
**Objective:** Twenty children with attention-deficit/hyperactivity disorder (ADHD) and low IQs, who participated in a drug study, were followed-up 4.5 years later, when their ages averaged 12.4 years (range: 8-20 years; SD=2.78). **Method:** Participants were assessed by their parents and teachers on the *Aberrant Behavior Checklist-Community* (ABC; Aman & Singh, 1994), on the *Child Symptom Inventory-4* (CSI-4; Gadow & Sprafkin, 1994), and on a structured interview. **Results:** A majority of children continued to screen positive for ADHD at follow-up, as well as display high rates of comorbid anxiety disorders, tics, and elimination disorders. Educational placement became slightly more restrictive over the follow-up interval. Multiple medication trials (30 in all, among 14 participants) were attempted between initial contact and follow-up. Ratings on the ABC by parents and teachers showed significantly lower scores at follow-up on the Hyperactivity subscale. Relatively few associations were found between initial ratings and follow-up ratings on standardized scales.


**Objective:** To assess the short-term effect and safety of citalopram in the reduction of impulsive aggression in children and adolescents. **Method:** Twelve subjects, aged 7 to 15 years, were attending a psychiatric outpatient clinic and had a profile of impulsive aggression. Semistructured interviews were conducted using the *Child and Adolescent Symptom Inventories-4* (CASI-4). Best estimate diagnoses were based, in part, on CASI-4 Symptom Count scores. Subjects were treated in an open label trial with citalopram for 6 weeks after a 1-week washout period. Dosage was regulated individually over a period of 4 weeks. The starting dose was 10 mg/day followed by 10 mg increments on a weekly basis (maximum < 40 mg/day). **Results:** Eleven subjects completed the study. Citalopram produced clinically and statistically significant reductions on target symptoms of impulsive aggression, independent of other behavioral problems, as measured by the Modified Overt Aggression Scale, the Child Behavior Checklist, and the Clinical Global Impressions at doses ranging from 20 to 40 mg/day (mean=27 mg). No major adverse reactions were associated with citalopram. **Conclusion:** Citalopram appears to be effective and well tolerated in this sample of children and adolescents with impulsive aggression.

**Objective:** Cognitive response repertoires to videotaped child noncompliance episodes were examined in mothers of aggressive (MAs) and nonaggressive 4-6-year-old boys. **Method:** Children were classified as aggressive based both on the opinion of a service-providing professional and maternal ratings of aggressive behavior (the Oppositional Defiant Disorder symptom category of the *Child Symptom Inventory-4* or the Aggressive Behavior subscale of the *Child Behavior Checklist*). Mothers provided open-ended solutions to three types of noncompliance under conditions of time pressure, or after they waited for 15 seconds to consider alternatives. Solutions were coded as assistance/facilitation, coercion, deference, or explanation/clarification. **Results:** Compared with controls (n=23), MAs (n=27) offered fewer explanation/clarification responses, more coercive responses, and fewer solutions during pressured responding. Two to 6 weeks later, mothers were videotaped while participating with their sons in a challenging block-building task. Maternal responses to the vignettes predicted conflict escalation during block building, even after rates of concurrent and past child noncompliance were partialled out. Implications for parent-training models are considered.


**Objective:** This study examines differences between children (ages 3 to 6 years) who have the symptoms of oppositional defiant disorder (ODD) with or without attention-deficit/hyperactivity disorder (ADHD), ADHD alone, and a non ODD/ADHD comparison group. **Method:** Parent (N=595) and teacher (N=538) ratings were obtained for children attending the same community early childhood programs and for youngsters evaluated in an outpatient clinic (N=224) using the *Early Childhood Inventory-4* (ECI-4), a DSM-IV-referenced rating scale. **Results:** ECI-4 ratings were minimally correlated with age (r<.14), SES (r<.20), or IQ (r<.14). Differences between symptom groups varied depending on how they were configured (teacher versus parent ratings) and setting (clinic versus community). In general, the ODD+ADHD group received the highest (and the comparison group the lowest) ratings of severity for the symptoms of other disorders, difficulties with peers, and developmental deficits. Moreover, the clinical impact of comorbidity was largely additive. Differences between youngsters with ODD versus ADHD symptoms were most apparent for teacher-defined groups in the community sample and parent-defined groups in the clinic sample. **Conclusion:** Collectively, these findings provide preliminary evidence for the notion that ODD and ADHD may constitute distinct clinical entities in preschool-aged children and suggest that informant may be an important consideration in the formulation of diagnostic criteria.


**Objective:** This study examined comorbid psychiatric symptoms in a large community-based sample of children and adolescents. The study sample was comprised of a total of 3,006 children in preschool (N=413; 3 to 5 years; 57% male), elementary school (N=1,520; 5 to 12 years; 52% male), and secondary school (N=1,073; 12 to 18 years; 53% male), all of whom were attending regular education programs. **Method:** Children were evaluated with teacher-completed, DSM-IV-referenced rating scales: *Early Childhood Inventory-4, Child Symptom Inventory-4,* or *Adolescent Symptom Inventory-4*. The sample was divided into four groups: attention-deficit/hyperactivity disorder with and without tics (ADHD×tics), tics without ADHD, and a comparison group (i.e., neither ADHD or tics). **Results:** The percentage of children with tic behaviors varied with age: preschoolers (22%), elementary school children (8%), and adolescents (3%). Tic behaviors were more common in males than females, regardless of comorbid ADHD symptoms, and more common in African-American than Caucasian
children. Rates were highest for ADHD:C (13%), least for ADHD:I (3%), and intermediate for ADHD:HI (9%). The rate for the comparison group was 0.6%. For many psychiatric symptoms, screening prevalence rates were highest for the ADHD groups (ADHD+tics>ADHD>tics>comparison). However, obsessive-compulsive and simple and social phobia symptoms were more common in the tic behavior groups. Ratings of tic behaviors dropped appreciably between 11 and 12 years of age and remained at very low levels during adolescence. Ratings of ADHD:HI symptoms decreased gradually through the entire age range, whereas ADHD:I symptoms showed a developmental course somewhat similar to tics. Conclusion: Findings for a community-based sample show many similarities with studies of clinically-referred samples suggesting that teacher-completed ratings of DSM-IV symptoms may be a useful methodology for investigating the phenomenology of tic disorders.

Objective: This study examined response to methylphenidate in children with attention-deficit/hyperactivity disorder (ADHD) and chronic multiple tic disorder. The primary goal was to determine if children with anxiety or depression symptoms showed a less favorable response to treatment. Method: Subjects were 38 prepubertal children who participated in an 8-week, double-blind, placebo-controlled, methylphenidate crossover evaluation. Treatment effects were assessed with direct observations of child behavior in public school and clinic settings; rating scales completed by parents, teachers, and clinicians; and laboratory analogue tasks. Results: There was little evidence (group data) that children with anxiety or depression symptoms (assessed with the Child Symptom Inventory-3R) responded in a clinically different manner to methylphenidate than youngsters who did not exhibit these symptoms, particularly in school observations of the core features of ADHD. Seeming differences between children with and without comorbid anxiety or depression symptoms and drug response are likely explained by differences in pretreatment levels of negativistic behaviors (i.e., symptoms of oppositional defiant disorder or conduct disorder). For example, of 54 partial correlations (controlling for negativistic behavior) between anxiety and drug response measures, 93% were less than -.10. (A negative correlation indicates a less favorable response to medication.) Conclusion: Methylphenidate appears to be effective for the management of ADHD behaviors in children with mild to moderate anxiety or depression symptoms; nevertheless, much research remains to be performed in this area.

This 179-page Manual is an update of the Childhood Symptom Inventory Screening Manual (Sprafkin & Gadow, 1998) and Childhood Symptom Inventory Norms Manual (Sprafkin & Gadow, 1997) and is divided into seven chapters: Introduction (Ch. 1), Diagnostic Criteria for Disorders (Ch. 2), Reliability and Validity of Parent Checklist (Ch. 3), Reliability and Validity of Teacher Checklist (Ch. 4), Norms for Parent Checklist (Ch. 5), Norms for Teacher Checklist (Ch. 6), and Clinical Applications (Ch. 7). Chapter 1 presents a brief overview of the rationale for the CSI-4, history of the SYMPTOM INVENTORIES, scoring procedures, and a brief synopsis of research on the CSI-3R. Chapter 2 provides a brief description of each disorder included in the CSI-4, DSM-IV diagnostic criteria and symptoms, and CSI-4 items. Chapter 3 (Parent Checklist) and Chapter 4 (Teacher Checklist) present the findings from studies of (a) internal consistency reliabilities (Cronbach's alpha) and test-retest reliability, (b) intercorrelations among categorical scores in normative and outpatient clinic samples, (c) predictive validity (comparisons with data-based clinical diagnoses) for an outpatient clinic sample, (d) correlation between Symptom Severity scores for Parent Checklist and Teacher Checklist in an outpatient clinic sample, (e) correlation between CSI-4 Symptom Severity ratings and Child Behavior Checklist / Teacher Report Form scores for clinic sample, (f) gender differences in clinic sample, and (g) discriminant validity of Symptom Severity scores comparing outpatient clinic and community
samples. Chapter 5 (Parent Checklist) and Chapter 6 (Teacher Checklist) present the findings of studies of (a) screening prevalence rates (i.e., percentage of children with Screening Cutoff scores for specific symptom categories) for children in the Parent Checklist \((N=551)\) and Teacher Checklist \((N=1,323)\) normative samples and for the Parent Checklist \((N=590)\) and Teacher Checklist \((N=548)\) clinic samples, (b) \(T\) scores and percentiles (Symptom Severity scores), and (c) clinical utility of Symptom Severity Cutoff scores. The last chapter reviews all the material in the Manual and provides guidelines for clinical applications of the CSI-4. Appendices list frequency of occurrence rates for each item of Parent Checklist and Teacher Checklist for boys and girls (separately) for normative and clinic samples (separately); and \(T\) scores and percentiles for Parent Checklist and Teacher Checklist for boys and girls (separately) in normative samples. Subject Index included.


Objective: To examine the reliability and validity of the Youth’s Inventory-4 (YI-4), a DSM-IV-referenced self report rating scale. Method: Youths \((N=239)\) between 11 and 18 years who were clinically evaluated between 1996 and 1999 completed the YI-4, and 79% completed at least one additional self report. Parents and teachers completed a companion measure. A second sample \((N=47)\) was retested 2 weeks after an initial evaluation. Results: Age was only minimally correlated \((r<.20)\) with YI-4 Symptom Severity scores, with the exception of the Substance Use \((r=.40)\). Similarly, neither IQ \((r<.20)\) nor SES \((r<.15)\) was associated with YI-4 scores. Gender differences were significant for only one symptom category, Eating Problems; females received higher scores than males. YI-4 symptom categories demonstrated satisfactory internal consistency (Cronbach’s alpha), especially considering that most have fewer than 10 items: ADHD:I (.81), ADHD:HI (.79), ADHD:C (.87), CD (.80), ODD (.86), GAD (.78), SAD (.66), Schizophrenia (.73), MDD (.82), Dysthymic Disorder (.80), Bipolar Disorder (.70), Eating Problems (.81), and Substance Use (.67). Test-retest reliabilities ranged from .54 to .92. YI-4 scales demonstrated convergent and to lesser extent divergent validity with three different dimensional self-report measures, the Youth Self Report (Achenbach, 1991), the Children’s Depression Inventory (CDI; Kovacs, 1992), and the Multidimensional Anxiety Scale for Children (MASC; March, 1997). The YI-4 MDD scale correlated .84 with the CDI Total Score, and the YI-4 GAD scale correlated .71 with the MASC Total Anxiety score. The YI-4 evidenced discriminant validity by differentiating children with and without diagnosed ADHD, conduct disorder, substance use, generalized anxiety disorder, or major depressive disorder. Youth-parent \((rs=.05\) to \(.50)\) and youth-teacher \((rs<.18)\) agreement was generally modest. Conclusion: These findings provide preliminary support for the clinical utility of the YI-4 for symptom assessment in referred youths.


Objective: This study explored how experiences in substitute care are related to behavioral disturbance among young adolescents in non-relative foster care. A model was defined in which placement movement, group placement, and inconsistent or decreasing parental visitation were expected to be correlated with weak informal social controls such as caregiver attachments and involvement in schools and churches. Through weakened attachments and community involvement, these experiences in care were expected to be associated with behavioral problems. Method: This correlational model was tested in a random sample of 199 urban foster children. Structured telephone interviews conducted at a single point in time with foster parents and caseworkers were the primary source of data. Behavioral disturbance was assessed with the Conduct Disorder category of the Child Symptom Inventory-4. Results: Some results were consistent with the study hypotheses, but the results varied for boys and girls. Fewer symptoms of conduct disorder were found among boys with stronger attachments to their foster families and girls with higher school achievement and investment.
Additionally, placement movement was indirectly associated with severity of conduct disorder for both boys and girls.


**Objective:** Special educators are increasingly called upon to communicate with community mental health professionals about problem behaviors in terms of DSM-IV psychiatric symptomatology. The teacher version of the *Child Symptom Inventory-4* (CSI-4T) is a screening instrument for DSM-IV emotional and behavioral disorders. **Method:** This study used the CSI-4T to investigate the presence of DSM-IV symptoms in four groups of 6- to 12-year old boys: students with E/BD who were referred for psychiatric consultation, students in special education, students referred to an outpatient clinic (42% receiving special education), and general education students. **Results:** The symptoms of ADHD and oppositional defiant disorder occurred most commonly across the groups. The general pattern of symptom severity was, in order of decreasing severity, E/BD consultation, outpatient clinic, special education, and general education. Overall, characteristics for all groups of boys appeared consistent with clinical expectations. Findings also provide preliminary support for the discriminant validity of the CSI-4T.


**Objective:** To determine whether risperidone is effective in reducing symptoms of disruptive behaviors associated with conduct disorder, oppositional defiant disorder, and disruptive behavior disorder—otherwise specified in children with subaverage IQs. **Method:** The trial consisted of a 1-week, single-blind, placebo run-in period and was followed by a 6-week, double-blind, placebo-controlled period. One hundred ten children (aged 5-12 years) with an IQ of 36-84 with disruptive disorder and a score of at least 24 on the Conduct Problem subscale of the *Nisonger Child Behavior Rating Form* (NCBRF) were enrolled. The *Child Symptom Inventory-4* was used to screen for psychiatric disorders and guide the clinical interview. Risperidone doses ranged from 0.02 to 0.06 mg/kg per day. **Results:** The risperidone-treated subjects showed a significant reduction in mean scores on the Conduct Problem subscale of the NCBRF. A subanalysis demonstrated that the effect of risperidone was unaffected by diagnosis, presence/absence of ADHD, psychostimulant use, IQ status, and somnolence. The most common side effects included somnolence, headache, appetite increase, and dyspepsia. Side effects related to extrapyramidal symptoms were reported in 7 (13%) and 3 (5%) of the subjects in the risperidone and placebo groups, respectively. **Conclusions:** Risperidone appears to be an adequately tolerated and effective treatment in children with subaverage IQs and severe disruptive behaviors such as aggression and destructive behavior.


**Objective:** Examined the reliability and validity of the parent version of the *Child Symptom Inventory-4* (CSI-4). **Method:** Parents rated the behavior of 247 boys between 6.0 and 10 years 11 months old referred for evaluation of behavioral and emotional problems with the CSI-4, a behavior rating scale whose items correspond to the symptoms of DSM-IV-defined disorders. **Results:** Findings indicated satisfactory internal consistency reliability: ADHD:I (.92), ADHD:HI (.91), ADHD:C (.91), ODD (.91), CD (.79), GAD (.75), Social Phobia (.77), SAD (.79), MDD (.69), Dysthymic Disorder (.61), Schizophrenia
(65), Autistic Disorder (.73), and Asperger’s Disorder (.67). The sample was divided into three groups based on the inter-test interval (1-month, 2-month and 4-month). With the exception of two categories (CD and Schizophrenia), test-retest reliability coefficients were at least .65, and all CSI-4 categories evidenced reasonable stability over 2- and 4-month intervals except for MDD. Parent ratings completed approximately 4 years after the initial assessment indicated considerable stability for disruptive behavior, social anxiety, and PDD symptoms; moderate stability for mood and general anxiety symptoms; and poor stability for symptoms of inattention and schizophrenia. CSI-4 ratings converged and diverged in a theoretically consistent pattern with respective scales of the Child Behavior Checklist (Achenbach, 1991a) and the Diagnostic Interview for Children and Adolescents-Revised-Parent Version (DICA-P; Reich, Shayka, & Taibleson, 1991). Discriminant validity was established in that boys with specific DICA-P diagnoses received significantly higher corresponding CSI-4 parent symptom ratings than boys not so diagnosed. Clinical utility (sensitivity, specificity, positive predictive power, negative predictive power) was evaluated for screening cutoffs based on categorical (DSM-IV) and dimensional (normative distribution of Symptom Severity scores) scoring methods. Across five symptom categories, sensitivity was highest using the moderate severity cutoff ($T$ score $\geq 60$). Correlations between parent CSI-4 Symptom Severity scores and child self-report ratings of anxiety and depression were very low.


**Objective:** To examine the validity of the Early Childhood Inventory-4 (ECI-4), a parent and teacher rating scale designed to screen for DSM-IV emotional and behavioral disorders. **Method:** The convergent, divergent, and discriminant validity and clinical utility of the ECI-4 was studied in a sample of 224 consecutive referrals (ages 3 to 6 years) to a child outpatient clinic. **Results:** Coefficient $\alpha$ for parent ratings were relatively high for ADHD:I (.91), ADHD:HI (.90), ODD (.93), CD (.87), Autistic Disorder (.90), and SAD (.83), but lower for depressive disorders (.59 to .68). Teacher ratings were similar: >.84 for the disruptive behavior disorders and Autistic Disorder, and .42 to .54 for depressive disorders. The ECI-4 demonstrated adequate criterion validity for the most common disorders (attention-deficit/hyperactivity disorder, oppositional defiant disorder, pervasive developmental disorder) when compared with data-based psychiatric diagnoses and correlated well with relevant scales of the Child Behavior Checklist, Teacher’s Report Form, and the IOWA Conners. For example, ECI-4 ODD symptom category was highly correlated with the IOWA Aggression (AG) scale ($r = .84$), but not the IOWA Inattention-Overactivity (IO) scale the ($r = .27$). Conversely, the ECI-4 ADHD:Inattention category correlated .75 and .16 with the IO and AG scales, respectively. Pearson correlations between parent and teacher ratings (Symptom Severity scores) indicated moderate agreement for the ADHD and PDD symptom categories: ADHD:I ($r = .40$), ADHD:HI ($r = .42$), ADHD:C ($r = .40$), and PDD ($r = .59$). For the remaining symptom categories, the degree of agreement was low: ODD ($r = .27$), CD ($r = .27$), MDD ($r = .16$), and Dysthymic Disorder ($r = .21$). **Conclusion:** The ECI-4 appears to be a useful screening measure for certain disorders in clinically referred children, but continued research is needed to determine its value in other settings (e.g., school and community), and its validity with other measurement methodologies.


**Objective:** To examine differences between source-specific manic symptoms. **Method:** In total, 104 consecutive adolescent outpatient referrals were evaluated for their psychiatric status using parent and teacher versions of the Adolescent Symptom Inventory-4 and the Youth’s Inventory-4, DSM-IV-referenced rating scales. **Results:** Approximately one third of the youths met symptom criteria for
mania by at least one informant; however, only 38% of these met criteria by at least two informants. Youths who had manic symptoms according to two informants were significantly more symptomatic both on mental status exam and in other dimensions of psychopathology than youths who did not have corroborated manic symptoms. Cross-informant agreement was generally poor when symptoms were scored dimensionally. **Conclusion:** Manic symptoms are relatively nonspecific in outpatient samples. Using more than one informant increases the likelihood of selecting subjects with serious and possibly manic disorders.

**YEAR: 2001**


**Objective:** T.P. Beauchaine (2001) recently proposed a model of autonomic nervous system functioning that predicts divergent patterns of psychophysiological responding across disorders of disinhibition. This model was tested by comparing groups of male adolescents with attention-deficit/hyperactivity disorder (ADHD) and ADHD plus conduct disorder (ADHD+CD) with controls.

**Method:** Groups were configured on the basis of Screening Cutoff scores for the parent-completed *Adolescent Symptom Inventory-4* and *T* scores for the *Child Behavior Checklist*. Participants performed a repetitive motor task in which rewards were administered and removed across trials. Participants then watched a videotaped peer conflict. Electrodermal responding (EDR), cardiac preejection period (PEP), and respiratory sinus arrhythmia (RSA) were monitored. **Results:** Compared with controls, the ADHD and ADHD+CD participants exhibited reduced EDR. The CD+ADHD group was differentiated from the ADHD and control groups on PEP and from control group on RSA. Findings are discussed in terms of motivational and regulational systems indexed. Implications for understanding rates of comorbidity between CD and ADHD are considered.


**Objective:** Relatively little is known about the prevalence of psychiatric symptoms or the validity of DSM-IV diagnostic criteria for emotional and behavioral disorders in young children (< 7 years). This study describes and compares ratings of psychiatric symptoms in community and clinic samples (ages 3 to 6 years) using the *Early Childhood Inventory-4* (*ECI-4*), a DSM-IV-referenced rating scale.

**Method:** Parent (/and teacher) ratings were obtained for community (N=531/398) and special education (N=64/140) samples (1995 to 1997) and an outpatient clinic (N=224/189) sample (1994 to 1996). **Results:** Cronbach’s alpha for parent/teacher ratings indicated satisfactory internal consistency for the ADHD:I (.87/.95), ADHD:HI (.87/.94), oppositional defiant disorder (ODD; .87/.95), conduct disorder (CD; .78/.93), generalized anxiety disorder (GAD; .63/.74), separation anxiety disorder (SAD; .81), major depressive disorder (MDD; .77/.75), Dysthymia (.72/.66), and Autistic Disorder (.83/.89) symptom categories and ECI-4 Developmental Deficits index (.75/.95). Age and socioeconomic status were only minimally (<.20) correlated with ratings of psychopathology and developmental deficits. Psychotropic drug prescribing for the community sample was uncommon, at least when compared with other age groups. The most commonly endorsed symptom categories were ADHD, ODD, anxiety disorder, CD (teacher), and pervasive developmental disorder (clinic). Groups were easily differentiated in terms of the rate and severity of symptoms (clinic>special education>community). Males generally received higher scores than females (especially teacher ratings), but the magnitude of these differences for the community sample was small, with the exception of teacher ratings of ADHD behaviors. Children with ADHD symptoms had higher ratings of impairment (developmental deficits)
than the nonADHD group. Teacher ratings completed 8 months apart (different school years) indicate considerable stability for disruptive behavior, but not attention, mood or anxiety symptoms in children receiving intensive special education services: ADHD:I ($r=.26$), ADHD:HI ($r=.61$), ADHD:C ($r=.46$), ODD ($r=.56$), CD ($r=.41$), Peer Conflict Scale ($r=.47$), Social Phobia ($r=.59$), GAD ($r=.22$), MDD ($r=.17$), Dysthymic Disorder ($r=.13$), Autistic Disorder ($r=.35$), and Asperger's Disorder ($r=.17$). **Conclusion:** Although these findings share a number of similarities with studies of older children, there are also differences which attest to the uniqueness of this age group.


**Objective:** Whereas parents and clinicians have described oppositional features as interfering with the management of children with anxiety, research on this relation is lacking. This study was designed to investigate the presence of oppositional defiant disorder (ODD) symptoms in children presenting with mood and anxiety symptoms. **Method:** In a mood and anxiety disorders clinic, the DSM-IV-referenced Child Symptom Inventory-4 (CSI-4) was used to document the presence and correlates of oppositional defiant symptoms in 145 preadolescents assessed during a 2-year period. **Results:** Clinicians did not commonly diagnose ODD despite the presence of symptoms. Teacher Screening Cutoff scores showed greater convergence with clinic diagnoses of ODD than parent scores. ODD Symptom Severity scores correlated with generalized anxiety symptom scores for both parent ($r=.36$) and teacher ($r=.39$) CSI-4 ratings. Correlations remained significant after controlling for the severity of ADHD symptoms: parent ($r=.23$) and teacher ($r=.23$) CSI-4 ratings. Parents rated children more severely ODD than teachers, and there was little overlap between parent- and teacher-defined ODD groups. Parents found both boys and girls to be equally oppositional, whereas teachers rated boys to be significantly more oppositional than girls. **Conclusion:** Oppositional features are found in clinically referred children with anxiety and are potentially significant for treatment and prognosis of anxiety disorders in children.


**Objective:** The use of DSM-IV based questionnaires in child psychopathology is on the increase. **Method:** The internal construct validity of a DSM-IV based model of ADHD, conduct disorder (CD), oppositional defiant disorder (ODD), generalized anxiety disorder (GAD), and depression was investigated in 11 samples from three countries by confirmatory factor analysis. The total parent and teacher samples were 6,152 and 6,740, respectively. Three scales were studied: the Ontario Health Study Scales-Revised (Canada), the Child Symptom Inventory-4 (CSI-4; United States), and a Dutch DSM-IV questionnaire (the Netherlands) based largely on Child Behavior Checklist and Teacher Report Form items. **Results:** The hypothesized DSM-IV model was corroborated by a consistent increase in model fit with the specification of additional factors in all samples. The covariance structure in the US samples (CSI-4) was most consistent with the DSM-IV model compared with the Canadian and Dutch samples. This conclusion was based on the relatively greater improvement in model fit for the US samples over and above that of the internalizing and externalizing problem domains. The finding indicates that the evidence for ADHD as being separate from internalizing and externalizing problems, and for problems with attention, hyperactivity-impulsivity, conduct, oppositional and defiant behavior, generalized anxiety, and depression, as being separate from one another was the most pronounced for the CSI-4 in the US samples. Further research is required, however, because the DSM-IV model did not meet absolute standards of adequate model fit. Two sources of error are discussed in detail: multidimensionality of syndrome scales, and the presence of many symptoms that are diagnostically ambiguous with regard to the target syndrome dimension. It is argued that measurement precision may be increased by more careful operationalism of the symptoms in the questionnaire. Additional
approaches towards improved conceptualization of DSM-IV are briefly discussed. **Conclusion:** A sharper DSM-IV model may improve the accuracy of inferences based on scale scores and provide more precise research findings with regard to relations with variables external to the taxonomy.


This book chapter provides guidelines on how to approach the evaluation of psychopathology in patients with epilepsy. The authors provide the nonpsychiatrist with a model that can be used to carry out such evaluations in the office. They also discuss the role of psychiatric rating scales in the overall assessment of the patients. Among the instruments used frequently by the authors and have been found to be of clinical value on a regular basis are the *Adult Self-Report Inventory-4* and the *Child Symptom Inventory-4*.


**Objective:** This study examines the prevalence of DSM-IV symptoms of attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), and conduct disorder (CD) and age, gender, and comorbidity differences in ADHD subtypes. **Method:** Teachers completed either the *Early Childhood Inventory-4* (preschoolers), *Child Symptom Inventory-4* (elementary school), or the *Adolescent Symptom Inventory-4* (secondary school). The study sample was comprised of 3,006 children in preschool (3 to 5 years; n=413), elementary school (5 to 12 years; n=1,520), and secondary school (12 to 18 years; n=1,073), all of whom were attending regular education programs. The rate of medication use for ADHD or another emotional or behavioral disorder was lowest for preschoolers (1 child), highest for elementary schools (4.4%), and intermediate for secondary schools (2.2%). **Results:** The screening prevalence rate of ADHD behaviors was 18.2% (preschool), 15.9% (elementary), and 14.8% (middle, junior, or high school); rates for individual subtypes (all ages) were 9.9% for inattentive (I), 2.4% for hyperactive-impulsive (HI), and 3.6% for combined (C). The I type was relatively uncommon in preschoolers (3.9%), whereas the HI type was least common in teenagers (0.8%). Male:female ratios for ADHD types ranged from 1:1 to 5:1 depending on type and age. Screening prevalence rates were higher for African-American (39.5%) than Caucasian (14.2%) students, but did not vary significantly (p<.05) as a function of geographic region or socioeconomic status. ADHD subtypes were rated as more impaired than the nonADHD group on most measures and were easily differentiated on the basis of comorbid symptoms, social skill impairment, and special education services. In general, youngsters with C type symptoms had higher Symptom Severity scores than the I and HI types, and the I type was the least impaired. The screening prevalence rate of ODD behaviors was 11.1% (preschool), 4.5% (elementary), and 3.8% (middle, junior, or high school). The screening prevalence rate of CD behaviors was 9.2% (preschool), 2.5% (elementary), and 3.0% (middle, junior, or high school). **Conclusions:** The findings of this and similar studies show relatively high convergence for the prevalence of ADHD behaviors and differences between ADHD subtypes. Moreover, the behavior rating scale format appears to be a simple and cost-effective way to obtain information about psychiatric symptoms from school personnel.


**Objective:** This study examined family antisocial characteristics according to whether biological fathers live at home and agree to be study participants. **Method:** Antisocial symptoms were tabulated for 161
clinic-referred children and their parents. Antisocial personality disorder symptoms in the parent was assessed with the 
Structured Clinical Interview for DSM-IV. Child conduct disorder (CD) was assessed with the parent version of the 
Diagnostic Interview Schedule for Children and CD and oppositional defiant disorder symptoms were assessed with the parent and teacher versions of the 
Child Symptom Inventory-4. **Results:** Cronbach’s alpha for the CD symptom category of the CSI-4 was .85 and .82 for teacher and parent versions, respectively. Families with fathers at home had fewer paternal, maternal, and child antisocial symptoms, and scored higher on multiple SES indicators, than did families with departed fathers. Antisocial characteristics were highest, and SES was lowest, when fathers could not be located or recruited. Results suggest that requiring father participation (as in family-trio genetic designs) screens out the more antisocial families. Of clinical interest, antisocial behavior in any family member is more likely if the father is absent and nonparticipating. The heightened antisocial behavior in children associated with absent biological fathers was not mitigated by presence of stepfathers and was not accounted for by lower SES. The ethical use of mother report on absent fathers is discussed.


**Objective:** An influential model for explaining the development of conduct disorder (CD) in boys proposed that there are two distinct trajectories through which boys develop CD that differ on the timing of onset, correlates, and outcome. In this study, the applicability of this two trajectory approach to the development of CD in girls was tested. **Method:** Participants were adolescents (mean=15.23±1.32 years of age) who were adjudicated for serious patterns of illegal behavior in secure detention facility, nearly all of whom (94%) met criteria for a diagnosis of CD. Youths completed the Youth's Inventory-4, a DSM-IV-referenced self-report rating scale. **Results:** Based on a combination of the YI-4 ratings and file interview, boys in the sample were fairly evenly split between a childhood-onset to their CD symptoms and an adolescent-onset to their symptoms. In contrast, girls more uniformly exhibited an adolescent-onset to their severe antisocial behavior. Despite this later age of onset, the antisocial girls tended to resemble the childhood-onset boys on personality traits such as showing problems of impulse control and showing combination of both callous and unemotional interpersonal style and poor impulse control. **Conclusion:** These findings suggest modifications of, or alternatives to the two-trajectory model may be needed to explain the development of CD in girls.


**Objective:** This study examined the clinical utility of the ADHD Symptom Checklist-4 (ADHD-SC4), a screening measure for attention-deficit/hyperactivity disorder (ADHD). The objectives were to assess the scale’s concurrent, differential, and predictive validity. The ADHD-SC4 contains the ADHD symptom category (18 items), the oppositional defiant disorder (ODD) symptom category (8 items), Peer Conflict Scale (10 items), and the Stimulant Side Effects Checklist (SSEC; 14 items). **Method:** Participants were 103 children between 5 and 17 years old referred to a child psychiatry outpatient service and who were diagnosed as having a variety of emotional and behavioral disorders. Children were assessed with a battery of standardized assessment instruments and clinical interviews. Clinical diagnoses were verified with an operationalized diagnostic criteria procedure. Parents and teachers completed several rating scales for each child including the ADHD-SC4, the Child Behavior Checklist (CBCL), Teacher Report Form (TRF), and the IOWA Conners Teacher's Rating Scale. **Results:** Findings support the internal consistency and validity of the ADHD-SC4 as a screening instrument for ADHD, ODD, and aggressive behavior. Coefficient alphas (internal consistency reliabilities) were adequate to high for most scales. To determine the accuracy of the ADHD-SC4 as a screening instrument, Screening Cutoff scores were compared with the data-based psychiatric diagnoses.
Sensitivity for ADHD was relatively high, especially when information from both parent and teacher ratings was used to determine the presence of symptoms (sensitivity=.91, specificity=.36). For screening instruments such as the ADHD-SC4 where it is very important to minimize false negatives, and the risks associated with more detailed followup evaluations of false positives are minimal, sensitivity is the more important consideration than specificity. Eighty-five percent of children with diagnosed ADHD received high (T70) ADHD-SC4 Symptom Severity scores. As expected, correlations between parent and teacher ADHD-SC4 ratings were low to moderate (.23 to .51). ADHD-SC4 ADHD:I ratings were moderately to highly correlated with CBCL/TRF Attention Problems scores, whereas ADHD:HI ratings highly correlated with Aggressive Behavior scores. Conversely, ADHD:I ratings scores correlated only a modest degree with the CBCL/TRF Delinquent Behavior and Aggressive Behavior scores. Predictably, scores for the ODD category were highly correlated with corresponding CBCL/TRF scale scores (Aggressive Behavior, Delinquent Behavior), but minimally with Attention Problems. Peer Conflict Scale ratings correlated most highly with the CBCL/TRF Delinquent Behavior and Aggressive Behavior scores. SSEC scores correlated most highly with the CBCL/TRF Anxious/Depressed scale (Mood index), Withdrawn scale (Attention-Arousal index), and Somatic Complaints scores (Physical Complaints index). Children with a clinical diagnosis of a mood or anxiety disorder (n=35), compared with those who did not (n=68), received significantly higher Mood index scores for both parent and teacher ratings. **Conclusions:** The ADHD-SC4 appears to be a clinically useful screening instrument for ADHD.

Objective: Clinical applications to psychopathy encompass downward extensions to adolescent populations. In alliance with clinical practice, several prominent researchers have formulated prediction models for adolescent psychopath that include various forms of behavioral dysregulation, including impulsivity, attention-deficit/hyperactivity disorder (ADHD), and sensation seeking. The goal of the current study was to explore these clinical constructs as predictors of psychopathy in adolescents whose cases were adjudicated. **Method:** As a cross-sectional study, the current investigation systematically examined behavioral dysregulation in 79 male adolescents who, as a result of adjudication, were placed in a maximum-security facility. Youths completed several measures including the Youth's Inventory-4 to assess ADHD, ODD, and conduct disorder symptoms. **Results:** Adolescents with high versus low levels of psychopathy were found to have higher levels of impulsivity, CD symptoms, and ODD symptoms. Impulsivity appeared to be the best predictor of both psychopathy and conduct problems. In addition, conduct-disordered symptoms were predicted mostly by impulsivity, with minor contributions from sensation seeking and ADHD symptoms.

This book chapter describes narrow-band rating scales completed by children and the adults who have contact with them. The psychometric properties of the ADHD Symptom Checklist-4 (ADHD-SC4) and other brief ADHD rating scales are reviewed.

**YEAR: 2000**

Assessment of autistic disorder (autism) symptoms, primary and secondary, poses more challenging problems than ordinarily found in multisite randomized clinical trial (RCT) assessments. For example, subjects may be uncommunicative and extremely heterogeneous in problem presentation, and current pharmacological treatments are not likely to alter most core features of autism. The Autism Research Units on Pediatric Psychopharmacology (RUPP Autism Network) resolved some of these problems during the design of a risperidone RCT in children/adolescents. The communication problems, compromising use of the patient as an informant, were addressed by several strategies, including careful questioning of care providers, rating scales, laboratory tests, and physical exams. This article describes the RUPP risperidone RCT assessment battery, which includes the Child & Adolescent Autism Symptom Inventory, which is comprised of the symptom categories from the Child Symptom Inventory-4 and the Adolescent Symptom Inventory-4, for use as a screening measure. Also discussed are many other measurement issues addressed by this RCT.


Objective: The objective of this study was to measure the sensitivity and specificity of the RAFFT, a screening instrument for problematic adolescent substance use. Method: Two hundred and twenty-six adolescent patients, aged 13 to 18, who were referred to an emergency room or an ambulatory evaluation clinic were included. Patients answered the five questions of the RAFFT before a comprehensive psychiatric assessment was completed. Diagnoses were made according to DSM-IV, and based in part on the parent-completed Adolescent Symptom Inventory-4. Results: The best results were obtained with two positive answers on the RAFFT: a sensitivity of 89% and a specificity of 69% in the screening for substance abuse or dependence. Conclusion: The RAFFT performed well in this highly selected patient population.


The primary objective of the present study was to assess the utility of (1) comorbid depression and (2) parasympathetic influence on cardiac function as markers for treatment response among aggressive preadolescent males. Inpatient records of 53 patients with conduct disorder and attention deficit hyperactivity disorder (17 with a comorbid depressive disorder) were examined, including intake electrocardiogram and daily tallies of several indices of aggressive behavior across 3 weeks of stay. Consensus diagnoses were based, in part, on the Child Symptom Inventory-3R. With regard to the frequency and duration of aggression, nondepressed patients with high vagal tone deteriorated, and depressed patients with high vagal tone improved during hospitalization. No such relation was found for ADHD symptoms. Patients in the comorbid group also exhibited greater heart rate variability than their nondepressed counterparts. Furthermore, residualized heart rate was predictive of maternal substance use and paternal incarcerations. These findings suggest complex relations among treatment response, comorbid depression, and emotional regulation in male preadolescents with severe behavior disorders.


Objective: Children with epilepsy have an increased risk of behavioral problems, but few studies have utilized both categorical and dimensional measures of psychopathology. Method: Evaluated 150
children, 9 to 14 years of age, who had epilepsy that had been treated for at least 6 months. The mother or primary caretaker completed the Child Behavior Checklist (CBCL), and either the Child Symptom Inventory-4 (CSI-4) or the Adolescent Symptom Inventory-4 (ASI-4). Correlation coefficients between CBCL scores and CSI-4/ASI-4 scores were performed. **Results:** On the CBCL, elevated scores were found for Total, Internalizing, Attention, Social, and Somatic Problems. On the CSI-4 or ASI-4, we found the following screening prevalence rates (possible diagnoses): ADHD, inattentive (34%), ODD (21%), conduct disorder (18%), phobia (35%), PTSD (36%), tics (22%), and panic disorder (37%). Significant correlations were found between CBCL and CSI-4/ASI-4 scores. **Conclusion:** Children with epilepsy have more behavioral difficulties measured either dimensionally by CBCL or categorically by CSI-4/ASI-4. Current validity for the CSI-4/ASI-4 in a chronic illness sample was demonstrated.


**Objective:** This article describes the results of a pilot study that evaluated the effectiveness of the Early Intervention Foster Care (EIFC) program in the period immediately following a child's placement in a new foster home. **Method:** Data were collected from an EIFC group, a regular foster care group, and a community comparison group—each with 10 participants—via questionnaires for children and their caretakers and cortisol sampling. The Total Symptom Score of the parent-competed Early Childhood Inventory-4 (ECI-4) was used to assess child behavior problems. **Results:** EIFC foster parents adopted and maintained positive parenting strategies; EIFC children's behavior as assessed with the ECI-4 improved; and changes occurred in several salivary cortisol measures. Moreover, regular foster care children exhibited decrements in functioning in several areas over the same time period. **Conclusions:** Results are discussed with regard to how such research fits into a larger program of prevention research for high-risk preschool children.


This study examined the structure of psychopathic traits in two samples of children. The nonreferred community sample included 1,136 children recruited from elementary schools in two school districts in the southeastern United States. The clinic sample included 160 children referred to an outpatient mental health clinic serving the same geographic region. In both samples, parent and teacher ratings of psychopathic traits were subjected to a principal-axis factor analysis, and the congruence of the factor structure across samples was examined using confirmatory factor analysis. In both samples, one dimension that consisted of the callous and unemotional traits that have been hallmarks of most clinical descriptions of psychopathology was isolated. Two other dimensions consisting of narcissistic traits and impulsivity emerged in the community sample. Both the narcissism and impulsivity dimensions were highly related to symptoms of oppositional defiant disorder, conduct disorder, and attention deficit hyperactivity disorder as assessed with the Child Symptom Inventory-4. However, the callous and unemotional traits were only weakly associated with these symptoms after controlling for the other dimensions of psychopathy.


Briefly describes the historical development of the Symptom Inventories and their psychometric
properties. The primary focus of the article is the use of the Symptom Inventories, particularly the ADHD Symptom Checklist-4, to evaluate response to medication and to assess comorbidities that may be associated with enhanced or attenuated response to treatment.


**Objective:** This study examined prevalence rates of attention-deficit/hyperactivity disorder (ADHD) behaviors and differences between subtypes in 10-to-12 year old Ukrainian children using a parent-completed, DSM-IV-referenced rating scale. **Method:** Six hundred parents and children residing in Kyiv, Ukraine, and their teachers participated in extensive clinical assessments during 1997 using standard Western measures, including the parent version of the Child Symptom Inventory-4 (CSI-4), Child Behavior Checklist (CBCL), and IOWA Conners Teacher’s Rating Scale. A US normative sample for the CSI-4, which consisted of 443 children (228 boys and 215 girls) between the ages of 9.0 years and 12.9 years was used for symptom prevalence analyses. A second US sample was comprised of 101 (70 boys, 31 girls) children between 6 and 12 years old referred to a child psychiatry outpatient service for whom parents had completed the CSI-4 and CBCL. Their data were used for symptom convergence analyses. **Results:** The screening prevalence rate of ADHD behaviors was 19.8%: 7.2% for inattentive (I), 8.5% for hyperactive-impulsive (HI), and 4.2% for combined (C). Post hoc comparisons indicated a number of significant (p<.05) group differences. Mothers of children with ADHD symptoms reported higher rates of disruptive behavior, negative mother-child interactions, and physical punishment than the nonADHD group. Teachers rated ADHD children as more hyperactive and inattentive, but only the HI subtype was rated more oppositional than nonADHD students. The I subtype was less academically proficient and socially adept (but less likely to have behavior problems). The C subtype was the most behaviorally disruptive (mother ratings), and their fathers were more likely to be aggressive and abuse alcohol. The HI subtype also had problems with disruptive behavior, but were less socially impaired. CSI-4 Symptom Severity scores for all three ADHD symptom categories correlated most highly with the CBCL Attention Problems, Social Problems, and Aggressive Behavior scales, with the exception of ADHD:HI and Social Problems scores. ADHD:HI and ADHD:C symptoms scores correlated most highly with the CBCL Aggression Problems scale. For the most part, the pattern of correlations was similar for the two countries, but the magnitude of significant relations was higher for the clinic-referred US sample. **Conclusions:** Although symptom prevalence rates are higher in Ukraine than the United States, this study provides additional evidence supporting DSM-IV ADHD subtypes as distinct clinical entities. Observed differences between ADHD subtypes support the importance of differential diagnosis and underscore the need to document (a) target behaviors (symptoms); (b) performance deficits in behavioral, emotional, academic, and social functioning; and (c) the impact of symptoms on caregiver behavior when formulating treatment plans.


This 117-page Manual is an update of the Early Childhood Inventories Manual (Sprafkin & Gadow, 1996) and is divided into four chapters: Introduction (Ch. 1), Diagnostic Criteria for Disorders (Ch. 2), Reliability and Validity (Ch. 3), and Clinical Applications (Ch. 4). Chapter 1 presents a brief overview of the rationale for the ECI-4, history of the SYMPTOM INVENTORIES, and scoring procedures. The Manual focuses primarily (but not exclusively) on the Symptom Count scoring procedure where Never=0, Sometimes=0, Often=1, and Very often=1. Chapters 2 provides a brief description of each disorder included in the ECI-4, DSM-IV diagnostic criteria and symptoms, and ECI-4 items. Chapter 3 presents the findings from several studies of the ECI-4: (a) test-retest reliability (3-month interval) of Parent Checklist (N=32) in a community-based sample; (b) screening prevalence rates (i.e., percentage
of boys with Screening Cutoff scores for specific symptom categories) for Parent Checklist in community \((N=271)\) and clinic \((N=75)\) samples; (c) predictive validity (comparisons with data-based clinical diagnoses) of Parent Checklist \((N=105)\) and Teacher Checklist \((N=36)\) for an outpatient clinic sample; (d) gender differences in Symptom Severity scores of Parent Checklist for clinic (boys, \(n=75\); girls, \(n=30\)) and community (boys, \(n=271\); girls, \(n=260\)) samples; and (e) comparison of (discriminant validity) Symptom Severity scores for Parent Checklist in a normative (boys, \(n=271\); girls, \(n=260\)) and clinic (boys, \(n=75\); girls, \(n=30\)) sample. Chapter 4 reviews all the material in the Manual and provides guidelines for clinical applications of the ECI-4. Appendix A lists frequency of occurrence rates for each item of Parent Checklist for children referred to outpatient clinic \((N=105)\). Additional information pertaining to the psychometric properties of the ECI-4 appears in the Early Childhood Inventory-4 Norms Manual (Gadow & Sprafkin, 1997).


Describes the findings of a study that examined the internal validity of the Child Behavior Checklist (CBCL) and the Teacher’s Report Form (TRF) and the internal validity of parent- and teacher-completed DSM-referenced behavior rating scales. The total CBCL and TRF sample was 13,226 and 8,893, respectively, which were collected in seven different countries. The construct representation of the cross-informant model of the CBCL and the TRF was evaluated using confirmatory factor analysis. The adequacy of fit for the cross-informant model was established on the basis of three approaches: conventional rules of fit, simulation and comparison with other models. The central question is: Is there sufficient evidence for the factorial validity of the empirically defined taxonomy of the CBCL and TRF to justify its use and interpretation? The results indicated that the cross-informant model fit these data poorly. These results were consistent across countries, informants, and both clinical and population samples. Since inadequate empirical support for the cross-informant syndromes and their differentiation was found, the construct validity of CBCL/TRF syndrome dimensions is questioned. The internal construct validity of a DSM-IV based model of ADHD, conduct disorder, oppositional defiant disorder, generalized anxiety disorder and depression was investigated in 11 samples from three countries by confirmatory factor analysis. The total parent and teacher samples were 6,152 and 6,740, respectively. Three scales were studied: the Ontario Health Study Scales-Revised (Canada), the Child Symptom Inventory-4 (United States), and a Dutch DSM-IV questionnaire (the Netherlands) based largely on CBCL and TRF items. The factorial structure of these syndromes was supported by the data. However, the model did not meet absolute standards of good fit. It is argued that measurement precision may be increased by more careful operationalism of the symptoms in the questionnaire. Sharper DSM-IV models may improve the accuracy of inferences based on scale scores and provide more precise research findings with regard to relations with variables external to the taxonomy. It was concluded that the DSM-IV syndromes show more consistency with the covariance structure of the data than the CBCL syndromes and this is attributed in the present thesis to the different methods used for the derivation of the CBCL and the DSM taxonomies.


The objective of this review is to provide clinicians with current information to assist in their consultations to schools on four major topics that are unique to the school environment and of serious concern to educators: absenteeism, disciplinary referrals, retention (nonpromotion), and dropping out. Computer literature searches and the major journals of the various school disciplines were used to identify empirically based articles with sound methodology. With regard to the Child Symptom Inventory-4 (CSI-4), the author states that "a behavioral screen could survey an identified student’s teacher(s) to pinpoint serious signs of classroom dysfunction, which then optimally could be followed by a more general screen for psychopathology such as the Teacher’s Report Form for dimensional
Children with attention-deficit hyperactivity disorder (ADHD) do not typically outgrow this condition in adolescence, which is a challenging period of development. Management of ADHD in adolescence requires specific accommodations. These include providing adolescents with as much control over treatment as possible, so that they perceive treatment to be widening their autonomy rather than limiting it. Wherever possible, medication needs to be long-acting to facilitate compliance and to minimize problems with rebound misbehavior and moodiness. Comorbid psychiatric symptoms and syndromes need to be evaluated carefully both pre- and posttreatment. Ongoing psychoeducation and support can help restructure the demands that an adolescent with ADHD faces at home and at school so that they are more manageable. With active treatment it may be possible to prevent serious morbidity associated with ADHD during this period and to lay a foundation for adulthood. "Psychiatric side effects [of medication] are also more important in adolescence because other psychiatric comorbidities often first present during this period of development....This makes differential diagnosis more difficult, and it also means that assessment for a wide range of psychiatric symptoms pre- and posttreatment is needed....Two useful scales specifically designed for use with adolescents are now available, the Brown Attention-Deficit Disorder Scales and the Adolescent Symptom Inventory-4. Both of these rating scales are sensitive to, change and therefore can be used to assess change in symptoms with treatment" (p. 722).
require data for additional children (662 males and 661 females), this sample remains unchanged and is described in the *Child Symptom Inventory-4 Norms Manual* (Gadow & Sprafkin, 1997).


This 170-page *Manual* is divided into four chapters: Introduction (Ch. 1), Validity and Clinical Utility (Ch. 2), Symptom Prevalence Rates and Norms (Ch. 3), and Clinical Applications (Ch. 4). Chapter 1 presents a brief overview of the YI-4 and scoring procedures. Chapter 2 presents the (a) intercorrelations between categorical scores in an outpatient clinic sample (N=134) and a norm sample (N=573); (b) predictive validity (comparisons with data-based clinical diagnoses) of Screening Cutoff scores for an outpatient clinic sample (N=134); (c) correlation between Symptom Severity scores for YI-4 and parent-completed ASI-4 and ASI-4:Teacher Checklist in an outpatient clinic sample (N=134); (d) concurrent validity of the YI-4 with the *Youth Self Report* and *Children’s Depression Inventory*; (e) gender differences; and (f) discriminant validity comparing clinic (N=134) and norm (N=573) samples. Chapter 4 presents the percentage of children in norm sample (N=573) who received Screening Cutoff scores for the various categories of the YI-4, gender differences in Symptom Severity scores, and T scores and percentiles (Symptom Severity scores) for the norm sample. T scores are classified according to symptom severity: low (T< 60), moderate (60≤ T < 69), and high (T≥ 70). The clinical utility of adopted severity cutoff scores was validated with a sample of adolescents evaluated in a psychiatry outpatient service (N=134). Chapter 4 reviews all the material in the *Manual* and provides guidelines for clinical applications of the YI-4. Appendix A lists frequency of occurrence rates for each YI-4 item for males in the norm sample (N=276); Appendix B lists frequency of occurrence rates for each YI-4 item for females in the norm sample (N=297); Appendix C lists frequency of occurrence rates for each YI-4 item in the clinic sample (N=134); Appendix D lists T scores and percentiles for each YI-4 category for males in the norm sample (N=276); Appendix E lists T scores and percentiles for each YI-4 category for females in the norm sample (N=297); and Appendix F presents the positive predictive values and the negative predictive values for the YI-4 categories in the clinic sample (N=134).


**Background:** This study examined changes in ADHD behaviors and motor and vocal tics during long-term treatment with methylphenidate. **Method:** Subjects, 34 prepubertal children with ADHD and chronic multiple tic disorder (who had participated in an 8-week double-blind placebo-controlled methylphenidate evaluation) were evaluated at 6-month intervals for 2 years as part of a prospective, nonblind followup study. Treatment effects were assessed using direct observations of child behavior in a simulated (clinic-based) classroom and behavior rating scales completed by parents (e.g., *Child Symptom Inventory-3R*, *Peer Conflict Scale*, *Stimulant Side Effects Checklist*) and physician. Videotapes of the simulated classroom were scored by coders who were "blind" to treatment status. **Results:** There was no evidence (group data) that motor tics or vocal tics changed in frequency or severity during maintenance therapy compared with diagnostic or initial double-blind placebo evaluations. Behavioral improvements demonstrated during the acute drug trial were maintained during followup. There was no evidence (group data) of clinically significant adverse drug effects on cardiovascular function or growth at the end of 2 years of treatment. **Conclusion:** Long-term treatment with methylphenidate seems to be safe and effective for the management of ADHD behaviors in many (but not necessarily all) children with mild to moderate tic disorder. Nevertheless, careful clinical monitoring is mandatory to rule out the possibility of drug-induced tic exacerbation in individual patients.

Objective: This study examined changes in attention-deficit hyperactivity disorder (ADHD) behaviors and motor and vocal tics during withdrawal from long-term maintenance therapy with stimulant medication. Method: Subjects were 19 prepubertal children with ADHD and chronic tic disorder who had received methylphenidate ($n=17$) or dextroamphetamine ($n=2$) for a minimum of 1 year. Children were switched to placebo under double-blind conditions. Treatment effects were assessed using direct observations of child behavior in a simulated (clinic-based) classroom and behavior rating scales completed by parents (e.g., *Child Symptom Inventory-3R*, *Peer Conflict Scale*, *Stimulant Side Effects Checklist*) and clinician. Results: There was no change (group data) in the frequency or severity of motor tics or vocal tics during the placebo condition compared with maintenance dose of stimulant medication (i.e., no evidence of tic exacerbation while receiving medication or of a withdrawal reaction). There was no evidence of tic exacerbation in the evening as a rebound effect. Treatment with the maintenance dose was also associated with behavioral improvement in ADHD behaviors, indicating continued efficacy. Conclusions: Abrupt withdrawal of stimulant medication in children receiving long-term maintenance therapy does not appear to result in worsening of tic frequency or severity. Nevertheless, these findings do not preclude the possibility of drug withdrawal reactions in susceptible individuals.


Attention-deficit/hyperactivity disorder (AD/HD) is the most prevalent child psychiatric disorder, and the current version of the DSM recognizes three subtypes: predominantly inattentive, predominantly hyperactive-impulsive, and combined (inattentive and hyperactive-impulsive). This study examined age, gender, and comorbidity differences in AD/HD subtypes, using the *Child Symptom Inventory-4*, a screening checklist based upon DSM-IV criteria. Parent- and teacher-completed checklists were obtained for clinic-referred children and adolescents between the ages of 3 and 18 years. Findings indicated that few youngsters exhibited symptoms of hyperactivity/impulsivity in the absence of inattention. Hyperactive-impulsive behavior was more common in the youngest age group (3 to 5 years), whereas inattention was more common in adolescents. Males were over-represented for each subtype of AD/HD, however, the proportion of males to females did not differ for the different subtypes. Youngsters who exhibited symptoms of both hyperactivity-impulsivity and inattention were more likely to show oppositional and conduct disorder behaviors and anxiety than those who were only inattentive. The findings from this study suggest that even among children who meet criteria for one of the subtypes of AD/HD, age and gender differences may be important variables in diagnosis.


This book recommends the use of the *Adult Self-Report Inventory-4* (for the patient) and the *Adult Inventory-4* (for caregiver or partner who knows patient well) in the assessment of adults who may have ADHD. Specifically, they authors state the following:

Checkmate Plus is currently developing an adult symptom checklist that is uniquely suited to assessment of ADHD and its comorbidity by clinicians (Gadow et al., 1998). Field test versions of the self-report (*Adult Self-Report Inventory-4*) and other-report (*Adult Inventory-4*) forms of this checklist appear in Appendixes 1 and 2 to this book and are reprinted with permission of the authors. The instrument is unique in that it can be scored either categorically, to indicate the presence or absence of a particular disorder, or dimensionally, to provide a symptom severity score for each disorder. The instrument contains the symptoms of over two dozen *DSM-IV* disorders, making it easy for the clinician to visualize areas of difficulty, even without formal scoring. In addition, it includes symptoms of
disorders that are not typically included in adult checklists (e.g., oppositional defiant disorder, conduct disorder, Tourette syndrome, and borderline personality disorder) but that facilitate comparative assessment across the life span. The distinct inclusion of the nine symptoms of inattention and nine symptoms of hyperactivity/impulsivity allows the clinician to provide a symptom severity score for each dimension in its own right, as well as for ADHD as a whole. These forms are an excellent baseline for further evaluation. Obtaining both the patient's symptom inventory and a report from a parent or spouse who knows the patient well provides an excellent screen for both ADHD and the most relevant comorbid diagnoses across different settings and from different informants. (p. 61-62)

YEAR: 1998


The purpose of this study was to (a) examine the occurrence of psychiatric symptomatology in children and adolescents with spina bifida, (b) investigate the relationship between psychiatric features and aspects of disability, and (c) explore the impact of spina bifida and psychiatric status on family functioning. Fifty-four children and adolescents ages 6 to 18 years (M=12.94, SD=3.59) were examined. Parents completed the Child Symptom Inventory-4 (CSI-4) and the Family Assessment Device (FAD). Using the CSI-4, a psychiatric diagnostic screen, 43% of the sample obtained one, and 13% obtained two or more screening cutoff scores reflective of psychiatric diagnoses (Screening Cutoff scores). The two most prevalent diagnostic categories were attention-deficit/hyperactivity disorder (33%) and oppositional defiant disorder (13%). The sample as a whole exhibited elevated levels of clinical symptoms (i.e., Symptom Severity scores, total number of symptoms rated as occurring "often" or "very often"), with internalizing symptoms (i.e., CSI-4 anxiety disorder and depressive disorder symptoms) more prominent than externalizing symptoms (i.e., CSI-4 Oppositional Defiant Disorder and Conduct Disorder categories). No differences in diagnostic categories or overall symptomatology were found based on age, gender, ambulation status, or lesion level. Overall symptom counts were positively correlated with scales on the FAD reflecting problematic family functioning (.42-.65). Results suggest that psychiatric symptomatology occurs at a high rate in children and youth with spina bifida. Although ADHD was the modal diagnostic category, the sample was a whole exhibited extensive psychiatric symptoms independent of specific diagnostic categories. Psychiatric symptoms were also associated with increased problematic functioning in families.


"Some of the newer validated, reliable behavioral checklists incorporating DSM-IV are listed in Table 1. The two-page *ADHD Symptom Checklist-4* (SC-4), developed by Gadow and Sprafkin, fulfills all the aforementioned criteria by evaluating for both ADD-H [hyperactive-impulsive type] and ADD-I [inattentive type], providing norms for age and gender, coupled with validated scales for aggression and oppositional defiance, and for assessing medication adverse effects (AEs) to compare pretherapy and post-therapy. For follow-up visits of children without comorbidities who are stable on their titrated dose, the front page alone may be used to enhance compliance of return of the forms....For adolescents...[the] *Adolescent Symptom Inventory-4* may be preferred for the first visit. Subsequent visits may require only the first...two pages of the form (p. 1060)."


Objective: To examine the clinical implications of manic symptoms in psychiatrically hospitalized
children aged 5-12. **Method:** DSM-III-R manic symptoms, along with symptoms of other psychiatric disorders, were rated by parents and teachers on the *Child Symptom Inventory-3R* (CSI-3R) prior to hospitalization. The *Child Behavior Checklist* (CBCL) was also completed. During hospitalization children were evaluated by structured interview (K-SADS-E) and numerous rating scales weekly. Using the parent-completed CSI-3R to define diagnostic groups, children with symptoms of mania (mania criteria with/without episodes) were compared to those without mania. Severity of attention deficit disorder (ADHD), oppositional defiant disorder (ODD), depression, CBCL factors, and comparable factors from teacher and parent inpatient rating scales were examined. Finally, a subgroup of both groups of children treated with stimulants were compared at baseline and at least two weeks of treatment. **Results:** Children with manic symptoms had more severe ADHD, ODD, and depressive symptoms. CBCL scores on aggression, social and thought problems were higher. Teacher and nursing staff made similar observations. Symptom Severity scores for the Manic Disorder category of the CSI-3R were significantly correlated with comparable scores for the ADHD ($r=.42$) and Oppositional Defiant Disorder ($r=.47$) categories. Time in hospital was greater for children with manic symptoms. Both groups improved significantly on stimulant medication though reduction in overall psychopathology was often modest. **Conclusion:** Manic symptoms, regardless of whether or not they represent bipolar disorder, are a marker of serious psychopathology and treatment resistance.


**Objective:** This study compares patient, parent, and teacher inter-rater agreement of psychiatric symptoms between two referred samples of children and adolescents. Patients were diagnosed either with attention-deficit/hyperactivity disorder (ADHD) or epilepsy. **Method:** Data obtained from parent and teacher versions of the *Child Symptom Inventory-4* and *Youth’s Inventory-4* for patients with ADHD ($N=75$) and epilepsy ($N=43$) are presented. **Results:** Correlations between self-report and parent report of internalizing disorders are significantly ($p<.05$) higher for epileptic than ADHD patients. Correlations for epilepsy and ADHD, respectively, were as follows: Major Depressive Disorder category ($r=.68$, $r=.32$), Dysthymic Disorder category ($r=.65$, $r=.37$), Generalized Anxiety Disorder category ($r=.67$, $r=.34$), and Posttraumatic Stress Disorder category ($r=.41$, $r=.04$). Both groups of patients evidenced low to moderate patient-parent agreement for disruptive behavior categories ($r=.28$ to $r=.41$). In general, parent-teacher and patient-teacher correlations were higher for the epilepsy group ($r=.00$ to $r=.77$) than for the ADHD group ($r=.00$ to $r=.38$), although not significantly so. **Conclusion:** Parents of youngsters with epilepsy are more likely to be aware of internalizing symptoms than parents of ADHD patients. Among the raters, parent-youth agreement is highest, although the magnitude of agreement is significantly higher in the epilepsy group.


This 117-page *Manual* is divided into five chapters: Introduction (Ch. 1), Diagnostic Criteria for Disorders (Ch. 2), Reliability and Validity (Ch. 3), and Clinical Applications (Ch. 4). Chapter 1 presents a brief overview of the rationale for the CSI-4, history of the SYMPTOM INVENTORIES, synopsis of research pertaining to the CSI-3R version, and scoring procedures. The *Manual* focuses primarily (but not exclusively) on the Symptom Count scoring procedure where Never=0, Sometimes=0, Often=1, and Very often=1. Chapters 2 provides a brief description of each disorder included in the CSI-4, DSM-IV diagnostic criteria and symptoms, and CSI-4 items. Chapter 3 presents the findings from several studies of the CSI-4: (a) test-retest reliability of Parent Checklist ($N=75$) and Teacher Checklist ($N=29$) in an outpatient clinic and medication clinic sample, respectively; (b) intercorrelations between
categorical scores for Parent Checklist \((N=590)\) and for Teacher Checklist \((N=548)\) in an outpatient clinic sample; (c) screening prevalence rates (i.e., percentage of children with Screening Cutoff scores for specific symptom categories) for Parent Checklist (boys, \(n=441\); girls, \(n=149\)) and Teacher Checklist (boys, \(n=410\); girls, \(n=138\)) in an outpatient clinic sample; (d) comparison of (discriminant validity) screening prevalence rates for Parent Checklist in a norm sample (boys, \(n=134\); girls, \(n=129\)) and Teacher Checklist in a norm sample (boys, \(n=662\); girls, \(n=661\)) with respective outpatient clinic samples; (e) predictive validity (comparisons with data-based clinical diagnoses) of Parent Checklist \((N=101)\) and Teacher Checklist \((N=94)\) for an outpatient clinic sample; (f) gender differences in Symptom Severity scores of Parent Checklist (boys, \(n=441\); girls \(n=149\)) and Teacher Checklist (boys, \(n=410\); girls \(n=138\)) in an outpatient clinic sample; (g) discriminant validity of Parent Checklist and Teacher Checklist Symptom Severity scores comparing outpatient clinic samples and norm samples; and (h) correlation between Symptom Severity scores for Parent Checklist and Teacher Checklist in an outpatient clinic sample \((N=94)\). Chapter 4 reviews all the material in the Manual and provides guidelines for clinical applications of the CSI-4. Appendix A lists frequency of occurrence rates for each item of Parent Checklist for boys referred to outpatient clinic \((N=441)\); Appendix B lists frequency of occurrence rates for each item of Parent Checklist for girls referred to outpatient clinic \((N=149)\); Appendix C lists frequency of occurrence rates for each item of Teacher Checklist for boys referred to outpatient clinic \((N=410)\); and Appendix D lists frequency of occurrence rates for each item of Teacher Checklist for girls referred to outpatient clinic \((N=138)\).  


This 168-page Norms Manual is divided into six chapters: Introduction (Ch. 1), Reliability and Validity of Parent-Completed Checklist (Ch. 2), Reliability and Validity of Teacher Checklist (Ch. 3), Norms for Parent-Completed Checklist (Ch. 4), Norms for Teacher Checklist (Ch. 5), and Clinical Applications (Ch. 6). Chapter 1 presents a brief overview of the ASI-4 and scoring procedures. The ASI-4 Norms Manual focuses primarily (but not exclusively) on the Symptom Severity scoring procedure where Never=0, Sometimes=1, Often=2, and Very often=3. Chapter 2 presents the findings from several studies of the parent-completed ASI-4 Checklist: (a) intercorrelations between categorical scores in an outpatient clinic sample \((N=144)\) and a norm sample \((N=824)\); (b) predictive validity (comparisons with data-based clinical diagnoses) of Screening Cutoff scores for an outpatient clinic sample \((N=144)\); (c) correlation between Symptom Severity scores for parent-completed Checklist and Teacher Checklist in an outpatient clinic sample \((N=123)\); (d) concurrent validity with Child Behavior Checklist \((N=143)\); and (e) test-retest reliability of CSI-4: Parent Checklist \((N=75)\) in an outpatient clinic sample. Chapter 3 presents the findings from several studies of the ASI-4: Teacher Checklist: (a) intercorrelations between categorical scores in an outpatient clinic sample \((N=123)\) and a norm sample \((N=1,072)\); (b) predictive validity (comparisons with data-based clinical diagnoses) of Screening Cutoff scores for an outpatient clinic sample \((N=123)\); (c) concurrent validity with Teacher Report Form \((N=122)\); and (e) test-retest reliability of AD/HD and ODD categories of the CSI-4: Teacher Checklist \((N=29)\) in a medication clinic sample. Chapter 4 presents the percentage of children in norm sample \((N=761)\) who received Screening Cutoff scores for the various categories of the parent-completed ASI-4 Checklist, gender differences in Symptom Severity scores, and \(T\) scores and percentiles (Symptom Severity scores) for the norm sample. \(T\) scores are classified according to symptom severity: low \((T<60)\), moderate \((60\leq T<69)\), and high \((T\geq70)\). The clinical utility of adopted severity cutoff scores was validated with a sample of adolescents evaluated in a psychiatry outpatient service \((N=144)\). Chapter 5 presents the percentage of youths in norm sample \((N=994)\) who received Screening Cutoff scores for the various categories of the ASI-4: Teacher Checklist, gender differences in Symptom Severity scores, and \(T\) scores and percentiles (Symptom Severity scores) for the norm sample. \(T\) scores are classified according to symptom severity: low \((T<60)\), moderate \((60\leq T<69)\), and high \((T\geq70)\). The clinical utility of adopted severity cutoff scores was validated with a sample of adolescents evaluated in a psychiatry outpatient service \((N=123)\). Chapter 6 reviews all the material in the Norms Manual and
provides guidelines for clinical applications of the ASI-4. Appendix A lists frequency of occurrence rates for each item of the parent-completed Checklist for males in the norm sample \((N=375)\); Appendix B lists frequency of occurrence rates for each item of the parent-completed Checklist for females in the norm sample \((N=386)\); Appendix C lists frequency of occurrence rates for each item of the ASI-4: Teacher Checklist for males in the norm sample \((N=508)\); Appendix D lists frequency of occurrence rates for each item of the ASI-4: Teacher Checklist for females in the norm sample \((N=486)\); Appendix E lists \(T\) scores and percentiles for each category of the parent-completed ASI-4 Checklist for males in the norm sample \((N=375)\); Appendix F lists \(T\) scores and percentiles for each category of the parent-completed ASI-4 Checklist for females in the norm sample \((N=386)\); Appendix G lists \(T\) scores and percentiles for each category of the ASI-4: Teacher Checklist for males in the norm sample \((N=508)\); and Appendix H lists \(T\) scores and percentiles for each category of the ASI-4: Teacher Checklist for females in the norm sample \((N=486)\).

YEAR: 1997


Objective: This study examines (1) the relationship between psychiatric symptoms and parameters of neurosurgical history in children and adolescents with spina bifida; (2) association between psychiatric symptoms and IQ and academic achievement; and (3) construct validity of the Stony Brook Child Symptom Inventory-4 (CSI-4) in this population. Method: Mothers of 34 children and adolescents (mean age=13.06) completed the CSI-4, Child Behavior Checklist (CBCL), and Personality Inventory for Children (PIC). Results: Patients with a history of infection and/or seizure disorder were less likely to exhibit psychiatric symptoms or disorders than those without such a history. This pattern was less consistent and robust for summary scales of the CBCL and PIC. CSI-4 scores were not associated with IQ or measures of academic achievement. CSI-4 scores were moderately correlated with the CBCL and PIC, with more positive correlations obtained with the PIC. Conclusion: Several neurosurgical history variables are important in the expression of psychiatric symptomatology. Psychiatric symptoms are unrelated to neurocognitive functioning and academic achievement. The CSI-4 displays adequate construct validity in this population.


This 198-page Manual is divided into seven chapters: Introduction (Ch. 1), Description of ADHD-SC4 categories (Ch. 2), Reliability and Validity: Parent-Completed Checklist (Ch. 3), Reliability and Validity: Teacher-Completed Checklists (Ch. 4), Norms for Teacher-Completed Checklists (Ch. 5), Norms for Parent-Completed Checklists (Ch. 6), and Scoring Guidelines and Clinical Applications (Ch. 7). Chapter 1 presents a brief overview of the ADHD-SC4 and scoring procedures. Chapter 2 provides a description of ADHD and ODD symptom categories, the Peer Conflict Scale, the Stimulant Side Effects Checklist, DSM-IV diagnostic criteria, and ADHD-SC4 items. Chapter 3 and Chapter 4 present data for the reliability (test-retest), predictive validity (compared with data-based child psychiatric diagnoses in a research and teaching hospital setting), concurrent validity (comparisons with the Child Behavior Checklist, Teacher Report Form, and IOWA Conners Teacher's Rating Scale), discriminant validity (comparisons between psychiatric referrals, children receiving special education, children enrolled in regular education programs), agreement between parent and teacher ratings, and sensitivity to treatment effects for parent-completed and teacher-completed Checklists, respectively. Data are also presented supporting the clinical utility of the ADHD-SC4 as a measure of responsiveness to stimulant medication in children with ADHD. Chapter 5 and Chapter 6 describe the percentage of children in
norm samples who receive Screening Cutoff scores for the ADHD-SC4 symptom categories and present $T$ scores and percentiles (Symptom Severity scores) for teacher- and parent-completed Checklists, respectively. Normative data for the Parent Checklist are based on a sample of 522 children between 3 and 18 years old. Normative data for the Teacher Checklist are based on a sample of 1,527 children between 3 and 12 years old. $T$ scores are classified according to symptom severity: low ($T<60$), moderate ($60 \leq T \leq 69$), and high ($T \geq 70$). The clinical utility of adopted severity cutoff scores was validated with a sample of children evaluated in a child psychiatry outpatient service with diagnosed AD/HD ($N=117$) and ODD ($N=86$). The last chapter reviews all the material in the Manual and provides guidelines for clinical applications of the ADHD-SC4, and for this reason, should be considered "must reading" for all users of the Checklist.


This 145-page *Screening Manual* is divided into five chapters: Introduction (Ch. 1), Diagnostic Criteria for Disorders (Ch. 2), Reliability and Validity of Parent Checklist (Ch. 3), Reliability and Validity of Teacher Checklist (Ch. 4), and Clinical Applications (Ch. 5). Chapter 1 presents a brief overview of adolescent development, psychopathology in adolescence, history of the SYMPTOM INVENTORIES, and scoring procedures. The ASI-4 *Screening Manual* focuses primarily (but not exclusively) on the Symptom Count scoring procedure where Never=0, Sometimes=0, Often=1, and Very often=1. Chapter 2 provides a brief description of each disorder included in the ASI-4, DSM-IV diagnostic criteria, and ASI-4 items. Chapter 3 and Chapter 4 address the predictive validity of ASI-4 categorical scores compared with data-based child psychiatric diagnosis in a research and teaching hospital setting. Because some ASI-4 users will have inquiries about either parent or teacher reports (but not both), the predictive validity of the parent- and teacher-completed Checklists are addressed in separate chapters. Data for the parent-completed Checklist are based on a sample of 144 youths between 12 and 18 years old. Data for the Teacher Checklist are based on a sample of 123 youths between 12 and 18 years old. Chapter 3 also presents data for the correlation between parent and teacher ratings. The last chapter reviews all the material in the *Screening Manual* and provides guidelines for clinical applications of the ASI-4, and for this reason, should be considered "must reading" for all users of the Checklist. Appendices present frequency of occurrence rates for each item of the parent-completed Checklist and the Teacher Checklist (separately) for clinic-referred youths.


This 154-page *Norms Manual* is divided into six chapters: Introduction (Ch. 1), Reliability and Validity of Parent Checklist (Ch. 2), Reliability and Validity of Teacher Checklist (Ch. 3), Norms for Parent Checklist (Ch. 4), Norms for Teacher Checklist (Ch. 5), and Clinical Applications (Ch. 6). Chapter 1 presents a brief overview of the CSI-4 and scoring procedures. The *CSI-4 Norms Manual* focuses primarily (but not exclusively) on the Symptom Severity scoring procedure where Never=0, Sometimes=1, Often=2, and Very often=3. Chapter 2 and Chapter 3 address the predictive validity of CSI-4 categorical scores compared with data-based child psychiatric diagnosis in a research and teaching hospital setting and concurrent validity with the *Child Behavior Checklist, Teacher Report Form*, and *IOWA Conners Teacher's Rating Scale*. Because some CSI-4 users will have inquiries about either parent or teacher reports (but not both), the predictive and concurrent validity of the parent- and teacher-completed Checklists are addressed in separate chapters. Data for the Parent Checklist are based on a sample of 101 children between 6 and 12 years old. Data for the Teacher Checklist are based on a sample of 94 children between 6 and 12 years old. Chapter 2 also presents data for test-retest reliability, intercorrelations between categorical scores, and correlation between parent and teacher ratings. Chapter 4 and Chapter 5 describe the percentage of children in the norm samples who receive Screening Cutoff scores for the various CSI-4 categories and present $T$ scores.
and percentiles (Symptom Severity scores) for parent- and teacher-completed Checklists, respectively. Normative data for the Parent Checklist are based on a sample of 263 children between 5 and 12 years old. Normative data for the Teacher Checklist are based on a sample of 1,323 children between 5 and 12 years old. T scores are classified according to symptom severity: low (T< 60), moderate (60≤ T ≤ 69), and high (T≥ 70). The clinical utility of adopted severity cutoff scores was validated with a sample of children evaluated in a child psychiatry outpatient service (N=101). The last chapter reviews all the material in the Norms Manual and provides guidelines for clinical applications of the CSI-4. Appendices present frequency of occurrence rates for each item for boys and girls separately (parent and teacher Checklists), T scores and percentiles for each symptom category for boys and girls separately (parent and teacher Checklists), and positive predictive values and negative predictive values for each symptom category of the Parent Checklist.


This 184-page Norms Manual is divided into six chapters: Introduction (Ch. 1), Reliability and Validity of Parent Checklist (Ch. 2), Reliability and Validity of Teacher Checklist (Ch. 3), Norms for Parent Checklist (Ch. 4), Norms for Teacher Checklist (Ch. 5), and Clinical Applications (Ch. 6). Chapter 1 presents a brief overview of the ECI-4 and scoring procedures. The ECI-4 Norms Manual focuses primarily (but not exclusively) on the Symptom Severity scoring procedure where Never=0, Sometimes=1, Often=2, and Very often=3. Chapter 2 and Chapter 3 address the predictive validity of CSI-4 categorical scores compared with data-based child psychiatric diagnosis in a research and teaching hospital setting and concurrent validity with the Child Behavior Checklist, Teacher Report Form, and IOWA Conners Teacher's Rating Scale. Because some ECI-4 users will have inquiries about either parent or teacher reports (but not both), the predictive and concurrent validity of the parent- and teacher-completed Checklists are addressed in separate chapters. Data for the Parent Checklist are based on a clinic sample of 105 children between 3 and 6 years old. Data for the Teacher Checklist are based on a clinic sample of 36 children between 3 and 6 years old. Chapter 2 also presents data on test-retest reliability, intercorrelations between categorical scores, and correlation between parent and teacher ratings. Chapter 4 and Chapter 5 describe the percentage of children in the norm samples who receive Screening Cutoff scores for the various ECI-4 categories and present T scores and percentiles (Symptom Severity scores) for parent- and teacher-completed Checklists, respectively. Normative data for the Parent Checklist are based on a sample of 531 children between 3 and 5 years old. Normative data for the Teacher Checklist are based on a sample of 398 children between 3 and 5 years old. T scores are classified according to symptom severity: low (T< 60), moderate (60≤ T ≤ 69), and high (T≥ 70). The clinical utility of adopted severity cutoff scores was validated with a sample of children evaluated in a child psychiatry outpatient service (N=105). The last chapter reviews all the material in the Norms Manual and provides guidelines for clinical applications of the ECI-4. Appendices present frequency of occurrence rates for each item in the Parent and Teacher Checklist for boys and girls separately, T scores and percentiles for each symptom category in the Parent and Teacher Checklist for boys and girls separately, and positive predictive values and negative predictive values for each symptom category in the Parent Checklist.


In a preliminary study of the predictive validity of the Youth's Inventory-4, 89 youths (66 males and 23 females) between 11 and 19 years of age (M=13.9, SD=1.7) who were consecutive referrals to a university hospital-based child and adolescent psychiatry outpatient clinic completed the Youth's Inventory-4 as part of their evaluation. Their final clinical diagnoses were as follows: AD/HD (63%), oppositional defiant disorder (18%), conduct disorder (17%), anxiety disorder (20%), and depressive disorder (28%). Predictive validity was assessed by comparing the self-report scores with data-based
psychiatric diagnoses. These diagnoses were made by staff child psychiatrists in a research-based teaching hospital setting. Diagnoses were based on interviews with the care provider and child patient; review of school history, school reports, and psycho-educational and special education evaluations; developmental, medical, and family histories; and scores from several teacher-completed and parent-completed behavior rating scales. As expected, agreement between scores for the Young's Inventory-4 and psychiatric diagnoses was greatest for emotional disorders (e.g., depression, anxiety) and least for behavioral disorders (e.g., AD/HD, oppositional defiant disorder).


Objectives: The paper compares comorbidity, severity and types of symptoms of attention-deficit/hyperactivity disorder (ADHD) in an ethnically diverse ADHD clinic. Method: The Stony Brook Child Symptom Inventory-4 (CSI-4) was completed by parents of 150 children and adolescents consecutively evaluated in our ADHD clinic; 144 met DSM-IV criteria for ADHD and were accepted for this study. Results: All families had at least one parent employed and had medical insurance. African-American children in this clinic were significantly younger. After adjusting for age, Caucasian children (N=84) still had significantly more inattention problems (p=.015) and comorbid mood disorders (p=.003) than African-American children (N=60). Groups did not differ in total severity of ADHD nor in hyperactive-impulsive symptoms or in comorbid oppositional, conduct or anxiety disorders. Among the Caucasian children, 22/30 cases of comorbid mood disorder were in Hispanic (13 cases/34 children) or Orthodox Jewish (9 cases/17 children) children (p=.05). Conclusions: These observed differences should be replicated in a study using multiple informants. If replicable, they suggest ethnocultural groups may have some differences in ADHD-related risks and therefore in need for services and treatment.


Objective: This study examined: (1) prevalence rates for the subtypes of attention-deficit/hyperactivity disorder (ADHD) in a non-referred sample, (2) gender differences and developmental changes in ADHD subtypes, and (3) ADHD subtypes in terms of co-existing psychiatric problems. Method: Data obtained from Early Childhood Inventories-4 (ECI-4): Teacher Checklists and Child Symptom Inventories-4 (CSI-4): Teacher Checklists for 1,721 children in public schools and preschools are presented. Results: Gender and age were significantly related to the prevalence of ADHD. Males had higher rates of all types of ADHD at all ages, but the gender discrepancy varied for different age groups. The minimum Symptom Severity score necessary for inclusion in a "risk" range for the ADHD subtypes varied according to age and gender. ADHD was much more likely to co-occur with another psychiatric problem for boys and for girls. Conclusion: Findings are discussed with respect to the selection of cutoff scores for assessment instruments in child psychopathology.


The test-retest reliability of the symptom categories of the Child Symptom Inventory-4 (CSI-4): Parent Checklist was examined in a study of 75 boys between 6 and 10 years of age (M=7.7; SD=1.3) who were enrolled in a diagnostic study of AD/HD directed by Dr. Jan Loney. The study sample was composed of children whose parents either (a) requested a child psychiatry outpatient service evaluation or (b) were recruited through a parent support group. The parents of these children
completed the CSI-4 prior to their first office evaluation and again while they were waiting for their son to finish the testing session. Ratings were completed, on the average, 6 weeks apart ($M=6.2; SD=3.5$). Test-retest reliabilities for all CSI-4 categories were significant at the $p<.0001$ level unless noted otherwise. Correlations for the Symptom Count and Symptom Severity scores, respectively, were as follows: AD/HD Inattentive Type ($r=.67, r=.76$), AD/HD Hyperactive-Impulsive Type ($r=.72, r=.82$), AD/HD Combined type ($r=.66, r=.78$), ODD ($r=.70, r=.75$), Conduct Disorder ($r=.64, r=.67$), Generalized Anxiety Disorder ($r=.63, r=.65$), Major Depressive Disorder ($r=.43, r=.56$), Dysthymic Disorder ($r=.41, r=.54$), Schizophrenia ($r=.02, N.S.; r=.37, p<.005$), Autistic Disorder ($r=.71, r=.74$), Social Phobia ($r=.62, r=.65$), and Separation Anxiety Disorder ($r=.50, r=.72$).


Objective: The assessment of ADHD in preschoolers and current approaches to treatment are reviewed. Method: The diagnostic procedures which are reviewed include: (1) the developmental history including temperament and attachment experiences; (2) structured and unstructured observation of the toddler with various caregivers; (3) specific structured assessment tools such as Denver 2, Toddler Temperament scales, Early Childhood Inventory-4, Functional Emotional Assessment (Stanley Greenspan); and (4) milieu assessment. Current treatment research and the clinical experience of an ADHD infant clinic are reviewed. Results: Demographic, diagnostic and treatment data on a series of 300 ADHD preschoolers are presented. Conclusion: ADHD can be rigorously diagnosed and effectively treated in the preschool population, thus preventing some of the serious family and secondary problems which might otherwise develop.


Objective: To assess the level of agreement between parents and children and their perceptions of psychological distress experienced by pediatric epilepsy (EPI) patients or by pediatric patients with attention-deficit/hyperactivity disorder (ADHD). Method: Administration of Child Symptom Inventory-4 (CSI-4) and Youth's Inventory-4 (YI-4) to adolescent patients with EPI ($n=19$) or ADHD ($n=24$).

Results: On the CSI-4, symptoms suggesting depression occurred in 25% of EPI patients versus 10% in ADHD. Anxiety symptoms were endorsed by 11% EPI and 4.5% ADHD patients. Pearson correlation coefficient between parental and patient surveys ranged between 0.4 and 0.8 for most categories except separation anxiety $r=.21$. Parents and youth were in most agreement for anxiety symptoms ($r=.78$) and depression ($r=.66$). Pearson correlation coefficients ranged between 0.4 and 0.5 for most categories in the ADHD group. For most other categories, correlations between youth and parent scores were higher in the EPI group. Conclusions: on the CSI-4 and YI-4, parental ratings of their children's psychiatric disturbance correlate reasonably well with ratings of pediatric patients with epilepsy or with ADHD, with higher correlation in the EPI group.

YEAR: 1996


Twenty-six of 30 participants (87%) who took part in a medication study for treatment of ADHD were followed up 2.9 to 4.8 years (mean=3.9 years) later. Parent ratings on the Aberrant Behavior Checklist-Community (ABC-C) (Aman & Singh, 1994) indicated continued problems on the acting-out subscales,
and parent assessments on the Stony Brook Child Symptom Inventory-3R (CSI-3R) (Gadow & Sprafkin, 1987) showed a high rate of difficulty on domains called ADHD, Conduct Disorder, and Separation Anxiety Disorder. A high percentage of children (69%) were taking psychotropic drugs, substantial numbers of their families had sought nonmedical treatments, friendships were often rudimentary, and a significant minority of children had disciplinary problems in school or difficulty with the law. Using Pearson correlations, we identified a number of initial variables that predicted follow-up parent ratings on the ABC-C and CSI-3R. The ABC-C Irritability subscale was useful in predicting both internalizing and externalizing problems at follow-up, whereas parent and teacher hyperactivity subscales failed to predict later hyperactivity. Children identified with both mental retardation and ADHD appear to have significant behavioral and emotional problems in their early adolescence, and there appear to be some important qualitative differences in the outcome of these youngsters as compared with children identified with ADHD and normal IQ.


Mental health disorders in adolescence are pervasive, often carry into adulthood, and appear to be inversely associated with social status. We examine how structural aspects of neighborhood context, specifically, socioeconomic stratification and racial/ethnic segregation, affect adolescent emotional well-being by shaping subjective perceptions of their neighborhoods. The subjects were a community-based sample of 877 adolescents in Los Angeles County. Dependent measures of child psychopathology were the Children's Depression Inventory, the Hopkins Symptom Checklist (anxiety symptoms), and the Conduct Disorder and Oppositional defiant Disorder categories of the Stony Brook Child Symptom Inventory-3R. Results indicated that youth in low socioeconomic status (SES) neighborhoods perceive greater ambient hazards such as crime, violence, drug use, and graffiti than those in high SES neighborhoods. The perception of the neighborhood as dangerous, in turn, influences the mental health of adolescents: the more threatening the neighborhood, the more common the symptoms of depression, anxiety, oppositional defiant disorder, and conduct disorder. Social stability and to a lesser extent, social cohesion, also emerge as contributors to adolescent disorder. This investigation demonstrates that research into the mental health of young people should consider the socioeconomic and demographic environments in which they live. Findings also indicate ethnic/racial differences in the distribution of symptoms of psychopathology. For example, the symptoms of oppositional defiant disorder were extremely low in working-class African-American communities and somewhat high in middle-class communities with dense concentrations of non-Hispanic Whites and Latinos, whereas the behavioral symptoms of conduct disorder were most common in underclass African-American neighborhoods and least common in impoverished Latinos living in Latino neighborhoods.


Presents a brief synopsis of research into the psychometric properties of the Early Childhood Inventory-4, Child Symptom Inventory-4, and Adolescent Symptom Inventory-4. Reviews studies of predictive validity (comparisons with data-based psychiatric diagnoses) and concurrent validity (comparisons with Child Behavior Checklist, Teacher Report Form, IOWA Conners Teacher's Rating Scale).


Presents a brief overview of the Child Symptom Inventory-4 (CSI-4). Topics include the rationale for the instrument, administration and scoring, psychometric properties, and recommendations for use.
The author concludes that "Despite these caveats, the CSI-4 is extremely useful in clinical practice. It is very easy to administer, since parents or teacher merely read the items and indicate the frequency of the behaviors. Because the CSI-4 takes most parents about 10 minutes to complete, it can be given to parents prior to the intake interview and then used to suggest directions for additional probing. Scoring is extremely simple, since items are already grouped into diagnostic categories; scoring is further simplified by an organized scoring sheet. As noted above, the CSI-4 is NOT a substitute for a clinical interview; rather, it can be used to structure the interview and to easily rule out some diagnoses, while providing structured, quantifiable data."


This 168-page Manual is divided into six chapters: Introduction (Ch. 1), Disruptive Behavior Disorders (Ch. 2), Anxiety and Mood Disorders (Ch. 3), PDD and Other Disorders (Ch. 4), Research (Ch. 5), and Scoring Guidelines and Clinical Applications (Ch. 6). Chapter 1 presents a brief overview of early childhood development, psychopathology in young children, history of the SYMPTOM INVENTORIES, and scoring procedures. The Manual focuses primarily (but not exclusively) on the Symptom Count scoring procedure where Never=0, Sometimes=0, Often=1, and Very often=1. Chapters 2-4 provide a brief description of each disorder included in the ECI-4, DSM-IV symptoms, and ECI-4 items. Chapter 5 presents the findings from two studies of the predictive validity (comparisons with data-based child psychiatric diagnosis in a research and teaching hospital setting), concurrent validity (comparisons with Child Behavior Checklist, Teacher Report Form, IOWA Conners Teacher's Rating Scale), and discriminant validity (comparisons between clinic-referred children, youngsters receiving special education, and children enrolled in regular education programs). One study involved 122 consecutive referrals (ages 3 to 6 years) to a child psychiatry outpatient service. Parents completed either the ECI-3R (n=67) or the ECI-4 (n=55) Parent Checklist. The second study involved the parents and teachers of children in a community preschool program. ECI-4: Teacher Checklists were completed for 152 children and ECI-4: Parent Checklists were completed for 77 children. The last chapter reviews all the material in the Manual and provides guidelines for clinical applications of the ECI-4, and for this reason, should be considered "must reading" for all users of the Checklist. Appendices show item-by-item comparisons between ECI-3R and ECI-4.


The current study investigated the impact of age and attributes of Attention-Deficit/Hyperactivity Disorder (ADHD) on children's peer relations and friendships. One hundred nine boys (mean age=9 years 10 months) and their parents were recruited as subjects from clinical, school, and community settings. The boys and their parents completed Friendship Questionnaires, and parents and teachers rated the children on three attributes of ADHD (i.e., hyperactivity-impulsivity, inattention, and aggression-oppositionality) using the Child Symptom Inventory-4. Specifically, it was determined to what extent age, hyperactivity-impulsivity, inattention, and aggression-oppositionality contribute to children's positive and negative peer interactions, extensiveness of peer/friend network, and quality of best and good friendships. Results from hierarchical regression analyses indicated that ADHD factors generally had a negative impact on children's peer relations and friendships. Interestingly, inattention had more of a negative effect than anticipated, and hyperactivity-impulsivity and aggression-oppositionality had less negative effects than expected. The effects of hyperactivity-impulsivity and aggression-oppositionality on children's peer relations also were moderated by the child's age. However, the current results should be interpreted with caution given that no findings were replicated using more than two of the four combinations of measures. Overall, results suggest that children diagnosed with ADHD-Predominantly Inattentive Type (who have problems only with inattention) may
be at risk for peer rejection just as children diagnosed with ADHD-Combined Type (who have problems with hyperactivity-impulsivity, inattention, and possibly aggression-oppositionality) have long been known to be. Implications for treatment and future research are discussed.


**Objective:** To conduct a retrospective follow-up study of psychosocial adjustment and educational outcome in adolescents with a childhood diagnosis of attention deficit disorder (ADD) and a group of clinical controls. **Method:** Groups included male and female subjects aged 14 to 18 years at follow-up with childhood diagnosis of ADD (cases; \(n=48\)) versus other neurodevelopmental disorders (clinical controls; \(n=37\)). Cases were also subdivided based on the presence of conduct disorder (CD) at followup as determined by the *Stony Brook Child Psychiatric Checklist* (CSI-3R). All groups were compared on measures of academic performance, self-esteem, behavior, alcohol and substance use, and adaptive functioning. **Results:** Cases had significantly lower academic performance and poorer social, emotional, and adaptive functioning than clinical controls. Cases with CD had significantly lower academic performance, greater externalizing behaviors and emotional difficulties, and lower adaptive functioning than cases without CD. Cases with CD fared worse than clinical controls on self-report measures of behavior, socialization skills, and alcohol and substance use. **Conclusions:** These academic and psychosocial problems in adolescents with a childhood diagnosis of ADD suggest potential long-term ramifications for vocational and psychological functioning in adulthood. In addition, the presence of CD in some of these cases during adolescence appears to further increase the risk for maladaptive outcome.

**YEAR: 1995**


This 80-page *Manual* is divided into two sections: Introduction (1) and Emotional and Behavioral Disorders (2). Section 1 presents a brief overview of adolescent development, psychopathology in adolescence, history of the SYMPTOM INVENTORIES, and scoring procedures. The *Manual* focuses primarily (but not exclusively) on the Symptom Count scoring procedure where Never=0, Sometimes=0, Often=1, and Very often=1. Chapter 2 provides a brief description of each disorder included in the ASI-4, DSM-IV diagnostic criteria, ASI-4 items, validity data, and screening guidelines and clinical applications. The findings from a study of 96 consecutive referrals (12 to 18 year olds) to a child psychiatry outpatient service are used to examine the predictive validity (comparisons with data-based child psychiatric diagnoses in a research and teaching hospital setting) and concurrent validity (comparisons with *Child Behavior Checklist, Teacher Report Form, IOWA Conners Teacher’s Rating Scale*) of the ASI-3R.


Thirty four prepubertal children with attention-deficit hyperactivity disorder and tic disorder received placebo and three dosages of methylphenidate hydrochloride (0.1, 0.3, and 0.5 mg/kg) twice daily for 2 weeks each, under double-blind conditions. Treatment effects were assessed using direct observations of child behavior in a simulated (clinic-based) classroom and using rating scales completed by the parents, teachers, and physician. Rating scales included the *Peer Conflict Scale (PCS)* and the *Stimulant Side Effects Checklist (SSEC)*, which are component scales of the *Early Childhood Inventory-4 (PCS)* and *ADHD-Symptom Checklist-4 (PCS, SSEC)*. Methylphenidate effectively suppressed hyperactive, disruptive, and aggressive behavior as assessed by observations
and rating scales. There was no evidence that methylphenidate altered the severity of the tic disorder, but it may have a weak effect on the frequency of motor (increase) and vocal (decrease) tics. Teacher SSEC ratings indicated an improvement in the Mood Index with methylphenidate, but parent SSEC ratings indicated a worsening in the Somatic Complaints index with methylphenidate.


Presents a synopsis of the 1994 Child Symptom Inventories Manual. Topics include the rationale for the instrument, administration and scoring, psychometric properties, and recommendations for use. The author concludes that "Overall, the CSI-4 appears to be a good screening instrument for childhood emotional and behavioral disorders. It can be used by clinicians as part of a comprehensive psychiatric evaluation of a child. It should not be used as a sole instrument for diagnosing a child with a psychiatric disorder. Overall, the adequacy of the manual is good. The CSI-4 manual (Gadow & Sprafkin, 1994) provides detailed information on CSI-4's development, content, and scoring, and it also provides information on CSI-3R."

YEAR: 1994


This 115-page Manual is divided into five chapters: Introduction (Ch. 1), Disruptive Behavior Disorders (Ch. 2), Anxiety and Mood Disorders (Ch. 3), PDD, Schizophrenia, and Other Disorders (Ch. 4), and Scoring Guidelines and Clinical Applications (Ch. 5). Chapter 1 presents a brief overview of the rationale for the CSI-4, history of the SYMPTOM INVENTORIES, and scoring procedures. The Manual focuses primarily (but not exclusively) on the Symptom Count scoring procedure where Never=0, Sometimes=0, Often=1, and Very often=1. Chapters 2-4 provide a brief description of each disorder included in the CSI-4, DSM-IV symptoms, CSI-4 items, differences between the CSI-3R and the CSI-4, and research into predictive validity (comparisons with structured psychiatric interviews and data-based clinical diagnoses) and concurrent validity (comparisons with Child Behavior Checklist, Teacher Report Form, IOWA Conners Teacher's Rating Scale). The Manual reports the findings from seven studies: (1) Kiddie-SADS inpatient study of CSI-3R: Parent Checklist (N=63) (Grayson & Carlson, 1991), (2) Little Rock inpatient study of CSI-3R and the Child Behavior Checklist (N=77) (Livingston et al., 1992), (3) Child Psychiatry Outpatient Clinic study of CSI-3R: Parent Checklist (N=151), (4) Outpatient Tic Disorders Clinic study of the CSI-3R: Parent Checklist (N=32), (5) Kiddie-SADS inpatient study of CSI-3R: Teacher Checklist (N=96), (6) Child Psychiatry Outpatient Clinic study of CSI-3R: Teacher Checklist (N=107), and (7) Outpatient PDD sample (N=15). The last chapter reviews all the material in the Manual and provides guidelines for clinical applications of the CSI-4, and for this reason, should be considered "must reading" for all users of the Checklist. Appendices show item-by-item comparisons between CSI-3R and CSI-4.


Examined the relation between ratings and observations of stimulant drug response in hyperactive children. The findings indicated that scores for several rating scales, including the Peer Conflict Scale, were significantly correlated with classroom, lunchroom, and playground observations of negativistic (e.g., aggression, noncompliance, interference) but not hyperactive (inattention, motor movement) behaviors. However, when these same data were analyzed controlling for the variance accounted for by the other dimension (partial correlations), there was clear evidence supporting the differential validity of the hyperactivity
and negativistic behavior scales of the *IOWA Conners Teacher’s Rating Scale* (Loney & Milich, 1982) and the *Abbreviated Teacher Rating Scales* (Conners, 1973) across settings and as measures of drug response. Test-retest reliabilities of most rating scales and classroom-observation code categories were comparable. [The *Peer Conflict Scale* is one of the component scales of the *ADHD Symptom Checklist-4* and the *Early Childhood Inventory-4*.]

**YEAR: 1993**


A continuing concern in child psychopharmacology is developing treatment evaluation procedures that are more scientifically rigorous and ecologically valid than the ones that are popularly used at the present time. One potential model for such a procedure is school-based medication evaluation (SBME). Measures include the *Stony Brook Child Psychiatric Checklist* (CSI-3R), *Stimulant Side Effects Checklist*, *Peer Conflict Scale*, and an early version of the *ADHD School Observation Code*. This article describes some of the practical considerations associated with its implementation based on experience with 35 consecutive cases over a 6-year period.

**YEAR: 1992**


Many hyperactive mentally retarded children in public school programs receive stimulant medication, but studies indicate that treatment monitoring practices are less than adequate. Standardized drug assessment instruments rarely are used, and the school typically plays a minor role in evaluating response to treatment. To improve this situation, a procedure developed originally for nonretarded children was adapted to evaluate drug effects in mentally retarded children in public school settings. This assessment procedure generates ecologically valid data, enables a high degree of precision in specifying target symptoms and measuring the magnitude of the therapeutic effect, and appears to generate useful information for making dosage adjustment decisions. Measures include the *Stimulant Side Effects Checklist* and an early version of the *ADHD School Observation Code*. Two case studies are presented to illustrate the use of this procedure and to highlight differences in the clinical utility of data from behavior rating scales versus direct observations. Although ratings and observations sometimes reveal similar dose-response profiles, the sole reliance on rating scales can lead to gross misperceptions of drug efficacy, even when the ratings are completed by highly motivated and cooperative teachers. Our experience in evaluating mentally retarded children supports (1) the value of assessment instruments designed specifically for this patient population (e.g., *Aberrant Behavior Checklist*), (2) the need for evaluating a broader range of target symptoms, and (3) the importance of being alert to the somewhat greater variability of responses to stimulant drugs in these children.


The *Stony Brook DSM-III-R Checklist* (CSI-3R) is a rating scale of DSM symptoms, completed by a parent. It was designed for use as a clinical screening instrument. Comparisons were made between CSI-3R and Achenbach *Child Behavior Checklists* (CBCL) scores for 77 psychiatrically hospitalized...
children. It was hypothesized that CSI-3R Symptom Severity scores for the ADHD, Conduct Disorder, and Oppositional Defiant Disorders categories would predict CBCL externalizing scores, whereas CSI-3R anxiety and mood disorder scores would predict CBCL internalizing scores. These hypotheses were tested by multiple regression and both main effects were highly significant (p=.0000). CSI-3R symptoms of ADHD accounted for about 9% of the variance in CBCL externalizing scores, conduct disorder 5%, and oppositional defiant 3%; all were statistically significant. CSI-3R Overanxious Disorder category scores contributed the most to the variance in CBCL internalizing scores (13.5%), followed by major depression (4%). The hypotheses were supported by the data. The CSI-3R was designed for a somewhat different purpose from the CBCL, but the finding that their results are broadly compatible provides some support for the validity of the CSI-3R. [Intercorrelations between CSI-3R categories are also reported.]

YEAR: 1991


Describes a school-based medication evaluation (SBME) procedure that employs direct observations of child behavior and behavior rating scales. Measures include the *Stony Brook Child Psychiatric Checklist* (CSI-3) and early versions of the *ADHD School Observation Code* and the *Stimulant Side Effects Checklist*. Numerous survey studies of hyperactive children receiving stimulant medication during the past 20 years have found procedures for evaluating drug response to be wanting. One of the major problems in this area is the lack of precision in dosage selection. A case study is presented to illustrate the strengths of the SBME for evaluating response to methylphenidate and for determining the minimal effective dose (MED) in a 10-year-old boy with ADD. Limitations of the SBME are addressed as are alternative models for assessing drug effects.


The *Stony Brook Child Psychiatric Checklist* (CSI-3R), a parent-completed rating instrument based on DSM-III-R, was used as part of a psychiatric inpatient admission evaluation. Data were collected on 63 5- to 13-year-old children. Checklist endorsements were compared with the same parent's responses to the *Kiddie-Schedule for Affective Disorders and Schizophrenia for School-Aged Children-Epidemiologic Version* structured interview for the most frequently occurring disorders. Sensitivity scores ranged from 0.69 to 0.93. Results suggest the CSI-3R: Parent Checklist can be useful in alerting the clinician to diagnostic areas warranting further pursuit.


The relationship between serum cholesterol an number of measures of impulsiveness and aggression (e.g., *Stony Brook Child Psychiatric Checklist*, CSI-3R) was examined in 38 prepubertal, psychiatrically hospitalized children. Although care was taken to use reports and direct observations of both variables within 2 weeks of admission and 8 weeks later, no consistent relationship was found. The reasons for these findings are discussed.

YEAR: 1990


On of the least documented "known" effects of methylphenidate in hyperactive children is the suppression of peer aggression. In this study, 11 aggressive-hyperactive children received a low (0.3 mg/kg) and a moderate (0.6 mg/kg) dose of methylphenidate and placebo for 2 weeks each under double-blind conditions. Diagnostic measures included the *Stony Brook Child Psychiatric Checklist* (CSI-3) and drug response measures included the *Stimulant Side Effects Checklist*, *Peer Conflict Scale*, and an early version of the *ADHD School Observation Code*. Children were observed in public school settings during classroom seatwork activities, lunch, and recess. Results showed that methylphenidate suppressed nonphysical aggression (p=0.06) in the classroom, and a moderate dose decreased physical aggression (p<0.01) and verbal aggression (p=0.07) on the playground. The effect on the rate of appropriate social interaction was variable. The majority of subjects exhibited either the same or higher levels of appropriate social interaction on the 0.6 mg/kg dose compared with placebo. In the classroom, both doses of methylphenidate also resulted in reduced levels of motor movement, off task behavior, noncompliance, and disruptiveness. Teacher ratings of hyperactivity and conduct problem symptoms revealed drug effects, whereas parallel parent instruments did not.


The purpose of this paper is to compare and contrast the disorders of infancy, childhood and adolescence in the DSM-III-R with those of its predecessor, the DSM-III. Design features of the child psychiatry sections of the DSM-III-R are described, with comparisons of reliability and validity assessments in the two classifications. Categorical and dimensional systems of psychiatric nosology are described; the DSM-III-R has features of both systems. To be most useful for child psychiatrists in ordinary clinical practice, DSM-III-R symptom criteria should be available in a standardized but brief fashion to ensure adequate data gathering from both child and parent. This avoids the problems inherent in lengthy standardized interventions based on DSM-III-R criteria; although these interviews are excellent for research purposes, clinicians tend to avoid them as clinically constraining. The commonly used alternate of clinicians' overall evaluations is of uncertain reliability and validity, since it is unclear whether all symptoms have been asked for. A symptom checklist approach is therefore suggested as an intermediate procedure to ensure that appropriate questions are asked from the parent and child, while allowing fuller exploration by the clinician. This approach also indicates parent-child variance, and allows for rank ordering of diagnoses which may indicate priorities for treatment of child psychiatric disorders. Examples of such checklists are the *Diagnostic Symptom Checklist* and the *Child Symptom Inventory-3R*.

YEAR: 1989


The effects of methylphenidate on four boys diagnosed as attention-deficit hyperactivity disorder (ADHD) and Tourette's syndrome (TS) were examined under single-blind, placebo-controlled conditions. Diagnostic measures included the *Stony Brook Child Psychiatric Checklist* (CSI-3) and drug response measures included the *Stimulant Side Effects Checklist*. Clinical ratings and playroom observations showed improvement in ADHD symptoms with methylphenidate. Results also indicated that methylphenidate had no untoward effects on the frequency of tic occurrence. In all four children, the highest dose resulted in improved classroom ratings of tics compared with initial placebo treatment. In three cases, mild tic exacerbation was reported for a lower dose. Because variability of tic status was observed in the experimental conditions, the findings suggest the possibility that tic response was
independent of clinical doses of methylphenidate. The findings were also consistent with the theory that methylphenidate, a dopamine agonist, might affect tic status by altering dopamine receptor sensitivity. Further investigation of these effects is indicated, given the efficacy of methylphenidate in treating ADHD symptoms of TS patients.

YEAR: 1987


Two separate studies were conducted to examine the discriminant validity of the Stony Brook Child Psychiatric Checklist: Teacher Version (CSI-3), which contains the behavioral symptoms of 12 different emotional or behavioral disorders. For these analyses, each disorder was scored using the Screening Cutoff score method: Never=0, Sometimes=0, Often=1, and Very often=1. In the first study 81 children with emotional and behavioral disorders (EBD) and 86 children with learning disabilities (LD) attending full-time special education classes in elementary schools were compared using the CSI-3: Teacher Checklist. A significantly higher number of children with EBD obtained Screening Cutoff scores for the Oppositional Disorder and Conduct Disorder Aggressive categories than children with learning disabilities. The number of children receiving Screening Cutoff scores for the Conduct Disorder Aggressive category was twice as large in the sample with EBD than the sample with LD. These findings are highly consistent with the results of other studies that compared the behavioral characteristics of children with EBD and LD (e.g., Sprafkin & Gadow, 1987). In the second study, CSI-3: Teacher Checklist scores for 103 LD and 138 nonlabeled elementary school-aged children were compared. All of the children in the sample with LD were attending full-time special education classes. Across all diagnostic categories, the sample with LD was characterized as having more psychiatric symptoms. Significant group differences were found for the ADD with and without Hyperactivity, Oppositional Disorder, Pervasive Developmental Disorder, Schizoid Disorder, and Avoidant Disorder categories.


Teachers of children between 2 and 6 years old in a public school for children with emotional and behavioral disorders were asked to complete the CSI-3: Teacher Checklist for each child in her classroom. A total of 55 children (40 boys, 15 girls) were evaluated. The most common problems were externalizing behaviors such as attention deficit disorder with hyperactivity, refusal to comply with adult directives (oppositional disorder), and aggression (conduct disorder). There were relatively few "pure" types of any disorder, particularly externalizing behavior problems. Relatively few children exhibited the symptoms of pervasive developmental disorder or schizophrenia. Interestingly, 47% of the sample did not receive a Screening Cutoff score for any CSI-3 category. As for gender differences, girls were a somewhat less likely than boys to be found deviant on the symptoms/behaviors listed in the CSI-3. This difference was most striking for the Oppositional Disorder category.

YEAR: 1984


Examined the reliability and validity of the SLUG Checklist, a DSM-III-based behavior rating scale that
included the behavioral symptoms of ADD with and without hyperactivity, oppositional disorder, conduct disorder aggressive, and conduct disorder nonaggressive. Each symptom was rated on a 4-point scale (Not at all=0, Just a little=1, Pretty much=2, Very much=3). To assess the reliability of the SLUG Teacher Checklist, a sample (N=36) of ED children were rated 6 weeks apart. Test-retest reliabilities for the four diagnostic categories ranged from .70 to .89. Studies of the convergent validity of the SLUG Teacher Checklist revealed low to moderate (.32 to .39) correlations between the Aggression subscale of the IOWA Conners Teacher’s Rating Scale (Loney & Milich, 1982) and the Symptom Severity scores for the Oppositional Disorder, Conduct Disorder Aggressive, and Conduct Disorder Nonaggressive categories of the SLUG Teacher Checklist. There were no statistically significant correlations between scores for the IOWA Conners Inattention-Overactivity scale and the SLUG Teacher Checklist symptom categories. Nor were there any significant correlations between the SLUG Teacher Checklist scores and laboratory playroom measures of inattention and motor activity. However, direct observations of the frequency of nonphysical aggression exhibited on the playground during recess were moderately correlated with Symptom Severity scores for the Conduct Disorder Aggressive ($r=.58$) and Oppositional Disorder ($r=.39$) categories of the SLUG Teacher Checklist.