Outline of Presentation

• “Top-down” & “bottom-up” challenges

• Multi-informant challenges

• Multi-cultural challenges

• Practical Solutions
“Top-Down” Approach

• Panels of experts negotiate diagnostic categories & criteria
• Categories are defined in terms of “yes” vs. “no” decision rules
• Field trials are used to evaluate criteria
• Criteria are uniform across age & gender
• Diagnoses are not operationally defined in terms of specific assessment procedures
TOP-DOWN APPROACH TO PSYCHOPATHOLOGY
STARTS WITH CONCEPTS OF DISORDERS

DEFINES CRITERIA

ADHD

INATTENTION
- Fails to give attention
- Difficulty sustaining attention
- Doesn’t listen

HYPER-IMPULS
- Fidgets
- Leaves seat
- Blurs out answers
- Interrupts

ASP

Deceitfulness
Impulsivity
Irritability
Irresponsibility
Empirically Based “Bottom-Up” Approach

- Start with data on large pools of items scored for large samples of individuals
- Derive syndromes by statistically analyzing item scores
- Norm syndrome scales on representative samples by age and gender
- Score individuals on normed profiles
- Syndromes are operationally defined by specific assessment procedures
BOTTOM-UP APPROACH TO PSYCHOPATHOLOGY

ATTENTION PROBLEMS

Can’t concentrate

Can’t sit still

AGGRESSIVE BEHAVIOR

Bullies

Fights

RULE-BREAKING BEHAVIOR

Lies

Steals

DERIVES SYNDROMES FROM STATISTICAL ASSOCIATIONS AMONG PROBLEMS

STARTS WITH DATA ON PROBLEMS
ID: 200105-002  
Name: Catherine A. Holcomb  
Clinician: Theresa Lopez

CBCL/6-18 - Syndrome Scale Scores for Girls 6-11
Gender: Female  
Age: 11  
Date Filled: 12/04/2000
Agency: School  
Relation: Biological Mother

Informant: Jane Holcomb  
Verified: Yes

<table>
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Copyright 2001 T.M. Achenbach  
B = Borderline clinical range; C = Clinical range  
Broken lines = Borderline clinical range
Relations Between “Bottom-Up” and “Top-Down” Approaches

- Similarities between some empirically based syndromes & DSM categories e.g., Attention Problems & ADHD
- Statistically significant associations between some syndromes & DSM diagnoses in numerous studies
- Findings vary according to assessment procedures, subjects, diagnosticians, & analytic methods
Multi-Informant Challenges

• Comprehensive assessment requires more than self-reports

• Informants’ reports often disagree with self-reports and with other informants’ reports
# Mean Correlations Between Informants' Ratings of Children

<table>
<thead>
<tr>
<th>Informant 1</th>
<th>$\bar{r}$</th>
<th>Parent</th>
<th>Teacher</th>
<th>Mental health worker</th>
<th>Observer</th>
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<tr>
<td>Parent</td>
<td>.60</td>
<td></td>
<td>.59</td>
<td></td>
<td></td>
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<td>Teacher</td>
<td></td>
<td>.27</td>
<td>.64</td>
<td></td>
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<tr>
<td>Mental health worker</td>
<td>.28</td>
<td>Box B</td>
<td>.24</td>
<td>.34</td>
<td>.54</td>
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<tr>
<td>Observer</td>
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<td>.57</td>
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<tr>
<td>Peer</td>
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<tr>
<td>Self</td>
<td>.22</td>
<td>Box C</td>
<td>.25</td>
<td>.20</td>
<td>.27</td>
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</table>

*Note.* The $\bar{r}$s were computed by $z$ transformation of $r$s weighted by the $df$ for each sample.

*Peers' correlations in all studies were based on aggregation of ratings by multiple peers.*
### Mean Correlations of Self x Informants’ Ratings of Adults

<table>
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<th>Problem type or instrument type</th>
<th>Mean Correlation</th>
<th>Df</th>
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<td><strong>Problem type</strong></td>
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<td>Substance use</td>
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<td>Interview</td>
<td>.35</td>
<td>1,063</td>
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<td>Questionnaire</td>
<td>.43</td>
<td>6,473</td>
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</table>
Why Self-Reports May Not Be Sufficient for Assessing Adults

- Mean self x informant correlations of .32-.45 for non-substance use, .66 for substance use

- 70% of diagnoses based on patient interviews were wrong when compared with diagnoses based on multiple sources (Meyer et al., 2001)

- Kappa = .12-.18 between diagnoses from interviews with patients vs. from other sources (Meyer et al., 2001)
Multi-Cultural Challenges

• Help for refugees & immigrants
• Differences in language, culture, SES, education, values, expectations
• Methods & criteria from one culture may not be applicable to other cultures
• Not realistic to have different methods for every cultural group
• Much blending of cultures
Practical Solutions:
1. Combining Top-Down & Bottom-Up Assessment

• Use same item pool to construct empirically based & DSM-oriented scales
• Derive empirically based scales via F.A.
• Experts from 20 cultures identified items consistent w. DSM diagnoses
• Empirically based & DSM-oriented scales displayed on profiles w. age/gender-specific norms
School-Age Syndrome Scales

• Anxious/Depressed
• Withdrawn/Depressed
• Somatic Complaints
• Social Problems
• Thought Problems
• Attention Problems
• Rule-Breaking Behavior
• Aggressive Behavior
School-Age DSM-Oriented Scales

• Affective Problems
• Anxiety Problems
• Somatic Problems
• Attention Deficit/Hyperactivity Problems
• Oppositional Defiant Problems
• Conduct Problems
Practical Solutions: 2. Integrating Multi-Informant Data

- Parallel forms for parents, teachers, adult collaterals, self-reports
- Side-by-side comparisons of item scores
- $Q$ correlations between informants
- Bar graph comparisons of scale scores
### Cross-Informant Comparison - Problem Items Common to the CBCL/CTRF/1.5-5

| ID: S65432 | Name: Kenny K. Randall | Gender: Male | Birth Date: 07/10/97 | Comparison Date: 01/31/00 |

<table>
<thead>
<tr>
<th>Form</th>
<th>Eval ID</th>
<th>Age</th>
<th>Informant Name</th>
<th>Relationship</th>
<th>Date</th>
<th>Form</th>
<th>Eval ID</th>
<th>Age</th>
<th>Informant Name</th>
<th>Relationship</th>
<th>Date</th>
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<tr>
<td>C15</td>
<td>001</td>
<td>30m</td>
<td>Amy Randall</td>
<td>Mother</td>
<td>01/12/00</td>
<td>C15</td>
<td>002</td>
<td>30m</td>
<td>Robert Randall</td>
<td>Father</td>
<td>01/13/00</td>
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<tr>
<td>T153</td>
<td>003</td>
<td>30m</td>
<td>Beatrice Jackson</td>
<td>Teacher (F)</td>
<td>01/18/00</td>
<td>T154</td>
<td>004</td>
<td>30m</td>
<td>Linda James</td>
<td>Teacher (F)</td>
<td>01/19/00</td>
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#### Emotionally Reactive
1. DistChange  2  1  2  1
2. Twitching   0  0  0  0
3. MoodChange  2  1  1  2
4. Sulks       2  1  0  0
5. UpsetByNew  1  1  2  1
6. Whining     0  0  0  1
7. Worries     0  0  0  0

#### Anxious/Depressed
1. Dependent   0  0  0  0
2. FeelingsHurt 0  0  0  0
3. UpsetBySep  0  0  0  0
4. LookUnhapp  1  0  0  0
5. Nervous     2  2  1  2
6. SelfConse   0  0  0  0
7. Fearful     1  1  2  1
8. Sad         0  0  0  0

#### Somatic Complaints
1. AchesPains  0  0  0  0
2. ThingsOut   1  2  2  2
3. Headaches   0  0  0  0
4. Nausea      0  0  0  0
5. Stomachache 0  0  0  0
6. Tired       1  0  1  2
7. Vomiting    0  0  0  0

#### Withdrawn
1. ActsYoung  1  2  2  1
2. AvoidEye   1  1  2  2
3. NoAnswer   2  2  2  1
4. RefusesAct  0  1  2  2
5. UnRespAft  1  0  1  2
6. LittleAffect 2  1  0  1
7. LittleInt  2  1  2  2
8. Withdrawn  1  1  1  2

#### Attention Problems
1. Concentrate 0  0  2  2
2. CantSitStill 0  0  2  2
3. Clumsy      0  0  0  0
4. ShiftsQuickly 2  2  2  1
5. Wanders     2  2  2  1
6. Can'tWait   1  2  2  2
7. Defiant     0  0  0  0
8. Demanding   1  2  1  2
9. DestroyOther 0  0  0  0
10. Disobedient 0  0  0  0
11. NGuilt     0  1  1  1
12. Frustrated 2  2  1  0
13. Fights     0  0  0  0
14. HitsOthers 0  0  0  0
15. HurtsAcciden 2  2  0  1
16. AngryMoods 0  0  0  0
17. Attacks    0  0  0  0
18. Punishment 0  0  2  1
19. Screams    0  0  0  1
20. Selfish    1  1  0  0
21. Stubborn   1  2  2  1
22. Temper     1  1  2  1
23. Uncoop  0  0  1  2
24. WantAttentio 0  0  0  0
25. NotSleepAlo 0  0  -  -
26. SleepProb  0  0  -  -
27. Nightmares 0  0  -  -
28. ResistBed  1  1  -  -
29. SleepLess  2  1  -  -
30. TalkInSleep 1  1  -  -
31. WakesOften 2  2  -  -

#### Other Problems
1. AfraidOfNew  1  2  1
2. ChewNonfood 0  1  1  0
3. SeeksHelp    0  0  0  0
4. Cries       0  0  0  0
5. NotGetAlong 2  2  2  1
6. NoFun       1  0  2  1
7. Jealous     0  0  0  0
8. EatNonFood  0  1  0  0
9. Fears       0  2  2  2
10. GetsHurt   0  0  0  0
11. GetsIntoThing 0  0  1  0
12. HoldsBreath 0  0  0  0
13. Overtired   0  0  0  0
14. PickySkin   0  0  0  0
15. SexParts   0  0  0  0
16. EyeProb    0  0  0  0
17. SkinProb   0  0  0  0
18. Won'TEat   0  0  1  0
19. RocksHead  1  0  1  1
20. LittleFear 0  0  1  0
21. Shy        1  2  1  2
22. SpeechProb 1  1  2  1
23. Stares     1  1  2  1
24. StrangeBeha 1  1  2  1
25. Underactive 0  0  0  0
26. Loud      0  0  0  0

#### CBCL/1.5-5 only: Sleep Problems

1. NotSleepOften 1  2  2  1
2. SleepProb    0  0  -  -
3. Nightmares   0  0  -  -
4. ResistBed    1  1  -  -
5. SleepLess    2  1  -  -
6. TalkInSleep  1  1  -  -
7. WakesOften   2  2  -  -

[F]=Female  [M]=Male
### Cross-Informant Comparison - Cross-Informant Correlations CBCL/TRF/YSR

**ID:** 200105  
**Name:** Catherine A. Holcomb  
**Gender:** Female  
**Birth Date:** 06/16/1989

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<th>Informant Name</th>
<th>Relationship</th>
<th>Date</th>
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<td>002</td>
<td>11</td>
<td>J. Holcomb</td>
<td>Biological Mother</td>
<td>12/04/2000</td>
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<tr>
<td>TRF2</td>
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<td>H. Saunders</td>
<td>Classroom Teacher (F)</td>
<td>12/01/2000</td>
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<tr>
<td>YSR3</td>
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<td>11</td>
<td>Self</td>
<td>Self</td>
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### Q Correlations Between Item Scores

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<th>Forms</th>
<th>Informants</th>
<th>Cross-Informant Agreement</th>
<th>Q Corr</th>
<th>25th %ile</th>
<th>Mean</th>
<th>75th %ile</th>
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<td>CBC1 x TRF2</td>
<td>Biological Mother x Classroom Teacher (F)</td>
<td>Above average</td>
<td>0.53</td>
<td>0.09</td>
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<td>0.37</td>
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<td>Biological Mother x Self</td>
<td>Average</td>
<td>0.23</td>
<td>0.17</td>
<td>0.29</td>
<td>0.40</td>
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<td>TRF2 x YSR3</td>
<td>Classroom Teacher (F) x Self</td>
<td>Average</td>
<td>0.20</td>
<td>0.07</td>
<td>0.19</td>
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Practical Solutions: 3. Multi-Cultural Applications

• Translations

• Cross-cultural comparisons of normative samples

• Multi-cultural factor analyses

• Research in multiple cultures
Multi-Cultural Applications

• ASEBA translations in 69 languages
• >1,500 published studies report ASEBA research in 62 countries beside the U.S.
• Research supports high degree of similarity in problem scores around the world
• More cultural variation in competence scores
ASEBA Translations

– African
  • Afrikaans, Amharic, Ghananian, Kiembu, Sepedi, Sesotho, Swahili, Zulu

– Asian
  • Bahasa-Indonesia, Bengali, Cambodian, Chinese, Gujerati, Hindi, Japanese, Kannada, Korean, Tagalog, Thai, Tibetan, Vietnamese

– Baltic
  • Estonian, Latvian, Lithuanian

– Northern European
  • Danish, Dutch, Finnish, Flemish, German, Icelandic, Norwegian, Swedish

– Latin American
  • Brazilian, Haitian Creole, Latino Spanish, Papiamento-Curacao, Portuguese Creole

– Romance
  • Catalan, French, Italian, Portuguese, Romanian, Spanish

– Slavic
  • Bosnian, Bulgarian, Croatian, Czech, Polish, Russian, Serbo-Croatian, Slovenian, Ukrainian

– Other
  • Arabic, Armenian, Greek, Hebrew, Hungarian, Iranian, Sami, Samoan, Sign, Turkish
Total Problems Scores in 28 Cultures
($N=56,636$)

- Belgium
- China
- Denmark
- Finland
- France
- Germany
- Greece
- Hong Kong
- Iceland
- Israel
- Italy
- Jamaica
- Japan
- Korea
- Lithuania
- Netherlands
- Norway
- Puerto Rico
- Portugal
- Romania
- Russia
- Switzerland
- Sweden
- Taiwan
- Thailand
- Turkey
- USA

omnicultural mean

Culture

Total Problems Raw Score
CBCL Competence Scales

• Activities
• Social
• School
• Total Competence
Adaptive Scales for Ages 18-59

- Purpose: To assess strengths and needs for help in major areas of adaptive functioning
- Scales
  - Friends
  - Spouse or partner (if relevant)
  - Family
  - Job (if relevant)
  - Education (if relevant)
- Composite: Mean of Adaptive Scales
Transmit Forms

Server

Transmit Data

YOUR PC

E-mail Scored Profiles

Web-Link

REMOTE PC

Transmit Forms

Transmit Data
Empirically Based Syndromes for Ages 18-59

- Anxious/Depressed
- Withdrawn
- Somatic Complaints
- Thought Problems
- Attention Problems
- Aggressive Behavior
- Rule-Breaking Behavior
- Intrusive
Empirically Based Syndromes for Ages 60-90+

• Anxious/Depressed
• Worries
• Somatic Complaints
• Functional Impairment
• Memory/Cognition Problems
• Thought Problems
• Irritable/Disinhibited
Summary

• Assessment of psychopathology & adaptive functioning faces multiple challenges

• Empirically based instruments provide top-down, bottom-up, multi-informant, & multi-cultural solutions
Extensive Research Base

• 25 years of ASEBA research
• >5,000 published studies
• ASEBA forms widely used in:
  – epidemiological studies
  – longitudinal studies
  – cross-cultural studies
  – therapy efficacy studies
  – studies of medical conditions
  – studies of parental & family factors
  – secular trend studies