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# Practical Applications of the Achenbach System of Empirically Based Assessment (ASEBA) for Ages 1.5 to 90+ Years

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Thomas M. Achenbach, Professor of Psychiatry and Psychology, is Director of the Center for Children, Youth, and Families at the University of Vermont Department of Psychiatry. A summa cum laude graduate of Yale, he received his Ph.D. from the University of Minnesota and was a Post-doctoral Fellow at the Yale Child Study Center. Before moving to the University of Vermont, Dr. Achenbach taught at Yale and was a Research Psychologist at the National Institute of Mental Health. He has been a DAAD Fellow at the University of Heidelberg, Germany; an SSRC Senior Faculty Fellow at Jean Piaget's Centre d'Epistémologie Génétique in Geneva; Chair of the American Psychological Association's Task Force on Classification of Children's Behavior; and a member of the American Psychiatric Association's Advisory Committee on DSM-III-R. He has given over 200 professional presentations and has authored over 200 publications, including *Developmental Psychopathology; Research in Developmental Psychology: Concepts, Strategies, Methods; Assessment and Taxonomy of Child and Adolescent Psychopathology; Empirically Based Taxonomy; Empirically Based Assessment of Child and Adolescent Psychopathology* (with Stephanie H. McConaughy); and *Manuals for the Child Behavior Checklist, Teacher's Report Form, Youth Self-Report*, and other standardized assessment instruments. Dr. Achenbach's honours include the Distinguished Contribution Award of the American Psychological Association's Section on Clinical Child Psychology and the University Scholar Award of the University of Vermont.

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## Introduction

This workshop presents instruments for assessing behavioural, emotional, and social problems and adaptive functioning. Developmentally appropriate instruments are designed for assessing preschool children, school-age children, adolescents, adults between the ages of 18 and 59, and adults over the age of 59. To obtain multiple perspectives, self-report forms are completed by the person who is being assessed and parallel forms are completed by people who know the person being assessed. The informants include parents, teachers, spouses, partners, caregivers, friends, and grown children of the person being assessed. ASEBA software systematically compares problems reported by each respondent. The systematic comparisons reveal similarities among and differences between problems reported by each respondent. The ASEBA also includes the *Semistructured Clinical Interview for Children and Adolescents* (SCICA) and the *Test Observation Form* (TOF), which documents problems observed during psychological testing.

We first present ASEBA assessment forms, scales for scoring problems and competencies, profiles for displaying item and scale scores, cross-informant comparisons, and multicultural applications. Thereafter, we illustrate applications of ASEBA instruments to particular cases.

## ASEBA instruments for ages 1.5 to 5 years

For ages 1.5 to 5, the primary instruments are the *Child Behavior Checklist for Ages 1.5-5 and Language Development Survey* (CBCL/1.5-5-LDS) and the *Caregiver-Teacher Report Form*

(CTRF). The CBCL/1.5-5 includes 99 items that describe specific kinds of behavioural, emotional, and social problems that characterise preschool children. Parents and surrogates rate each item as 0 = *not true*, 1 = *somewhat or sometimes true*, or 2 = *very true or often true* of the child, based on the preceding two months. There are also open-ended items for describing additional problems, illnesses and disabilities, what concerns the respondent most about the child, and the best things about the child. The LDS requests information about risk factors related to language development, the child's use of phrases, and the child's vocabulary, based on a list of 310 words typical of children's early language.

The C-TRF is a parallel form completed by preschool teachers and daycare providers. It has many of the same problem items as the CBCL/1.5-5, but also has items specific to group settings in place of CBCL/1.5-5 items that are specific to home settings.

## Scales for scoring the CBCL/1.5-5-LDS and C-TRF

The LDS is scored on normed scales for the number of vocabulary words and the length of phrases reported for the child. The problem items of the CBCL/1.5-5 and C-TRF are scored on the following empirically based syndromes: *Emotionally Reactive; Anxious/Depressed; Somatic Complaints; Withdrawn; Attention Problems; and Aggressive Behavior*. The CBCL/1.5-5 also has a *Sleep Problems* syndrome. The syndrome scales were constructed 'from the bottom up' by starting with data on problems reported for large samples of children and then using multivariate statistical analyses to identify sets of problems that co-occur.

The preschool forms are also scored on DSM-oriented scales constructed from the 'top-down' by having experts from many cultures identify items that they judged to be very consistent with diagnostic categories of the American Psychiatric Association's *Diagnostic and Statistical Manual* (the DSM). The DSM-oriented scales are: *Affective Problems*; *Anxiety Problems*; *Pervasive Developmental Problems*; *Attention Deficit/Hyperactivity Problems*; and *Oppositional Defiant Problems*. The empirically based syndromes and DSM-oriented scales are displayed on profiles in relation to percentiles and standard scores (T scores) based on national normative samples.

## **ASEBA instruments for ages 6 to 18 years**

For ages 6 to 18, the *Child Behavior Checklist for Ages 6-18* (CBCL/6-18) is completed by parents and surrogates, while the *Teacher's Report Form* (TRF) is completed by teachers and other school personnel. The *Youth Self-Report* (YSR) is completed by youths to describe their own functioning. The problem items of the CBCL/6-18, TRF, and YSR are scored on the following empirically based syndromes: *Anxious/Depressed*; *Withdrawn/Depressed*; *Somatic Complaints*; *Social Problems*; *Thought Problems*; *Attention Problems*; *Rule-Breaking Behavior*; and *Aggressive Behavior*. The CBCL/6-18, TRF, and YSR are also scored on the following DSM-oriented scales: *Affective Problems*, *Anxiety Problems*, *Somatic Complaints*; *Attention Deficit/Hyperactivity Problems*; *Oppositional Defiant problems*; and *Conduct Problems*. The scales are displayed on profiles in relation to gender and age-specific percentiles and T scores based on national normative samples.

The CBCL/6-18 and YSR are also scored on competence scales for activities, social involvement, school, and total competence. The TRF is scored on

scales for academic performance and adaptive functioning. Like the problem scales, the competence, academic, and adaptive scales are displayed on profiles in relation to percentiles and T scores based on national normative samples.

## **ASEBA instruments for ages 18 to 59 and 60 to 90+ years**

The *Adult Self-Report* (ASR) and *Adult Behavior Checklist* (ABCL) are used to obtain self-reports and informants' reports, respectively, of problems and adaptive functioning for ages 18 to 59. The *Older Adult Self-Report* (OASR) and *Older Adult Behavior Checklist* (OABCL) are similarly used to assess problems and adaptive functioning for ages over 59. The normative samples for the older adult forms included substantial numbers of people who were 60 to 90 years old, but the research samples included ages up to 102.

For ages 18 to 59, the syndrome scales are: *Anxious/Depressed*; *Withdrawn*; *Somatic Complaints*; *Thought Problems*; *Attention Problems*; *Aggressive Behavior*; *Rule-Breaking Behavior*; and *Intrusive*. For ages above 59, the syndrome scales are: *Anxious/Depressed*; *Worries*; *Somatic Complaints*; *Functional Impairment*; *Memory/Cognition Problems*; *Thought Problems*; and *Irritable/Disinhibited*. For ages 18 to 59, the DSM-oriented scales are: *Depressive Problems*; *Anxiety Problems*; *Somatic Problems*; *Avoidant Personality Problems*; *Attention Deficit/Hyperactivity Problems*; and *Antisocial Personality Problems*. For ages above 59, the DSM-oriented scales are: *Depressive Problems*; *Anxiety Problems*; *Somatic Problems*; *Dementia Problems*; *Psychotic Problems*; and *Antisocial Personality Problems*.

The adult forms also have items for assessing substance use and adaptive functioning, including *Friends*;

*Spouse/Partner*; *Family*; *Job*; *Education*; and *Mean Adaptive*. For ages above 59, there is also a scale for *Personal Strengths*.

## **Cross-informant comparisons**

Hand- and computer-scored profiles for parallel forms can be visually compared to identify similarities and differences in scores obtained from self-reports and informants' reports. The ASEBA software prints side-by-side comparisons of item scores and histograms of scale scores obtained from all forms completed for an individual. To indicate how well particular respondents agree, the software prints *Q* correlations between item scores obtained from pairs of informants. It also prints *Q* correlations from large reference samples of respondents as a basis for determining whether agreement between particular informants is below average, average, or above average.

## **Cross-cultural applications**

ASEBA instruments are the most widely used empirically based instruments in the world, with translations in 69 languages. Over 5,000 published studies by over 8,000 authors report use of ASEBA instruments in 62 cultures.

## **Case illustrations**

The following cases illustrate how practitioners use ASEBA forms to obtain information from multiple informants in order to make diagnostic formulations, assess treatment needs, and guide interventions.

### **Kenny, age 30 months**

Kenny was referred by his preschool teacher, who was concerned about his

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lack of peer interaction and his talking to himself. CBCLs were completed by Kenny's parents and C-TRFs were completed by his two teachers. On the LDS, Kenny scored in the normal range for vocabulary and phrase length. However, comments written by his parents on the LDS indicated that he rarely used language to communicate with other children.

Scores from the four ASEBA forms were in the clinical range on the Withdrawn syndrome and the DSM-oriented *Pervasive Developmental Problems* scale. Scores were in the borderline range on the Emotionally Reactive syndrome. Ratings by both teachers, but not by Kenny's parents, were in the clinical range on the *Attention Problems* and *Somatic Complaints* syndromes. The side-by-side display of item scores made it easy to see which specific behavioural and emotional problems were endorsed by all informants and which were reported only by teachers or parents. ASEBA data and clinical observations strongly suggested a pervasive developmental disorder.

### Alex, age 9.

Alex's parents sought an evaluation related to academic underachievement. His parents had recently separated and Alex spent time with each of them. Alex's main teacher reported the most problems, with scores in the borderline or clinical range on the *Anxious/Depressed*, *Withdrawn/Depressed*, and *Thought Problems* syndromes and on the DSM-oriented *Affective Problems* and *Anxiety Problems* scales. When Alex was interviewed with the SCICA, he obtained high scores on *Aggressive/Rule-Breaking Behavior* but low scores on anxiety and depression scales. Alex's *Kinetic Family Drawing* helped to explain the apparent discrepancy between his self-reports on the SCICA and reports by his parents and teachers. Alex's drawing depicted a

plane crash involving his family dressed in their Christmas clothes. After first depicting himself as a masked monster and then as a little boy trying to save the plane, he settled on depicting himself as a daredevil who had anticipated the plane's crash and bailed out in a dramatic plunge.

### Jim, age 15

Jim was hospitalised for self-injurious behaviour, paranoid thinking, and school-refusal. Jim was previously diagnosed with attention deficit hyperactivity disorder, obsessive-compulsive disorder, and learning disability. He had been in an "emotional support" class for many years. ASEBA profiles were obtained from Jim's mother, three hospital staff members, and Jim himself. Ratings by all the adult informants placed Jim in the borderline or clinical range on the *Social Problems*, *Thought Problems*, *Attention Problems*, and *Aggressive Behavior* syndromes. Only the hospital staff rated Jim in the clinical range on the *Withdrawn* syndrome, whereas only his mother rated him as in the clinical range on the *Anxious/Depressed* syndrome. The most striking discrepancy was that Jim's YSR ratings yielded scores in the normal range on all syndromes except *Somatic Complaints* and *Social Problems*. Jim's case illustrates how ASEBA forms can document the presence of significant comorbidity, with elevations in syndromes that reflect both *Internalizing* and *Externalizing* problems in the same person. The relatively low YSR scores illustrate that youths may fail to report problems that are reported by others, although youths may also report problems that are *not* evident to others. In Jim's case, the adults' high ratings for *Thought Problems* suggest that Jim's failure to report such problems might be symptomatic of a severe mental illness.

### Paul, age 4, and his parents

This case illustrates how practitioners can use ASEBA adult forms to facilitate work with parents of children presenting with behavioural and emotional problems. Paul Sternberg was referred for behavioural problems in nursery school. Lack of parental cooperation with behavioural management led the therapist to suggest that his parents each complete an ASR and an ABCL. Ms Sternberg's ASR yielded clinical range scores on the *Anxious/Depressed*, *Withdrawn*, and *Somatic Complaints* syndromes, on the DSM-oriented *Depressive Problems* scale, and on the *Spouse/Partner* and *Family* scales. The ABCL Mr Sternberg completed for his wife yielded clinical range scores on the *Attention Problems*, *Aggressive Behavior*, and *Anxious/Depressed* syndromes. Both adults concurred that Ms Sternberg was having difficulties with household responsibilities and was feeling depressed and overwhelmed. Mr Sternberg's ASR yielded clinical range scores on the *Aggressive Behaviour* and *Rule-Breaking Behavior* syndromes, the *Tobacco* and *Alcohol* scales, and the *Spouse/Partner* scale. Ms Sternberg's ABCL placed her husband in the clinical range on the *Aggressive Behavior* and *Withdrawn* syndromes and the DSM-oriented *Antisocial Personality Problems* scale. The therapist used this ASEBA information to recommend help for the Sternbergs in addressing their individual and marital problems in order to help their son.

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