The Cascades Mental Health Assessment (CMHA)

The Cascades Mental Health Assessment (CMHA) is a 57-item measure of common behavioral health problems, designed with a concrete response scale in terms of days out of the last month. This approach avoids reference group effects and facilitates direct comparisons of how symptom patterns vary across groups.

Why the CMHA?

A paper in preparation (Thalmayer, Marshall, & Scalise, in preparation) describes the creation of this efficient screening inventory to facilitate early intervention and prevention efforts, using large samples of employed adults in the United States. Current measures for psychological disorders typically focus on a single domain and/or focus on psychiatric level problems. Often, they are unnecessarily long and offer too few subscale scores. A common problem across both broad and domain specific inventories is vague response scales. Inventories typically ask for levels of agreement or subjective frequency. Such scales are highly subject to reference group effects (Heine, Lehman, Peng, & Greenholtz, 2002; Peng Nisbett, & Wong, 1997). For relatively visible personality traits, such as conscientiousness or extraversion, people can assess themselves in comparison to many others, including classmates or colleagues. However, they are limited by their contextual experiences and their self-evaluations are shaped by local expectations. This leads to surprising survey results. For example, among 26 nations, observing the lowest average scores on conscientiousness in Japan (Thalmayer & Saucier, 2014), a place not known for a lackadaisical approach to responsibilities. Instead, this low average likely speaks to high local standards, which make individuals highly aware of their own shortcomings.

This measurement challenge is even more pronounced among variables which are not as visible, such as psychological disorder symptoms. Information about depressive and anxious feelings or about sleep patterns is not obvious to lay observers, and in most contexts is considered highly personal information. Most individuals will know about such experiences for only a few intimates, if any. Thus, what does it mean when an individual reports that they worry “a lot” or “seldom”? Only that they do so in comparison to a few close others, or perhaps to social assumptions or media depictions of “normal” functioning.

This problem is addressed in the Cascades Mental Health Assessment by using items that are as concrete and behavioral as possible (e.g. “my worrying got in the way of doing something I had planned to do”), and by using a response scale referring to specific frequencies within the last month. This approach is designed to maximize validity in general, and in particular when for comparing across groups: cultural, subcultural, regional, or by gender, age, social class, education level, etc.

The CMHA in Africa

A second project in progress (Thalmayer, Shino, et al., n.d.) adapts the CMHA for use in Namibia, strongly testing it’s cross-cultural potential. Diagnosis in mental health settings in Namibia often relies on the *Diagnostic and Statistical Manual* (DSM) of the American Psychological Association, a source validated entirely in North America. The Namibian government has noted that little is known about the specific mental health needs throughout the country (Republic of Namibia Ministry of Health and Social Services, 2005). The current project seeks to establish norms for mental health problems among adult Namibians, in order to better inform local psychologists in Namibia and to provide a basis for future work improving mental health services.

The CMHA was translated into the two most widely-spoken home-languages in Namibia (Oshiwambo and Khoekhoegowab), and was administered to samples of over 600 participants in these languages, and in English, Namibia's national language since 1990. The two main goals of this study are: (1) to establish a better understanding of the occurrence rates and patterns of association of mental disorder symptoms in the local context and (2) to provide evidence to distinguish between universal versus culturally specific rates and patterns of mental health symptoms.

All surveys were translated into Oshiwambo (Oshikwanyama dialect) and Khoekhoegowab involving multiple professional translators and native speakers, using a multi-step process defined by the World Health Organization (https://www.who.int/substance_abuse/research_tools/translation/en/). The number of items per scale ranges from 2-8: depression (8), anxiety (8) post-traumatic stress (6), substance use (4) substance abuse (6), anger (6), relationship conflict (3), partner conflict (5), sleep issues (4), life stress (5), work disengagement (2). Additional items to measure ADHD (5) and psychosis (2) were adapted from other inventories and included in a current study, for a total of 64 items administered.

References

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