

## EMOTIONAL AND BEHAVIOURAL PROBLEMS IN SINGAPOREAN CHILDREN BASED ON PARENT, TEACHER AND CHILD REPORTS

Dear Sir,

I read with great interest the recently published article by Woo et al in your prestigious journal.<sup>(1)</sup> I have to commend their work and effort. However, I would like to raise few comments because of the importance of the subject.

Firstly, in view of the low response rate (60%) that the authors already acknowledged in their paper, I would recommend doing the statistical analysis on a weighted sample. Assigning weight to each record and using it in the analysis would help to avoid selection bias that was manifested in this case. The authors admitted that the study participants were of higher social class and they also referred to the association of “low socioeconomic status with higher rates of mental health problems”.<sup>(2)</sup> Therefore, it is not unlikely that the “actual prevalence of mental health problems [was actually] underestimated”, not only because of the low sensitivity of the CBCL, but also because of selection bias.

Secondly, albeit the authors successfully briefed the reader in their methods on the scales used in the study as the CBCL, TRF, MASC, CDI, and the NIMH DISC-IV, they did not mention the aforementioned reliability scores especially if used in previous Singaporean studies. Moreover, the authors confused the reader by mentioning that “the prevalence rates of clinically significant anxiety and depressive symptoms were calculated based on the recommended clinical cut points in the MASC and CDI manuals”, whereas in their results, they stated that “9.6% of children scored above the recommended clinical cut-off point T-score of 66 on the MASC, and 17.8% of children scored above the recommended clinical cut-off point T-score of 66 on the CDI”.

Thirdly, the authors used the ROC curve to have the best cut-off score of CBCL against a gold standard (NIMH DISC-IV). The results showed a T-score of 66 on the CBCL. Then, they used the same cut-off score with TRF. Given the low correlation between CBCL and TRF, the significantly apparent higher mean score of CBCL and higher standard deviation for both scales, I wonder if it was better to test the TRF against the same gold standard to have the TRF cut-off score.

Finally, Table II showed that the overall SD was high (above one third of the mean) for CBCL and TRF. Hence, it was recommended to test for linearity before running ANOVA or Pearson’s correlation for the two groups. Skewness would be suspected given the high standard deviations. If linearity was not met, the authors could either transform variables or use nonparametric tests.<sup>(3)</sup>

Yours sincerely,

Mustafa Afifi

Department of Non Communicable Diseases Control  
Minsitry of Health Headquarters  
PO Box 393  
PC 113  
Muscat  
Oman  
Email: afifidr@yahoo.co.uk

### REFERENCES

1. Woo BSC, Ng TP, Fung DSS, et al. Emotional and behavioural problems in Singaporean children based on parent, teacher and child reports. Singapore Med J 2007; 48:1100-6.
2. Keitley MK, Lofthouse N, Bates JE, Dodge KA, Petit GS. Differential risks of covarying and pure components in mother and teacher reports of externalizing and internalizing behavior across ages 5 to 14. J Abnorm Child Psychol 2003; 31:267-83.
3. Bland M. An Introduction to Medical Statistics. 3rd ed. Oxford: Oxford University Press, 2000: 200.