and adaptive functioning scales scored from the ASEBA instruments for ages 1½ to 59 years.

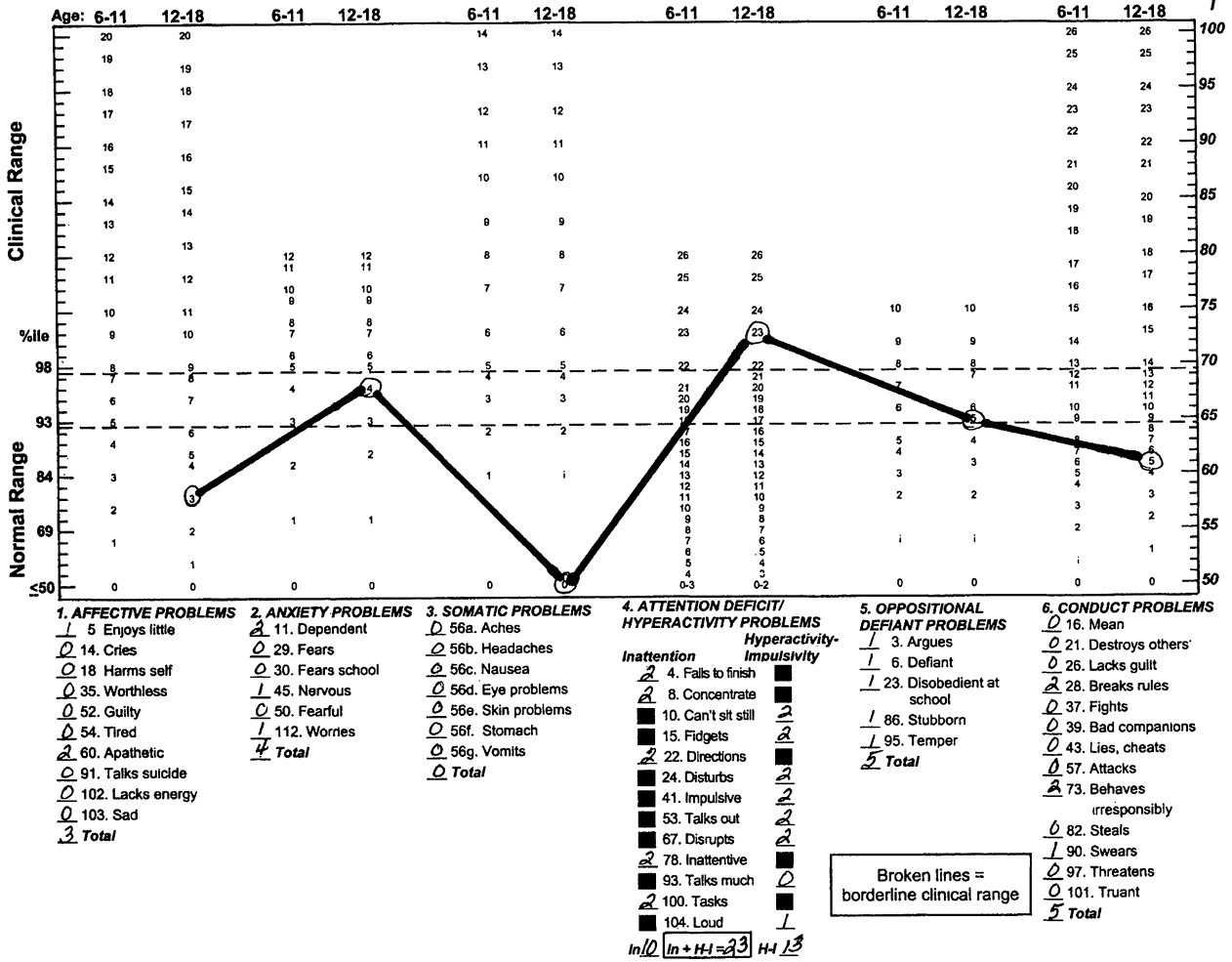


FIGURE 19–3. Hand-scored profile of DSM-oriented scales scored from a TRF completed by 14-year-old Lonnie's math teacher.

Competence scales for ages 6 to 18. The CBCL/6–18 and YSR assess competence in terms of items and scales for activities, social relationships, school, and total competence, which is the sum of the scores for the specific kinds of competence scored on the other scales. Figure 19–4 illustrates a computer-scored profile for the competencies reported by Lonnie's mother on the CBCL/6–18. Unlike the high scores that are clinically significant on the problem scales, low scores are clinically significant on the competence scales, because low scores indicate lower levels of competence than are reported for normative samples of peers. If you look at the competence profile scored for Lonnie in Figure 19–4, you can see that broken lines are printed across the lower portion of the graphic display. Scores below the bottom broken line, like Lonnie's score for the School scale, are in the clinical range of $T <$ 31, <3rd percentile, because they are lower than the scores obtained by the upper 97% of the national normative sample. Scores between the two broken lines, like Lonnie's score for the Social scale, are in the borderline clinical range (T 31 to 35; 3rd to 7th percentiles). And scores above the broken lines, like Lonnie's score for the Activities scale, are in the normal range ($T > 35$; >7th percentile).

On the right side of Figure 19–4 you can see Lonnie's Total Competence score, which is the sum of his scores on the Activities, Social, and School scales. Because the Total Competence score encompasses a broader spectrum of competencies than each of the more specific scales, the cutpoints for the clinical range ($T < 37$; <10th percentile) and borderline clinical range (T 37 through 40; 10th to 16th percentiles) are less conservative than those on

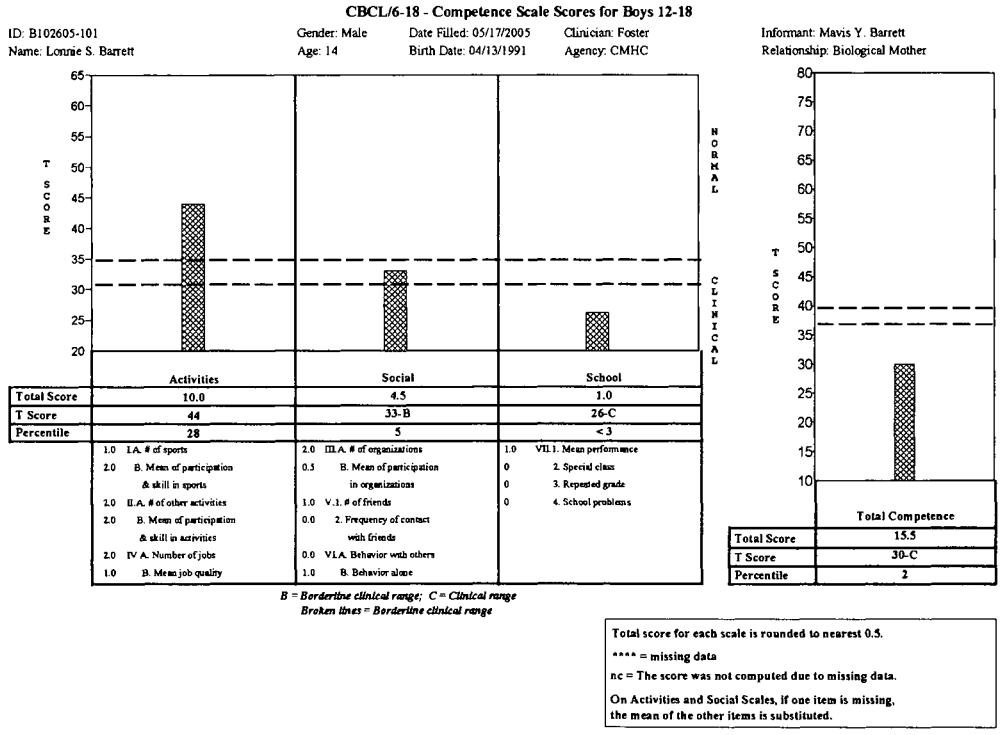


FIGURE 19–4. Computerized competence profile scored for 14-year-old Lonnie from CBCL/6–18 completed by his mother. (Hand-scored profiles are also available.)

the more specific scales. As Figure 19–4 shows, Lonnie's Total Competence score was in the clinical range. Strengths observed by teachers are scored on TRF scales for academic performance and adaptive functioning.

Adaptive functioning scales for ages 18 to 59. For ages 18 to 59, the Adult Self-Report (ASR) is scored on normed adaptive functioning scales designated as *Friends, Spouse/Partner, Family, Job*, and *Education*. The Spouse/Partner, Job, and Education scales are scored only for people who, during the preceding six months, were married or living with a partner, had a paid job, or were enrolled in an educational program, respectively. A *Mean Adaptive* score is computed as the average of the *T* scores for all the adaptive scales that are completed for the person being assessed. In addition to the adaptive functioning scales, the ASR and the Adult Behavior Checklist (ABCL) are scored on normed scales for use of tobacco, alcohol, and drugs for nonmedical purposes, and the mean of the specific substance use scales. The adaptive functioning and substance use scales enable clinicians to quickly assess important aspects of adults' functioning that are not tapped by the empirically based problem scales or DSM-oriented scales.

TYPICAL PROCEDURES FOR CLINICAL USE OF THE ASEBA

Children and adolescents seldom refer themselves for mental health services. Instead, parents, teachers, school psychologists, physicians, and other adults typically decide that help is needed. As part of the intake process, clinicians can request that each parent or guardian and other relevant adults complete the CBCL/1½–5 or CBCL/6–18. If a 1½- to 5-year-old child attends day care or preschool, the clinician can request the parents' permission for daycare providers and/or preschool teachers to complete the Caregiver-Teacher Report Form for Ages 1½ to 5 (C-TRF).

For ages 6 to 18, the clinician can request the parents' permission for as many teachers as possible to complete TRFs. These forms provide a great deal of information from multiple perspectives without requiring any of the clinician's time.

With the ASEBA Assessment Data Manager (ADM) computer program, clerical workers can enter and score the data. They can then give the clinician scored profiles, narrative reports, results for critical items, and systematic cross-informant comparisons, which are described in the following sections. To assess progress and outcomes, clinicians can request that the same people complete ASEBA forms on subsequent occasions for comparison with the profiles and scores obtained at intake. To avoid the need for staff to key or hand-score ASEBA forms, machine-readable CBCL/6–18, TRF, and YSR forms are available in both optical mark reading (OMR) and Teleform versions. A client-entry computer program is also available that enables parents and adolescents to key enter their own data at the clinician's office. In addition, ASEBA *Web-Link* makes it possible to send forms electronically from the clinician's computer to web-connected computers elsewhere for direct entry of data by parents, adolescents, and teachers. Web-Link then transmits the data back to the clinician's computer. For respondents who are not computer literate, Web-Link can be used to electronically print paper ASEBA forms on web-connected computers. After respondents fill out the forms, data clerks can enter the data from the paper forms at remote sites. Other options include faxing the completed forms, scanning them for electronic transmission, and mailing them to the clinician.

Cross-Informant Comparisons

When CBCL, C-TRF, TRF, YSR, ASR, and ABCL forms are entered into ADM, forms completed for the same individual can be systematically compared in a variety of ways, as described in the following sections.

Bar Graph Comparisons. To compare scores from up to eight forms on the empirically based syndromes, ADM prints a page of bar graphs showing the *T* scores obtained for each syndrome from ratings by each informant. ADM also prints bar graphs comparing scores from all informants on the DSM-oriented scales, Internalizing, Externalizing, and Total Problems. The bar graphs enable the clinician to quickly identify areas in which all or most informants report either many or few problems and areas in which there may be important differences between the kinds of problems reported by certain informants. These differences provide clinically valuable data both on how children and adolescents function in different contexts and on how they are perceived by different informants.

For example, Figure 19–5 shows the scores obtained by Lonnie on each DSM-oriented scale from CBCL/6–18 ratings by his mother and father, YSR ratings by Lonnie, and TRF ratings by his math, English, and science teachers. As you can see in Figure 19–5, there were some important variations in scores on the Affective Problems, Attention Deficit Hyperactivity Problems, Oppositional Defiant Problems, and Conduct Problems scales. These are discussed in the case illustration following this section.

Side-by-Side Comparisons of Item Ratings. In addition to the bar graph comparisons, ADM prints side-by-side comparisons of the 0–1–2 ratings obtained from each informant

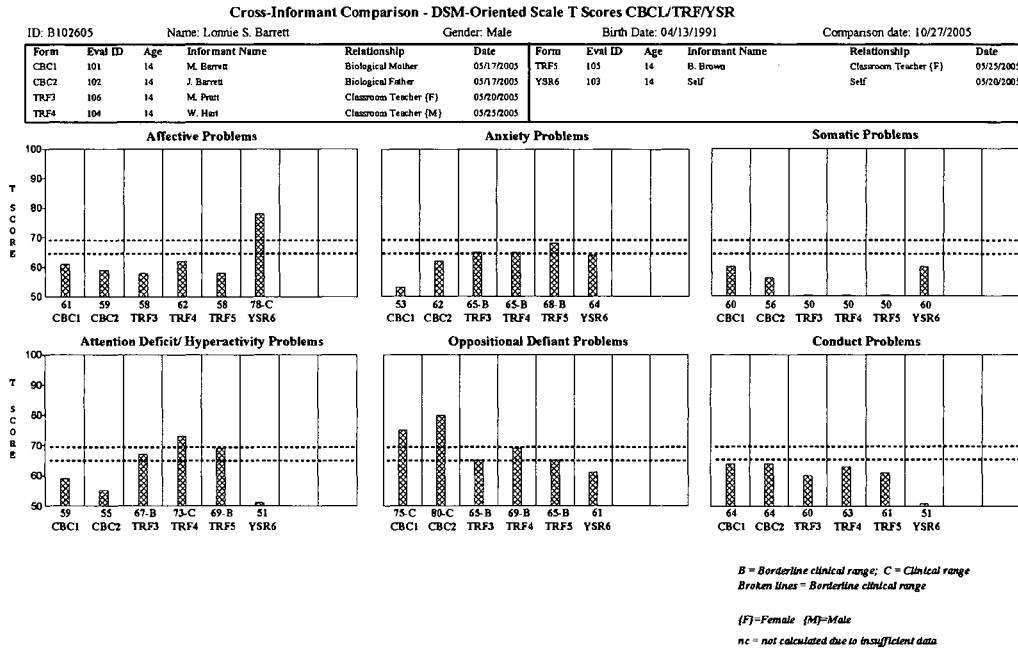


FIGURE 19–5. Bar graph comparisons of DSM-oriented scale scores for 14-year-old Lonnie from ASEBA forms completed by his mother, father, three teachers, and Lonnie himself.

on each problem item of each scale. By looking at the side-by-side printouts of item scores, the clinician can quickly identify items that are reported by all informants (i.e., are rated 1 or 2), those that are not reported by any informant (i.e., are rated 0), and those that are reported by some informants but not by others.

Correlations between Ratings by Different Informants. Because meta-analyses have shown only modest levels of agreement between most combinations of informants (Achenbach et al., 1987, 2005; Duhig et al., 2000; Renk & Phares, 2004), ADM provides clinicians with guidelines for judging the levels of agreement found between informants for each case. ADM does this by printing *Q* correlations between the 0–1–2 ratings of each problem item by each pair of informants. ADM then compares these *Q* correlations with the *Q* correlations previously found for large reference samples of similar pairs of informants. A *Q* correlation indicates the degree of consistency between ratings of a large number of items by two different raters. This differs from the more familiar type of correlation (known as *R* correlation) between two variables, each of which is scored for many individuals, such as the correlation between ability and achievement measured in 100 individuals.

ADM helps the clinician judge the relative magnitude of the *Q* correlation between two informants, such as a mother and father who each completed the CBCL/6–18. ADM does this by printing the 25th percentile, mean, and 75th percentile of the *Q* correlations from a large reference sample, such as mothers' and fathers' CBCL/6–18 ratings. On the printout, *Q* correlations below the 25th percentile of a reference sample are labeled as *below average*, those between the 25th and 75th percentiles are labeled as *average*, and those above the 75th percentile are labeled as *above average*. For example, if the *Q* correlation between CBCL/6–18 ratings by Lonnie's mother and father were below the 25th percentile of the reference sample, the printout would label the *Q* correlation between the CBCL/6–18 ratings as "below average." The clinician could then note that the exceptionally low agreement between Lonnie's mother and father warrants exploration. By interviewing the parents, the clinician may learn that the parents hold opposing views of Lonnie's behavior or that one parent has too little contact with Lonnie to be aware of certain problems. Another possible reason for a low *Q* correlation between parents' ratings is that one parent's relationship with Lonnie tends to trigger certain problem behaviors that are not observed by the other parent.

CASE ILLUSTRATION

Lonnie's mother brought him to a clinician at the urging of the school psychologist at Lonnie's school. Although Lonnie had previously been an excellent student, his academic performance and behavior had become very erratic. The school psychologist said that Lonnie seemed to be preoccupied, failed to pay attention, and had three angry outbursts in class. Lonnie's parents were also concerned about his conflicts with them.

As part of his standard evaluation procedure, the clinician requested that Lonnie's parents each complete the CBCL/6–18. He also requested that each parent complete the ASR to describe their own functioning and the ABCL to describe their spouse's functioning. Because Lonnie's father was away on an extended business trip, the clinician's receptionist used Web-Link to transmit the CBCL/6–18, ASR, and ABCL to him. Lonnie's father then completed and returned the forms to the clinician's office via Web-Link. To obtain a picture of Lonnie's functioning in school, the clinician requested parental permission to have Lonnie's

teachers complete TRFs. The TRFs were sent via Web-Link to the school psychologist, who agreed to have Lonnie's teachers complete them.

When the clinician initially met with him, Lonnie was sullen and uncommunicative. However, when the clinician told Lonnie that he'd like to have him complete the YSR and that Lonnie could complete it either on a computer at the office or at home via Web-Link, Lonnie agreed to complete the YSR on the office computer. The clinician's receptionist printed profiles and cross-informant comparisons from the completed CBCL/6–18, TRF, and YSR forms. Figure 19–5 displays the cross-informant comparisons of DSM-oriented scales from the CBCLs completed by each parent, the TRFs completed by three teachers, and the YSR completed by Lonnie. Figure 19–6 displays the syndrome profile scored from Lonnie's YSR.

As you can see in Figure 19–6, Lonnie's YSR ratings yielded scores in the clinical range (above the broken lines) on the Anxious/Depressed and Withdrawn/Depressed syndromes. His scores were in the borderline clinical range (between the two broken lines) on the Social Problems and Thought Problems syndromes. And his scores were in the normal range (below the bottom broken line) on the other syndromes. ADM also prints a narrative report (not shown) that describes the ASEBA results and that lists scores for critical items. These are items that clinicians have judged to be of particular concern. On the critical items, the clinician noted that Lonnie gave item *91, I think about killing myself*, a rating of 2, indicating *very*

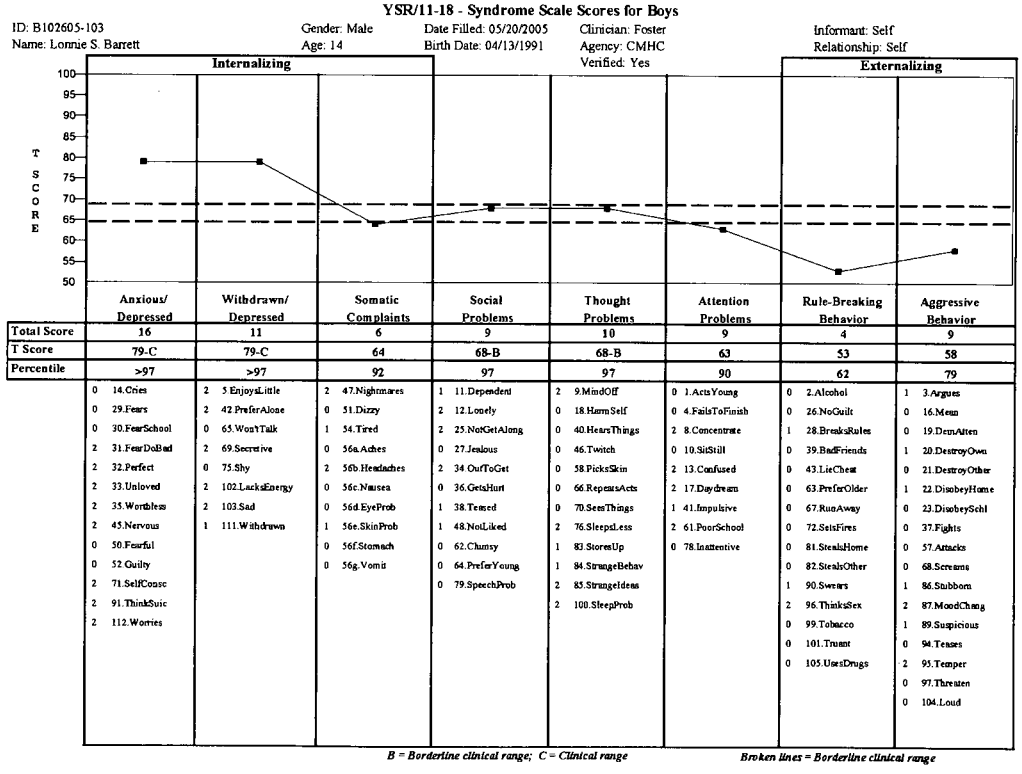


FIGURE 19–6. Computerized syndrome profile scored from YSR completed by 14-year-old Lonnie.

true or often true. In the spaces provided for answering open-ended items that request youths to report any concerns about school and any other concerns, Lonnie had entered "Since I changed school, I can't seem to keep up with the work," "My parents arguments are really getting to me," and "Kids at my new school are out to get me."

As Figure 19–7 shows, the cross-informant comparisons of syndrome scale scores revealed that Lonnie's YSR was the only form that yielded a score in the clinical range on the Anxious/Depressed syndrome. The CBCL/6–18 completed by Lonnie's mother yielded scores in the clinical range on the Withdrawn/Depressed and Aggressive Behavior syndromes, and the CBCL/6–18 completed by Lonnie's father yielded a score in the clinical range only on the Aggressive Behavior syndrome. The TRFs completed by two of Lonnie's teachers yielded scores in the clinical range on the Attention Problems syndrome, and the third TRF yielded a score in the borderline clinical range. Similarly, two of the TRFs yielded scores in the clinical range on the Social Problems syndrome, and the third yielded a score in the borderline clinical range.

The side-by-side comparisons of the 0–1–2 ratings of individual problem items showed that item *91* regarding suicidal thoughts and item *103* regarding being unhappy, sad, or depressed were endorsed only by Lonnie. Lonnie's suicidal thoughts and unhappiness were thus evidently not apparent to his parents or teachers. The relatively high CBCL/6–18 scores for Withdrawn/Depressed and Aggressive Behavior indicated that Lonnie's parents saw his problems mainly in terms of withdrawn and aggressive behavior. The aggressive behavior was especially marked in his fathers' ratings. Ratings by Lonnie's teachers, on the other hand, reflected deviance mainly in social and attentional problems. As shown previously in Figure 19–4, the CBCL/6–18 completed by Lonnie's mother yielded scores for the Activities scale in the normal range, the Social scale in the borderline clinical range, and the School scale in the clinical range. The YSR completed by Lonnie and the CBCL/6–18 completed by his father also indicated greater strength on the Activities scale than in social relations or school. On the TRF, scores were relatively low for academic performance and for adaptive functioning.

Profiles scored from the ASRs and ABCLs completed by Lonnie's parents revealed marked differences between their self-descriptions and how they were described by their spouse. Lonnie's mother's self-ratings on the ASR yielded a score in the clinical range on the Anxious/Depressed syndrome and in the normal range on the other syndromes. The ABCL completed by Lonnie's father to describe his wife, by contrast, yielded scores in the clinical range on the Somatic Complaints and Aggressive Behavior syndromes. The ASR completed by Lonnie's father yielded scores in the clinical range on the Withdrawn syndrome and scores in the normal range on the other syndromes. However, the ABCL completed by his wife yielded scores in the clinical range on the Attention Problems, Aggressive Behavior, Rule-Breaking Behavior, and Intrusive syndromes. The profiles of DSM-oriented scales scored from the two ASRs and ABCLs also revealed disparities between relatively high self-reported depression and social withdrawal versus spouse-reported problems in other areas.

Based on the cross-informant comparisons of problems reported for Lonnie and for his parents, the clinician inferred that the social and attentional problems reported by Lonnie's teachers and the decline in his grades were probably by-products of the suicidal thoughts and depressive affect that Lonnie was experiencing. Lonnie's recent move to a much bigger school and the negative affectivity and conflicting views of each other that were evident in Lonnie's parents' ASR and ABCL profiles, and in the arguments reported by Lonnie on the YSR, were likely factors in Lonnie's problems. The clinician decided that a possible cornerstone for work with Lonnie and his family would be to discuss with Lonnie's parents their contrasting views of each other and the consequences for Lonnie. If each parent granted

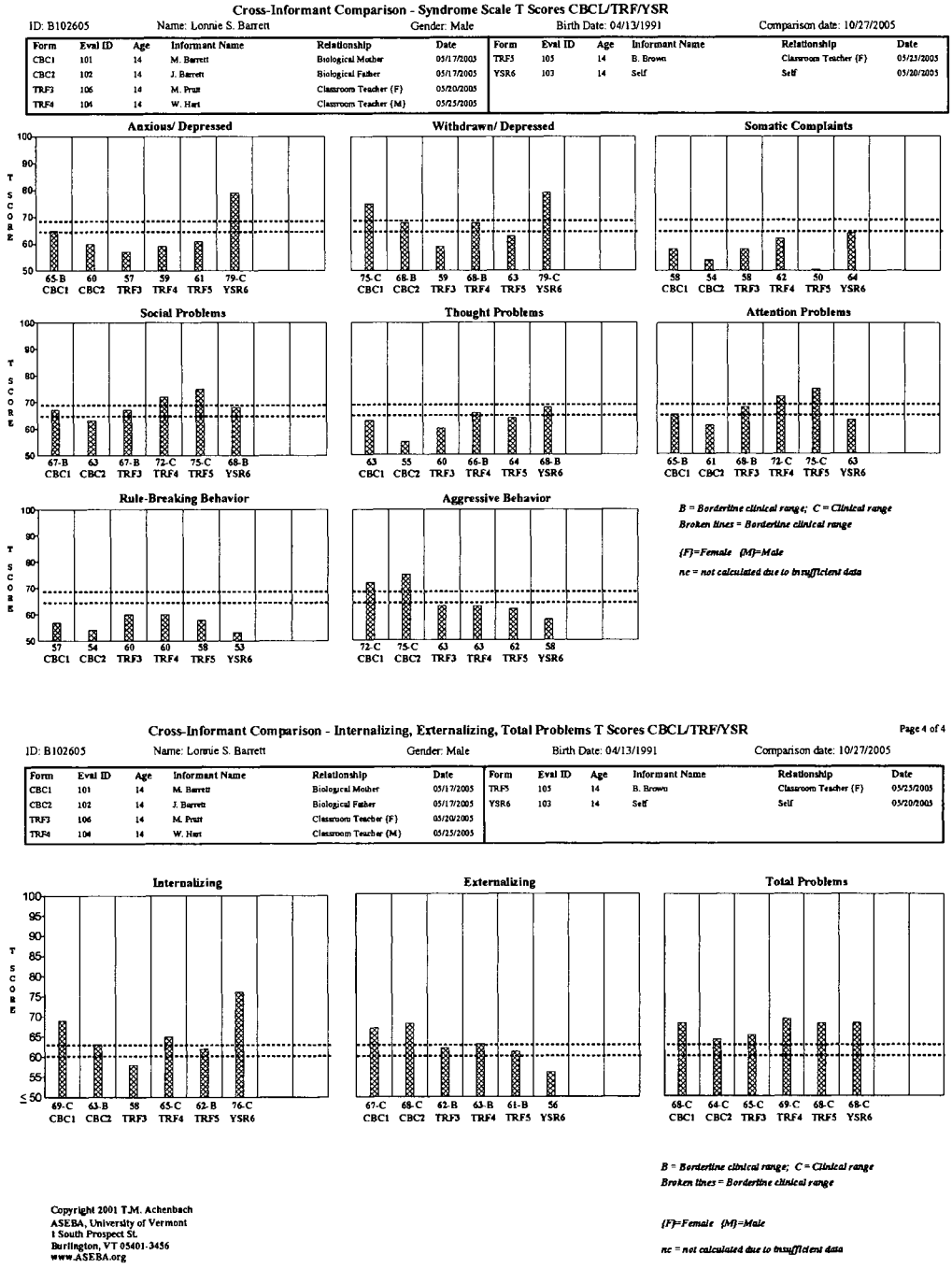


FIGURE 19–7. Bar graph comparisons of syndrome, internalizing, externalizing, and total problems scale scores for 14-year-old Lonnie from ASEBA forms completed by his mother, father, three teachers, and Lonnie himself.

permission, the clinician planned to show the ASR and ABCL profiles to both parents and to encourage a therapeutic alliance for improving their communication with each other and with Lonnie. Depending on how they responded, he would then propose the options of couples therapy for them with another therapist while he saw Lonnie for treatment or conjoint family therapy in which he would meet with Lonnie and both parents together. If the parents seemed unwilling or unable to work together in either of these modalities, he would suggest that they each obtain treatment for themselves while he worked primarily with Lonnie. Whichever treatment modality was selected, he would plan to have the ASEBA forms completed again in six months to evaluate progress.

The clinician's initial treatment goals were to improve communication and cooperation between the parents, to improve their communication with Lonnie, and to help Lonnie adapt to his new school. Accomplishing these goals seemed necessary to reduce Lonnie's depressive affect and suicidal ideation, which, in turn, interfered with his social and academic functioning. Progress could be measured in terms of improved social and school scores on the CBCL/6–18 and YSR competence scales, improved academic and adaptive functioning scores on the TRF, and reductions in scores on the DSM-oriented and syndrome scales that were deviant on the CBCL/6–18, TRF, and YSR forms completed during the initial evaluation, as shown in Figures 19–5 and 19–7. The problems reported for Lonnie and the evidence for impairment in academic and social functioning were consistent with a DSM-IV diagnosis of Dysthymic Disorder (American Psychiatric Association, 1994, 2000).

SUMMARY AND CONCLUSIONS

This chapter outlined the ASEBA and its applications to clinical assessment of children, adolescents, and their parents. ASEBA forms are tailored to the ages of the people being assessed, to different types of informants, and to the contexts in which they see the people who are being assessed. Because no one source of data can serve as a gold standard, the ASEBA is designed to obtain and systematically compare data from multiple informants. Differences between informants' reports are as clinically valuable as similarities, because they can reveal contextual variations in functioning and in informants' perspectives. Not only initial assessments but reassessments to evaluate the course and outcome of treatment should include data from self-reports and reports from multiple informants. Assessment of children and adolescents should also include assessment of parent figures whenever possible. Parents can easily be assessed via standardized self-reports and reports by people who know each parent, especially the parent's spouse or partner.

ASEBA forms are scored on profiles that display scores for items and scales, including strengths, syndromes, DSM-oriented, Internalizing, Externalizing, and Total Problems scales. The scale scores are displayed in relation to norms that are age-, gender-, and informant-specific. Percentiles, *T* scores, and cutpoints for normal, borderline, and clinical ranges are based on the norms. Clinical applications of the ASEBA were illustrated in the evaluation of 14-year-old Lonnie, as seen by each parent, three teachers, and Lonnie himself. As an important part of the evaluation of Lonnie, Lonnie's parents each completed the Adult Self-Report (ASR) to describe their own functioning and the Adult Behavior Checklist (ABCL) to describe the other parent's functioning. Without any cost in clinical time to obtain these assessments, they provided valuable information for understanding the family dynamics and for planning interventions.

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