

<b>Outcome Measure</b>	<b>Strengths &amp; Difficulties Questionnaire (SDQ); Peer Relations and Prosocial Behavior subscales</b>
<b>Sensitivity to Change</b>	Yes
<b>Population</b>	Paediatrics
<b>Domain</b>	Social Role Participation and Social Competence Psychological Status
<b>Type of Measure</b>	Parent-report, teacher-report, youth self-report
<b>ICF-Code/s</b>	d710-d729
<b>Description</b>	<p>The <b>Strengths and Difficulties Questionnaire (SDQ)</b> is a brief behavioural screening questionnaire about 3-16 year olds. It exists in several versions to meet the needs of researchers, clinicians and educationalists. Each version includes between one and three of the following components:</p> <p><b><u>A) 25 items on psychological attributes.</u></b></p> <p>All versions of the SDQ ask about 25 attributes, some positive and others negative. These 25 items are divided between 5 scales:</p> <ol style="list-style-type: none"> <li>1) emotional symptoms (5 items)</li> <li>2) conduct problems (5 items)</li> <li>3) hyperactivity/inattention (5 items)</li> <li>4) peer relationship problems (5 items)</li> <li>5) prosocial behaviour (5 items)</li> </ol> <p>1) to 4) added together to generate a total difficulties score (based on 20 items).</p> <p>The same 25 items are included in questionnaires for completion by the parents or teachers of 4-16 year olds.</p> <p>A slightly modified informant-rated version for the parents or nursery teachers of 3 (and 4) year olds. 22 items are identical, the item on reflectiveness is softened, and 2 items on antisocial behaviour are replaced by items on oppositionality.</p> <p>Questionnaires for self-completion by adolescents ask about the same 25 traits, though the wording is slightly different. This self-report version is suitable for young people aged around 11-16, depending on their level of understanding and literacy.</p>

**B) An impact supplement**

Several two-sided versions of the SDQ are available with the 25 items on strengths and difficulties on the front of the page and an impact supplement on the back. These extended versions of the SDQ ask whether the respondent thinks the young person has a problem, and if so, enquire further about chronicity, distress, social impairment, and burden to others. This provides useful additional information for clinicians and researchers with an interest in psychiatric caseness and the determinants of service use.

**C) Follow-up questions**

The follow-up versions of the SDQ include not only the 25 basic items and the impact question, but also two additional follow-up questions for use after an intervention. Has the intervention reduced problems? Has the intervention helped in other ways, e.g. making the problems more bearable? To increase the chance of detecting change, the follow-up versions of the SDQ ask about 'the last month', as opposed to 'the last six months or this school year', which is the reference period for the standard versions. Follow-up versions also omit the question about the chronicity of problems.

**Properties**

**OVERVIEW AND USES**

The SDQ (Goodman, 1997) is a brief behavioural screening questionnaire that asks about 25 attributes, some positive and others negative.

The 25 SDQ items are divided between five scales of five items each, generating scores for conduct problems, hyperactivity-inattention, emotional symptoms, **peer problems** and **prosocial behaviour**. All but the last one are summed to generate a total difficulties score. Ten of the items would generally be thought of as strengths, 14 of which would generally be thought of as difficulties, and one of which — " gets on better with adults than with other children" — is neutral.

An informant-rated version of the SDQ can be completed by either the parents or teachers of 4-16 year olds, while a self-report version of the SDQ can be completed by 11-16 year olds themselves. The extended version of the SDQ includes not just the 25 items on symptoms and positive attributes but also an impact supplement that asks whether the respondent thinks that the child or teenager has a problem, and if so, enquires further about overall distress, social impairment, burden and chronicity. For clinicians and researchers with an interest in psychiatric caseness and the determinants of service use, the impact supplement appears to provide useful additional information without taking up much more of respondents' time.

The SDQ is available in over 30 languages and is being widely used in epidemiological, developmental, and clinical research, as well as routine clinical and educational practice.

### **USES OF THE SDQ**

**Clinical assessment.** Many child and adolescent mental health clinics now use the SDQ as part of the initial assessment, getting parents, teachers and young people over the age of 11 to complete questionnaires prior to the first clinical assessment. The findings can then influence how the assessment is carried out and which professionals are involved in that assessment. For example, if a child has been referred with marked conduct problems, an assessment that focused too narrowly on these behaviours and related family issues might overlook associated hyperactivity. Advance knowledge that the child has been given high SDQ hyperactivity ratings by parents and teachers can help ensure that the assessment enquires in detail about hyperactivity; it may also be important to obtain a psychiatric or paediatric opinion early on in the assessment process with a view to establishing suitability for medication.

**Evaluating outcome.** "Before" and "after" SDQs can be used to audit everyday practice (e.g. in clinics or special schools) and to evaluate specific interventions (e.g. parenting groups). Studies using the SDQ along with research interviews and clinical ratings have shown that the SDQ is sensitive to treatment effects. Child and adolescent mental health services, and other specialist services for children with emotional and behavioural difficulties, can use an ['added value' score](#) based on the SDQ as one index of how much help they are providing to the young people they see.

**Epidemiology.** The SDQ's emphasis on strengths as well as difficulties makes it particularly acceptable to community samples. It has been widely used in large epidemiological studies. The SDQ is well adapted for studies of the general population since it is a dimensional measure across its full range, with each one-point increase corresponding to an increased rate of disorder. In addition, the same risk factors that predict change in total difficulty score across the entire range also predict it in children one standard deviation above and one standard deviation below the mean. In Britain, mean SDQ scores can be used to generate prevalence estimates in subpopulations defined by a wide range of characteristics (E.g. ethnicity, family type, socio-economic deprivation). Note, however, that these prevalence estimators cannot be used to generate valid prevalence estimators cross-nationally.

## ADMINISTRATION OPTIONS

### Formats available

self-administered (paper-and-pencil)

clinician-administered

Designed for self-administration but they can be administered verbally if literacy is too low.

### Time required

Administration time is approximately 10 minutes.

### Languages available

English

French

Other (Dutch, German, Swedish, Arabic, Urdu, Finnish, Portuguese, Italian, Spanish and Croatian – see [website](#) for details.)

### Accessibility and cost

no charge for use

### Where to access

[www.sdqinfo.com](http://www.sdqinfo.com)

### Summary of test development data

Quality of reporting: High, based on [STARD rating](#)

### Summary of validity and reliability data

High, based largely on the variety and strength of the reliability and validity data across so many languages and cultural contexts.

## SCORING THE SDQ

- 1) **The fast SDQ scoring site** for online scoring and report generation.
- 2) Instructions in English for scoring by hand **SDQs for 4-17 year olds**, as completed by parents, teachers or youths. Instructions in many other languages are also available, accessed through the page for that [language](#).
- 3) Instructions in English for scoring by hand **SDQs for 2-4 year olds**, as completed by parents or teachers.
- 4) **Black-and-white transparent overlays for hand scoring** the English versions of the SDQ. There is one overlay for each of the five subscales (emotional, conduct, hyperactivity, peer and prosocial). You can print the five pages onto paper and then photocopy onto transparency films. Or you can print directly onto transparency films if they are suitable for your printer. To calculate total score,

add the emotion, conduct, hyperactivity and peer scores - but don't include the prosocial score. Similar overlays are also available in many other languages, accessed through the page for that [language](#).

- 5) A **record sheet** in English for hand-scored questionnaires. Record sheets in many other languages are also available, accessed through the page for that [language](#).
- 6) **Computerised algorithm** for predicting disorders from multi-informant SDQ scores.
- 7) An "added value" score for specialist services

There is also a **computerised scoring and report-writing program** that runs using the Access component of Microsoft Office Professional. This is available without charge for non-profit organisations that do not make any charge to families.

## **PSYCHOMETRIC PROPERTIES**

### **Validity and Reliability**

- 1) Identify two thirds of psychiatric disorders in the community, sensitive to treatment effects, reliable;
- 2) Internal consistency (Mean Cronbach a: 0.73);
- 3) Test-retest reliability (after 4-6 months mean: 0.62);
- 4) Cross Informant reliability (mean 0.34) above meta-analytic mean of Achenbach SDQ correlates highly with Rutter scales (long-standing measure of parent informant of child symptomatology) (.78-.88-parent) (.87-.92 teacher);
- 5) The SDQ is able to discriminate between clinical and community sample with self-report;
- 6) It demonstrates reasonable cross informant correlations and good internal consistency;
- 7) In comparison to the Child Behaviour Checklist (CBCL), the CBCL was developed empirically from USA case files, while the SDQ was developed empirically based on nosology (DSM4 and ICD9). The SDQ is brief 25 vs 118 items of the CBCL. The SDQ correlates higher with clinical interview than the CBCL;
- 8) On hyperactivity/inattention, SDQ correlation of .43 compares to the CBCL of .15 with clinical interview, with some suggestion that CBCL overestimates hyperactivity. In a community sample, mothers preferred SDQ to CBCL (Goodman and Scott, 1999);

[Goodman R.](#)

A nationwide epidemiological sample of 10,438 British 5-15-year-olds obtained SDQs from 96% of parents, 70% of teachers, and 91% of 11-15-year-olds. Blind to the SDQ findings, all subjects were also assigned DSM-IV diagnoses based on a clinical review of detailed interview measures.

**RESULTS:** The predicted five-factor structure (emotional, conduct, hyperactivity-inattention, peer, prosocial) was confirmed. Internalising and externalising scales were relatively "uncontaminated" by one another. Reliability was generally satisfactory, whether judged by internal consistency (mean Cronbach  $\alpha$ : .73), cross-informant correlation (mean: 0.34), or retest stability after 4 to 6 months (mean: 0.62). SDQ scores above the 90th percentile predicted a substantially raised probability of independently diagnosed psychiatric disorders (mean odds ratio: 15.7 for parent scales, 15.2 for teacher scales, 6.2 for youth scales).

#### **REFERENCES**

Goodman, R. The Strengths and Difficulties Questionnaire: A Research Note . *Journal of Child Psychology and Psychiatry*. 1997, 38: 581-586.

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Proceedings 1st Australian Mental Health National Outcomes Training Forum. Melbourne June 23 -26 2002.

	<p>Proceedings 2nd Australian Mental Health National Outcomes Training Forum. Adelaide April 7 – 8 2003.</p> <p>More reference material is available on the Mental Health National Outcomes and Case-mix Collection website <a href="http://www.mhnocc.org">www.mhnocc.org</a></p>
<b>Advantages</b>	<ol style="list-style-type: none"> <li>1) The SDQ is being used as a research tool throughout the world - in developmental, genetic, social, clinical and educational studies;</li> <li>2) In community samples, multi-informant SDQs can predict the presence of a psychiatric disorder with good specificity and moderate sensitivity;</li> <li>3) Applicable: addresses dimensions suitable to consumers; useful to clinicians in formulating and conducting treatment; data can be aggregated in a meaningful way to address requirements of managers;</li> <li>4) Acceptable: Brief and consumer friendly; Functions as well as the Achenbach and Rutter Questionnaires;</li> <li>5) Practical: Minimal cost; scoring and interpretation simple: training minimal;</li> <li>6) covers an area of social functioning not often covered in other questionnaires, E.g. peer relations and prosocial behaviour subscales;</li> <li>7) can be downloaded (free);</li> <li>8) short;</li> <li>9) covers a range of age ranges;</li> <li>10) some Australian norms (7-17 years);</li> <li>11) available in many languages;</li> <li>12) multiple informants;</li> <li>13) used in research and clinically.</li> </ol>
<b>Disadvantages</b>	<ol style="list-style-type: none"> <li>1) No 16+ availability</li> <li>2) No categorical scores</li> </ol>
<b>Additional Information</b>	<ol style="list-style-type: none"> <li>1) The is a Core measure in the Psychiatric and Psychological Functioning Domain in McCauley et al (2012)</li> <li>2) The SDQ (Peer Relations and Prosocial Behaviour subscales) are Core measures in the Social Role Participation and Social Competence Domain in McCauley et al. (2012)</li> </ol>

	3) In low-risk or general population samples, SDQ may be better to use an alternative three-subscale division of the SDQ into 'internalising problems' (emotional+peer symptoms, 10 items), 'externalising problems' (conduct+hyperactivity symptoms, 10 items) and the prosocial scale (5 items)
<b>Reviewers</b>	Vicki Anderson Cathy Catroppa

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