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Abstract	<p>This chapter seeks to provide an overview of some common assessment measures for emotional/behavioral problems in Asian-American youth. Measures for which psychometric data are available only for Asian populations are also noted. Rating scales in the current youth behavioral assessment literature discussed include: (1) Global impairment scales, (2) Domain-specific scales, and (3) Symptom-specific scales. We conclude the chapter with recommendations of how to utilize these measures and provide suggestions for future research to improve the utility of behavioral assessments for Asian-American youth.</p>	

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[AU1] **Assessment of Childhood Behavioral Disorders**

[AU2] **Judy Ho, Natalia Moss, and May Yeh**

4 **Introduction**

5 The purpose of this chapter is to provide an  
6 overview of some of the common assessment  
7 measures for emotional/behavioral problems,  
8 and to review whether they have been tested for  
9 use with Asian-American youth samples. When  
10 psychometric data is lacking for Asian-  
11 American groups in the extant literature, we dis-  
12 cuss psychometric studies undertaken in Asian  
13 countries. Some measures for which psycho-  
14 metric data are available only for Asian popula-  
15 tions are also highlighted. Asian-American  
16 youths in the USA are quite diverse, consisting  
17 of immigrants and first generation individuals  
18 who may ascribe more to the values of their  
19 country of origin, as well as those youth whose  
20 families have been in the USA for several gen-  
21 erations and/or those who have adopted a strong  
22 affiliation to the mainstream American culture.  
23 In comparison, their counterparts who reside in  
24 Asian countries may more readily behave in

accordance with the values of the indigenous 25  
culture. Although the two populations are quite 26  
different, learning about how the instrument 27  
operates with samples from Asian countries 28  
might represent an important step towards 29  
understanding how these assessment tools might 30  
work for their Asian-American counterparts, 31  
particularly those who report a higher cultural 32  
affiliation to their indigenous cultures. In addi- 33  
tion, such information may help inform the 34  
selection of assessment tools and interpretation 35  
of results. Finally, we conclude with recommen- 36  
dations of how to utilize these measures and 37  
provide suggestions for future research to 38  
improve the utility of behavioral assessments 39  
for Asian-American youth. 40

41 **Overview of the Organization**  
42 **of Assessments**

43 The following sections will be organized by the 43  
types of rating scales in the current youth behav- 44  
ioral assessment literature: (1) Global impair- 45  
ment scales, (2) Domain-specific scales, and (3) 46  
Symptom-specific scales (Park, Lee, & Schachar, 47  
2011). Global impairment scales enable the rat- 48  
ing of a child on a single scale of functioning. 49  
Domain-specific impairment scales provide 50  
scores for one or several domains of function- 51  
ing. Finally, symptom-specific impairment 52  
scales measure the degree of disability associ- 53  
ated with a specific symptom or diagnosis (Park 54  
et al., 2011). 55

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56 **Global Impairment Scales**

57 **The Children's Global Assessment**  
58 **Scale (CGAS)**

59 The Children's Global Assessment Scale (CGAS: Shaffer et al., 1983) assesses general functioning in youth aged 1–16 on a scale from 1 to 100, with scores ranging from 1 to 40 (normal), 41–60 (slight disability), 61–80 (moderate disability), 64 and 81–100 (serious disability). Test–retest reliability was assessed by having five distinct raters conduct a new CGAS on the same 19 participants 6 months later. All but one rater was found to be consistent over time (ICC=0.87, 0.92, 0.93, 0.95, and 0.69; Shaffer et al., 1983). In this study a modest correlation was found between CGAS and the Conners' Ten Item Abbreviated Parent Checklist. However, these two instruments are different in that the CGAS is a global measure rated by clinicians while Conners' Checklist is a syndrome-specific measure rated by parents. The authors also investigated the discriminant validity for the CGAS between inpatients and outpatients. The mean CGAS score for outpatients was 65.4 (SD=14.8) and for inpatients 46.0 (SD=19.0), which was significant at the  $p < 0.001$  level. To date, the CGAS has not been specifically validated with Asian-American populations in the USA, and no psychometric studies have been undertaken in Asian countries.

86 **Child and Adolescent Functional**  
87 **Assessment Scale (CAFAS)**

88 The Child and Adolescent Functional Assessment Scale (CAFAS: Hodges, 2000a; 2000b) assesses emotional behavioral, and psychological problems in youth. Information is collected during a routine interview and the clinician then selects items that best describe the youth's problematic behaviors, strengths and goals on eight domains: (1) at home, (2) at school, (3) in the community, (4) behavior towards others, (5) moods/emotions, (6) self-harm, (7) substance use, and (8) thinking

(which assessing irrationality). A total score and subscale scores are calculated with higher scores indicating greater impairment in functioning. The CAFAS has been used to evaluate Evidence Based Treatments and interventions in the community. Results indicate that the CAFAS is able to discriminate between youth in various levels of treatment (e.g., inpatient vs. outpatient; Hodges & Wong, 1996), different living situations (e.g., home, foster care, inpatient; Hodges, Doucette-Gates, & Liao, 1999), and with varying levels of severity and comorbidity of psychological diagnoses (Ezpeleta, Granero, de la Osa, Domenech, & Bonilla, 2006; Hodges et al., 1999). Previous studies have shown the CAFAS to be sensitive to the degree and rate of change over time. For example, in an investigation conducted at Fort Bragg, a statistically significant reduction in impairment was observed from intake to 6 months and intake to 12 months, with large to moderate effect sizes (Hodges, 1999; Hodges & Wong, 1996; Hodges, Wong, & Latessa, 1998). Additionally, the CAFAS has been shown to be a reliable indicator of youth's psychological functioning in a variety of settings, cultural contexts, and among youth with diverse backgrounds (e.g., in mental health facilities, schools, foster care, youth and adolescent justice system, etc.). The CAFAS has not been specifically validated on Asian-American or Asian populations.

128 **The Child and Adolescent**  
129 **Functioning Impairment Scale (CAFIS)**

130 The Child and Adolescent Functioning  
131 Impairment Scale (CAFIS) is a symptom-specific  
132 rating scale that assesses the most severe level of  
133 dysfunction in the youth within the past month  
134 and has established preliminary reliability and  
135 validity for the diagnosis of youth with ADHD in  
136 Korea. It utilizes a Likert Scale (0 indicating no  
137 impairment to 4 indicating severe impairment),  
138 includes both the CAFIS-parent and CAFIS-  
139 teacher forms, and has been used to measure  
140 functional impairment in Korean children and  
141 adolescents. The scales were developed in the  
142 Korean language, and developed based on the

143 collection of items from widely used, validated  
 144 scales measuring global impairment in youth  
 145 with the addition of open-ended questions. The  
 146 CAFIS-parent consists of 14 items and has four  
 147 factors: (1) family relationship; (2) teacher rela-  
 148 tionship; (3) peer relationship; and (4) academic  
 149 achievement. The CAFIS-teacher form consists  
 150 of ten items and has three factors: (1) peer rela-  
 151 tionship; (2) teacher relationship; and (3) aca-  
 152 demic achievement.

153 The CAFIS was examined for its reliability  
 154 and validity in a sample of 114 youth (72 children  
 155 diagnosed with ADHD using the DSM-IV crite-  
 156 ria, and 42 children who did not meet DSM-IV  
 157 criteria for ADHD) aged 6–14 years who had  
 158 visited the department of psychiatry at  
 159 Soonchunhyang University Bucheon Hospital for  
 160 the assessment of inattention, hyperactivity, and  
 161 impulsivity. Factor structures of the CAFIS-  
 162 parent and CAFIS-teacher were confirmed in this  
 163 sample (Variance accounted for in four factors of  
 164 CAFIS-parent=64 %; variance accounted for by  
 165 three factors of CAFIS-teacher=66 %). The  
 166 internal consistency of both scales was satisfac-  
 167 tory, with Cronbach’s alpha ranging from 0.71 to  
 168 0.90 for the CAFIS-parent and from 0.74 to 0.90  
 169 for the CAFIS-teacher. The test–retest reliability  
 170 coefficients of the CAFIS-parent subscales were  
 171 between  $r=0.71$  and  $r=0.86$ , and between  
 172  $r=0.81$  and  $r=0.89$  for the CAFIS-teacher sub-  
 173 scales. Convergent validity was demonstrated by  
 174 significant correlations between the subscale  
 175 scores of the CAFIS-parent and the CAFIS-  
 176 teacher to the Children’s Global Assessment  
 177 Scale (C-GAS; Shaffer et al., 1983). Discriminant  
 178 validity was confirmed by analyzing the mean  
 179 subscale scores of the CAFIS-parent and CAFIS-  
 180 teacher forms between the ADHD and non-  
 181 ADHD youth subsamples. All subscales of the  
 182 CAFIS-parent and CAFIS-teacher forms of the  
 183 ADHD group were significantly higher than the  
 184 control group. Receiver Operating Characteristic  
 185 (ROC) analyses were calculated to assess the  
 186 sensitivity and specificity for the CAFIS sub-  
 187 scales with clinician diagnosis of ADHD as the  
 188 gold standard. Results demonstrated that for all  
 189 subscales on both forms, areas under the curve  
 190 (AUCs), which is a measure of overall accuracy

(Sackett, Haynes, Tugwell, & Guyatt, 1985), 191  
 were significant. The optimal cutoff score of the 192  
 CAFIS-parent form was a total score of 7 (sensi- 193  
 tivity: 0.75, specificity: 0.83), 3 for the family 194  
 relationship subscale (sensitivity: 0.60; specifi- 195  
 city: 0.74), 1 for the teacher relationship subscale 196  
 (sensitivity: 0.61; specificity: 0.76), 1 for the peer 197  
 relationship subscale (sensitivity: 0.64; specifi- 198  
 city: 0.67), and 3 for the academic achievement 199  
 subscale (sensitivity: 0.63; specificity: 0.79). In 200  
 the CAFIS-teacher form, optimal cutoff scores 201  
 were 6 for total score (sensitivity: 0.68; specifi- 202  
 city: 0.69), 1 for the teacher relationship subscale 203  
 (sensitivity: 0.54; specificity: 0.72), 3 for the peer 204  
 relationship subscale (sensitivity: 0.63; specifi- 205  
 city: 0.67), and 3 for the academic achievement 206  
 subscale (sensitivity: 0.58; specificity: 0.79; Park 207  
 et al., 2011). There are several limitations to this 208  
 measure. The CAFIS is not able to distinguish 209  
 among psychiatric symptoms other than ADHD 210  
 symptoms, it has limited generalizability as 211  
 nationally representative normative data in Korea 212  
 has not yet been collected and no evidence exists 213  
 for how this measure might perform for Korean 214  
 Americans, and the impact of comorbid diagno- 215  
 ses on ratings of youth functional impairment is 216  
 unknown as it was not directly assessed. 217

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**Domain-Specific Scales** 218

**The Achenbach Scales** 219

The Achenbach Scales (Achenbach, 1991; 220  
 Achenbach & Rescorla, 2001) are a collection of 221  
 comparable questionnaires designed for different 222  
 respondents (parents, teachers, and youth) used 223  
 to assess child emotional and behavioral prob- 224  
 lems and competencies. The Child Behavior 225  
 Checklist for ages 6–18 (CBCL 8/6–18) is a 226  
 parent-report questionnaire composed of 113 227  
 items based on a 3-point Likert scale [0=Not true 228  
 (as far as you know), 1=Somewhat or Sometimes 229  
 True, 2=Very True or Often True]. The Teacher’s 230  
 Report Form for ages 6–18 (TRF) is a teacher- 231  
 report questionnaire composed of 113 items 232  
 based on a 3-point Likert scale [0=Not true (as 233  
 far as you know), 1=Somewhat or Sometimes 234

235 True, 2=Very True or Often True]. The Youth  
236 Self-Report (YSR) (Achenbach, 1991;  
237 Achenbach & Rescorla, 2001) is a reliable and  
238 valid self-report measure for ages 11–18  
239 (YSR/11–18) composed of 112-item form based  
240 on a 3-point Likert scale [0=Not true,  
241 1=Somewhat or Sometimes True, 2=Very True  
242 or Often True]. The CBCL/6–18, TRF, and YSR  
243 scales are based on factor analysis of the follow-  
244 ing Empirically based syndrome scales: Anxious/  
245 Depressed, Withdrawn/Depressed, Somatic  
246 Complaints, Social Problems, Thought Problems,  
247 Attention Problems, Rule-Breaking Behavior,  
248 and Aggressive Behavior. Internalizing problems  
249 are measured through the Anxious/Depressed,  
250 Withdrawn/Depressed, and Somatic Complaints  
251 scales, Externalizing Problems consist of Rule-  
252 Breaking Behavior, and Aggressive Behavior  
253 scales. Reports are scored using age- and gender-  
254 normed national comparisons. The three compo-  
255 nents of the CBCL measure have well-established  
256 reliability (mean  $r$  test–retest for CBCL and  
257 TRF=0.90) and construct validity (Achenbach &  
258 Rescorla, 2001). Normative data was obtained  
259 from parents of 1,300 children who were propor-  
260 tionate to the general US population with respect  
261 to race and socioeconomic status (Achenbach,  
262 1991). CBCL and TRF scales correlate with cor-  
263 responding Conners' Parent Rating Scale-  
264 Revised and Teacher Rating Scale-Revised  
265 (Conners, Sitarenios, Parker, & Epstein, 1998)  
266 ranging from 0.71 to 0.85. In this study of 2,200  
267 participants ranging in age from 3 to 17 years,  
268 84 % were European American, 5 % were  
269 African-American, 4 % were Hispanic, and 7 %  
270 were designated as Other. Correlations between  
271 CBCL scales and the Behavior Assessment  
272 System for Children (BASC: Reynolds &  
273 Kamphaus, 2004) ranged from 0.38 to 0.89.  
274 Correlations between BASC and CBCL  
275 Internalizing, Externalizing, and Total Problems  
276 scales ranged from 0.74 to 0.89.

277 A confirmatory factor analysis using robust  
278 weighted least squares estimation of the CBCL  
279 was conducted in a sample of 516 girls adopted  
280 from China aged 6–15.7 years (average age=8.2,  
281 SD=1.9). Results suggested that the fit of the  
282 8-factor model was good (root-mean-square error

of approximation=0.047). Support was found for  
283 the second order factor structure of Internalizing  
284 and Externalizing Problems which further pro-  
285 vide evidence of the factorial validity of the  
286 scores from the CBCL in Chinese girls.  
287 Comparisons of average scores for the  
288 Internalizing scale, Externalizing scale, and Total  
289 Problems scale revealed mostly small differences  
290 between the sample of adopted Chinese girls and  
291 the normative samples reported by Achenbach  
292 and Rescorla (2001), and the pattern of syndrome  
293 correlations and factor loadings was consistent  
294 with Achenbach and Rescorla's (2001) model.  
295 Internal reliability for the Chinese sample were  
296 lower (ranged from 0.57 to 0.93 on all scales)  
297 than those reported by Achenbach and Rescorla  
298 (2001) (ranged from 0.89 to 0.97 on all scales),  
299 with the lowest reliabilities reported on Somatic  
300 Complaints (0.57), Thought Problems (0.61), and  
301 Rule-Breaking Behavior (0.61). These results  
302 suggest that reliability may not be an intrinsic  
303 property of the questionnaire but may fluctuate as  
304 a function of sample characteristics and testing  
305 conditions (Thompson & Vacha-Haase, 2000).  
306

307 Liu, Cheng, and Leung (2011) examined the  
308 cross-cultural factor validity of the CBCL/1.5–5  
309 and C-TRF to a community sample of 876  
310 Mainland Chinese preschoolers (462 males) aged  
311 4–5 years (average age=66.6 months, SD=5).  
312 Parents and teachers were asked to assess the  
313 children with the Chinese language version of the  
314 CBCL/1.5–5 and C-TRF which was translated  
315 and back-translated, then finalized by a team of  
316 expert child psychologists to ensure equivalence  
317 of the translation. Confirmatory factor analysis  
318 confirmed the seven-syndrome and two-higher-  
319 order-broadband-problem factor structure as  
320 reported by Achenbach and Rescorla (2001) with  
321 a US sample. The six-syndrome and two-higher-  
322 order-broadband-problem factor structure of the  
323 C-TRF was also confirmed in this Mainland  
324 Chinese sample. These findings support the fac-  
325 torial validity of the parent and teacher report,  
326 and suggest that the US-derived taxonomy is  
327 appropriate for assessing Chinese preschool chil-  
328 dren for psychopathology. In the CBCL/1.5–5,  
329 significant difference between Chinese and US  
330 samples confirm prior findings that Chinese and

331 Asian youth experiencing more internalizing  
332 symptoms and Western children experience more  
333 externalizing symptoms (Liu et al., 2001; Yang,  
334 Soong, Chiang, & Chen, 2000). On the C-TRF,  
335 teachers also reported fewer externalizing prob-  
336 lems for Chinese preschoolers compared to  
337 teacher reports in Western countries, but no sig-  
338 nificant differences were found for the report of  
339 internalizing problems for Chinese preschoolers  
340 compared to teacher reports in Western countries.  
341 It may be that Chinese teachers are less able to  
342 detect covert internalizing problems than parents  
343 because of their relatively less frequent interac-  
344 tions with students (Yang et al., 2000). Ratings of  
345 Total Problems by either parents or teachers are  
346 mostly similar between Chinese and US samples,  
347 with boys scoring significantly higher than girls  
348 on all externalizing symptom scales across both  
349 parent and teacher report. No gender differences  
350 were found on the internalizing symptoms on  
351 either the parent or teacher report. Finally agree-  
352 ment between parents' and teachers' ratings was  
353 relatively low ( $r=0.18$ ) compared to the US sam-  
354 ple ( $r=0.40$ ). These findings corroborate other  
355 studies of standardized assessments of psychopa-  
356 thology in Chinese youth samples which have  
357 reported ranges of  $r=0.07$  to  $r=0.36$  (Deng, Liu,  
358 & Roosa, 2004; Ho et al., 1996). Future research  
359 should continue to employ confirmatory factor  
360 analyses and reliability analyses with additional  
361 samples of Chinese American children to test the  
362 generality of present findings. Additionally, a  
363 further examination of the factor structure of the  
364 CBCL is needed to evaluate how the scores cor-  
365 relate with other measures (e.g., strength-based)  
366 in Chinese American youth.

367 Confirmatory factor analyses were performed  
368 on the YSR on a sample of 30,243 youths  
369 11–18 years old from 23 societies to test the gen-  
370 eralizability of an 8-syndrome taxonomy model  
371 for youth psychopathology (Ivanova et al., 2007).  
372 Three societies represented Asian samples: (1)  
373 Hong Kong,  $N=1,593$  (53 % male), aged 12–18  
374 years (average age=14.7) (Leung et al., 2006);  
375 (2) Japan,  $N=2,542$  (48 % males), aged 11–15  
376 years (average age 13.1) (Kuramoto et al., 2002);  
377 and (3) Korea,  $N=3,211$  (39 % males), aged  
[AU3]378 12–17 years (average age=14.8) (Oh et al.,

1997). The 8-syndrome taxonomic model met 379  
criteria for good fit to the data from each of the 23 380  
societies, which corroborated the findings for the 381  
CBCL and TRF as reported by Achenbach and 382  
Rescorla (2001). Specifically, for Hong Kong, 383  
the root-mean-square error of approximation 384  
(RMSEA) was 0.043, with a comparative fit 385  
index (CFI) of=0.845. For Japan, RMSEA=0.037 386  
and CFI=0.856; and for Korea, RMSEA=0.038, 387  
CFI=0.863, indicating acceptable to good 388  
model fit. 389

Another study utilized a sample of 100 ado- 390  
lescents in Southern India who had been exposed 391  
to traumatic life events to revise, translate, and 392  
explore the construct validity of the Post- 393  
traumatic Stress Disorder Scale of the CBCL in 394  
Tamil (Russell, Subramanian, & Russell, 2005). 395  
Revision of the content of the scale was com- 396  
pleted by three psychiatrists and one psycholo- 397  
gist who assigned each of the 113 CBCL items to 398  
one of the three DSM-IV-TR symptom catego- 399  
ries for PTSD, which resulted in 13 final items 400  
for the Post-traumatic Stress Disorder Scale. 401  
Translation of the CBCL was achieved through 402  
independent forward–backward translations by 403  
experts who were knowledgeable of both lan- 404  
guages in order to ensure semantic convergence 405  
of the English and Tamil version of the instru- 406  
ment. Exploratory factor analysis results sug- 407  
gested three underlying factors, and the ROC 408  
analysis threshold score of 0.5 was determined to 409  
be an effective screening score for individuals 410  
who have experienced trauma. 411

A study was designed to provide standardized 412  
norms for the Japanese version of Child Behavior 413  
Checklist/4–18 (CBCL/4–18) and to examine the 414  
scale's reliability and validity (Itani et al., 2001) 415  
in a sample of 5, 159 parents of children aged 416  
4–15 years. Within the full community-based 417  
sample, 432 parents had children who received 418  
consultation from or visited medical institutions 419  
and consulting agencies, thus approximating a 420  
clinical subsample. Based on the standardization 421  
process of the original CBCL as reported by 422  
Achenbach and Rescorla (2001),  $T$ -scores were 423  
calculated for eight Syndrome Scales, two broad- 424  
band scales (Internalizing and Externalizing), 425  
and the total score. High internal consistency was 426

427 confirmed in seven syndrome scales with the  
 428 exception for Thought Problems which yielded a  
 429 lower than adequate Cronbach's alpha coefficient  
 430 ( $r < 0.70$ ). Construct validity was confirmed  
 431 through high correlations with scores on the  
 432 Rutter's Questionnaires for parents. Cutoff criteria  
 433 for normal, borderline, and clinical ranges  
 434 were established (Itani et al., 2001).

435 A study investigated interrater agreement  
 436 between Japanese parents and teachers regarding  
 437 the emotional/behavioral problems of 316 youth  
 438 (141 males) 6–12 years old (average age=9.4,  
 439 SD=1.7) in Japan (Satake, Yishida, Yamashita,  
 440 Kinukawa, & Takagishi, 2003). Comparison of  
 441 average scores did not yield significant differences  
 442 from the Japanese published standardization  
 443 data (Itani et al., 2001) on internalizing scale,  
 444 externalizing scale, and total problems. Parent–  
 445 teacher agreement was examined through three  
 446 indices; mean scores, correlations, and *D* scores  
 447 (generalized distance between item profile).  
 448 Parent–teacher correlations were in the low to  
 449 medium range (Pearson's correlation=0.13,  
 450  $p < 0.05$  for internalizing scale; Pearson's correlation=0.30,  
 451  $p < 0.001$  for externalizing and total  
 452 problems scales). Greater parent–teacher agreement  
 453 occurred on the externalizing scale ( $z = 1.87$ ,  
 454 effect size  $q = 0.21$ ,  $p < 0.05$ ) and total problems  
 455 scale ( $z = 1.86$ , effect size  $q = 0.21$ ,  $p < 0.05$ ) for  
 456 boys than girl with small effect sizes. Results  
 457 suggest that Japanese parents and teachers assess  
 458 youth problems differently, namely, with parents  
 459 indicating more serious problems (significantly  
 460 higher average scores), similar to findings in  
 461 Western countries (Touliatos & Lindholm, 1981).  
 462 This was also observed in Thailand (Weisz et al.,  
 463 1989) and China (Weine, Phillips, & Achenbach,  
 464 1995) but not in Taiwan (Yang et al., 2000).  
 465 Results suggest that there may be greater contrasts  
 466 between home and school settings in developing  
 467 countries than in developed countries  
 468 (Weine et al., 1995). In a study by Weisz, Weiss,  
 469 Suwanlert, and Chaityasit (2003) findings suggested  
 470 that certain child psychopathology syndromes  
 471 may not match up very well when  
 472 comparing markedly different cultures. For  
 473 example, comparing syndromes for Thai children  
 474 with those obtained for US children by Achenbach  
 475 and Edelbrock (1983) and Achenbach (1991),

476 they observed mixed findings. Seven of 41 specific  
 477 narrowband syndrome comparisons (17 %) met  
 478 Landis and Koch's (1977) thresholds for substantial  
 479 to almost perfect agreement (i.e., kappas ranging  
 480 from 0.61 to 1.00), and 23 of the 41 comparisons  
 481 (56 %) showed only slight to fair agreement,  
 482 with kappas ranging from 0.00 to 0.40. Similarly,  
 483 Weisz et al. (1988) found Thai and American  
 484 caregivers and teachers made similar judgments  
 485 about patterns of child behavior, yet they appeared  
 486 to view the behavior from different perspectives.  
 487 Thai adults expressed less concern than Americans  
 488 (e.g., they were much more confident than  
 489 Americans that problem behavior would improve).  
 490 In the studies with the Japanese language version  
 491 of the scale, substantial sample attrition, small  
 492 sample size, and limited geographical area for  
 493 participant recruitment preclude generalization  
 494 of findings to the national population (Satake  
 495 et al., 2003). Future studies that utilize large  
 496 sample sizes with participants from various  
 497 regions in Japan would be helpful.

498 A study conducted with a Korean community-based  
 499 sample of 46 subjects (33 boys) examined the  
 500 clinical utility of the CBCL in identifying children  
 501 with attention-deficit hyperactivity disorder  
 502 (ADHD) (Kim et al., 2005). Thirty-three subjects  
 503 were diagnosed as having ADHD utilizing a  
 504 *T*-score of 60 on the Attention Problems scale  
 505 of the CBCL, a cutoff which resulted in a reasonable  
 506 level of sensitivity (0.727) or positive predictive  
 507 value (0.750) in the diagnosis. This corroborates  
 508 previous findings that a *T*-score of 60 was  
 509 associated with the optimal level of diagnostic  
 510 discrimination in psychiatric samples in Western  
 511 countries (Biederman et al., 1993; Steingard,  
 512 Biederman, Doyle, & Sprich-Buckmister,  
 513 1992). Future studies are needed to establish  
 514 national norms in Korea and to examine the  
 515 clinical utility of the Achenbach scales with  
 516 Asian-American groups in the USA.

**Eyberg Child Behavior Inventory (ECBI)**

517  
 518  
 519 The Eyberg Child Behavior Inventory (ECBI)  
 520 (Boggs, Eyberg, & Reynolds, 1990) is comprised  
 521 of 36 items designed to measure the parent's

[AU4]

522 perception of their children aged 2–16 years. The  
 523 measure produces a “problem score” which mea-  
 524 sures the frequency of disruptive behaviors and  
 525 an “intensity score” which is the sum of the par-  
 526 ticipants’ intensity of behavior ratings on a  
 527 7-point scale. More specifically, the measures  
 528 assess whether the behavior is currently occur-  
 529 ring (i.e., yes or no), and severity (i.e., never, sel-  
 530 dom, sometimes, often, and always) of disruptive  
 531 behaviors in home and school settings, using par-  
 532 ent and/or teacher report. The assessment was  
 533 normed on a sample of 159 children (87 % White,  
 534 11 % Black, and 2 % Other) mostly from lower  
 535 to middle class families who were referred for  
 536 evaluation at a university psychology clinic.  
 537 Norms for chronically ill children and other spe-  
 538 cial populations were reported. The ECBI  
 539 Intensity and Problem scales demonstrate high  
 540 internal consistency, significant test–retest reli-  
 541 ability, and significant interrater reliability, as  
 542 well as convergent, concurrent, and discriminant  
 543 validity (Boggs et al., 1990). The correlation  
 544 between the ECBI Intensity scale (IS) and  
 545 Problem scale (PS) for the total sample was 0.74.  
 546 Concurrent validity was established through sig-  
 547 nificant correlations with both the Internalizing  
 548 and Externalizing scales of the CBCL (Boggs  
 549 et al., 1990). Discriminant validity was estab-  
 550 lished by differentiating between the behavior  
 551 problem treatment groups from the learning dis-  
 552 ability and no treatment groups, and the learning  
 553 disability group from the no treatment group  
 554 (Boggs et al., 1990).

555 Leung, Sanders, Leung, Mak, and Lau (2003)  
 556 examined test–retest reliability with 91 parents  
 557 attending Maternal and Child Health Centers  
 558 (MCHC;  $n=74$ ) and Child Assessment Centers  
 559 (CAC;  $n=17$ ) with children 3–7 years who were  
 560 referred because of child behavior problems.  
 561 The youth and caregiver participants had been  
 562 living in Hong Kong for a minimum of 12 con-  
 563 secutive months. Of the youth participants, there  
 564 were 25 females and 44 males attending kinder-  
 565 garten or elementary school. Test–retest reli-  
 566 ability estimated at pre- and post-intervention  
 567 were 0.88 and 0.94 (problem), and 0.91 and  
 568 0.95 (intensity). The mean pre-intervention  
 569 scores of the Triple P Positive Parenting

Program intervention group and waitlist groups 570  
 were in the elevated range on the ECBI (inten- 571  
 sity > 127 or problem > 11). 572

**Vineland Adaptive Behavior Scales-Survey (VABS-II) 573  
 574**

The Vineland Adaptive Behavior Scales-Survey 575  
 (VABS-II) Form (Sparrow, Balla, & Cicchetti, 576  
 1984) aids in clarifying diagnosis of intellectual 577  
 and developmental disabilities of youth through a 578  
 semi-structured interview with a primary care- 579  
 giver. The instrument assesses five areas of adap- 580  
 tive behavior including: Communication 581  
 (receptive, expressive, and written language), 582  
 Daily Living Skills (self-care, contribution to a 583  
 household, and community involvement), 584  
 Socialization (interpersonal relationships, leisure 585  
 activities, and play activities), Motor Skills (fine 586  
 and gross motor abilities), and Maladaptive 587  
 Behavior (an optional scale that assesses prob- 588  
 lematic behaviors that interfere with function- 589  
 ing). The Composite Scale is made up of the first 590  
 three scales, and the Total Scale comprises the 591  
 four required scales. Each item is scored on the 592  
 basis of whether the behavior never occurs (0 593  
 points), occurs sometimes or partially (1 point), 594  
 or is usually exhibited (2 points; Oakland & 595  
 Houchins, 1985). Additionally it is possible to 596  
 translate single scale, composite, and total scores 597  
 into age-equivalent scores. The median split-half 598  
 reliability coefficients are 0.94 for the composite 599  
 score and range between 0.83 and 0.90 for the 600  
 specific domains, demonstrating acceptable 601  
 internal consistency. The assessment was admin- 602  
 istered to 484 participants in a 1-month span, 603  
 demonstrating acceptable test–retest stability 604  
 through a reliability index of 0.88 for the com- 605  
 posite score and reliability indices between 0.81 606  
 and 0.86 for the domain scores. Interrater reli- 607  
 ability was demonstrated with two distinct inter- 608  
 viewers assessing 160 participants within a 609  
 2-week interval. The coefficients for the VABS 610  
 were 0.74 for the composite and ranged 0.62 and 611  
 0.78 for the domains. The lower coefficient (0.62) 612  
 was demonstrated on the Socialization domain. 613  
 The measure demonstrated construct validity 614

615 through an increase in raw scores at successive  
616 age groups while criterion related validity was  
617 assessed through correlations between the VABS  
618 and the ABIC (0.58), AAMD Adaptive Behavior  
619 Scale (0.40–0.70), Kaufman Assessments Battery  
620 for Children (K-ABC) Achievement Scale (0.52),  
621 K-ABC Mental Processing Composite (0.32),  
622 and the Peabody Picture Vocabulary Test-Revised  
623 (0.28) (Oakland & Houchins, 1985).

624 Tombokan-Runtukahu and Nitko (1992)  
625 investigated whether this measure could be suc-  
626 cessfully adapted to the Indonesian population.  
627 The translation phase applied both an ethno-  
628 graphic translation procedure (Brislin, 1983;  
629 Hulin, Dragow, & Parsons, 1983) and an empiri-  
630 cal tryout. Each of the 252 items of the survey  
631 was translated from English to Bahasa Indonesian  
632 and back-translated to English. The correlation  
633 coefficients between the scores on the English  
634 version and the back-translation of each subtest  
635 ranged from 0.926 (Maladaptive Behavior) to  
636 0.995 (Daily Living Skills), which were deemed  
637 satisfactory. Tittle's (1982) guidelines were fol-  
638 lowed to review the translated items for fairness.  
639 Twenty-five item translations were judged inad-  
640 equate by the panel and were rewritten with the  
641 help of an Indonesian language teacher. Four  
642 items were eliminated because they were inap-  
643 propriate to the Indonesian context and equiva-  
644 lent cultural behaviors could not be substituted  
645 easily, and three items were modified to incorpo-  
646 rate Indonesian-equivalent content. The resulting  
647 set of 245 items was moved forward to the valida-  
648 tion phase.

649 Forty-three children with mental retardation  
650 were matched on the basis of age, gender, and  
651 SES with 43 children of normal intelligence.  
652 Internal consistency was examined by analyzing  
653 the parent-based ratings after pooling the two  
654 groups of children. The coefficient alphas were  
655 0.98, 0.98, 0.96, and 0.99 for Communication,  
656 Daily Living Skills, Socialization, and Composite,  
657 respectively, suggesting high internal consistency.  
658 Examination of the frequency distributions of the  
659 two groups of children showed statistically sig-  
660 nificant differences in the mean scores of the two  
661 groups, with children of normal intelligence scor-  
662 ing higher. These differences were replicated

663 with both teachers' and parents' ratings. This  
664 finding provides support for the interpretation  
665 that IVABS is capable of distinguishing between  
666 children with various degrees of development in  
667 adaptive behavior and of distinguishing between  
668 children with mental retardation and those with  
669 normal intelligence in this Indonesian sample.  
670 Although the sample at each age level was small,  
671 there is a general tendency for the Indonesian  
672 data to support the contention that the IVABS  
673 appears to follow an incremental development  
674 pattern similar to that found with the VABS in the  
675 USA. The procedures developed and used in this  
676 study also serve as a model to operationalizing  
677 the domain of adaptive behavior in new cultural  
678 contexts.

679 A study was conducted by Goldberg, Dill,  
680 Shin, and Nhan (2009) to examine the adaptation  
681 of the Vineland Adaptive Behavior Scale to the  
682 Vietnamese culture (VVABS). The Vineland was  
683 translated into Vietnamese and was evaluated for  
684 cultural relevance and semantic equivalence by  
685 three bilingual Vietnamese clinicians. The par-  
686 ticipants in the study were 120 Vietnamese moth-  
687 ers of preschool-age children (3–6 years of age)  
688 who were enrolled in kindergarten programs in  
689 Hue City, Vietnam. The mean age of the children  
690 was 4.9 (SD=1.1) with a range of 3–6 years with  
691 75 males and 44 females. The mean age of the  
692 mothers was 33.4 (SD=5.2) with a range of  
693 23–51 years. Coefficient alpha was used to assess  
694 internal consistency for the 11 sub-domains of  
695 the VABS. Internal consistency of the VVABS  
696 sub-domains were shown to be high with the  
697 exception of receptive communication. Construct  
698 validity was assessed through a correlation matrix  
699 for the 11 sub-domains which were statistically  
700 significant (all  $ps < 0.001$ ) and ranged from 0.39  
701 to 0.84. The VVABS was found to successfully  
702 discriminate between disabled and non-disabled  
703 children. In another study that adapted the VABS  
704 through empirical testing for the Vietnamese  
705 population, the researchers adapted items to fit  
706 the cultural context, and made necessary adjust-  
707 ments to test and administration procedures (i.e.,  
708 deleting items that could not be successfully  
709 translated or adapted; Goldberg et al., 2009).  
710 However, further exploration of this method of

711 adaptation is needed in order for cross-cultural  
712 adaptation of other psychological constructs to  
713 be empirically tested for reliability and validity.

#### 714 **Social Skills Rating System (SSRS)**

715 The Social Skills Rating System (SSRS; Gresham  
716 & Elliott, 1990) is a psychometrically sound  
717 (Demaray, Ruffalo, Carlson, & Busse, 1995),  
718 nationally standardized, norm-referenced, social  
719 skills assessment for 3–18-year-old children.  
720 Informants rate the frequency of children's pro-  
721 social behaviors on a 3-point Likert scale  
722 (0=never, 1=Sometimes, and 2=Very Often).  
723 Examples of social skills include the display of  
724 prosocial behaviors such as sharing, initiating  
725 interactions with others, and management of  
726 interpersonal conflicts such as controlling one's  
727 temper. There are three versions of the SSRS to  
728 gather data from different respondents: The  
729 SSRS-P (parent), SSRS-T (teacher), and SSRS-S  
730 (student). Effect size estimates presented by  
731 Renk and Phares (2004) in their meta-analysis of  
732 74 studies showed an average parent–teacher cor-  
733 relation of 0.38, a mean self–teacher correlation  
734 of 0.25, and a mean self–parent correlation of  
735 0.21. The teacher form (SSRS-T) includes three  
736 subscales (ten items each): (a) social skills (e.g.,  
737 invites others to join in activities), which is  
738 divided into the subscales, cooperation, assertion,  
739 and self-control; (b) problem behaviors (e.g.,  
740 argues with others), with the subscales of hyper-  
741 activity, internalizing, and externalizing; and (c)  
742 academic competence (e.g., "In reading, how  
743 does this child compare with other students?").  
744 The SSRS-P and SSRS-S includes four subscales  
745 (ten items each): cooperation, assertion, empa-  
746 thy, and self-control. Sample items include: (a)  
747 e.g., "I make friends easily" (assertion), (b) "I do  
748 my homework on time" (cooperation), (c) "I lis-  
749 ten to adults when they are talking with me"  
750 (empathy), and (d) "I ignore other children when  
751 they tease or call me names" (self-control). For  
752 each of the forms, cutoff points are provided to  
753 assign children's scores for each subscale (as  
754 well as their Total Social Skills score) into three  
755 categories: below-average (below one standard

756 deviation of the mean), average (within one  
757 standard deviation of the mean), and above-aver-  
758 age (above one standard deviation of the mean).  
759 In the national normative sample, the percentage  
760 of children in the below-average, average, and  
761 above-average categories are 16, 68, and 16 %  
762 for both parent and teacher ratings.

763 A study was conducted with 869 girls residing  
764 in the USA and adopted from China utilizing the  
765 SSRS-P (parent sample=869) and SSRS-T forms  
766 (teacher sample=611; Tan & Camras, 2011).  
767 Average age of adoption was 15.6 months  
768 (SD=13.9) and average current youth age was  
769 6.9 years (SD=2.9). Adoptive mother's average  
770 age was 44.2 (SD=6.1) years and the adoptive  
771 father's average age was 45.3 (SD=7.3) years.  
772 Internal consistency was good for both the  
773 SSRS-P and SSRS-T subscales, ranging from  
774 0.67 (the Responsibility subscale on the SSRS-P)  
775 to 0.93 (the scale of Academic Competence on  
776 SSRS-T). The adopted Chinese girls in all three  
777 age-groups (preschool-age, elementary-age, and  
778 secondary age) scored similar to or higher than  
779 same-age girls from the US normative sample on  
780 both parent and teacher rating. For 10 of the 15  
781 comparisons on parent ratings and 11 of the 14  
782 comparisons on teacher ratings, the adopted  
783 Chinese girls outperformed the normative US  
784 sample, which may be explained by examining  
785 characteristics of Chinese adopted children  
786 which includes more favorable prenatal experi-  
787 ences compared to the US sample (Tan, Marfo, &  
788 Dedrick, 2010) and possibly easier temperament  
789 associated with Chinese youth (Kagan & Fox,  
790 2006). Investigators propose that temperamental  
791 qualities may put adopted Chinese children at a  
792 relative advantage. For example, Kagan, Kearsley,  
793 and Zelazo (1978) suggest that Chinese children  
794 may have easier temperaments than Caucasian  
795 children serving as a protective factor. Parent–  
796 teacher agreement for youth social behaviors  
797 was significant but modest in magnitude, similar  
798 to existing literature on parent–teacher agree-  
799 ment on non-adopted children's behaviors (see  
800 meta-analysis by Achenbach, McConaughy, &  
801 Howell, 1987). This sample was limited to  
802 adopted Chinese girls and findings might not  
803 reflect Chinese American children as a whole.

804 Further research needs to be conducted to examine  
805 the psychometric properties of this scale in other  
806 Asian-American samples in the USA.

### 807 **The Strengths and Difficulties** 808 **Questionnaire (SDQ)**

809 Strengths and Difficulties Questionnaire (SDQ;  
810 Goodman, 1997) is a brief behavioral screening  
811 questionnaire for 3–16 year old children. The  
812 SDQ includes 25 items on psychological attri-  
813 butes: emotional symptoms (five items), conduct  
814 problems (five items), hyperactivity/inattention  
815 (five items), peer relationship problems (five  
816 items), and prosocial behavior (five items), that  
817 are administered to parents. All forms rate items  
818 on a 3-point scale (not true, somewhat true, and  
819 certainly true). In a recent study (Janssens &  
820 Deboutte, 2009), internal consistency was ade-  
821 quate (0.72 for parent SDQ, and 0.75 for teacher  
822 SDQ, 0.62 for youth SDQ), interrater reliability  
823 was adequate, and the concurrent validity of the  
824 SDQ was established through significant correla-  
825 tions with the Achenbach System of Empirically  
826 Based Assessment (ASEBA) scores and with the  
827 Child Behavior Checklist (CBCL) scores.

828 The psychometric properties of the SDQ have  
829 not been explicitly examined in any Asian-  
830 American samples, but there are several studies  
831 that have examined translations of the SDQ inter-  
832 nationally. Du, Kou, and Coghill (2008) estab-  
833 lished normative data and examined the reliability  
834 and validity of a Chinese translation of the SDQ  
835 (parent, teacher, and youth self-report versions).  
836 Parent and teacher data were used for 1,965 sub-  
837 jects and self-report data for 690 subjects from  
838 Shanghai. Students ranged in age from 3 to  
839 17 years. In this study, the SDQ was translated  
840 into Chinese and back-translated into English by  
841 academic staff at the Center for Clinical Trials  
842 and Epidemiological Research at the Chinese  
843 University of Hong Kong. Principle components  
844 analysis indicated a partial agreement with the  
845 original five-factored subscale structure.  
846 However, this appears to hold more strongly for  
847 the Prosocial Behavior, Hyperactivity–  
848 Inattention, and Emotional Symptoms subscales

849 than for Conduct Problems and Peer Problems. 849  
850 Internal reliability for subscales were generally 850  
851 adequate (range 0.30–0.83) with only parent and 851  
852 teacher Hyperactivity–Inattention and teacher 852  
853 Prosocial Behavior subscales having an 853  
854  $\alpha < 0.7$ . Mellor, Wong, and Xu (2011) exam- 854  
855 ined 752 school-aged children (320 males) with 855  
856 an average age of 8.7 years ( $SD = 1.69$ ) in China. 856  
857 Internal reliability coefficients ranged from 0.25 857  
858 to 0.71, and were lower than what is usually con- 858  
859 sidered to be adequate (0.70; Cicchetti, 1994), 859  
860 particularly for the Conduct and Peer Problem 860  
861 subscales. Similarly, in another study with 861  
862 Chinese preschool children in Hong Kong (Leung 862  
863 et al., 2003) internal consistency coefficients also 863  
864 ranged from 0.41 to 0.77, which are lower than 864  
865 what is usually considered to be adequate. In yet 865  
866 another study with 457 Chinese preschool chil- 866  
867 dren in Hong Kong (230 males) aged 4 and 5 867  
868 years old, Cronbach's alphas for the SDQ sub- 868  
869 scales were 0.59 (emotional problems), 0.52 869  
870 (conduct problems), 0.73 (Hyperactivity), 0.46 870  
871 (peer relationship problems), 0.69 (prosocial 871  
872 behavior), and 0.77 (total problem behavior) 872  
873 (Leung, Lo, & Leung, 2012), again, lower than 873  
874 what is usually considered to be adequate. These 874  
875 findings are also consistent with large studies in 875  
876 Australia (Mellor, 2004), China (Du et al., 2008), 876  
877 and Japan (Matsuishi et al., 2008). Interrater cor- 877  
878 relations were low to moderate (range 0.23–0.49), 878  
879 and correlations among parents and teachers 879  
880 were found to be higher for the younger children 880  
881 (3–10 years) than for the older children (11–17 881  
882 years) (Du et al., 2008). In another study, inter- 882  
883 rater reliability was again in the low to moderate 883  
884 range (range 0.40–0.79). With regard to interrater 884  
885 reliability, interparent agreement is higher for 885  
886 externalizing problems than emotional problems 886  
887 regardless of the gender of the target child. For 887  
888 both boys and girls, mother and father correla- 888  
889 tions were strongest for total difficulties and the 889  
890 combined Externalizing Problems subscale, 890  
891 whereas the lowest correlations were for emo- 891  
892 tional symptoms (Mellor et al., 2011). 892

893 Convergent validity was demonstrated by sign- 893  
894 ificant correlations between the parent- 894  
895 completed SDQ and the Parent Symptoms 895  
896 Questionnaire (PSQ). Discriminant validity was 896

897 established by effectively distinguishing between  
898 47 subjects from the normative sample with 47  
899 age and gender matched ADHD outpatient par-  
900 ticipants using ROC curves. Total difficulty  
901 scores cutoffs were calculated with the intention  
902 of placing approximately 10 % of the sample  
903 with the most extreme scores as "abnormal," the  
904 next 10 % as "borderline" and the remaining  
905 80 % in the "normal." About 85 % of the subjects  
906 were placed in the "normal" range and 7.5 % in  
907 the "abnormal" and "borderline" ranges.

908 Findings regarding the Chinese language ver-  
909 sion need to be replicated in other Chinese sam-  
910 ples, including those from rural rather than urban  
911 settings. Du and colleagues (2008) observed pos-  
912 sible differences in the way the Chinese interpret  
913 the questions relating to Conduct and Peer  
914 Problems. Further investigation should be made  
915 to clarify this issue and assess whether particular  
916 items should be altered or removed from the  
917 Chinese version.

918 Matsuishi and colleagues (2008) attempted to  
919 establish community-based normative data for  
920 the Japanese language version of the SDQ  
921 (Goodman, 1997). Because translated versions  
922 can yield different results, Matsuishi et al. (2008)  
923 established national norms rather than applying  
924 the recommended score bandings and cutoffs  
925 established for the English version SDQ. The  
926 impact of age and gender on the SDQ parent  
927 form was assessed in addition to evaluating the  
928 structure, and homogeneity of the Japanese  
929 scales. Following these steps, culturally informed  
930 score bandings were proposed for normal, bor-  
931 derline, and clinical ranges, and were defined for  
932 the total score as well as for each of the five sub-  
933 scales of the SDQ. In this study, investigators  
934 assessed 2,899 Japanese children (1,463 males)  
935 aged 4–12 years. Parents were asked to complete  
936 the extended version of the SDQ (Goodman,  
937 1999) which supplements the 25 core items with  
938 an overall rating of whether their child has emo-  
939 tional or behavioral problems. The proposed  
940 factor structure of the 25 SDQ items was verified  
941 through an exploratory factor analysis with vari-  
942 max rotation. The results illustrated that the  
943 pattern of main loadings replicated the original  
944 SDQ subscales. Cronbach's alpha of the total

945 difficulties score (comprising of 20 items) was  
946 0.77, which suggests adequate internal consis-  
947 tency. For the total difficulties score, the clinical  
948 range (defining approximately 10 % of commu-  
949 nity cases with the highest scores) for the  
950 Japanese sample included total difficulties rat-  
951 ings of 16 or more points, whereas the British  
952 normative data suggested a slightly higher cutoff  
953 requiring a total score of at least 17. Overall, the  
954 obtained findings were consistent with previous  
955 work investigating the psychometric properties  
956 of the SDQ in other countries including Sweden  
957 (Smedje, Broman, Hetta, & von Knorring, 1999),  
958 Germany (Klasen et al., 2000), the Netherlands  
959 (Van Widenfelt, Goedhart, Treffers, & Goodman,  
960 2003), and Australia (Hawes, Hawes, & Dadds,  
961 2004). The investigators noted concerns with  
962 comparing results across international studies  
963 because they use different study methods, chil-  
964 dren of different ages, and were performed in dif-  
965 ferent eras. Further investigation is needed to  
966 establish national norms and to assess whether  
967 these results may be generalized for use as part of  
968 clinical screening programs, in pediatric neuro-  
969 logy clinics, and in child psychiatric research set-  
970 tings for Japanese youth (Matsuishi et al., 2008).

## 971 **Clinical Interview** 972 **Schedule-Revised (CIS)**

973 The Clinical Interview Schedule-Revised (CIS-  
974 R) (Lewis, Pelosi, Araya, & Dunn, 1992) is a  
975 structured diagnostic instrument designed for use  
976 by a variety of trained interviewers in assessing  
977 minor psychiatric needs in the community, gen-  
978 eral hospital, occupational and primary care  
979 research in a standardized way. The CIS-R was  
980 developed from the Clinical Interview Schedule  
981 (CIS), which was designed specifically for use by  
982 clinically experienced interviewers (i.e., psychia-  
983 trists). In Britain, the CIS-R instrument was vali-  
984 dated in a community setting by comparing it  
985 with the Schedule for Clinical Assessment in  
986 Neuropsychiatry (SCAN), a semi-structured  
987 instrument. The participants this study ranged in  
988 age from 16 to 64 years. Results evidenced over-  
989 all specificity of the CIS-R instrument to be good,

990 but sensitivity was shown to be poor (Lewis et al.,  
 991 1992). Interrater agreement ranged from 0.7 to  
 992 0.9. Concordance of diagnoses by the two instru-  
 993 ments was in the poor to very poor range demon-  
 994 strated by low kappas.

995 In a study by Subramaniam, Krishnaswamy,  
 996 Jemain, Hamid, and Patel (2006), the investiga-  
 997 tors describe the psychometrics of the Malay ver-  
 998 sion of the CIS-R. The CIS-R questionnaire was  
 999 translated into Malay and back translated into  
 1000 English. Next, the original questionnaire and the  
 1001 back-translated questionnaire were compared for  
 1002 meanings and necessary corrections were made to  
 1003 the Malay version with the help of a language  
 1004 teacher. Interrater reliability was established for  
 1005 raters who were medical student in this study.  
 1006 Participants included 59 psychiatric inpatients,  
 1007 outpatients, relatives and other visitors who were  
 1008 there at the National University of Malaysia  
 1009 Hospital (33 clinical cases and 26 control cases).  
 1010 The sample included 51 % Malays, 29 % Chinese  
 1011 and 20 % Indians. The overall sensitivity, specific-  
 1012 ity, positive predictive value, and negative predic-  
 1013 tive value for the instrument were calculated. The  
 1014 Malay version of CIS-R showed 100 % sensitivity  
 1015 and 96.15 % specificity at a cutoff score of 9.

1016 **National Institute of Mental Health**  
 1017 **Diagnostic Interview Schedule**  
 1018 **for Children (NIMH DISC-IV)**

1019 The Diagnostic Interview Schedule for Children  
 1020 (DISC) is a structured diagnostic instrument  
 1021 designed for use by non-clinicians. Several ver-  
 1022 sions have been produced with the most recent  
 1023 being the National Institute of Mental Health  
 1024 Diagnostic Interview Schedule for Children  
 1025 (NIMH DISC-IV). The NIMH DISC-IV is  
 1026 equipped to assess over 30 mental health disor-  
 1027 ders in children and adolescents. There are parent  
 1028 and youth versions of this instrument. The parent  
 1029 form is for caregivers of youth ranging in age  
 1030 from 6 to 17 years while the youth form is for  
 1031 children and adolescents aged 9 to 17 years.  
 1032 Preliminary reliability and acceptability results  
 1033 of the NIMH DISC-IV in a clinical sample of 84  
 1034 parents and 82 children (aged 4–17 years) drawn

1035 from outpatient child and adolescent psychiatric  
 1036 clinics at three sites. Sixty percent of this sample  
 1037 was African-American and/or Hispanic. Despite  
 1038 its greater length and complexity, the NIMH  
 1039 DISC-IV was shown to compare favorably with  
 1040 earlier versions.

1041 Doi, Roberts, Takeuchi, and Suzuki (2001)  
 1042 published a multiethnic comparison of adoles-  
 1043 cent major depression in a school-based study in  
 1044 the USA and Japan. Subjects were participants in  
 1045 the Teen Life Changes Survey conducted in 1994  
 1046 where questionnaires were collected from 5,496  
 1047 students in grades 6–8 in a Houston, TX school  
 1048 district, and 504 students in grades 7–9 in a pub-  
 1049 lic junior high school in Maebashi, Japan.  
 1050 Surveys were administered in English only in the  
 1051 US sample and in Japanese only in the Japanese  
 1052 sample. The Japanese version of the NIMH  
 1053 DISC-IV was developed through the process of  
 1054 various translation stages including translating  
 1055 the original version from English into Japanese,  
 1056 then the translated Japanese version was back-  
 1057 translated, and finally, both versions were exam-  
 1058 ined by different bilinguals. The preliminary  
 1059 Japanese version was pretested for word mean-  
 1060 ings, and content on each item among Japanese  
 1061 junior high school students who were not  
 1062 involved in the study. The authors then reviewed  
 1063 the results and the final Japanese version for use  
 1064 in this study was created. Prevalence rates in this  
 1065 study were highest for Mexican-American stu-  
 1066 dents followed by African-American students,  
 1067 then Anglo-American students, and the lowest  
 1068 rate of major depressions was found in the  
 1069 Japanese student population. After sociodemo-  
 1070 graphic adjustments were made, ethnicity was  
 1071 not found to be significantly associated with ado-  
 1072 lescent major depression, although father's level  
 1073 of education and family financial status were sta-  
 1074 tistically significant.

1075 In Ho et al. (2005), authors report on the devel-  
 1076 opment of the Chinese version of DISC-IV and  
 1077 examine its test–retest reliability. Participants  
 1078 included 78 Chinese parents and 79 youths (mean  
 1079 age=13) attending child psychiatric clinics.  
 1080 Participants were interviewed at two time  
 1081 points about 22 days apart using the Chinese  
 1082 DISC-IV. All participants were Cantonese speaking.

1083 The initial translation from English to Chinese was  
 1084 completed by a bilingual-speaking Chinese  
 1085 teacher. The authors reviewed this version and  
 1086 made semantic adjustments to better fit psychiat-  
 1087 ric content. The modified version was then tested  
 1088 in the clinics. Following this phase, revisions  
 1089 were made to improve semantic equivalence once  
 1090 again. Finally, an independent translator (blind to  
 1091 the first translation process) back-translated the  
 1092 revised version into English. The kappa coeffi-  
 1093 cients in this study were good to excellent for  
 1094 obsessive compulsive disorder (OCD) for both  
 1095 youth and parent participants, major depressive  
 1096 disorder (MDD) for parent participants, and  
 1097 attention deficit hyperactivity disorder (ADHD)  
 1098 for parent participants. Kappa coefficients were  
 1099 fair for anxiety disorder (i.e., generalized anxiety  
 1100 disorder, separation anxiety disorder, panic disorder,  
 1101 agoraphobia, social phobia, and specific pho-  
 1102 bia) for parent participants, fair for oppositional  
 1103 defiant disorder (ODD) in both youth and parent  
 1104 participants, and fair MDD for youth participants.  
 1105 Kappa coefficients were found to be poor for anx-  
 1106 iety disorder and poor for ADHD in the youth  
 1107 participants. Overall, parent informants had better  
 1108 test–retest reliability than youth informants, and  
 1109 the Chinese DISC-IV had comparable test–retest  
 1110 reliability with the original English version.

1111 In a study evaluating the reliability and valid-  
 1112 ity of the Korean version of the DISC-IV, Cho  
 1113 et al. (2007) interviewed 91 children and adoles-  
 1114 cents in an outpatient clinic at the Seoul National  
 1115 University, and the community. Of these partici-  
 1116 pants, 44 were selected for an evaluation of test–  
 1117 retest reliability. Results indicated kappa values  
 1118 ranging from 0.25 to 0.40 in the clinical sample  
 1119 and 0.65–1.00 in the community sample showing  
 1120 good reliability and validity for the DISC-IV in  
 1121 the Korean youth.

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1122 **Symptom-Specific Scales**

1123 **Conners' 3rd Edition (Conners 3)**

1124 The Conners' 3rd Edition (Conners 3) (Conners,  
 1125 2008) is a measure designed for assessing atten-  
 1126 tion deficit hyperactivity disorder (ADHD) and

common comorbid problems/disorders (e.g., 1127  
 oppositional defiant disorder, and conduct disorder) 1128  
 in children and adolescents. The measure 1129  
 has three forms: parent and teacher forms for 1130  
 children and adolescents 6–18 years old and self- 1131  
 report measure for youth aged 8–18 years. For 1132  
 each version (parent, teacher, and self-report), 1133  
 full-length and short versions are available. The 1134  
 Conners 3 contains multiple scales including, 1135  
 content scales (Inattention, Hyperactivity/ 1136  
 Impulsivity, Learning Problems/Executive 1137  
 Functioning, Aggression, Peer Relations, and 1138  
 Family Relations), DSM-IV-TR Symptom Scales 1139  
 (ADHD Inattentive, ADHD Hyperactive- 1140  
 Impulsive, ADHD Combined, Conduct Disorder, 1141  
 and Oppositional Defiant Disorder), and validity 1142  
 scales (Positive Impression, Negative Impression, 1143  
 and an Inconsistency Index). All test items are 1144  
 scored on a 4-point Likert-type scale (0=not at 1145  
 all, 1=just a little true, 2=pretty much true, and 1146  
 3=very much true) with higher scores indicating 1147  
 a greater number and/or frequency of concerns. 1148

Normative data on the Conners 3 includes 1149  
 1,200 parents, 1,200 teachers, and 1,000 self- 1150  
 report raters who were matched on the 2000 US 1151  
 Census information on ethnicity/race, gender, 1152  
 and parent education level (Conners, 2008). The 1153  
 Conners 3 reliability was assessed by Gallant 1154  
 (2007, 2008) where internal consistency was 1155  
 measured using Cronbach's alpha. Mean alphas 1156  
 for the Content scales were parent=0.91, 1157  
 teacher=0.94, and self-report=0.88, respec- 1158  
 tively. Mean reliability coefficients for the DSM- 1159  
 IV-TR Symptom scales were parent=0.90, 1160  
 teacher=0.90, and self-report=0.85. For the 1161  
 validity scales, Cronbach's alphas were par- 1162  
 ent=0.90, teacher=0.72, and self-report=0.56. 1163  
 For test–retest reliability, two separate adminis- 1164  
 trations of the test were given between 2- and 1165  
 4-week intervals. Mean correlation coefficients 1166  
 for Content scales were parent=0.85, 1167  
 teacher=0.94, and self-report=0.88, and for the 1168  
 DSM-IV-TR Symptom scales, the correlation 1169  
 scores were parent=0.89, teacher=0.90, and 1170  
 self-report=0.85. Interrater reliability was 1171  
 assessed using correlation scores, and moderate 1172  
 to strong levels of rater agreement were found 1173  
 across all scales, indicating high levels of 1174

1175 consistency between parent–parent and/or  
 1176 teacher–teacher ratings of youth participants.  
 1177 Mean Content scale correlations were par-  
 1178 ent=0.81, and teacher=0.73; and DSM-IV-TR  
 1179 Symptom scale scores were parent=0.84 and  
 1180 teacher=0.70. An exploratory factor analysis uti-  
 1181 lizing both the general and clinical samples indi-  
 1182 cated that the general factor structure of the three  
 1183 forms remained consistent across demographic  
 1184 groups (Kao & Thomas, 2010). A confirmatory  
 1185 factor analyses indicated the teacher model was  
 1186 slightly lower than the parent models but both  
 1187 were adequately fit. Informant correlations were  
 1188 significant showing high consistency between  
 1189 various raters of the same youth. The mean  
 1190 parent-to-teacher rating was 0.60 (range=0.52–  
 1191 0.67), the mean parent-to-youth correlation was  
 1192 0.56 (range=0.49–0.62), and the mean teacher-  
 1193 to-youth correlation was 0.48 (range=0.43–0.56)  
 1194 (Conners, 2008). Convergent and divergent valid-  
 1195 ity was determined by comparing Conners 3  
 1196 scores with scores from the Behavior Assessment  
 1197 System for Children, Second Edition, the  
 1198 Conners' Rating Scales-Revised, the Achenbach  
 1199 System of Empirically Based Assessment, and  
 1200 the Behavior Rating Inventory of Executive  
 1201 Functioning (Kao & Thomas, 2010). Overall,  
 1202 correlations indicated the constructs converged  
 1203 and diverged in the expected directions (Kao &  
 1204 Thomas, 2010). To date, the Conners 3 has not  
 1205 been specifically validated in Asian-American  
 1206 populations in the USA, and no psychometric  
 1207 studies have been undertaken in Asian countries.

### 1208 **Depression Self-Rating Scale** 1209 **for Children (DSRSC)**

1210 The Depression Self-Rating Scale for Children  
 1211 (DSRSC) is an 18-item self-report measure for  
 1212 children and adolescents (Birleson, 1981) that  
 1213 has been used in a range of cross-cultural con-  
 1214 texts. Items are presented as statements, e.g., “I  
 1215 sleep very well” and measure symptoms over the  
 1216 past week. Responses are a 0=mostly, 1=some-  
 1217 times, 2=never, with higher scores indicating  
 1218 more severe depression (maximum score=36  
 1219 points). Cronbach's alpha with a sample of

1220 psychiatric inpatients was 0.90, and the split-half  
 1221 correlation was 0.85, suggesting high internal  
 1222 reliability. Eighty-one of the psychiatric inpa-  
 1223 tients also rated their symptoms using the Beck  
 1224 depression inventory (BDI), and the scores were  
 1225 highly correlated suggesting convergent validity  
 1226 ( $r=0.79, p<0.01$ ; Birleson, 1981).

1227 A study was conducted to establish standard-  
 1228 ized norms of the DSRSC in Chinese urban youth  
 1229 and to examine the scale's reliability and validity  
 1230 (Su, Wang, Zhu, Luo, & Yang, 2003) in a sample  
 1231 of 1,943 subjects (968 males) from 14 cities of  
 1232 China with an average age of 11 years ( $SD=2$ ).  
 1233 Test–retest reliability coefficients, split-half reli-  
 1234 ability coefficients, and Cronbach alpha coeffi-  
 1235 cients ranged from 0.53 to 0.73, indicating  
 1236 acceptable reliability. Significant correlations  
 1237 were found between DSRSC total score, the  
 1238 depressive symptoms subscale of the CBCL, and  
 1239 the Piers-Harris Children's Self-concept Scale,  
 1240 suggesting good convergent validity. The scores  
 1241 of children with the depressive disorders as deter-  
 1242 mined by the DSRSC were significantly higher  
 1243 than that of nondepressed children, suggesting  
 1244 discriminant validity. Results demonstrate that  
 1245 the Chinese language version of the DSRSC is  
 1246 may be utilized to assess depressive symptoms in  
 1247 Chinese urban children.

1248 The 18-item version of the DSRSC was uti-  
 1249 lized to assess depressive symptoms over the past  
 1250 week on a 3-point scale in a school-based cross-  
 1251 sectional survey of junior high schools in Bengby  
 1252 city of Anhui Province in China (Cao et al.,  
 1253 2011). The sample consisted of 5,003 adoles-  
 1254 cents (2,606 males) aged 11–16 years (average  
 1255 age=13.2 years,  $SD=1$ ). Test–retest reliability,  
 1256 split-half, and Cronbach's alphas in this sample  
 1257 ranged from 0.53 to 0.73. The clinically signifi-  
 1258 cant cutoff utilized in this sample was a score of  
 1259 15 (with possible scores ranging from 0 to 36).

1260 A Japanese language version of the DSRSC  
 1261 was prepared by Murata, Shimizu, Mori, and  
 1262 Oshima (1996) utilizing the translation/back-  
 1263 translation technique. The internal consistency of  
 1264 the Japanese language DSRSC was examined by  
 1265 administering the measure to 456 students rang-  
 1266 ing from elementary school second-graders to  
 1267 students in the second year of middle school.

1268 Cronbach's alpha was 0.77, suggesting adequate  
 1269 internal consistency (Murata et al., 1996). The  
 1270 test-retest reliability of the Japanese language  
 1271 version of the DSRSC was tested on 65 elementary  
 1272 school students (35 third-graders and 30 fourth-  
 1273 graders) twice at an interval of 2 weeks. The cor-  
 1274 relation coefficients for the administrations were  
 1275 0.55 for the third-graders and 0.79 for the fourth-  
 1276 graders ( $p < 0.001$ ) (Murata et al., 1996).  
 1277 Convergent validity was established between the  
 1278 Japanese language DSRSC and the Japanese lan-  
 1279 guage version of the Child Depression Inventory  
 1280 (CDI) to 62 third-graders and fourth-graders  
 1281 ( $r = 0.71$ ). The Japanese language DSRSC has  
 1282 also demonstrated utility for distinguishing  
 1283 between depressed and nondepressed youth in 99  
 1284 patients (aged 7–14 years) as diagnosed by an  
 1285 outpatient psychiatrist, suggesting discriminant  
 1286 validity. The mean score was 19.3 for the group  
 1287 with depression ( $n = 36$ ) and 10.7 for the group  
 1288 without depression ( $n = 63$ ) ( $t = 7.49$ ,  $p < 0.001$ ).  
 1289 The cutoff score determined from the ROC curve  
 1290 was 16 points (sensitivity 75 %, specificity  
 1291 88.9 %) (Murata et al., 1996).  
 1292 The Japanese language DSRSC was utilized  
 1293 in a sample of 2, 453 elementary and middle  
 1294 school children (1,114 males) ranging from 6 to  
 1295 15 years old (average age = 8.76 years,  $SD = 5.68$ )  
 1296 in two medium-sized cities in Japan to assess the  
 1297 prevalence of depressive symptoms in youth in  
 1298 the general community population (Denda, Kako,  
 1299 Kitagawa, & Koyama, 2006). Cronbach's alpha  
 1300 in this sample was 0.84, suggesting good internal  
 1301 consistency. Subjects with DSRSC scores above  
 1302 the 15 point cutoff as utilized by Birlerson,  
 1303 Hudson, Buchanan, and Wolff (1987) constituted  
 1304 the depressed group (14.9 % of the sample).  
 1305 Average DSRSC score was 8.15 in the total sam-  
 1306 ple ( $SD = 5.14$ ), 8.47 ( $SD = 5.22$ ) for boys and  
 1307 8.98 ( $SD = 5.99$ ) for girls, but this gender score  
 1308 difference was nonsignificant. The average score  
 1309 in the total sample was similar to the average  
 1310 score obtained by Murata et al. (1996) (average  
 1311 score = 9.08,  $SD = 4.87$ ) in a sample of 395 sub-  
 1312 jects ranging from second to sixth grade (ages  
 1313 7–12). DSRSC score increased significantly with  
 1314 each year of age (average score for elementary  
 1315 school students = 7.97,  $SD = 5.02$ ; average score

for middle school students = 11.10,  $SD = 6.73$ ). 1316  
 Further studies including the screening and psy- 1317  
 chiatric evaluation of nonclinical populations 1318  
 using the DSRSC are needed to generalize the 1319  
 use of this measure for other populations includ- 1320  
 ing Japanese Americans in the USA. 1321

**Beck Depression Inventory (BDI-II)** 1322

The Beck Depression Inventory-II (BDI-II) con- 1323  
 sists of 21 items assessing various emotional, 1324  
 neurovegetative, cognitive, and somatic symp- 1325  
 toms of depression experienced over the previous 1326  
 2 weeks rated on a four-point scale (BDI; Beck, 1327  
 Steer, & Garbin, 1988). The BDI-II was devel- 1328  
 oped to measure depression in adolescents and 1329  
 adults from 13 to 80 years. The summation of all 1330  
 items yields a total score with specific ranges 1331  
 indicating levels of severity (0–9 indicates no 1332  
 depression, 10–16 indicates mild depression, 1333  
 17–29 indicates moderate depression, and 30–63 1334  
 indicates severe depression). The alpha coeffi- 1335  
 cient of the BDI-II was 0.92 indicating high inter- 1336  
 nal consistency (Beck, Stanley, & Zebb, 1996) 1337  
 with a replication study corroborating these find- 1338  
 ings (Steer & Clark, 1997). The correlation 1339  
 between the BDI-II and the BAI was 0.56 1340  
 ( $p < 0.001$ ) for 160 outpatients, comparable to the 1341  
 correlation of 0.60 reported by Beck et al. (1996) 1342  
 for 297 of their outpatients (Steer & Clark, 1997). 1343  
 The Chinese version of the BDI-II (BDI-II-C) 1344  
 was translated by the Chinese Behavioral Science 1345  
 Corporation in the year 2000 and has been used 1346  
 to diagnose the severity of depression as indi- 1347  
 cated through self-report of nonclinical popula- 1348  
 tions in Taiwan. Wu and Chang (2008) explored 1349  
 the BDI-II-C with a focus on dimensionality, 1350  
 appropriateness of item difficulty, and category 1351  
 functioning for nonclinical adolescents. 1352  
 Participants were 2,095 (925 males) 10th to 12th 1353  
 grade senior high school students in Taiwan rang- 1354  
 ing from 14 to 18 years old with an average age 1355  
 of 16.75 years old ( $SD = 1.7$ ). The average BDI- 1356  
 II-C total score was 12.90 ( $SD = 8.64$ ). All 21 1357  
 items produced mean square statistics within an 1358  
 acceptable range (0.60–1.40) except for Item 10 1359  
 (crying) and Item 21 (interest in sex), which may 1360

1361 be explained by cultural variations in the expres- 1406  
 1362 sion of depressive symptoms. Findings also sug- 1407  
 1363 gest that item difficulty overall is inappropriate 1408  
 1364 for differentiating differences in depressive 1409  
 1365 symptoms for nonclinical community samples 1410  
 1366 because items do not target individuals with low 1411  
 1367 levels of depression. Further, people who endorse 1412  
 1368 cognitive-affective symptoms are more apt to 1413  
 1369 appear more depressed with respect to their 1414  
 1370 BDI-II score than those with somatic symptoms 1415  
 1371 as reported on the BDI-II, which may warrant 1416  
 1372 further study concerning the construct validity of 1417  
 1373 the BDI-II in Chinese and other international 1418  
 1374 samples. Yeung et al. (2002) noted limitations 1419  
 1375 that may be useful considerations in assessing 1420  
 1376 Asian-Americans in future studies. The research- 1421  
 1377 ers found an overall reluctance of participants to 1422  
 1378 self-report their symptoms, which makes for dif- 1423  
 1379 ficulty in assessing the psychometric properties 1424  
 1380 of the BDI-II in screening for depression among 1425  
 1381 Asian-Americans in primary care. For future 1426  
 1382 depression screening among Asian-Americans in 1427  
 1383 primary care, it may be necessary to develop a 1428  
 1384 briefer screening scale to improve participation 1429  
 1385 rate. It was also noted that often times Asian- 1430  
 1386 Americans tend to avoid mental health services 1431  
 1387 because of their fear and rejection of mental 1432  
 1388 health disorders. Future efforts should focus on 1433  
 1389 providing easier access to mental health services 1434  
 1390 for Asian-Americans in an effort to decrease cul- 1435  
 1391 tural barriers to the treatment of depressive 1436  
 1392 symptoms. 1437

### 1393 **Children's Depression Rating Scale-** 1394 **Revised (CDRS-R)**

1395 The Children's Depression Rating Scale-Revised 1440  
 1396 (CDRS-R) aids in diagnosing and monitoring 1441  
 1397 depression in youth aged 6–12 years (Mayes, 1442  
 1398 Bernstein, Haley, Kennard, & Emslie, 2010). It is 1443  
 1399 administered as a 15–20 min semi-structured 1444  
 1400 interview. The interviewer rates, on a 7-point 1445  
 1401 scale, 17 symptom areas including: impaired 1446  
 1402 school-work, difficulty having fun, social with- 1447  
 1403 drawal, appetite disturbance, sleep disturbance, 1448  
 1404 excessive fatigue, physical complaints, irritabil- 1449  
 1405 ity, excessive guilt, low self-esteem, depressed 1450

1406 feelings, suicidal ideation, excessive weeping, 1407  
 1408 depressed facial affect, listless speech, and hypo- 1409  
 1410 activity. A recent study (Mayes et al., 2010) 1411  
 1412 sought to evaluate the reliability and validity of 1413  
 1414 the CDRS-R in adolescents aged 7–18 years. 1415  
 1416 Adolescent participants were seen at three visits 1417  
 1418 (screening, baseline, and exit). Internal consis- 1419  
 1420 tency for the CDRS-R was good at all three visits, 1421  
 1422 and total score was highly correlated with global 1423  
 1424 severity ( $r=0.87, 0.80, \text{ and } 0.93; p<0.01$ ). Only 1425  
 1426 the exit CDRS-R score was significantly corre- 1427  
 1428 lated with global functioning (Children's Global 1429  
 1430 Assessment Scale;  $r=-0.77; p<0.01$ ) suggesting 1431  
 1432 some convergent validity. Reductions on the 1433  
 1434 CDRS-R total score were highly correlated with 1435  
 1436 improvement scores at exit (Clinical Global 1437  
 1438 Impressions–Improvement;  $r=-0.83; p<0.01$ ). 1439  
 1440 The results of this study demonstrate good reli- 1441  
 1442 ability and validity of the CDRS for use with ado- 1443  
 1444 lescents with depression (Mayes et al., 2010). 1445

1426 The reliability and the validity of the CDRS-R 1427  
 1428 was examined with 181 adolescents (106 males) 1429  
 1430 ranging from 14 to 17 years old (average 1431  
 1432 age=15.3, SD=0.4) from three schools in 1433  
 1434 Southern India. The six factor structure explained 1435  
 1436 60.6 % of the variance. Cronbach's alpha for the 1437  
 1438 scale was 0.76 suggesting adequate internal con- 1439  
 1440 sistency. The interrater reliability between pedia- 1441  
 1442 trician and clinical psychologist respondents was 1442  
 1443 found to be good (ICC=0.73) and test–retest reli- 1444  
 1445 ability was found to be high (ICC=0.98). 1446  
 1447 Convergent validity between the total CDRS-R 1448  
 1449 score and total Beck's Depression Inventory 1450  
 1451 (BDI) score was high ( $r=0.71, p<0.001$ ). 1452  
 1453 Divergent validity was examined by correlating 1454  
 1455 total CDRS-R score with total Impact of Events 1456  
 1457 scale (IES) score which measures posttraumatic 1458  
 1459 stress ( $r=0.28, p>0.05$ ). There was moderate 1460  
 1461 concordance with the reference standard of ICD- 1462  
 1463 10 diagnosis (45.5 %) in identifying depression 1464  
 1465 with this scale. The average CDRS score was 1466  
 1467 27.5 (SD=8.3) in this sample with a range of 1468  
 1469 17–54. A cutoff score of 30 (sensitivity=83 %, 1470  
 1471 specificity=84 %; Area Under Curve (AUC) in 1472  
 1473 ROC=87 %) in CDRS-R is suggested for diag- 1474  
 1475 nosing depression. 1475

1452 These results suggest that the CDRS-R dem- 1453  
 1454 onstrates good reliability and validity for use 1455

1454 with adolescents in India, but several limitations  
 1455 are noted. First, the researchers are unable to  
 1456 assert whether or not their results can be general-  
 1457 ized to the general Indian pediatric population as  
 1458 the study was based in a school population.  
 1459 Second, the researchers found a low prevalence  
 1460 of depression which may have limited the power  
 1461 and stability of the sensitivity analyses. Third,  
 1462 this study utilized convenience sampling to  
 1463 improve participation, resulting in an overrepresenta-  
 1464 tion of male participants. Finally, additional  
 1465 studies are needed to produce national norms of  
 1466 this instrument in India and to test its utility with  
 1467 Indian Americans in the USA.

**Screen for Child Anxiety Related  
 Emotional Disorders (SCARED)**

1470 The Screen for Child Anxiety Related Emotional  
 1471 Disorders (SCARED) was developed by  
 1472 Birmaher et al. (1997) for the screening of  
 1473 DSM-IV childhood anxiety disorders. It is a  
 1474 41-item self-report measure designed to screen  
 1475 for DSM-IV anxiety disorders. The SCARED  
 1476 includes five scales: somatic/panic (13 items),  
 1477 generalized anxiety (9 items), separation anxiety  
 1478 (8 items), social phobia (7 items), and school  
 1479 phobia (4 items). The participants rate the items  
 1480 of each factor on a 3-point scale (0=not true or  
 1481 hardly ever true, 1=sometimes true, and 2=true  
 1482 or often true). The SCARED total score is derived  
 1483 by adding the responses, with scores ranging  
 1484 from 0 to 82. Exploratory factor analysis of the  
 1485 SCARED revealed five factors that parallel the  
 1486 DSM-IV classification of anxiety disorders:  
 1487 panic/somatic, generalized anxiety, separation  
 1488 anxiety, social phobia, and school phobia.  
 1489 Birmaher et al. (1999) added three items reflect-  
 1490 ing social phobia to the original version in a rep-  
 1491 lication study, resulting in a 41-item self-report  
 1492 questionnaire. The psychometric properties of  
 1493 this screening instrument have been examined in  
 1494 clinical, community, and primary care settings in  
 1495 primarily Caucasian samples in Western coun-  
 1496 tries, and was found to be reliable in regard to  
 1497 internal consistency, test–retest reliability  
 1498 (Birmaher et al., 1997, 1999; Boyd, Ginsburg,  
 1499 Lambert, Cooley, & Campbell, 2003; Essau,  
 1500 Muris, & Ederer, 2002; Hale, Raaijmakers,

Muris, & Meeus, 2005; Muris, Merckelbach, 1501  
 Schmidt, & Mayer, 1999), and parent–child 1502  
 agreement (Birmaher et al., 1997; Muris et al., 1503  
 1999; Wren, Bridge, & Birmaher, 2004). The 1504  
 convergent validity of the SCARED was sup- 1505  
 ported because of its significant correlations with 1506  
 other measures for childhood anxiety disorders 1507  
 including the Revised Children’s Manifest 1508  
 Anxiety Scale (Boyd et al., 2003; Muris et al., 1509  
 1998) and the Spence Children’s Anxiety Scale 1510  
 (Essau et al., 2002). Evidence has also accumu- 1511  
 lated for the good discriminant validity of the 1512  
 SCARED both between anxiety and other clinical 1513  
 disorders, and among different anxiety disor- 1514  
 ders (Birmaher et al., 1997, 1999). 1515

The reliability and the validity of the 41-item 1516  
 SCARED was examined in a large community 1517  
 sample of school children in China which con- 1518  
 sisted of 1,559 youth (49.6 % males) aged 1519  
 8–16 years (average age=11.8, SD=2.1) (Su, 1520  
 Wang, Fan, Su, & Gao, 2008). The Chinese lan- 1521  
 guage version was created utilizing the transla- 1522  
 tion/back-translation method. Females had 1523  
 significantly higher anxiety scores on the total 1524  
 anxiety, separation anxiety, and social phobia 1525  
 scales which corroborate previous studies (Hale 1526  
 et al., 2005). Consistent with existing literature, 1527  
 children had higher scores on separation anxiety 1528  
 than adolescents (Birmaher et al., 1997). This 1529  
 study also supported previous findings of 1530  
 SCARED’s high internal consistency especially 1531  
 for total score (0.89; subscale alpha ranges 0.43– 1532  
 0.77) and moderate test–retest reliability (2-week 1533  
 and 12-week Pearson correlations 0.61 and 0.57 1534  
 for total score; Intraclass correlation coefficients 1535  
 (ICCs)=0.57 and 0.50 for total score). The 1536  
 SCARED total score was significantly correlated 1537  
 with the internalizing factor of the child behavior 1538  
 checklist (0.41), suggesting convergent validity. 1539  
 Further, the SCARED total score was also found 1540  
 to correlate significantly better with the internal- 1541  
 izing than with the externalizing scale on the 1542  
 CBCL, demonstrating evidence for good diver- 1543  
 gent validity (Su et al., 2008). Discriminant valid- 1544  
 ity was supported as the SCARED total score and 1545  
 the five subscale scores significantly differenti- 1546  
 ated youth with anxiety disorders from youth 1547  
 with ADHD. It also significantly discriminated 1548

1549 between anxious and depressed children on the  
 1550 total score and panic, somatic, separation anxiety,  
 1551 and social phobia subscales. Consistent with  
 1552 Birmaher and colleagues (1999) a cutoff point of  
 1553 25 on the Chinese language version of the  
 1554 SCARED yielded optimal sensitivity (79 %) and  
 1555 specificity (82 %). Results suggested that the  
 1556 Chinese language version of the SCARED has  
 1557 appropriate psychometric properties and is a clin-  
 1558 ically useful instrument to screen for DSM-IV  
 1559 anxiety disorders in Chinese youth.

1560 The 41-item SCARED (Birmaher et al., 1999)  
 1561 was utilized to assess anxiety symptoms over the  
 1562 past week on a 3-point scale in a school-based  
 1563 cross-sectional survey of junior high schools in  
 1564 Bengbu city of Anhui Province in China (Cao  
 1565 et al., 2011). The sample consisted of 5,003 ad-  
 1566 olescents (2,606 males) aged 11–16 years (aver-  
 1567 age age=13.2 years, SD=1). The clinically  
 1568 significant cutoff utilized in this sample was a  
 1569 score of 23.

1570 Su and colleagues (2008) found some areas  
 1571 that should be considered when adapting this  
 1572 instrument for Chinese youth. For example, Item  
 1573 9 (people tell me I look nervous) did not load on  
 1574 any of the factors, which may be explained by  
 1575 the indirectness of Chinese culture. In Chinese  
 1576 culture, people tend to rely on indirect, more  
 1577 complex methods of communication like indefi-  
 1578 nite comments while Westerners tend to adopt  
 1579 direct and simple methods. Additionally, the  
 1580 study had a relatively small sample of children  
 1581 and findings need to be replicated in larger and  
 1582 more representative samples in order to establish  
 1583 national norms. Future studies also need to  
 1584 include larger samples of children with various  
 1585 anxiety disorders and other psychopathologies to  
 1586 further evaluate the usefulness of the SCARED  
 1587 in clinical populations. Finally, the utility of this  
 1588 instrument as well as the original English instru-  
 1589 ment should be examined in Asian-American  
 1590 samples in the USA.

### 1591 **The Penn State Worry Questionnaire** 1592 **for Children (PSWQ-C)**

1593 The Penn State Worry Questionnaire for Children  
 1594 (PSWQ-C) was developed by Chorpita and col-  
 1595 leagues (Chorpita, Tracey, Brown, Collica, &

1596 Barlow, 1997). It consists of 14 items with a 1596  
 1597 4-point scale: 0=not at all, 1=sometimes, 2=fre- 1597  
 1598 quently, 3=always, with a range of 0–42 points 1598  
 1599 (higher score indicates higher worry tendencies). 1599  
 1600 The instrument showed good concurrent and dis- 1600  
 1601 criminative validities, internal consistency, and 1601  
 1602 test–retest reliability for children and youth aged 1602  
 1603 6–18 years (Chorpita et al., 1997). In another 1603  
 1604 validation study (Muris, Meesters, & Gobel, 1604  
 1605 2001), the authors recommended discarding the 1605  
 1606 three reverse-scored questions and utilizing an 1606  
 1607 11-item questionnaire due to problems with fac- 1607  
 1608 tor loadings of these items. 1608

1609 The reliability and validity of a Korean lan- 1609  
 1610 guage version of the PSWQ-C (PSWQ-CK) was 1610  
 1611 investigated in a study with 973 elementary 1611  
 1612 school children (aged 8–12 years, average 1612  
 1613 age=10.6, SD=1.1). The PSWQ-CK is a 14-item 1613  
 1614 questionnaire with a 4-point scale: 0=not at all, 1614  
 1615 1=sometimes, 2=frequently, 3=always, with a 1615  
 1616 range of 0–42 points (higher score indicates 1616  
 1617 higher worry tendencies). The authors utilized 1617  
 1618 the translation guidelines recommended by 1618  
 1619 Guilleman, Bombardier, and Beaton (1993) and 1619 [AU6]  
 1620 Beaton, Bombardier, Guillemin, and Ferraz 1620  
 1621 (2000). The average PSWQ-CK score for all par- 1621  
 1622 ticipants was 14.49 (SD=8.06). There was no 1622  
 1623 significant difference in terms of gender, and 1623  
 1624 sixth graders scored significantly higher than 1624  
 1625 fourth or fifth graders ( $p<0.05$ ). Internal consis- 1625  
 1626 tency was high (Cronbach's alpha=0.90), and 1626  
 1627 when the three reverse items were removed, 1627  
 1628 Cronbach's alpha improved to 0.91. Test–retest 1628  
 1629 reliability (three weeks apart) was high ( $r=0.83$ , 1629  
 1630  $p<0.001$ ), suggesting test stability. Convergent 1630  
 1631 validity was established by comparing the results 1631  
 1632 of the PSWQ-CK (both the 14-item version and 1632  
 1633 the 11-item version with the three reverse-scored 1633  
 1634 items removed) to the RCMAS. Z-test for the 1634  
 1635 comparison of dependent correlations revealed 1635  
 1636 that the 14-item PSWQ-CK had excellent correla- 1636  
 1637 tion in the worry/oversensitivity subscales of 1637  
 1638 RCMAS ( $p<0.01$ ), while the 11-item version of 1638  
 1639 the PSWQ-CK demonstrated lower but signifi- 1639  
 1640 cant correlation with the RCMAS subscales. The 1640  
 1641 factor load and item-total correlations of the three 1641  
 1642 revised-scored items was greater than that found 1642  
 1643 in either the Chorpita et al. (1997) or Muris et al. 1643

1644 (2001) validation studies. In this study, the three  
 1645 reverse-scored items demonstrated an influence  
 1646 on the instrument's validity and were recom-  
 1647 mended by the researchers to be included in the  
 1648 survey. The researchers propose a linguistic  
 1649 structure difference between English and Korean  
 1650 to be accountable for the discrepancy. Unlike in  
 1651 English, the verb comes at the end of the sentence  
 1652 in Korean. Therefore, the positive or negative  
 1653 word also comes at the end with the result that  
 1654 students may be giving more attention to the last  
 1655 part of the sentence. In addition, more studies are  
 1656 needed to examine the reliability and validity of  
 1657 PSWQ-CK for youths and to assess the contents  
 1658 of children's worry in Korea. The PSWQ-CK  
 1659 necessitates further validation in Korean in order  
 1660 to establish national norms and to replicate factor  
 1661 structure findings of this study. Further, both the  
 1662 original PSWQ-C (in English) and the PSWQ-CK  
 1663 needs to be investigated for its utility with Korean  
 1664 Americans in the USA.

### 1665 **Childhood Autism Rating** 1666 **Scale (CARS)**

1667 The Childhood Autism Rating Scale (CARS) is a  
 1668 behavioral rating scale developed as an aid in  
 1669 diagnosing and describing the severity of autism  
 1670 in children aged two years and above. The CARS  
 1671 contains 15 items addressing the following areas  
 1672 of functioning: Relating to People; Imitation;  
 1673 Emotional Response; Body Use; Object Use;  
 1674 Adaptation to Change; Visual Response; Taste,  
 1675 Smell, and Touch Response and Use; Fear or  
 1676 Nervousness; Verbal Communication; Nonverbal  
 1677 Communication; Activity Level; Level of  
 1678 Consistency of Intellectual Responses; and  
 1679 General Impressions. The Childhood Autism  
 [AU7]1680 Rating Scale (CARS; Schopler, Van Bourgondien,  
 1681 Wellman, & Love, 2010) is one of the most  
 1682 widely used instruments to evaluate the degree of  
 1683 autism in developmentally disabled children  
 1684 through clinical observation by a trained rater.  
 1685 The CARS consists of 15 items involving defini-  
 1686 tions of autism by Rutter and by Ritvo and  
 1687 Freeman. Each item is rated on a 4-point scale  
 1688 and the total CARS score ranges from 15 to 60.

The CARS has demonstrated good internal 1689  
 consistency, interrater reliability, and validity. 1690  
 The overall interrater reliability estimate for the 1691  
 CARS was 0.84. Mesibov et al. recommended 1692  
 that cutoffs of CARS for diagnosing autism be 1693  
 30 in children and 27 in adolescents. The overall 1694  
 interrater reliability estimate for the CARS was 1695  
 0.84. In using this cutoff value 87 % of individu- 1696  
 als were correctly identified in the sample as 1697  
 autistic or not autistic. Using the total raw score 1698  
 alone, identification of those with or without an 1699  
 autism diagnosis resulted in a sensitivity value of 1700  
 0.88 and a specificity value of 0.86 (Schopler 1701 [AU8]  
 et al., 2010). 1702

Kurita, Miyake, and Katsuno (1989) devel- 1703  
 oped a Japanese language version of the CARS 1704  
 (CARS-TV) and demonstrated its reliability and 1705  
 validity with 167 developmentally disabled 1706  
 Japanese children under 16 years of age. 1707  
 Cronbach's alpha was 0.87 suggesting good 1708  
 internal reliability of the scale. The interrater 1709  
 reliability for each of the 15 subscales based on 1710  
 a subsample of 128 children was moderate and 1711  
 ranged from 0.43 to 0.77 with an average of 1712  
 0.62. In the full sample ( $N=167$ ), the total 1713  
 CARS-TV score demonstrated a good level of 1714  
 taxonomic validity on DSM-III diagnostic 1715  
 groups. Further, total CARS-TV score discrimi- 1716  
 nated infantile autism and other pervasive devel- 1717  
 opmental disorders from mental retardation 1718  
 without an additional diagnosis of pervasive 1719  
 developmental disorder. 1720

Another study was conducted to evaluate the 1721  
 cutoffs and sensitivity/specificity of the 1722  
 Childhood Autism Rating Scale—Tokyo Version 1723  
 (CARS-TV) with 430 children (357 males) with 1724  
 Pervasive Developmental Disorders (PDD) rang- 1725  
 ing from 25 to 294 months old (average 1726  
 age=80.8 months,  $SD=46.4$ ) and 75 children 1727  
 (26 males) ranging from 37 to 352 months old 1728  
 with mental retardation without a history of PDD 1729  
 (average age=80.5 months,  $SD=50.1$ ) living in 1730  
 Tokyo (Tachimori, Osada, & Kurita, 2003). The 1731  
 CARS-TV total score was compared among 1732  
 these children who were classified into four 1733  
 DSM-IV diagnostic groups: (1) 212 (180 males) 1734  
 with autistic disorder, (2) 31 (24 male) with 1735  
 Asperger's Disorder, (3) 6 (5 males) with 1736

1737 Childhood Disintegrative Disorder (CDD), and  
 1738 (4) 181 (149 male) with PDD not otherwise spec-  
 1739 ified (PDDNOS). Values of Cronbach's alpha  
 1740 were 0.91 for the PDD group and 0.89 for the  
 1741 non-PDD mental retardation (MR) group, and  
 1742 0.93 for both groups combined, suggesting good  
 1743 internal consistency for both subsamples. The  
 1744 CARS-TV total score was significantly higher in  
 1745 PDD (mean=30.1, SD=4.5) than in non-PDD  
 1746 MR (mean=22.9, SD=3.3),  $t(503)=13.7$ ,  
 1747  $p<0.0001$ . The cutoff to distinguish PDD from  
 1748 non-PDD MR was 25.5/26, with sensitivity,  
 1749 specificity, positive predictive value and negative  
 1750 predictive value of 0.86, 0.83, 0.97, and 0.50,  
 1751 respectively. In addition, the CARS-TV total  
 1752 score differed significantly among the four  
 1753 DSM-IV subgroups, with CDD and AD sub-  
 1754 groups being significantly higher than both  
 1755 PDDNOS and Asperger's disorder, and with the  
 1756 PDDNOS subgroup CARS total score being sig-  
 1757 nificantly higher than Asperger's disorder. No  
 1758 significant difference was found between CDD  
 1759 and AD. The cutoff to distinguish AD from  
 1760 PDDNOS was 30/30.5, with sensitivity, specific-  
 1761 ity, positive predictive value and negative predic-  
 1762 tive value of 0.71, 0.75, 0.77, and 0.69,  
 1763 respectively. Results suggest that the CARS-TV  
 1764 may have clinical utility for differentiating  
 1765 between PDD and non-PDD MR and between  
 1766 AD and PDDNOS.

1767 To assess whether the CARS-TV can differen-  
 1768 tiate between high-functioning atypical autism  
 1769 (HAA) with  $IQ \geq 70$  and childhood autism  
 1770 (HCA), 74 children and young adults (63 males)  
 1771 aged 2–23 years (average age 6.6, SD=0.5 years)  
 1772 with either a classification HAA (53 children, 45  
 1773 males, average age=6 years, SD=0.5 years,  
 1774 range 2–23 years) or HCA (21 children, 18  
 1775 males, average age=8.2 years, SD=1.1 years,  
 1776 range 3–18 years) were examined. On the  
 1777 CARS-TV with IQ and total CARS-TV score  
 1778 controlled for, the HAA children were signifi-  
 1779 cantly less abnormal than the HCA children on  
 1780 two items of the CARS-TV, specifically, relation-  
 1781 ship with people and general impressions. In  
 1782 addition, affect reports tended to be significantly  
 1783 milder in HAA than HCA, and anxiety reaction  
 1784 was significantly more abnormal in HAA than

HCA. These findings suggest that the CARS-TV  
 may be useful to clinically distinguish between  
 HAA and HCA youth.

In looking at several studies which assess the  
 use of the CARS-TV with Japanese children  
 some limitations need to be addressed in future  
 research. First, findings need to be verified by  
 longitudinal studies as autistic symptoms change  
 over time (Kanai et al., 2004; Tachimori et al.,  
 2003). Findings also need verification with a  
 clear criterion for high-functioning autism in  
 larger sample sizes. Finally, cutoff scores for per-  
 vasive developmental disorders need replication  
 in varied populations within Japan (Kanai et al.,  
 2004; Tachimori et al., 2003) as well as with  
 Japanese Americans in the USA.

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## Recommendations

Many of the assessments discussed in this chapter  
 are still in early stages of test validation, and most  
 of the surveys have been validated with interna-  
 tional samples with Asian youth but not yet  
 explicitly examined for their psychometric prop-  
 erties with different Asian-American youth resid-  
 ing in the USA. Thus, caution is needed when  
 utilizing and interpreting the results of these sur-  
 veys for Asian-American youth. One issue that is  
 important to consider is whether it would be more  
 appropriate to utilize the norms of the general US  
 population which often does not contain Asian-  
 American groups (or at least not a substantial  
 proportion of Asian-Americans) in the validation  
 sample, or if it would be more appropriate to uti-  
 lize the norms for the specific cultural group  
 established in another country. Another consider-  
 ation is whether or not it is appropriate to apply  
 Asian-American norms established in the USA to  
 a specific cultural group (e.g., Chinese Americans,  
 Vietnamese Americans, East Indian Americans),  
 and many validation studies do not include the  
 collection of factors such as immigrant status,  
 years in the USA, primary language, and accul-  
 turation status that may help aid the clinician or  
 researcher in determination which norms to uti-  
 lize as a comparison. To assist in the decision  
 making process, it may be helpful to supplement

1830 the implementation of the survey instrument with  
 1831 data from structured and semi-structured inter-  
 1832 views and surveys that measure acculturation or  
 1833 ethnic identity. These methods of evaluation  
 1834 allow the clinician to ask the youth and his or her  
 1835 parent questions about the youth's participation  
 1836 and affiliation with the mainstream American  
 1837 culture and the ethnic culture of origin. Armed  
 1838 with this information, the clinician may be able to  
 1839 make a more informed decision regarding which  
 1840 normative sample would be most relevant for the  
 1841 interpretation of the youth's survey results.

1842 In addition, it may be helpful to address in a  
 1843 follow-up interview with the youth certain  
 1844 responses on the survey instrument when there is  
 1845 a question of whether or not there is equivalence  
 1846 across cultures on specific items. This is particu-  
 1847 larly important when there are known or sus-  
 1848 pected differences in symptom expression on  
 1849 specific domains of functioning or culture-bound  
 1850 syndromes that approximate certain diagnostic  
 1851 categories for a specific cultural group. For  
 1852 example, there may be differences in how traits  
 1853 like extraversion and agreeableness are viewed in  
 1854 different Asian cultures. Some Asian cultural  
 1855 groups may value agreeableness more highly  
 1856 than some Americans, as agreeableness may  
 1857 reflect collectivistic ideals. Extraversion may or  
 1858 may not be desired as a personal quality if some  
 1859 Asian groups interpret it as synonymous with  
 1860 being boisterous or as a quality that goes against  
 1861 values of humility and stoicism which are preva-  
 1862 lent in several Asian cultures. These differences,  
 1863 if they exist, may be more salient for Asian-  
 1864 Americans who are recent immigrants versus  
 1865 those who are second or third generation resi-  
 1866 dents in the USA.

1867 Finally, more research on the psychometric  
 1868 properties for existing behavioral assessments  
 1869 needs to be undertaken to establish norms, cut-  
 1870 offs, and reliability and validity in specific Asian-  
 1871 American populations in the USA. Most of the  
 1872 assessments in this chapter have validated the  
 1873 original versions of the surveys or the translated  
 1874 versions of the surveys in other countries, but no  
 1875 data to date has been produced for their ethnic  
 1876 counterparts in the USA. This research should  
 1877 be undertaken with specific Asian-American

samples instead of grouping these heterogeneous 1878  
 youth into one overall sample in validation stud- 1879  
 ies whenever possible to ensure applicability. In 1880  
 addition, within these specific ethnic samples, 1881  
 other factors that will likely play a significant 1882  
 role in the youths' interpretation of and responses 1883  
 to the survey items such as acculturation level, 1884  
 generational status, and ethnic identity should 1885  
 also be examined via cohort or block designs. 1886

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# Author Queries

Chapter No.: 24      0002114236

Queries	Details Required	Author's Response
AU1	Chapter title "Assessment of Childhood Behavioral Disorders" given in chapter opener does not match with the TOC. Please check.	
AU2	"Judy Ho" has been treated as the corresponding author. Please check if it is ok.	
AU3	(Oh et al., 1997) is cited in the body but its bibliographic information is missing. Kindly provide its bibliographic information. Otherwise, please delete it from the text/body.	
AU4	(Landis and Koch's 1977) is cited in the body but its bibliographic information is missing. Kindly provide its bibliographic information. Otherwise, please delete it from the text/body.	
AU5	"Su, Wang, Zhu, Luo, & Yang, 2003" has been changed to "Su, Wang, Fan, Su, & Gao, 2008" as per the list. Please check if it is ok.	
AU6	(Guilleman, Bombardier, and Beaton 1993) is cited in the body but its bibliographic information is missing. Kindly provide its bibliographic information. Otherwise, please delete it from the text/body.	
AU7	"Schopler, Van Bourgondien, Wellman, & Love, 1980" has been changed to "Schopler, Van Bourgondien, Wellman, & Love, 2010" as per the reference list. Please check.	
AU8	"Schopler, 2010" has been changed to "Schopler et al. 2010" as per the reference list. Please check.	
AU9	Please check the edits made in the reference "Achenbach and Rescorla 2001" for correctness.	