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Positive attributes in children and reduced risk of future psychopathology

Pablo Vidal-Ribas, Robert Goodman and Argyris Stringaris

Background
There is little research on children’s positive attributes and their association with psychiatric outcomes.

Aims
To examine the hypothesis that children’s positive attributes are associated with a reduced risk of developing psychopathology in future.

Method
Positive attributes, measured with the Youth Strengths Inventory (YSI) and psychiatric outcomes were assessed on two occasions over 3 years in a large epidemiological sample of British children and adolescents (n = 5325).

Results
The YSI showed high to moderate cross-informant correlations and longitudinal stability. Children scoring high on positive attributes at baseline had fewer psychiatric symptoms and disorders at follow-up, adjusting for symptoms at baseline, disorder at baseline and child and family factors. Analyses with propensity score matching also suggested that positive attributes decrease the likelihood of psychiatric morbidity.

Conclusions
Children’s positive attributes are associated with significantly less psychopathology across time and may be a target for intervention.

Declaration of interest
None.

Participants
The B-CAMHS04 involved a sample of 5–16 year olds (n = 7977) representative of the general British population; it has previously been described in detail. The study used ‘child benefit’ (a state benefit payable at that time in Great Britain for each child in a family) to develop a sampling frame of 5- to 16-year-olds in different postal sectors in England, Wales and Scotland. After excluding families with no recorded postal code, it was estimated that this represented 90% of all British children. Out of the 12 294 contacted, there were n = 1085 who opted out and n = 713 who were non-eligible or had moved without trace, leaving 10 496 who were approached in person. Of those, n = 7977 participated (65% of those selected; 76% of those approached). If the child was aged 5–10, a face-to-face interview was conducted with the parent and if the child was aged 11–16, the parent was interviewed first followed by the young person. In 2007, i.e. 36 months after the baseline survey, families were approached once more unless they had previously opted out or the child was known to have died. Of the original n = 7977 participants, n = 5325 (67%) participated in the detailed follow-up. All study procedures received multicentre research ethics committee approval and informed consent was obtained from parents and assent from children participants.

Method
The 2004 British Child and Adolescent Mental Health Survey (B-CAMHS04), a longitudinal multi-informant study of young people in the general population; it has previously been described in detail. The study used ‘child benefit’ (a state benefit payable at that time in Great Britain for each child in a family) to develop a sampling frame of 5- to 16-year-olds in different postal sectors in England, Wales and Scotland. After excluding families with no recorded postal code, it was estimated that this represented 90% of all British children. Out of the 12 294 contacted, there were n = 1085 who opted out and n = 713 who were non-eligible or had moved without trace, leaving 10 496 who were approached in person. Of those, n = 7977 participated (65% of those selected; 76% of those approached). If the child was aged 5–10, a face-to-face interview was conducted with the parent and if the child was aged 11–16, the parent was interviewed first followed by the young person. In 2007, i.e. 36 months after the baseline survey, families were approached once more unless they had previously opted out or the child was known to have died. Of the original n = 7977 participants, n = 5325 (67%) participated in the detailed follow-up. All study procedures received multicentre research ethics committee approval and informed consent was obtained from parents and assent from children participants.
Assessment
Development and Well-Being Assessment
The DAWBA9,10 is a structured interview administered by lay interviewers who also record verbatim accounts of problems. The questions are closely related to DSM-IV and ICD-10 diagnostic criteria and focus on current problems. The kappa (k) statistic for chance-corrected agreement between two raters was 0.86 for any disorder (s.e. = 0.04), 0.57 for internalising disorders (s.e. = 0.11) and 0.98 for externalising disorders (s.e. = 0.02). Values of k < 0 indicate no agreement, 0–0.20 slight agreement, 0.21–0.40 fair agreement, 0.41–0.60 moderate agreement, 0.61–0.80 substantial agreement and 0.81–1 almost perfect agreement.16 Children were assigned a diagnosis only if their symptoms were causing significant distress or social impairment. The DAWBA was completed at baseline and at 36 months (further information on the DAWBA is available from http://www.dawba.info). This paper focuses on the overall presence of disorder (i.e. any DSM-IV disorder), externalising disorders (the combination of conduct, oppositional defiant and attention-deficit hyperactivity disorders) and internalising disorders (the combination of depressive and anxiety disorders).

Youth Strengths Inventory
The YSI forms part of the DAWBA (Section N) and asks about positive attributes of the child, with similar but not identical parent-report and youth-report versions. The first part of the YSI asks how applicable various descriptions are to the child (for example generous, affectionate, caring), while the second part asks about things the child does that please the parents (for parent report) or that the child is proud of (for self-report). Examples include being good with friends, helpful at home and polite. The parent version has 12 items in each part, whereas the self-report version has 8 items in the first part and 11 items in the second part. Each item is scored on a three-point Likert scale (i.e., no; a little; a lot), with scores ranging from 0 to 48 for the parent version and 0 to 37 for the self-report version. Examining the psychometric properties, we found that all YSI scales showed high internal consistencies, similar to other existing strengths measures.4,17,18 For parent report, Cronbach’s alphas were 0.84 at baseline (mean 39.2, s.d. = 6.0, median 40, IQR = 36–44) and 0.86 at 36 months (mean 38.9, s.d. = 6.4, median 40, IQR = 36–44). For child report, they were 0.77 at baseline (mean 27.1, s.d. = 5.1, median 27, IQR = 24–31) and 0.73 at follow-up (mean 28.3, s.d. = 3.7, median 28, IQR = 26–31). A preliminary factor analysis yielded an unrotated single-factor structure for all informants and time points. For the parent-reported YSI scores, this single factor explained 79% of the variance at both time points. For the youth-reported YSI scores, the variance explained by this single factor was 83% in 2004 and 81% in 2007. It should be noted that the item ‘polite’ was dropped from the factor analysis of youth-reported positive attributes in 2007 because of zero variance (i.e. all children answered ‘A lot’ in this item). Parent-rated YSI scores were used in the analyses unless otherwise specified.

Strengths and Difficulties Questionnaire
The Strengths and Difficulties Questionnaire (SDQ) asks about 25 attributes, some positive and others negative; respondents use a three-point Likert scale to indicate how far each attribute applies to the target child.19 The 25 items are divided between five scales of five items each, generating scores for emotional symptoms, conduct problems, hyperactivity–inattention, peer problems and prosocial behaviour; all but the last are summed to generate a total difficulties score ranging 0–40. The SDQ also has an impact supplement19 that asks whether the respondent thinks that the child or youth has a problem, and if so, enquires further about overall distress, social impairment, burden and chronicity. This instrument has robust psychometric properties.20,21 In our sample, Cronbach’s alphas for parent reports were 0.84 at baseline (mean 3.9, s.d. = 4.8) and 0.86 at 36 months (mean 5.7, s.d. = 4.6). It is important to note that in this study, the SDQ was used to generate a difficulties score, but not to generate a strengths score: the strengths score used in the analyses reported in this paper was based on the YSI. The SDQ was used in addition to the DAWBA because there is increasing recognition of the great importance of assessing psychopathology as a dimension in addition to the diagnostic approach.22

Psychosocial adjustment
Measures of psychosocial adjustment such as contact with psychiatric services, self-harm, truancy and contact with police were gathered in the baseline survey (2004). A participant was coded as having ever experienced one of these outcomes as rated by youth, teacher or parent report. In the follow-up survey (2007), informants were asked again about the same outcomes — we analysed new onsets of these outcomes.

Family factors
Sociodemographic details were collected at the parental interview covering the following information: (a) ethnic group, (b) housing tenure (rented accommodation v. owner-occupiers), (c) gross household income, (d) maternal highest educational qualification, (e) family type (reconstituted with step-parent and/or step/half-siblings v. other, lone-parent v. other), (f) parental anxiety and depression, assessed with the 12-item version of the General Health Questionnaire,23 (g) family discord, assessed with the general functioning scale of the McMaster Family Assessment Device, which includes 12 items, scored on a 1–4 scale with a maximum score of 48,24 and (h) stressful life events during the child’s lifetime, including parental separation, court appearance, bereavement and serious illness or accident.25

Child factors
Parents also provided information about (a) age, (b) gender, (c) their child’s general health, using a five-point Likert scale, including the report of any physical disorders affecting their child, (d) neurodevelopmental disorders like cerebral palsy, difficulties with coordination, epilepsy and muscle disease or weakness and (e) ‘generalised learning disability’ (intellectual disability, referred to as learning disability in UK health services). Parents and teachers were asked to estimate each child’s mental age, and teachers reported whether a child had a written statement of special educational needs related to cognitive and intellectual needs (including specific, moderate, severe and profound intellectual difficulties, but not distinguishing between them). For the purpose of these analyses, a child was considered to have a ‘generalised learning disability’ when one or both informants estimated that mental age was 60% or less of the chronological age (such as a mental age of 6 or less at a chronological age of 10).

Statistical analyses
Inter-rater associations and longitudinal stability
We examined whether there was a correspondence between parent-rated positive attributes and their children’s self-perceptions. Concurrent and longitudinal associations of positive attributes...
scores were tested using Pearson’s correlations within and across informants.

Distinction between positive attributes and psychiatric symptoms across time

A path analysis model was estimated to test whether total SDQ score (symptoms) and YSI score (positive attributes) exhibited distinguishable predictions across time.

Positive attributes predicting future psychiatric symptoms

The prediction of psychiatric symptoms by positive attributes was estimated in regression models with the total SDQ symptom score as the outcome (i.e. at 36 month) and baseline YSI score (positive attributes) as the predictor. In subsequent steps, regression models were adjusted for total SDQ symptom score at baseline, as well as relevant family factors (i.e. ethnicity, single-parent family, reconstituted family, maternal highest educational qualification, gross household income, housing tenure, family functioning, General Health Questionnaire and life events) and child factors (i.e. age, gender, general health, neurodevelopmental disorder, generalised learning disability and any psychiatric disorder at baseline) as covariates.1,8,26–28 This way we were able to test the specific association between positive attributes and psychiatric outcomes without the overestimation bias because of common related factors.

Positive attributes predicting future psychiatric disorders

The prediction of psychiatric diagnoses at 36-month follow-up (dependent variable) by baseline positive attributes was estimated in logistic regression models where baseline YSI score was used as an independent variable. We predicted three domains of psychiatric disorders; these were ‘any psychiatric disorder’, ‘emotional–internalising disorder’, and ‘disruptive behaviour–externalising disorder’. In adjusted models, diagnoses at baseline were used as covariates. In subsequent steps, the same child and family factors employed as covariates in the prediction of psychiatric symptoms were also added to these models. In addition, to examine whether parental ratings of positive attributes may lead to psychiatric disorders or be a consequence of them, we employed path analytical models. Doing so, we were able to look at the longitudinal association taking into account the correlation at baseline and follow-up.

Association with psychosocial adjustment

We employed logistic regression models in which the independent variable was positive attributes at baseline, and the dependent variables were the new emergence of the following factors in the 36-month follow-up: contact with psychiatric services, self-harm, truancy and contact with police. The models were examined unadjusted and adjusted for baseline psychiatric symptoms.

Difference in symptoms at follow-up between matched groups differing in level of positive attributes

Propensity score matching is an attempt to reduce bias in causal inference in observational studies. Through this method, a ‘treated’ group (for example high positive attributes) is matched on plausible confounders to a ‘control’ group (for example low positive attributes). If a good balance is achieved (i.e. approximately equal distribution of baseline covariates in both groups) and assuming that this model includes all relevant confounders, then this observational study should emulate what a RCT does by randomisation. Hence, a difference in the outcome (for example symptoms at follow-up) can be attributed to being ‘treated’ or not – unless there were strong confounders that were neither measured directly nor correlated with matching variables that were measured.

Propensity score analysis has several advantages over multiple linear regression approaches. First, when a good covariate balance is achieved, propensity score analysis does not rely on the correct specification of the functional form of the relationship (for example linearity or log linearity) between the outcome and the covariates, which is not the case with linear regression models when covariate distributions are very different between groups.29,30 Second, propensity score methods make it easier to determine whether the model has been correctly specified than with regression approaches.11 Finally, propensity score analyses are considered objective in the sense that the model is specified without relying on the outcome. (It is also possible to combine propensity score analyses with regression adjustment to reduce slight imbalances in the covariates and increase precision.)31–33

In this study we used a propensity score matching approach to test whether children only differing in levels of positive attributes at baseline showed different levels of psychiatric symptoms at follow-up.13 Our aim was to compare children at both extremes of the distribution of levels of positive attributes. A binary variable of baseline positive attributes was computed selecting the extremes of the distribution of this variable (high positive attributes v. low positive attributes) using percentiles 20 and 80 as cut-off points. Doing so, we kept approximately the same proportion of people in each group. We matched both groups on the same covariates that were adjusted for in the previous regression models, plus psychiatric symptoms and disorder at baseline. In this case, a logit regression model was used to estimate the propensity score. The resulting propensity score was the predicted probability of belonging to the high positive attributes group for each child. Propensity score matching was performed employing a one-to-one nearest-neighbour method within a caliper (or distance) of 0.5.11,34 With one-to-one nearest-neighbour matching, only one ‘control’ participant is selected for each ‘treated’ participant, namely the one whose propensity score is closest to the ‘treated’ participant.12 Caliper is defined as the difference in propensity scores between selected matches. By setting a caliper of 0.5 we pre-specify the largest allowable absolute difference in propensity scores for matched participants, thus ensuring closer balance. We only analysed observations that were inside the common support area. That is, there might be substantial overlap of the propensity score distributions in the two groups, but potentially density differences. Therefore, we discard individuals with propensity score values outside the range of the other group, thereby also ensuring a better balance.13 Balance of the covariates was assessed before and after matching using a measure of standardised differences.13 Standardised differences of means < 0.20 are acceptable,12,13 and differences < 0.10 are considered negligible (i.e. no mean differences in a covariate between groups). Regression models were employed to test the difference in means of SDQ total score at follow-up between matched groups as well as the change of SDQ total score over time in each group. Cohen’s d were calculated as a measure of effect size.

The Stata 11 software package for Windows was employed to test all study hypotheses, except for the path analyses, which were run with MPlus version 7.56

Results

Interrater correlation and longitudinal stability

As shown in Table 1, there was a moderately strong cross-sectional correlation between parent- and child-rated positive attributes as measured with the YSI. The stability of positive attributes scores within informants ranged from moderate in children to high in
parents. Finally, positive attributes scores at baseline were significantly better (as evidenced in non-overlapping CIs) in predicting positive attributes scores at 36 months within informants than across informants.

**Distinction between positive attributes and symptoms across time**

The path analysis model in Fig. 1 shows that the within-domain prediction is much stronger than the across-domain prediction: positive attributes are a better predictor of positive attributes, whereas symptoms are a better predictor of symptoms (as evidenced in non-overlapping CIs).

**Positive attributes predicting future psychiatric symptoms**

As seen in Table 2, higher levels of positive attributes measured at baseline were significantly predictive of fewer psychiatric symptoms at follow-up. This was even true in models adjusted for SDQ total symptom score at baseline, family factors and child factors.

**Positive attributes predicting future psychiatric disorders**

Table 3 shows that a higher level of parent-rated positive attributes at baseline was a significant predictor of less psychiatric disorders at follow-up, no matter what domain of disorder was predicted. This was even true when adjusting for baseline disorder, family factors and child factors.

Figure 2 shows that positive attributes predicted less psychiatric disorders (beta coefficient range: $-0.19$ to $-0.32$) to a significantly higher extent than disorders predicted less positive attributes (beta coefficient range: $-0.05$ to $-0.08$).

**Association with psychosocial adjustment**

As can be seen in Table 4, parent-rated positive attributes were significant predictors of less subsequent psychiatric and police

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### Table 1  Association of positive attributes within and across informants at baseline and follow-up

<table>
<thead>
<tr>
<th>Positive attributes score</th>
<th>Parent</th>
<th>Child</th>
<th>Parent</th>
<th>Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>0.30 (0.24–0.36)</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Parent</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Child</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>36 months</td>
<td>0.64 (0.62–0.65)</td>
<td>0.24 (0.18–0.31)</td>
<td>0.46 (0.41–0.51)</td>
<td>0.30 (0.24–0.36)</td>
</tr>
<tr>
<td>Parent</td>
<td>0.29 (0.23–0.33)</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Child</td>
<td>0.46 (0.41–0.51)</td>
<td>0.30 (0.24–0.36)</td>
<td>0.30 (0.24–0.36)</td>
<td>0.30 (0.24–0.36)</td>
</tr>
</tbody>
</table>

$r$, Pearson correlations; $n$, number of observations. P $\leq 0.001$ in all cells. All findings in bold are significant ($P \leq 0.05$).
### Table 3 Standardised positive attributes at baseline as a predictor of psychiatric disorders in adjusted and unadjusted models

<table>
<thead>
<tr>
<th>Prediction</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any disorder predicted by:</td>
<td></td>
</tr>
<tr>
<td>Positive attributes only</td>
<td>0.42 (0.39–0.46)</td>
</tr>
<tr>
<td>Positive attributes adjusted for any disorder at baseline</td>
<td>0.57 (0.51–0.63)</td>
</tr>
<tr>
<td>Positive attributes adjusted for any disorder at baseline and family factors</td>
<td>0.59 (0.53–0.66)</td>
</tr>
<tr>
<td>Positive attributes adjusted for any disorder at baseline and child factors</td>
<td>0.60 (0.53–0.66)</td>
</tr>
<tr>
<td>Any emotional disorder predicted by:</td>
<td></td>
</tr>
<tr>
<td>Positive attributes only</td>
<td>0.62 (0.56–0.70)</td>
</tr>
<tr>
<td>Positive attributes adjusted for any emotional disorder at baseline</td>
<td>0.69 (0.61–0.78)</td>
</tr>
<tr>
<td>Positive attributes adjusted for any emotional disorder at baseline and family factors</td>
<td>0.74 (0.64–0.85)</td>
</tr>
<tr>
<td>Positive attributes adjusted for any emotional disorder at baseline and child factors</td>
<td>0.73 (0.64–0.83)</td>
</tr>
<tr>
<td>Any externalising disorder predicted by:</td>
<td></td>
</tr>
<tr>
<td>Positive attributes only</td>
<td>0.40 (0.36–0.45)</td>
</tr>
<tr>
<td>Positive attributes adjusted for any externalising disorder at baseline</td>
<td>0.54 (0.48–0.62)</td>
</tr>
<tr>
<td>Positive attributes adjusted for any externalising disorder at baseline and family factors</td>
<td>0.61 (0.52–0.70)</td>
</tr>
<tr>
<td>Positive attributes adjusted for any externalising disorder at baseline and child factors</td>
<td>0.55 (0.48–0.63)</td>
</tr>
</tbody>
</table>

a. Family factors are ethnicity, single parent family, reconstituted family, maternal highest education, gross household income, housing tenure, family functioning, General Health Questionnaire and life events. Child factors are age, gender, general health, neurodevelopmental disorder and generalised learning disability. All findings in bold are significant ($P < 0.05$). Note that odds ratios significantly less than 1 represent a protective effect.

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**Fig. 2** Path analyses of the relation between positive attributes and any domain of disorder (a), any internalising disorder (b) and any externalising disorder (c) across time.

Significant paths ($P < 0.001$) and correlations with standard errors and 95% confidence intervals are presented as straight and curved lines respectively. $R^2$, proportion of variance explained.
contact in individuals who had not had such contact previously, even with adjustment for baseline psychiatric symptoms. By contrast, unadjusted prediction to new truancy or self-harm did not remain significant once adjusted for baseline psychiatric symptoms.

**Difference in symptoms at follow-up between matched groups differing in level of positive attributes**

As seen in Fig. 3, the reduction in standardised bias was acceptable after carrying out the propensity score matching; there was only one covariate with a standardised bias > 0.10. The mean standardised bias in the covariates was 42.3% (s.d. = 39.5, range 9.2–162.3) before matching, and decreased to 3.7% (s.d. = 2.8, range 0.3–10.5) after matching. The outcome analyses (after matching) revealed that there were significant differences in the SDQ total score at follow-up between matched groups with high and low levels of positive attributes (effect size 0.25, 95% CI 0.11–0.38, \( P < 0.001 \)). Moreover, the change in SDQ total score over time was significant for the matched low positive attribute group (effect size 0.39; 95% CI 0.08–0.69, \( P < 0.05 \)) but not for the matched high positive attribute group (effect size 0.15, 95% CI –0.18 to 0.47, \( P = 0.372 \)) (Fig. 4).

**Discussion**

**Main findings**

This study examined the extent to which parental perceptions of positive attributes in their own children predicted psychiatric outcomes. Analyses were carried out in a large epidemiological sample of young children and adolescents employing a longitudinal design. Overall, we found that higher levels of parental perceptions of positive attributes added to the prediction of fewer future
In line with previous studies, higher levels of positive attributes at baseline were predictive of fewer psychiatric symptoms 3 years later. As expected, the predictions were still significant even after accounting for symptoms at baseline and relevant child and family factors. As we predicted, effect sizes were moderate in the unadjusted models (for example −0.48 for parent-reported positive attributes to symptoms 3 year later) and substantially attenuated in adjusted models (for example about −0.10 for parent-reported positive attributes to symptoms 3 years later). However, the propensity score matching approach demonstrated that children who only differ in levels of positive attributes at baseline showed different levels of psychiatric symptoms at follow-up. As expected, differences in psychiatric symptoms were lower but still significant. This approach, which is more similar to an RCT, confirms that positive attributes are independently related to psychiatric symptoms.

In addition, a path analytical model showed that positive attributes were best predicted by positive attributes and symptoms were best predicted by symptoms, suggesting different constructs. Our data are more in keeping with a vulnerability model than a model in which positive attributes and psychopathology are on the same continuum. Supporting previous results in adolescent samples, we also found that higher positive attributes scores at baseline added to the prediction of reduced risk for psychiatric disorders 3 years later. For example, our results showed that every decrease in parent-reported positive attributes score increased the probability of future psychiatric disorder (all sorts combined) by 76%, of emotional disorder by 45% and of externalising disorder by 85%. These probabilities were only attenuated by 10% after accounting for child and family factors. Of note, higher positive attributes scores were more likely to predict reduced risk for externalising disorders than for emotional disorders. This was an unexpected finding and should be confirmed in future studies. Previous research found a significant association with emotional disorders and any psychiatric disorder, although only the last remained significant after controlling for socioeconomic confounders. In contrast to our results, the same study did not find an association with disruptive disorders.

The difference in the prediction of internalising and externalising disorders might be for different reasons. First, the prevalence of each domain of disorder differs across different ages. Second, externalising problems may cause more burden in families and therefore parents may underreport their children's positive attributes; however, in our sample, adjusting for parental burden did not change the pattern of the results.

In path analyses we showed that higher positive attributes at baseline predicted fewer psychiatric disorders 3 years later; this direction of effect was significantly stronger than that of psychiatric disorders predicting fewer positive attributes. The weaker prediction to symptoms than to disorders may be explained by the methods employed for collecting the data. Psychiatric diagnoses were based on clinical ratings of interviews, including extensive open-ended comments — a substantially different method than the respondent-based YSI measure of positive attributes. By contrast, SDQ-based symptoms and YSI-based positive attributes shared a respondent-based approach, so that adjusting for baseline symptoms will substantially attenuate prediction as a result of common method variance. Indeed, if adjustment is restricted to child and family factors, without adjustment for baseline symptoms, effect sizes remained around −0.40 for parent-reported positive attributes predicting symptoms 3 years later.

Finally, lower parent-reported positive attributes scores increased the probability of new future contact with psychiatric services by 20% and contact with police by 33% after adjusting for baseline symptoms. Interestingly, contact with police was the category most strongly associated with externalising disorder whereas contact with psychiatric services was the category most strongly associated with all types of disorder combined.

Implications

Our findings suggest benefits of measuring positive attributes alongside symptoms in day-to-day mental health assessments of children and young people. This adds to the prediction of psychiatric symptoms and psychiatric disorders, in line with previous results. This enables clinicians to recognise a particularly high-risk group independently of the level of symptoms at admission — something that may be especially useful as regards externalising disorders. It is plausible that interventions aiming to increase the recognition of and further develop positive attributes may alleviate or prevent externalising disorders.

Furthermore, previous research suggests that strength-based assessment approaches promote family involvement in treatments and result in more caregiver satisfaction and treatment adherence. Assessing a child’s positive attributes can be a less stigmatising way
Limitations

The findings of this study must be considered in the light of its limitations. First, as is often the case in longitudinal studies, there was considerable attrition. Although this would be most likely to bias prevalence estimates rather than the associations between disorders and other factors,1,4 it has meant that those with high levels of psychopathology at baseline were less likely to participate in the study. Second, propensity score matching in non-experimental studies cannot adjust for unobserved covariates, so residual confounding is still possible.13 A third limitation is that the YSI, unlike other longer strengths measures such as the Values in Action Inventory of Strengths (VIA-IS)4 or the Behavioral and Emotional Rating Scale (BERS)14 measures positive attributes as a single factor. Although simple and quick, this could be a disadvantage if different positive attributes show different associations with specific psychiatric outcomes. Future studies should compare the YSI with longer multiscale measures to establish what, if anything, is lost through using a brief unidimensional measure of positive attributes. Finally, it is conceptually unclear what is actually relevant in the assessment of positive attributes. That is, we cannot determine how far reported positive attributes reflect the presence of objective strengths in the child – as opposed to subjective rater biases. However, the same limitation applies to all parent-reported psychopathology, and is not specific to positive attributes. Future research to examine this issue might use a variety of informants (including teachers and peers) and approaches (including systematic observation schedules, intervention studies and qualitative studies).

To sum up, our findings suggest that positive attributes can be easily and reliably measured with the YSI from the DAWBA and can provide useful information regarding psychosocial and psychiatric outcomes in children and young people.

References


