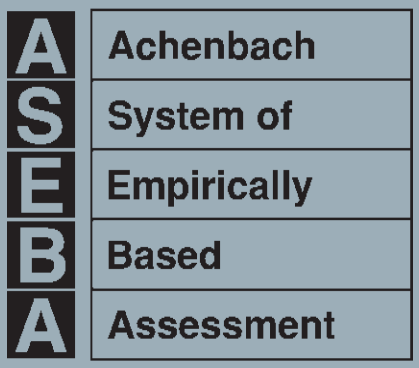
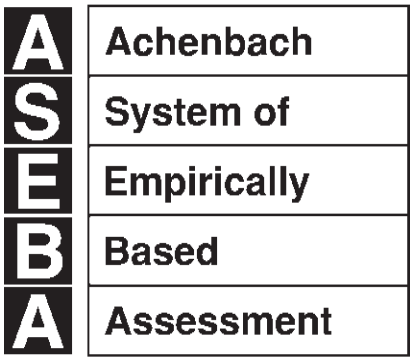


Guide to Gender-Inclusive Assessment Using the Achenbach System of Empirically Based Assessment (ASEBA®)

An Integrated System of Multi-Informant Assessment

Thomas M. Achenbach, Ph.D.
Masha Y. Ivanova, Ph.D.



Guide to Gender-Inclusive Assessment Using the Achenbach System of Empirically Based Assessment (ASEBA®)

An Integrated System of Multi-Informant Assessment

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Ordering Information: This *Guide* and other ASEBA materials can be ordered from ASEBA at:

1 South Prospect Street E-mail: mail@ASEBA.org
Burlington, VT 05401-3456 Web: www.ASEBA.org

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User Qualifications

This *Guide* explains changes that have been made in the ASEBA to take account of gender designations in addition to female and male. The *Gender* fields on the latest versions of ASEBA paper forms are open-ended. These forms include forms printed from ASEBA-Web. The open-ended fields for gender enable respondents to enter whatever gender designation is appropriate for the person being assessed. Online ASEBA-Web forms have gender fields that include options for *Female*, *Male*, and *Another*, with space for the respondent to specify a gender designation for the assessed person. Chapter 1 outlines procedures for deciding which norms to use for assessed individuals whose gender does not correspond to female or male and for using raw scale scores. Chapter 1 also provides an overview of ASEBA forms that are completed by people who are being assessed and by people who know them (designated as "collaterals").

When a form is given to a respondent, the user should explain that its aim is to obtain a picture of the individual's behavior as the respondent sees it. It is important to tell respondents that the forms are designed to describe diverse people. If an item does not seem applicable to a particular individual, respondents should still rate the item, but they should also write an explanation for their response. For example, a respondent who lacks opportunities to observe the behavior described by a particular problem item should rate the item *0* to indicate *Not true (as far as you know)*, but may wish to write "No chance to observe."

A person familiar with the form should be available to answer questions about it. Answers to questions should be objective and factual, rather than probing or interpretive.

If a respondent has difficulty completing a form independently, it can be read aloud by an interviewer who enters the respondent's answers on the form. If a version of the form is available in a language known to the respondent, it is helpful for the respondent to have a copy to look at, unless the respondent is totally unable to read.

Whenever possible, it is desirable to have multiple informants independently complete separate forms describing the individual. For comprehensive assessment of children, it is especially desirable to have forms completed by both parents or surrogates and as many caregivers or teachers as possible, as well as having the YSR completed by adolescents. As detailed in this *Guide*, the profiles scored from the forms should then be compared to identify similarities and differences in how the individual is seen by different informants. The modules for ages 1½-5, 6-18, 18-59, and 60-90+, MFAM, and the BPM forms provide systematic comparisons between reports from different informants.

If an individual has a disability or is in a special setting for people with disabilities, respondents should be told to base their ratings on expectations for typical peers of the person's age, i.e., people who do not have disabilities. This is necessary to provide appropriate comparisons with the multicultural norms for the ASEBA scales.

For proper use of the ASEBA forms, the data should be scored on the appropriate profiles. The modules for ages 1½-5, 6-18, 18-59, and 60-90+, MFAM, and the BPM forms provide instructions that can be followed by users familiar with basic computer procedures. The profiles from all respondents should be compared with each other and with other relevant data. Users should be trained in the theory and methodology of standardized assessment, as well as in work with the kinds of people who are assessed. The training required will differ according to the specific applications of ASEBA forms. Graduate training equivalent to the Master's degree level or two years of residency in pediatrics, geriatrics, psychiatry, or family practice is usually necessary. However, no amount of prior training can substitute for professional maturity, a thorough knowledge of the procedures and cautions presented in the relevant supplement and manual, as well as adherence to professional ethical codes.

All users should understand that ASEBA instruments are designed to provide standardized descriptions of functioning. Scores on ASEBA scales should not be automatically equated with diagnoses or disorders. Instead, responsible professionals will integrate ASEBA data with other data to provide comprehensive evaluations of functioning.

Contents

Chapter 1
Introduction

Readers who are not familiar with the ASEBA may find it helpful to first read the *Overview,* which follows the sections on gender-inclusive ASEBA forms and scale scores. This *Guide* explains changes that have been made in the ASEBA to accommodate people who do not identify themselves as female or male. When ASEBA forms were developed and norms were obtained for scoring them, most people formally identified themselves as female or male. Regardless of their biological sex or possible histories of gender changes, individuals who currently identify themselves as female or male can be evaluated in relation to female or male norms, respectively.

GENDER-INCLUSIVE ASEBA FORMS

The *Gender* fields on the latest versions of ASEBA paper forms are open-ended. These forms include the paper versions printed from ASEBA-Web. The open-ended fields for *Gender* enable respondents to write in whatever gender designation is appropriate for the person being assessed. Online ASEBA-Web forms have *Gender* fields that include options for *Female*, *Male*, and *Another*, with space for the respondent to specify a gender designation for the assessed person. The *Another* option is provided because some people object to "Other" as an option. Because there are so many possible gender designations and these designations may change, it is not realistic for ASEBA-Web to list all possible designations for gender. In addition to providing inclusive options for specifying gender, ASEBA forms now use gender-inclusive wording elsewhere.

NORM-REFERENCED SCALE SCORES

Users who hand score ASEBA forms on paper profiles can be guided by responses entered in a form's *Gender* field to decide whether to enter the assessed person's item ratings on profiles that display scale scores in relation to norms for females or for males or for both (used separately). Similarly, users of ASEBA-PC, ASEBA-Network, and ASEBA-Web can elect to have scale scores displayed in relation to female norms, male norms, or both. If a user elects to display an assessed person's scale scores in relation to both female and male norms, the user can then decide whether the assessed person needs help according to scores that are in the borderline or clinical range for either the female or male norms or both.

Using Female and Male Norms to Determine *T* Scores

If neither female nor male norms are selected, ASEBA-PC, ASEBA-Network, and ASEBA-Web software do the following: For each problem scale, the software determines whether the assessed individual's *T* score (i.e., norm-based standard score) would be higher if based on female norms or on male norms. If the *T* score based on female norms is higher than the *T* score based on male norms, the software assigns the *T* score based on female norms. Conversely, if the *T* score based on male norms is higher than the *T* score based on female norms, the software assigns the *T* score based on male norms. Consequently, the assessed person's profile of problem scales displays bar graphs comprising *T* scores for the gender for which the *T* score for each scale would indicate the higher level of clinical concern. By contrast, on each scale where low scores are of clinical concern (competence, adaptive functioning, strengths), the software assigns the lower of the *T* scores for female versus male norms. We call the use of female and male norms to determine *T* scores *Integrated Norm-Referenced Scoring*.

GENDER-NEUTRAL RAW SCALE SCORES

For every scale, a raw scale score is computed by summing the ratings of the items comprising the scale. *This raw scale score is the same regardless of the assessed person's gender identification.* On hand-scored profiles, the raw scale score is displayed beneath the items comprising the scale, in the space labeled ***Total***. On profiles generated by ASEBA-PC, ASEBA-Network, and ASEBA-Web, the raw scale score is generated as output that can be exported for analysis and is displayed beneath the bar graph for the scale in the space labeled ***Raw Score (sum)***. For statistical analyses, users can employ the raw scale scores exported from ASEBA-PC, ASEBA-Network, and ASEBA-Web. In their analyses, users can then group individuals' scores according to gender designations of their choice.

OVERVIEW OF THE ASEBA

The ASEBA provides user-friendly tools for assessing behavioral, emotional, social, and thought problems, competencies, adaptive functioning, and strengths for ages 1½ through 90+ years. The ASEBA includes standardized forms completed by people (collaterals) who know the assessed person, and—for ages 11 and above—by the assessed persons themselves. The forms can be completed online or on paper by people who have at least 5th grade reading skills. For people who cannot complete forms independently, an interviewer with no specialized training—such as a receptionist in a clinic—can read a form aloud and record the responses. Table 1-1 lists ASEBA collateral and self-report forms. Forms completed by trained interviewers—the *Semistructured Clinical Interview for Children and Adolescents* (SCICA), by people trained to administer individual ability and achievement tests—the *Test Observation Form* (TOF), and by trained observers—the *Direct Observation Form* (DOF)—are not addressed in this *Guide*. Some 11,000 publications report use of the ASEBA in over 100 societies and cultures, as listed in the *Bibliography of Published Studies Using the ASEBA* (Carvalho & Achenbach, 2022), which is available online at www.aseba.org.

Table 1-1

ASEBA Collateral- and Self-Report Forms

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)	School staff
Youth Self-Report for Ages 11-18 (YSR)	Youths
Brief Problem Monitor for Ages 6-18 (BPM/6-18)	Parents, school staff, youths
Adult Behavior Checklist for Ages 18-59 (ABCL)	Spouses, partners, parents, grown children, other relatives, friends, therapists
Adult Self-Report for Ages 18-59 (ASR)	Adults
Brief Problem Monitor for Ages 18-59 (BPM/18-59)	Adults, collaterals
Older Adult Behavior Checklist for Ages 60-90+ (OABCL)	Spouses, partners, grown children, other relatives, caregivers, friends, therapists
Older Adult Self-Report for Ages 60-90+ (OASR)	Older adults

Note: All forms, hand-scoring profiles, manuals, multicultural supplements, scoring software, and online accounts can be ordered at www.aseba.org. The manuals and multicultural supplements are listed in the *References* at the end of this *Guide*.

To illustrate a widely used ASEBA form, Figure 1-1 displays the *Child Behavior Checklist for Ages 6-18* (CBCL/6-18), which is completed by parents and others who see 6-18-year-olds from a parental perspective. Pages 1 and 2 of the CBCL/6-18 assess children's competencies, which are scored on scales designated as *Activities*, *Social*, *School*, and *Total Competence* (scored by summing scores from the first three scales). Page 2 also includes open-ended items for describing special school services received by the child, repetition of grades, problems in school, illnesses and disabilities, what concerns the respondent about the child, and the best things about the child. Pages 3 and 4 list descriptions of behavioral, emotional, social, and thought problems. Respondents rate each problem *0 = not true (as far as you know)*, *1 = somewhat or sometimes true*, or *2 = very true or often true*, based on the preceding 6 months.

Scales for Scoring Problems

The CBCL/6-18 problem items are scored on eight syndrome scales designated as *Anxious/Depressed*, *Withdrawn/Depressed*, *Somatic Complaints*, *Social Problems*, *Thought Problems*, *Attention Problems*, *Rule-Breaking Behavior*, and *Aggressive Behavior*. Derived from statistical analyses of ratings of thousands of children, the syndrome scales embody patterns of co-occurring problems. The problem items are also scored on a broad-spectrum grouping of syndromes designated as *Internalizing* (comprising the Anxious/Depressed, Withdrawn/Depressed, and Somatic Complaints syndromes) and on a second broad-spectrum grouping designated as *Externalizing* (comprising the Rule-Breaking Behavior and Aggressive Behavior syndromes).

To provide cross-walks with DSM-5, the CBCL/6-18 problem items are scored on six DSM-oriented scales designated as *Depressive Problems*, *Anxiety Problems*, *Somatic Problems*, *Attention Deficit/Hyperactivity Problems*, *Oppositional Defiant Problems*, and *Conduct Problems*, as detailed in the *DSM-Oriented Guide for the Achenbach System of Empirically Based Assessment* (*ASEBA*) (Achenbach, 2014). *The Manual for the ASEBA School-Age Forms & Profiles* (Achenbach & Rescorla, 2001) details the development and applications of the competence, syndrome, Internalizing, Externalizing, and DSM-oriented scales, as well as the Total Problems (general psychopathology) scale. Scales designated as *Obsessive-Compulsive Problems*, *Posttraumatic Stress Problems* (now designated as *Stress Problems*), and *Sluggish Cognitive Tempo* were added in 2007, when multicultural norms spanning societies from around the world were also added, as detailed by Achenbach and Rescorla (2007). The *Teacher's Report Form* (TRF) and *Youth Self-Report* (YSR) have many of the same items and scales as the CBCL/6-18. The scales scored from the forms listed in Table 1-1 are tailored to their designated age ranges and kinds of respondents appropriate for those age ranges.

Manuals for each age range are listed in the *References* at the end of this *Guide*. The Manuals provide details and illustrations of many options for scoring each form.

MULTICULTURAL OPTIONS

ASEBA forms are available in some 113 languages, which are listed at www.aseba.org. Not all translations have gender-inclusive terminology like the English language ASEBA forms. In some societies, such terminology is not generally accepted. However, users of translations that lack gender-inclusive terminology can instruct respondents in gender-inclusive usage. They can also elect to score forms in relation to norms for females, males, both females and males (used separately), use Integrated Norm-Referenced Scoring, and obtain raw scale scores.

If users score forms via ASEBA-PC, ASEBA-Network, or ASEBA-Web, they can elect to display scale scores in relation to norms for female, males, both (used seperately), or use In-

Please print **CHILD BEHAVIOR CHECKLIST FOR AGES 6-18** For office use only ID #

CHILD'S FULL NAME: First Remi; Middle Anders; Last Watkins

CHILD'S GENDER: Trans | CHILD'S AGE: 16 | CHILD'S ETHNIC GROUP OR RACE: Mixed

TODAY'S DATE: Mo. 12 Day 10 Year 21 | CHILD'S BIRTHDATE: Mo. 11 Day 1 Year 2005

GRADE IN SCHOOL: 11

NOT ATTENDING SCHOOL ☐

Please fill out this form to reflect *your* view of the child's behavior even if other people might not agree. Feel free to print additional comments beside each item and in the space provided on page 2. ***Be sure to answer all items.***

PARENTS' USUAL TYPE OF WORK, even if not working now. (Please be specific — for example, auto technician, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)

PARENT 1 (or FATHER) TYPE OF WORK: High School Teacher

PARENT 2 (or MOTHER) TYPE OF WORK: High School Teacher

THIS FORM FILLED OUT BY: (print your full name): Marie Watkins

Your Gender: Female

Your relation to the child (e.g., parent): Mother

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

	Compared to others of the same age, about how much time does child spend in each?				Compared to others of the same age, how well does child do each one?			
	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
☐ None								
a. Skiing	☐	☑	☐	☐	☐	☑	☐	☐
b. Swimming	☐	☑	☐	☐	☐	☑	☐	☐
c.	☐	☐	☐	☐	☐	☐	☐	☐

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: video games, dolls, reading, piano, crafts, cars, computers, singing, etc. (Do *not* include listening to radio, TV, or other media.)

	Compared to others of the same age, about how much time does child spend in each?				Compared to others of the same age, how well does child do each one?			
	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
☐ None								
a. Reading	☐	☐	☑	☐	☐	☐	☑	☐
b. Computers	☐	☑	☐	☐	☐	☑	☐	☐
c.	☐	☐	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs, teams, or groups your child belongs to.

	Compared to others of the same age, how active is child in each?			
	Less Active	Average	More Active	Don't Know
☐ None				
a. Ski team	☐	☑	☐	☐
b. Swim team	☐	☑	☐	☐
c.	☐	☐	☐	☐

IV. Please list any jobs or chores your child has. For example: doing dishes, babysitting, making bed, working in a store, etc. (Include both paid and unpaid jobs and chores.)

	Compared to others of the same age, how well does child carry them out?			
	Below Average	Average	Above Average	Don't Know
☐ None				
a. Working in store	☐	☑	☐	☐
b.	☐	☐	☐	☐
c.	☐	☐	☐	☐

Please be sure you answered all items. Then see other side.

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PAGE 1

Figure 1-1. CBCL/6-18 completed for Remi Watkins by mother.

Please print. Be sure to answer all items.

V. 1. About how many close friends does your child have? (Do *not* include brothers & sisters)

☐ None ☑ 1 ☐ 2 or 3 ☐ 4 or more

2. About how many times a week does your child do things with any friends outside of regular school hours? (Do *not* include brothers & sisters)

☐ Less than 1 ☑ 1 or 2 ☐ 3 or more

VI. Compared to others of similar age, how well does your child:

	Worse	Average	Better	
a. Get along with brothers & sisters?	☐	☐	☐	☑ Has no brothers or sisters
b. Get along with other kids?	☐	☑	☐	
c. Behave with parents?	☐	☑	☐	
d. Play and work alone?	☐	☑	☐	

VII. 1. Performance in academic subjects. ☐ Does not attend school because _____

Check a box for each subject that child takes

		Failing	Below Average	Average	Above Average
Other academic subjects–for example: computer courses, foreign language, business. Do *not* include gym, shop, driver's ed., or other nonacademic subjects.	a. Reading, English, or Language Arts	☐	☐	☐	☑
	b. History or Social Studies	☐	☐	☑	☐
	c. Arithmetic or Math	☐	☐	☑	☐
	d. Science	☐	☐	☑	☐
	e. French	☐	☑	☐	☐
	f. Computer Science	☐	☐	☑	☐
	g. _____	☐	☐	☐	☐

2. Does your child receive special education or remedial services or attend a special class or special school?

☑ No ☐ Yes—kind of services, class, or school:

3. Has your child repeated any grades? ☑ No ☐ Yes—grades and reasons:

4. Has your child had any academic or other problems in school? ☑ No ☐ Yes—please describe:

When did these problems start?

Have these problems ended? ☐ No ☐ Yes—when?

Does your child have any illness or disability (either physical or mental)? ☑ No ☐ Yes—please describe:

What concerns you most about your child? Lack of interest in school, unwilling to plan for future, too much time on phone and media, concerns about fitting in

Please describe the best things about your child. Usually easy to get along with, Very reliable

PAGE 2 *Please be sure you answered all items.*

Figure 1-1 (continued). CBCL/6-18 completed for Remi Watkins by mother.

Please print. Be sure to answer all items.

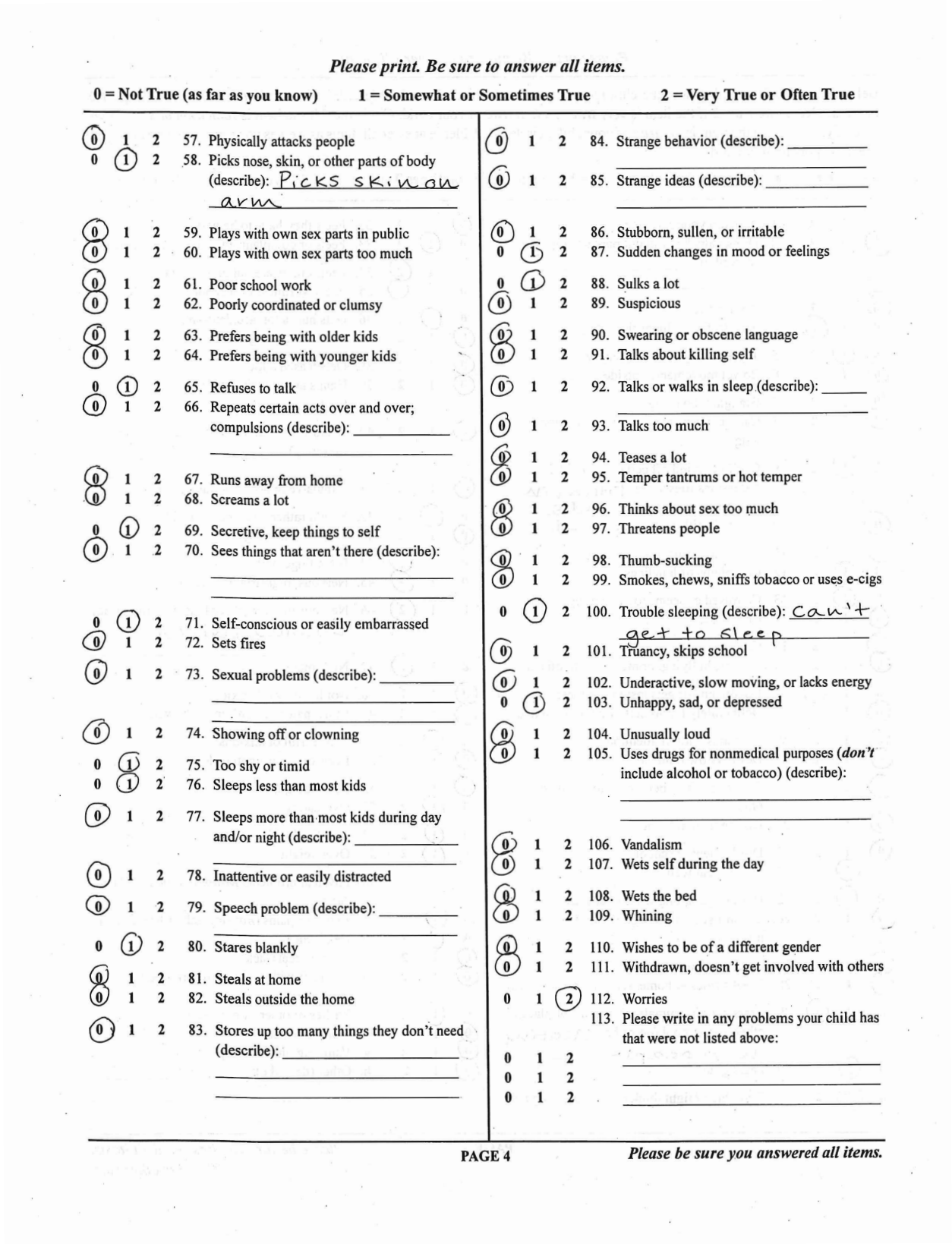
Below is a list of items that describe children and youths. For each item that describes your child ***now or within the past 6 months***, please circle the ***2*** if the item is ***very true or often true*** of your child. Circle the ***1*** if the item is ***somewhat or sometimes true*** of your child. If the item is ***not true*** of your child, circle the ***0***. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

(0) 1 2 1. Acts too young for age
(0) 1 2 2. Drinks alcohol without parents' approval (describe): _____
_____
(0) 1 2 3. Argues a lot
0 1 (2) 4. Fails to finish things they start
0 (1) 2 5. There is very little they enjoy
(0) 1 2 6. Bowel movements outside toilet
(0) 1 2 7. Bragging, boasting
(0) 1 2 8. Can't concentrate, can't pay attention for long
0 (1) 2 9. Can't get mind off certain thoughts; obsessions (describe): Fitting in with other kids
(0) 1 2 10. Can't sit still, restless, or hyperactive
(0) 1 2 11. Clings to adults or too dependent
0 (1) 2 12. Complains of loneliness
0 (1) 2 13. Confused or seems to be in a fog
(0) 1 2 14. Cries a lot
(0) 1 2 15. Cruel to animals
(0) 1 2 16. Cruelty, bullying, or meanness to others
0 1 (2) 17. Daydreams or gets lost in thoughts
(0) 1 2 18. Deliberately harms self or attempts suicide
(0) 1 2 19. Demands a lot of attention
(0) 1 2 20. Destroys own things
(0) 1 2 21. Destroys things belonging to family or others
(0) 1 2 22. Disobedient at home
(0) 1 2 23. Disobedient at school
0 (1) 2 24. Doesn't eat well
0 (1) 2 25. Doesn't get along with other kids
(0) 1 2 26. Doesn't seem to feel guilty after misbehaving
(0) 1 2 27. Easily jealous
(0) 1 2 28. Breaks rules at home, school, or elsewhere
0 1 (2) 29. Fears certain animals, situations, or places, other than school (describe): Meeting new people
0 (1) 2 30. Fears going to school
0 (1) 2 31. Fears they might think or do something bad
(0) 1 2 32. Feels they have to be perfect
0 (1) 2 33. Feels or complains that no one loves them
0 1 (2) 34. Feels others are out to get them
0 1 (2) 35. Feels worthless or inferior
0 (1) 2 36. Gets hurt a lot, accident-prone
(0) 1 2 37. Gets in many fights
(0) 1 2 38. Gets teased a lot
(0) 1 2 39. Hangs around with others who get in trouble
(0) 1 2 40. Hears sounds or voices that aren't there (describe): _____
_____
(0) 1 2 41. Impulsive or acts without thinking
0 (1) 2 42. Would rather be alone than with others
(0) 1 2 43. Lying or cheating
0 1 (2) 44. Bites fingernails
0 1 (2) 45. Nervous, highstrung, or tense
0 1 (2) 46. Nervous movements or twitching (describe): Eyelids twitch
_____
0 1 (2) 47. Nightmares
(0) 1 2 48. Not liked by other kids
(0) 1 2 49. Constipated, doesn't move bowels
0 (1) 2 50. Too fearful or anxious
(0) 1 2 51. Feels dizzy or lightheaded
(0) 1 2 52. Feels too guilty
0 (1) 2 53. Overeating
0 (1) 2 54. Overtired without good reason
0 (1) 2 55. Overweight
56. Physical problems ***without known medical cause:***
0 (1) 2 a. Aches or pains (***not*** stomach or headaches)
0 (1) 2 b. Headaches
(0) 1 2 c. Nausea, feels sick
(0) 1 2 d. Problems with eyes (***not*** if corrected by glasses) (describe): _____
0 (1) 2 e. Rashes or other skin problems
(0) 1 2 f. Stomachaches
(0) 1 2 g. Vomiting, throwing up
(0) 1 2 h. Other (describe): _____
_____

PAGE 3 ***Please be sure you answered all items. Then see other side.***

Figure 1-1 (continued). CBCL/6-18 completed for Remi Watkins by mother.



Please print. Be sure to answer all items.

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 57. Physically attacks people
0 (1) 2 58. Picks nose, skin, or other parts of body (describe): Picks skin on arm
(0) 1 2 59. Plays with own sex parts in public
(0) 1 2 60. Plays with own sex parts too much
(0) 1 2 61. Poor school work
(0) 1 2 62. Poorly coordinated or clumsy
(0) 1 2 63. Prefers being with older kids
(0) 1 2 64. Prefers being with younger kids
0 (1) 2 65. Refuses to talk
(0) 1 2 66. Repeats certain acts over and over; compulsions (describe): _____
(0) 1 2 67. Runs away from home
(0) 1 2 68. Screams a lot
0 (1) 2 69. Secretive, keep things to self
(0) 1 2 70. Sees things that aren't there (describe): _____
0 (1) 2 71. Self-conscious or easily embarrassed
(0) 1 2 72. Sets fires
(0) 1 2 73. Sexual problems (describe): _____
(0) 1 2 74. Showing off or clowning
0 (1) 2 75. Too shy or timid
0 (1) 2 76. Sleeps less than most kids
(0) 1 2 77. Sleeps more than most kids during day and/or night (describe): _____
(0) 1 2 78. Inattentive or easily distracted
(0) 1 2 79. Speech problem (describe): _____
0 (1) 2 80. Stares blankly
(0) 1 2 81. Steals at home
(0) 1 2 82. Steals outside the home
(0) 1 2 83. Stores up too many things they don't need (describe): _____
(0) 1 2 84. Strange behavior (describe): _____
(0) 1 2 85. Strange ideas (describe): _____
(0) 1 2 86. Stubborn, sullen, or irritable
0 (1) 2 87. Sudden changes in mood or feelings
0 (1) 2 88. Sulks a lot
(0) 1 2 89. Suspicious
(0) 1 2 90. Swearing or obscene language
(0) 1 2 91. Talks about killing self
(0) 1 2 92. Talks or walks in sleep (describe): _____
(0) 1 2 93. Talks too much
(0) 1 2 94. Teases a lot
(0) 1 2 95. Temper tantrums or hot temper
(0) 1 2 96. Thinks about sex too much
(0) 1 2 97. Threatens people
(0) 1 2 98. Thumb-sucking
(0) 1 2 99. Smokes, chews, sniffs tobacco or uses e-cigs
0 (1) 2 100. Trouble sleeping (describe): can't get to sleep
(0) 1 2 101. Truancy, skips school
(0) 1 2 102. Underactive, slow moving, or lacks energy
0 (1) 2 103. Unhappy, sad, or depressed
(0) 1 2 104. Unusually loud
(0) 1 2 105. Uses drugs for nonmedical purposes (*don't* include alcohol or tobacco) (describe): _____
(0) 1 2 106. Vandalism
(0) 1 2 107. Wets self during the day
(0) 1 2 108. Wets the bed
(0) 1 2 109. Whining
(0) 1 2 110. Wishes to be of a different gender
(0) 1 2 111. Withdrawn, doesn't get involved with others
0 1 (2) 112. Worries
113. Please write in any problems your child has that were not listed above:
0 1 2 _____
0 1 2 _____
0 1 2 _____

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Please be sure you answered all items.

Figure 1-1 (continued). CBCL/6-18 completed for Remi Watkins by mother.

tegrated Norm-Referenced Scoring in multicultural norm groups for particular informants (self, parents, teachers, adult collaterals) for societies that had relatively low scores (Group 1), intermediate scores (Group 2), or high scores (Group 3). For each form (e.g., CBCL/6-18), the assignment of a society to Group 1, 2, or 3 is based on the mean of ASEBA scale scores found in a population sample of people (e.g., parents of 6-18-year-olds) in that society. For all the societies for which population samples were assessed with a particular form (e.g., CBCL/6-18), the mean scale scores from every society were averaged to obtain the mean of all the societal mean scores, which is dubbed the *omnicultural mean*. Societies whose mean scale scores are >1 standard deviation (*SD*) below the omnicultural mean are designated as Group 1 (low scoring) societies. Societies whose mean scale scores are within ±1 *SD* of the omnicultural mean are designated as Group 2 (medium scoring) societies. And societies whose mean scale scores are >1 *SD* above the omnicultural mean are designated as Group 3 (high scoring) societies.

Norms provide metrics with which users can compare scores obtained on a particular form (e.g., CBCL/6-18) to scores obtained on that form by people in a population sample. By comparing scores for an individual with normative scores from a population sample, users can see whether scores for the individual are in the range defined as normal, borderline-clinical, or clinical. The raw scale scores are computed as the sum of ratings on items comprising a scale in the same way for all societies. For ages 1½-5, 6-18, 18-59, and 60-90+, the *References* at the end of this *Guide* list multicultural supplements that provide details of how the multicultural norms were constructed from ASEBA scores in many societies, plus case illustrations of how multicultural norms are used. The *Multicultural Guide for ASEBA Forms & Profiles for Ages 1½-90+* (Achenbach & Rescorla, 2019) provides a quick introduction to practical multicultural applications of the ASEBA.

SUMMARY

For readers who are not familiar with the ASEBA, this chapter provides an overview section. This *Guide* explains changes that have been made in the ASEBA to accommodate people who do not identify themselves as female or male. The changes include providing inclusive options for designating gender, as well as providing gender-inclusive wording elsewhere on the forms.

ASEBA users can display scale scores for assessed individuals in relation to norms for females, males, or both (used separately). If a user elects to display scale scores in relation to both female and male norms, the user can decide whether help is needed by evaluating scores in relation to both sets of norms. For assessed people who are not designated as either female or male, ASEBA-PC, ASEBA-Network, and ASEBA-Web additionally assign *T* scores to each scale based on which gender's *T* score would be higher (for problem scales) or lower (for competence, adaptive functioning, and strengths scales). We call this *Integrated Norm-Referenced Scoring*. Raw scale scores are computed for all scales by summing the ratings of the items comprising the scale. They are the same regardless of the assessed person's gender identification.

Multicultural norms enable users to display scale scores for female and male norms appropriate for societies found to have relatively low scores (Group 1), intermediate scores (Group 2), or relatively high scores (Group 3). The raw scale scores are computed in the same way for all societies.

Chapter 2

Applying Gender-Inclusive ASEBA Assessment Procedures in Practice

As described in Chapter 1, informants completing ASEBA forms can indicate any gender identity for the assessed individual using open-ended fields. Users can display and interpret scores for assessed individuals in relation to norms for females, males, both females and males, and raw scoring of ASEBA scales.

In this chapter, we provide practical illustrations of how to use the ASEBA forms and scoring procedures when assessing individuals who endorse diverse gender identities. The following cases of Alex, Andy, and Arya illustrate these procedures for assessing adolescents, young adults, and adults. The cases are inspired by real people, but names and key details are fictitious to protect confidentiality. For ease of presentation, we focus on the empirically-based ASEBA syndromes and broad-spectrum scales.

ALEX, AGE 11

Alex is a 7th grader who lives with her mother and father. Alex uses the "she/her" pronouns. She stopped by the school drop-in mental health center and requested to see a "counselor." During the first meeting with the school clinical social worker, Alex shared that she has been feeling sad lately. She described "feeling on the verge of tears" and "like everything was a super big deal" many times a day. Alex also said that there were "private" things that she wanted to talk about that she couldn't share with her parents or friends. After conducting a safety assessment that indicated no concerns, the social worker requested Alex's permission to contact her parents to obtain their consent for Alex's care, and to invite them to participate in her assessment and therapy, as needed.

At the next session, Alex shared her "private" issue by revealing that she thought that she may be "gay, bisexual, or maybe trans." Alex explained that she found herself physically attracted to a female friend, which was uncomfortable because she never had such feelings toward a female before. She was also going through puberty and disliking how her changing body was looking and feeling. She missed her kid body.

ASEBA Findings for Alex

The social worker asked Alex to complete the YSR, her mother and father to each complete the CBCL/6-18, and her homeroom teacher to complete the TRF. The social worker involved Alex in selecting gender norms for displaying her ASEBA scale scores. She first explained the idea of norm-referenced assessment to Alex, and then presented the available ASEBA gender norms. Alex decided to score her data in relation to male and female norms (used separately) because she "did not feel non-binary, or outside of gender, but felt like there was something different going on with her gender and wanted to see herself in relation to both male and female norms."

According to both male and female norms on all three forms, Alex's scale scores indicated that problems of anxiety, worry, and depression were elevated. On the YSR and her mother's CBCL/6-18, Alex's scores on the Anxious/Depressed and Withdrawn/Depressed syndromes and the Internalizing Problems scale approached the borderline-clinical range according to female norms and were in the borderline-clinical range according to male norms. On her father's CBCL/6-18, Alex's score was in the borderline-clinical range on the Anxious/Depressed syndrome according to male and female norms. Finally, on the TRF, Alex's scores were in the borderline-clinical range on the Withdrawn/Depressed and Social Problems syndromes and approached the borderline-clinical range on the Internalizing Problems scale

for both male and female norms. For all four forms, all other problem scale scores were in the normal range, according to both sets of norms. Ratings by all informants also placed Alex in the normal range on the Competence and Adaptive Functioning scales, according to both male and female norms.

Clinical interviews with Alex and her parents indicated significant and long-standing inter-parental conflict, which worsened during the stay-at-home order of the COVID-19 pandemic. It may have contributed to Alex's recent difficulties with anxiety, depression, and worry. The parents shared that they had seen a couples' counselor for years, though not in the past year. They understood that conflict and tension between them could have affected Alex. They also said that Alex did not previously have emotional or behavioral difficulties and has always been "a sensitive, but easygoing child."

Intervention

Over the next 6 months Alex received a psychotherapeutic intervention from the school clinical social worker. Initially, the intervention focused on building up Alex's coping skills for handling her worry, anxiety, and depression. It included elements of cognitive behavioral therapy, such as scheduling pleasant activities and challenging unhelpful thoughts. With the help of the school's athletic department, the social worker also encouraged Alex to join the cross-country team, which increased Alex's physical activity, got her and her family out of the home on the weekends to attend meets, and expanded Alex's social circle.

As Alex's anxiety and depression problems improved and her relationship with the social worker strengthened, her therapy additionally focused on supporting her understanding of her developing sexual orientation and gender identity. The therapy emphasized approaching these aspects of identity with flexibility and patience, and allowing them to emerge. As a result of this work, Alex decided that she felt gay or bisexual in her sexual orientation. She also felt solidly female in her gender identity, but experienced puberty-associated stress. This stress felt to Alex like a response to the increasing sexualization of her appearance by the outside world, rather than the increasing incongruence between her felt gender and her gender's physical manifestations in her body.

At the social worker's suggestion, Alex's parents resumed their work with their couples' counselor. While Alex worked with the social worker, the parents worked with their counselor to improve their relationship and reduce the level of conflict between them.

Subsequent Assessments

To evaluate Alex's response to the intervention, the social worker repeated the ASEBA assessment about 6 months after the initial assessment. She asked Alex, her parents, and teacher to fill out the same forms they had completed for the initial assessment. As Alex no longer questioned her gender identity, she elected to have the forms scored only in relation to female norms. The social worker used Alex's initial scores based on female norms for comparison.

According to all four informants, Alex now scored in the normal range on all ASEBA problem scales. Her Competence scale scores remained in the normal range, with the CBCL and YSR Activities and Social Competence scale scores moving from the low to the mid-normal range over the course of the intervention.

Interviews with Alex and her parents indicated that Alex looked happier and more engaged. Alex said that she was feeling better and had enjoyed her season on the cross-country team. She was considering trying out for track in the spring. Her mother and father reported that, although their relationship required more work, they had benefited from their meetings with their

counselor and had been fighting less is front of Alex.

ANDY, AGE 18

Andy lives in a group home for transitional-age youth and is a rising high school senior. Andy identifies as nonbinary and uses "they/them" pronouns. Andy lived in two foster homes before moving to their current group home about a month ago, the summer before their senior year. Andy has always been a strong student, loves math and science, and is interested in studying for a biomedical field.

Andy's case worker met with them for a routine check-in about a month after they moved to the group home and shortly after the start of the school year. Andy shared that they were adjusting to the group home and enjoying more freedom than in foster homes, like making themselves whatever they wanted for dinner and taking a bus downtown independently. Andy said that the other residents were "friendly and harmless" and the staff were "relatable," because they were mostly recent college graduates who were close to Andy's age.

When asked about how they were feeling, Andy said that they definitely felt the stress of the looming senior year. They were especially worried about completing college applications. Andy said they were working with a school guidance counselor and their community mentor on completing the Common Application, and that it has been going OK. However, sometimes thinking about all that they needed to do in the next few months felt overwhelming to the point of paralysis. Andy said that they have been feeling anxious most of the time, and have often awakened in the middle of the night, unable to fall back asleep. They also said that some days it was hard to focus in class and on homework.

ASEBA Findings for Andy

Andy's case worker asked Andy to complete the YSR and two group home workers to complete the CBCL/6-18. With Andy's approval, the case worker used Integrated Norm-Referenced Scoring to score Andy's ASEBA data. This type of scoring assigns norm-referenced *T* scores based on whichever gender's *T* score would be higher for problem scales and lower for competence and personal strengths scales.

Andy's scores on the Anxious/Depressed syndrome were elevated, according to all three informants: Andy scored in the clinical range on the YSR and one CBCL/6-18, and in the borderline-clinical range on the other CBCL/6-18. Andy's self-reports on the YSR also placed them in the borderline-clinical range on the Attention Problems syndrome. Andy's Competence scale scores were all in the normal range. According to all informants, Andy's Social and Activities scores were the lowest Competence scores, both falling in the low normal range.

Intervention

Andy's case worker encouraged Andy to reconnect with the psychotherapist with whom Andy had worked several years ago to address their traumatic childhood experiences. The psychotherapist worked in the same community mental health center as Andy's case worker, so this was easy to arrange. Over the next few months, Andy worked with the psychotherapist on strengthening coping skills that worked for Andy in the past, such as creating a calendar of upcoming deadlines, problem solving, reaching out for help, establishing a healthy sleep routine, and exercising.

The case worker also organized a team meeting for Andy, including their psychotherapist, primary group home worker, school guidance counselor, and community mentor. The team devised a 3-month plan for Andy that incorporated concrete steps and deadlines for college applications, as well as activities supporting Andy's overall health. These activities included reconnecting with friends at the center for gender and sexually diverse youth, joining the residents

of the group home on evening walks, and reconnecting with their foster parents and siblings. Over the next three months, Andy successfully completed their college applications, reconnected with old friends at the youth center and their foster parents and siblings, and began increasing their physical activity by walking to and from school.

Subsequent Assessments

After about 3 months, the case-worker asked Andy to complete another YSR, and asked the same group home workers to complete CBCL/6-18 forms. The case worker again used Integrated Norm-Referenced Scoring to score all ASEBA forms. Andy's scores on the Anxious/Depressed syndrome were now in the normal range according to all informants, although their YSR Anxious/Depressed syndrome score approached the borderline-clinical range. Andy's score on the YSR Attention Problems syndrome was now solidly in the normal range. Their scores on the Competence scales had also improved according to all informants, now falling solidly in the middle to high normal range.

During a clinical interview, Andy reported feeling "much better and more hopeful about the future." They were still feeling worried about the upcoming life transitions, but no longer overwhelmed. Andy also reported having an easier time focusing at school and on homework. Interviews with Andy's psychotherapist and group home staff supported Andy's reports by indicating that they appeared calmer and more socially engaged. Reports by night staff at the group home indicated that Andy's sleep had improved as well.

ARYA, AGE 30

Arya is a software engineer who sought help at an onsite health clinic at her company's office. Arya stopped by the clinic about two months after returning to in-person employment after working remotely for 18 months during the COVID-19 pandemic. On the intake form, Arya identified as trans-female and selected the "she/her" pronouns.

During the intake appointment, Arya said that she didn't find herself suffering too much during the stay-at-home orders. She and her husband felt safe and comfortable in their home, maintained full-time employment, and enjoyed the company of several beloved pets. Like everyone else, they experienced losses associated with the pandemic, such as having two friends die from the virus. However, these losses did not feel devastating, and the grief associated with them was not disabling.

As she transitioned back to in-person employment, Arya found herself struggling. She described it as "finally hitting a wall." She reported "difficulty falling asleep and getting going in the morning, feeling irritated with those around her, and having no energy for anything." She also felt like she "wasn't recharging enough on the weekends to face the week," as well as having frequent headaches. A recent check-up with her primary care physician revealed no medical causes for her symptoms.

ASEBA Findings for Arya

Arya's psychotherapist asked her to complete the ASR and her husband to complete the ABCL. Because Arya identified as trans-female on the intake form, the psychotherapist proposed to use the female norms to score Arya's data, which Arya approved. On the ASR, Arya scored in the borderline-clinical range on the Anxious/Depressed syndrome and in the clinical range on the Withdrawn/Depressed syndrome and the Internalizing Problems scale. On the ABCL, ratings by Arya's husband placed her in the borderline-clinical range on the Withdrawn/Depressed syndrome, with no other problem scale score elevations.

On the Adaptive Functioning scales, Arya scored in the clinical range on the Friends scale according to both the ASR and ABCL. However, conversations with Arya suggested that the social

distancing restrictions of the pandemic may have contributed to her low scores. She mentioned having a large group of friends and feeling eager to see them when it would be safe to do so. Arya's ASR and ABCL scores on all other Adaptive Functioning scales were in the normal range.

Intervention

Arya received therapy for anxiety and depression from the psychotherapist at the onsite health center. The therapy focused on the chronic stresses of the pandemic, such as fear of infection for oneself and loved ones, barriers to social connection, fears of the economic fallout, and a general loss of predictability and controllability of life events. Arya worked with the psychotherapist to acknowledge and express rather than avoid and push down her difficult thoughts and feelings. With the help of the psychotherapist, Arya also developed an arsenal of effective coping strategies for dealing with her worry, anxiety, and depression, such as scheduling pleasant activities, reaching out for social support, and finding ways to be useful in her community. The psychotherapist also connected Arya with a health coach working in the same onsite clinic to help her return to exercise and develop a healthy sleep routine. With the health coach's encouragement, Arya joined a daily walking group of coworkers in her office building, which offered her both physical activity and social connection.

Subsequent Assessments

After 6 months, the psychotherapist asked Arya and her husband to again complete the ASR and ABCL. Arya's scores were now in the normal range on all problem scales. With the exception of the Friends scale, Arya's scores were also in the normal range on all ASR and ABCL Adaptive Functioning scales. On the Friends scale, Arya again scored in the clinical range according to both informants.

An interview with Arya indicated that she was doing much better. She felt more hopeful and relaxed and was working with relative ease and enjoyment. Her work with the health coach helped her realize how important it was for her emotional and behavioral health to stay physically active. She was enjoying her exercise program and her lunchtime walks with her walking group. When asked about her score on the Friends scale, Arya said that, because of the continued pandemic, she wasn't spending much face-to-face time with her friends and also not initiating telecontact because everyone was tired of teleconferencing. However, because of her walking group, Arya no longer felt socially isolated and thought that her social needs were being met "fairly well, given the circumstances."

SUMMARY

This chapter illustrates how to score data for assessed individuals in relation to different ASEBA gender norms.

As in the case of Alex who was actively questioning her gender identity, users can compute scale scores in relation to norms for *either* male or female gender or both.

When assessing individuals who do not identify with male or female gender, or who identify as nonbinary, users can compute their scale scores using the ASEBA Integrated Norm-Referenced Scoring. These norms assign norm-referenced *T* scores based on whichever gender's norm-referenced *T* score would be higher for problem scales and lower for competence, adaptive functioning, and personal strengths scales. The case of Andy, who identified as nonbinary, illustrated this option.

Finally, the case of Arya, who identified as trans-female, demonstrated the use of female norms. This is because the ASEBA gender norms are based on the self-identified gender of the assessed persons, rather than on their sex assigned at birth.

Chapter 3
Applications of the ASEBA in Various Settings

The ASEBA is designed for many kinds of users in many different settings. Because ASEBA forms can be completed on paper or online by individuals who are being assessed and by people who know the assessed individuals, no user time is required to obtain the assessment data. If the forms are completed via ASEBA-Web, they are automatically scored to provide output for users to view on paper or on screen. Data from paper forms can be key entered by users or data clerks into ASEBA-PC, ASEBA-Network, or ASEBA-Web, which generate output viewable on screen or printed on paper. Data from paper forms can also be entered by users or data clerks on hand-scored paper profiles. For users' records and for research, data scored by ASEBA-PC, ASEBA-Network, or ASEBA-Web can be stored in electronic files for future access.

Stored data are especially valuable for comparing assessments of clients at intake, during the course of services, and at termination in order to identify changes in problems and strengths. The *ASEBA P&O App* compares scale scores at whatever intervals users choose to have ASEBA forms completed by clients and by collaterals. The App's output includes bar graphs of scores, plus reports of whether changes in scores from one assessment to another exceed chance expectations, based on statistical tests performed by the App (users do not need statistical skills). Use of the App to test changes for individual clients and also to compare outcomes for different services are detailed in the *ASEBA Manual for Assessing Progress & Outcomes of Problems & Strengths* (Achenbach, 2019). The following sections outline applications of the ASEBA in diverse settings. The acronyms for ASEBA forms are explained in Chapter 1, Table 1-1.

MENTAL HEALTH SETTINGS

The *Mental Health Practitioners' Guide for the Achenbach System of Empirically Based Assessment* (*ASEBA)* (Achenbach & Rescorla, 2018) details applications of the ASEBA in mental health settings. A typical sequence involves having ASEBA forms completed as part of the intake process. For children and adolescents, this would include having each parent figure or other adults in a child's household fill out the CBCL/1½-5 or CBCL/6-18. (For brevity, we use "child" to include ages 1½-18 years.) The YSR can be completed by 11-18-year-olds. In order to evaluate parental functioning and its relations to the child's functioning, parent figures can be asked to complete the ASR to describe themselves and the ABCL to describe their partner or other relevant adults.

The *Multicultural Family Assessment Module* (MFAM) (Achenbach, Rescorla, & Ivanova, 2015) enables users to display side-by-side bar graphs of syndrome and DSM-oriented scale scores obtained by children and their adult family members on scales that have counterparts for ages 6-18 and 18-59. For 1½-5-year-olds who attend preschool or group daycare, the C-TRF can be completed by preschool teachers and daycare providers to assess functioning in group settings outside the family. For 6-18-year-olds who attend school, the TRF can be completed by relevant teachers and other school staff to assess functioning in school contexts.

For 18-59- and 60-90+-year-olds who seek mental health services, they can be asked to complete the ASR or OASR, respectively. During initial interviews, they can be asked to consent to having a collateral who knows them—such as a spouse, partner, grown child, other family mem-

ber, friend, etc.—complete the ABCL or OABCL. For adults who are referred by family members rather than seeking help for themselves, the referring family members can be asked to complete the ABCL or OABCL as part of the referral process. The referred adult can subsequently be asked to complete the ASR or OASR or can have it administered to them by reading it aloud and entering their responses.

To measure changes in functioning, any of the ASEBA forms mentioned in the preceding paragraphs can be filled out again by the respondents who filled them out previously at intervals chosen by the user, such as after 6 months of services and again at termination of services. The P&O App can display bar graphs of scale scores obtained at each assessment and can flag changes that exceed chance expectations.

For brief re-assessments at user-selected intervals of days, weeks, or a couple of months, the appropriate version of the BPM can be completed in 1-2 minutes by people who are receiving services and by people who can observe their functioning. For ages 6-18, there are separate BPM forms for completion by parent figures (BPM-P) and school staff (BPM-T). For 11-18-year-olds, there is a self-report form (BPM-Y). And for ages 18-59, the BPM/18-59 can be used to obtain self- and collateral-ratings.

CHILD AND FAMILY SERVICES

The *Child & Family Service Workers' Guide for the Achenbach System of Empirically Based Assessment* (*ASEBA*) (Achenbach, Pecora, & Wetherbee, 2015) details applications of the ASEBA to child and family services. A particularly valuable application of the ASEBA in child and family service work is to assess children and parent figures for whom decisions about services and placement need to be made. In cases where child placement is being considered, it is helpful to have the CBCL/1½-5 or CBCL/6-18 filled out by whatever adults know the child.

The ASR, ABCL, OASR, and OABCL can be completed by relevant adults to describe themselves and other relevant adults. If the birth parents are not available or are poor informants, other family members, foster parents, and child care workers may know enough about the assessed individuals to complete relevant ASEBA forms. Adolescents can be asked to complete the YSR. If informants cannot complete forms independently, a worker can read the form's items aloud and enter the responses on paper or online.

The completed ASEBA forms and profiles of scale scores obtained from them can be used as evidence on which to base decisions about services and placement. With appropriate consents, the completed forms and profiles can be shared with other professionals who work with the assessed children and families. The completed profiles of scale scores obtained during initial assessments for services and placements can serve as baselines with which to compare ASEBA scores obtained at subsequent re-assessments. For example, if an adolescent is moved from one living situation to another—such as a group home or foster home—the P&O App can be used to compare scores obtained on the YSR and TRF from the initial living situation to subsequent placements in order to evaluate changes in the adolescent's functioning that exceed chance expectations.

SCHOOL SETTINGS

The *School-Based Practitioners' Guide for the Achenbach System of Empirically Based Assessment* (*ASEBA*) (Achenbach & McConaughy, 2015) details applications of the ASEBA in school settings. School psychologists, special educators, and mental health providers affiliated with schools can ask teachers and counselors to complete the TRF as part of the process of referring students for help. If students have multiple teachers, it is helpful to ask each one to complete a TRF to document consistencies and variations

in how students are seen by different informants.

If fuller evaluations of students are warranted, parent figures can be asked to complete the CBCL/1½-5 or CBCL/6-18. With parental permission, 11-18-year-old students can be asked to complete the YSR. ASEBA-PC, ASEBA-Network, and ASEBA-Web can be used to display systematic comparisons between item ratings and scale scores obtained from different informants. If certain scales—such as the Attention Problems syndrome scale and DSM-oriented ADH Problems scale—are elevated in ratings by most informants, including parents and teachers, this would suggest a need for treatment beyond what may be feasible in the school setting, although school personnel may need to collaborate in treatment.

In some cases, certain problems may be reported by teachers but not by parents. For example, teachers' but not parents' ratings may yield high scores on the Attention Problems syndrome scale and DSM-oriented ADH Problems scale. However, parents may report that the student spends hours engrossed in video games, implying the absence of ADHD. The difference between teacher- and parent-ratings of attention problems may argue for a primarily school-based intervention for attention problems.

The *School-Based Practitioners' Guide* illustrates applications of ASEBA data to decisions about various special education services and to assessing individual students' progress and outcomes. The *Guide* also outlines applications of the ASEBA to evaluating the effects of different programs on groups of students.

MEDICAL SETTINGS

The *Medical Practitioners' Guide for the Achenbach System of Empirically Based Assessment* (ASEBA) (Achenbach & Ruffle, 2015) details applications of the ASEBA in medical settings. Because parents often consult pediatricians and pediatric nurse practitioners about preschool children's behavioral, emotional, social, and thought problems, it is useful to have parents routinely complete the CBCL/1½-5, which includes the Language Development Survey. If parents complete the CBCL/1½-5 at home on ASEBA-Web or in the pediatric waiting room using a tablet or computer, the scored profiles can be given to the provider to view before or during the appointment with the parent and child. If parents complete the paper CBCL/1½-5, the data can be key-entered into ASEBA-PC or ASEBA-Network or can be entered on a hand-scored profile.

If parents ask about their children's problems, providers can look at the scored profiles to identify scales that are in the clinical or borderline-clinical range. If scale scores are elevated, providers may elect to obtain additional assessment data, such as a CBCL/1½-5 completed by another family member and/or C-TRFs completed by preschool teachers and/or daycare providers. Pediatric providers may also consider asking for a history of problems and may provide guidance for managing particular problems. If there is a need for ongoing interventions, such as for sleep problems or attention problems, providers may collaborate with parents in continuing management of the problems. On the other hand, providers may elect to discuss with parents the need for mental health, special education, or speech/language services (e.g., if the Language Development Survey shows delayed language development).

For school-age children, pediatric providers may find it helpful to have parents routinely complete the CBCL/6-18 and 11-18-year-olds complete the YSR. The scored profiles can help pediatric providers quickly spot elevated scores on scales such as Attention Problems, for which the providers may consider interventions such as medication. They may also spot elevations on other scales or on multiple scales that would argue for encouraging parents and/or youths to obtain mental health services. As problems of attention and overactivity are often of particular

concern to school personnel, pediatric providers may work with school personnel and parents to provide medication management. In medical services for adults and older adults, ASEBA forms can be used to identify problems that may warrant referral for mental health services.

APPLICATIONS TO TRAINING

The ASEBA can be used to enhance training in several ways. One way is by teaching trainees about the methods of empirically based assessment. This can include instruction in the multiple levels of information provided by ASEBA forms. Scored output from ASEBA forms displays informants' ratings of specific problem and strength items, scales that compare assessed individuals' scores with scores obtained by normative samples of peers on empirically based sets of items and DSM-oriented scales, and comparisons of item ratings and scale scores obtained from multiple informants.

A second way is by providing trainees with completed ASEBA forms and scored profiles prior to clinical interviews in which people who filled out an ASEBA form can be asked whether they have questions about the form and can then be asked about their responses to specific items. For example, if an assessed person gave a rating of *1* or *2* to the item *I can't get my mind off certain thoughts (describe)* and entered "death," the interviewer can say "I see you wrote 'death' to describe thoughts that you can't get your mind off. Can you tell me more about that?"

A third way is to have trainees complete ASEBA forms to describe clients and then to compare the trainees' item ratings and scale scores with those obtained from self-ratings, collateral ratings, and ratings by supervisors. The reasons for discrepancies can then be discussed with supervisors. This is especially useful for helping trainees understand how both consistencies and discrepancies between informants can provide crucial information about variations between informants' perspectives and between aspects of clients' functioning in different contexts.

SUMMARY

This chapter provides an overview of applications of the ASEBA in various settings. In mental health settings, ASEBA forms can be completed as a routine part of the intake process. For 6-18-year-olds, the Multicultural Family Assessment Module (MFAM) enables users to display side-by-side bar graphs of scale scores obtained by children and their family members on scales that have counterparts for ages 6-18 and 18-59.

For all ages from 1½-90+ years, ASEBA forms are available for completion by different kinds of informants. ASEBA software compares item ratings and scale scores obtained from different informants. To assess progress and outcomes, the P&O App displays ASEBA scale scores obtained at each assessment and flags changes that exceed chance expectations. For brief re-assessments, the BPM can be completed in 1-2 minutes by people who are receiving services and by people who can observe their functioning.

In child and family service contexts, ASEBA forms can be used to assess children and their parent figures for whom decisions about placement need to be made. The ASEBA data provide evidence on which to base decisions about services and placement. Initial ASEBA scores can provide baselines with which to compare ASEBA scores obtained at subsequent re-assessments, such as after new placements.

As part of the process for referring students for help, school psychologists, special educators, and mental health providers can ask teachers and counselors to complete the TRF. If fuller evaluations of students are warranted, parents can be asked to complete the CBCL/1½-5 or CBCL/6-18, and 11-18-year-olds can be asked to complete the YSR. Comparisons of ASEBA data from different informants can be used to identify problems and strengths that may be specific to school versus home or to particular classes. Interventions can then be tailored to particular settings or more broadly across settings.

In medical settings, providers can ask parents of preschoolers to routinely complete the CBCL/1½-5 as a basis for providing advice to parents and for identifying problems that may require systematic interventions and/or referral for mental health, special education, or speech/language services. For school-age children, providers may find it useful to have parents complete the CBCL/6-18 and 11-18-year-olds complete the YSR as a basis for identifying problems that may be manageable in the pediatric setting or may warrant referral to other providers. Providers may have adults complete the ASR or OASR as a basis for determining whether help may be needed for behavioral, emotional, social, or thought problems.

The ASEBA can be used to enhance training by teaching trainees about empirically based assessment. When trainees view completed ASEBA forms and scored profiles before conducting clinical interviews, they can use them as a basis for asking interviewees about their responses to particular items. It is also useful to have trainees complete ASEBA forms for comparison with item ratings and scale scores obtained from self-ratings, collateral ratings, and ratings by supervisors. This is especially useful for helping trainees understand how cross-informant consistencies and discrepancies can reveal variations among informants' perspectives, as well as variations in clients' functioning in different contexts.

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