Strengths and difficulties questionnaire (sdq) pdf

A number of instruments have been used to determine mental health concerns in young people. An early measure of difficulties (eg conduct, emotional problems) in the young was the 118-item Child Behaviour Checklist (see Achenbach & Edelbrock, 1983). This section reviews the commonly used and widely available Strengths and Difficulties Questionnaire (SDQ). The SDQ has been used in a number of studies with COPMI participants. Click the headings to read more. Strengths and Difficulties Questionnaire – the concept The SDQ is a brief screening instrument that can be used with children and adolescents aged 3-16 years. Available in over 60 languages, the SDQ is a validated screening instrument widely used in Europe, Asia, Australia and the United States (Warnick, Braken & Kasl, 2008). The questionnaire takes approximately 10 minutes and can be completed by: parents and teachers about 3-16 year olds 11-16 year olds about themselves (Goodman, 1997, 1999; Goodman et al., 1998). Theoretical background The SDQ was developed from the Rutter (1967) parent and teacher questionnaires in the UK (Goodman, 1997) to identify behavioural and emotional problems in children and adolescents. The questionnaire consists of 25 items on psychological attributes, some positive and others negative, divided between 5 subscales. The measure affords a combined total difficulty score as well as total strengths score. Some versions of the SDQ have additional impact items and follow-up questions. An important feature of the SDQ is that it also focuses on children's strengths, particularly in the prosocial arena (Whyte & Campbell, 2008). The SDQ is widely used for health surveys, research, and epidemiological studies and mass screenings where clinical interviews are not possible (Dickey & Blumberg, 2001). Mellor (2005) suggests that the value of the SDQ as a validated screening instrument for use by workers with little or no training in mental health has influenced its uptake. The SDQ's sensitivity in discriminating clinical from non-clinical subjects and predicting psychiatric disorders suggests that it is a relevant screening instrument for use with the COPMI population (Maybery et al., 2009). Goodman (1997) established three bands of SDQ scores that discriminate between the likelihood of having and the severity of a clinical problem. The lowest 80 percent of the normative sample is considered in the normal range or unlikely to have clinical problems. Those scoring between the 80th and 90th percentile are considered to be in the borderline range with elevated scores that may reflect clinically significant problems. The highest 10 percent are considered to be in the clinical range indicating a substantial risk of clinically significant problems. These indicative scores allow a comparison of children who have received COPMI intervention with those who have not, across risk categories. Definition of strength and difficulties The SDQ asks respondents to rate 25 attributes using a 3-point Likert scale ('Not True', 'Somewhat True' or 'Certainly True') based upon the child's behaviour over the last six months or the current school year. The five subscales are: Emotional symptoms: 'mood or emotional responses dissonant with or inappropriate to the behaviour and/or stimulus' (Medical.Webends.com) Conduct problems: 'identifiable behaviours in the individual that fail to conform to societal norms and encroach on the rights of others' (Larmar & Gatfield, 2006) Hyperactivity-inattention: level of attention deficit or hyperactivity disorder, which is characterised by persistent and impairing symptoms of inattention, hyperactivity and impulsivity (Galéra, Melchior, Chastang, Bouuvard & Frombonne, 2009) Peer problems: evidence that children who experience difficulty making friends and getting along with their peers are at increased risk of a wide range of psychosocial outcomes (Woodward & Fergusson, 2000) Prosocial behavior: 'voluntary behavior that benefits others or promotes harmonious relations with others' (Bergin, Talley & Hamer, 2002). The 25 items can also be conceptualised as a three-factor model consisting of internalising problems, externalising problems, and positive behaviour (Dickey & Blumberg 2004; Hill & Hughes, 2007). The SDQ and children of parents with a mental illness Cunningham et al. (2004) invited 13 mothers, previously admitted to a psychiatric hospital for mental illness, to complete an SDQ on their 21 children. While not indicating actual scores on the SDQ, the authors reported that mean scores were mostly within the normal range, but a higher range of 'cases' was found for each of the difficulties subscales. Cowling et al. (2004) had 10 men and 51 women from a mental health clinic complete the SDQ about their 101 children aged 4-16. Mean difficulties were generally higher than published normative scores and 25 percent of children were reported to have scored in the clinical range (total difficulties). Children also had higher scores on emotional, peer relationship and conduct problems SDQ subscales. Mathai et al. (2008) had 29 parents with 'chronic psychiatric disorders' from a mental health program complete the SDQ on their 39 children (average age 7.86 years). Fifty percent of children (mean score = 15.72) scored in the clinical range and scores on subscales were between 36 percent for hyperactivity to 44 percent for emotional symptoms and conduct problems. Maybery et al. (2009) compared the SDQ scores of 833 children aged 8-12 years, of whom 134 were children of parents with a mental illness who attended an intervention program, 101 were children of parents with a mental illness from the general community, and 598 were a normative sample. The intervention group scored significantly higher than the other groups on all difficulties. The general community group scored significantly higher than the normative group on total difficulties, emotional symptoms and hyperactivity-inattention subscales. Both the community and intervention group children scored at two and three times respectively above the normative level of risk to their mental health. These examples indicate the value of the SDQ as an evaluation tool with the COPMI population. Measures and versions of the SDQ Versions of the SDQ are available for use by parents, teachers, and 11-16 year old adolescents. An impact supplement version and a follow-up questions version of the scale are also available for use by the three respondent groups (parents, teachers, 11-16 year old adolescents). Information detailing these expanded versions is available on the SDQ website. Scoring the SDQ Comprehensive information about how the SDQ is scored is available on the SDQ website. The site includes: instructions for scoring the various versions of the SDQ access to overlays for hand scoring and a record sheet scoring syntax for use with SPSS, SAS and STATA access to a computerised algorithm for predicting disorders added value scores for specialist services information about a computerised scoring and report writing program. Validity The SDQ has been shown to be reliable in identifying psychiatric disorders in community samples (Goodman et al., 1999; Koskelainen et al., 2000) and behavioural problems in children and adolescents (Goodman et al., 2003; Hawes & Dadds, 2001). It is increasingly being used as a treatment outcome measure (Vostanis, 2006). Reliability Cronbach alphas of 0.70 and above for the Total Difficulty scores have consistently been reported (Goodman, 2001; Goodman, Meltzer & Bailey, 2003; Hawes & Dadds, 2001; Mellor, 2004; Widenfelt et al., 2003; Smedje et al., 1999) and investigators consistently report Cronbach alphas of 0.70 and above for all Teacher rated subscales (Goodman, 2001; Mellor, 2004; Widenfelt et al., 2003). Parent rated subscales vary between hyperactivity-inattention alphas of 0.84 to peer problems and prosocial behaviour alphas of 0.57 (Goodman, 2001; Mellor, 2004; Widenfelt et al., 2003). The reliability of self-rated subscales is generally less robust. Peer problem alphas range from 0.39 to 0.59 and the hyperactivity-inattention subscale from 0.66 to 0.80 (Goodman, 2001; Hawes & Dadds, 2001; Mellor, 2004; Widenfelt et al., 2003). Goodman (2001) and Widenfelt et al. (2003) report a cross-informant correlation mean of 0.34 and 0.35 respectively. Mellor (2004) details specific cross-informant correlation means of Parent-Self rated 0.38, Parent-Teacher rated 0.38, and Teacher-Self rated 0.36. Goodman (2001) and Mellor (2004) report total difficulties test-retest reliability results of 0.72-0.81 for Parents, 0.74 to 0.80 for Teachers, and 0.62-0.79 for Self ratings. Warning about using the SDQ Research has suggested that parents experiencing a mental health problem may over-inflate their child's mental health concerns. For example, Najman et al. (2000) suggest that: "Current maternal mental health impairment appears to have a substantial effect on the reporting of child behavior problems by the mother, thereby raising questions about the validity of reports of child behavior by persons who are currently emotionally distressed" (p. 253). Resources Information about the SDQ, versions of the questionnaire, scoring information, normative values, uses, articles and comparison to other questionnaires can be accessed on the SDQ website. Questionnaires are available free of charge from this site. Download the Australian version of the survey Parent and teacher 4-10 year olds Parent and teacher 11-17 year olds Self rating 11-17 year olds Download scoring instructions for the Australian version of the survey Parent and teacher scales Self rating scale Normative SDQ data from Australia Scoring the SDQ Other language versions of the SDQ Programs or interventions Families where a Parent has a Mental Illness (FaPMI) (formerly the VicChamps Project): this Service Development Strategy's strategic objective is to provide a family-focused response. Key readings General articles about the SDQ. The following papers have used the SDQ in relation to COPMI. Information from these papers is summarised in the section that follows. 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