Respondent Psychopathology and Interpretive Accuracy of the Personality Inventory for Children: The Evaluation of a "Most Reasonable" Assumption

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This study investigates the relationship between maternal psychopathology and the validity of the Personality Inventory for Children (PIC). Specifically, we tested the hypothesis that psychopathology in the parent informant limits the ability of the resulting scale scores to predict actuarially derived descriptions of child emotional and behavior disorders. Mothers of 223 children and adolescents who had been referred for an evaluation to a child psychiatry service completed the PIC. These mothers also completed the Minnesota Multiphasic Personality Inventory (MMPI). The sample of mothers and their children was divided into two subsamples according to the mother's MMPI profile: within normal limits and clinically elevated. Nineteen factor dimensions scores derived from three separate behavior rating forms served as external criteria. Analyses indicated that maternal psychopathology, as represented by MMPI scale elevations, did not moderate or limit the predictive accuracy of PIC scales.

The application of self-report methodology to the development of objective personality inventories for children has proven problematic because of the very characteristics that motivate caregivers to refer children to mental health professionals: Children who are noncompliant and/or problem readers can hardly be expected to become successfully engaged in reading large sets of possible self-descriptions. An additional problem posed in the development of such instru-
ments for younger children is the need to restrict item content to the child’s level of verbal comprehension as well as reading skills (if the inventory items are to be read by, instead of read to, the child).

One solution to these considerable problems has been to design measures that are to be completed by adults who are quite familiar with a given child’s behavior and adjustment. Parents, and often specifically mothers, are designated the respondent to the items of such measures as the Revised Behavior Problem Checklist (Quay & Peterson, 1983), the Child Behavior Checklist (Achenbach, 1978), the Behavioral Classification Inventory (Dreger, 1977, 1981), the Institute for Juvenile Research Checklist (Lessing, Black, Barbera, & Seibert, 1976), the Louisville Behavior Checklist (Miller, 1977), and the Personality Inventory for Children (PIC; Lachar, 1982; Wirt, Lachar, Klinedinst, & Seat, 1984). The collection of responses from adult informants has overcome the technical and logistic problems posed by the limited motivation and verbal comprehension of many referred children.

The practice of using parents as respondents has not been without its critics, however. In the case of the PIC, such criticism has been raised in spite of the availability of considerable empirical evidence to the contrary. As noted in the second edition of the manual (Wirt et al., 1984), the PIC profile scales have been successfully applied in such areas as hyperactivity (Breen & Barkley, 1983; Forbes, 1985; Voelker, Lachar, & Gdowski, 1983), depression (Leon, Kendall, & Garber, 1980; Lobovits & Handal, 1986), the effects of divorce (Kurdek, Bisk, & Siesky, 1981; Schreiber, 1982), and the need for special education services (Clark, 1982; DeKrey & Ehly, 1985; Lachar, Kline, & Boersma, 1986; Porter & Rourke, 1985; Schnel, 1982). Several studies have established the empirical validity of the 20 profile scales through the identification of external correlates (Gdowski, Lachar, & Kline, 1985; Kline, Lachar, & Sprague, 1985; Lachar, 1982; Lachar, Butkus, & Hryhorczuk, 1978; Lachar & Gdowski, 1979a, 1979b; Lachar, Gdowski, & Snyder, 1982, 1984, 1985).

The criticisms about the source of PIC responses have taken two basic forms. In the first, established scale validity is minimized by the concern that PIC results, as they come from mothers, basically reflect maternal perceptions and concerns. For example, Cronbach (1984) has stated, “Users are encouraged to think of the instrument as measuring the child. In fact, it is summarizing the mother’s perception of the child or, more precisely, the perception the mother wants the clinician to think she has” (p. 524). A second position, as articulated by Achenbach (1981), is even more extreme because it assumes that maternal individual differences are reflected in PIC scale variance: “The use of the child’s mother as a respondent means that the PIC most directly taps her personality rather than the child’s” (p. 333).

In making this “most reasonable” assumption that the use of an informant essentially compromises test accuracy, these reviewers discount available evidence of scale validity and focus solely on the source of PIC responses and the assumed
implications of this sort of data. The psychometric performance of the PIC scales has been offered as evidence of a lack of problematic bias and distortion (Lachar & Wirt, 1981; Wirt & Lachar, 1981). Indeed, studies that have identified external behavior correlates of PIC profile scales have not excluded protocols with significant elevations on the scales that may indicate respondent distortion (Lie, Frequency, Defensiveness); nevertheless, strong evidence of PIC scale validity has been obtained. It appears that potential users of informant-derived child evaluation measures are often unable to move beyond their initial reaction to the source of questionnaire response. This reaction appears to limit their appreciation of the psychometric process by which these responses are transformed into measures that allow the generation of actuarial predictions.

Because of a previous study of the relation between parent and child personality (Lachar & Sharp, 1979), data were available that could allow evaluation of the most extreme position of parental bias, namely, that many mothers of referred children, due to their own emotional disturbance, are unable to describe their children's behavior status accurately (e.g., Beversluis, 1983). This sample also had available for each child multidimensional behavior rating forms independently completed by parents, school teachers, and clinicians. Although the form completed by parents may have been subject to the same potential distortion from maternal psychopathology as the PIC, the forms completed by teacher and clinician were independent of such influence (see Lachar et al., 1985, for a discussion of this issue).

The availability of child behavior data independent of the PIC allowed evaluation of two specific questions in this study, both relating to the accuracy of PIC scale predictions. First, would the PIC profiles generated by mothers with emotional problems, as reflected by the MMPI, predict external child behavior criteria as well as the PIC profiles obtained from mothers without significant evidence of psychopathology? Second, would mothers be able to describe via the PIC their children's specific emotional and conduct problems independently of their own adjustment difficulties?

METHOD

Subjects

The total sample included 223 children and adolescents referred to a child psychiatry service for a wide variety of emotional and behavioral problems and their mothers who accompanied them. Sources of referral included parents (29%), mental health agencies (27%), school personnel (25%), private psychiatrists (12%), courts (4%), and family physicians (3%). The sample included 135 boys (61%) and 88 girls (39%); 148 (66%) were white and 75 (34%) were black. The mean subject age was 11.3 years. The mothers had an average age of 37.3 years
and a mean education of 11.5 years; 49% of the mothers were married, 27% divorced, 11% separated, 8% single, and 5% widowed.

This sample of mothers and their children was partitioned into two subsamples according to the mothers’ MMPI profiles: Those that were within normal limits (WNL; n = 108) had T scores less than 70 for all clinical scales excluding Mf. Those that were clinically elevated (CLIN; n = 115) had significant elevation, T greater than 69, on at least one of the MMPI clinical scales, excluding Mf. The mothers of the two subsamples differed significantly across all MMPI clinical scales, except Mf. Within CLIN, 43 (37%) had “spike” profiles characterized by an isolated single scale elevation (42% of these had T > 69 elevations on Pd), 23 (20%) had clinical elevations on only two scales (52% of these included Pd in the 2-point code), and 49 (43%) had three or more significantly elevated scales. Subsequent univariate comparisons revealed that these two MMPI-derived samples did not differ significantly on child age, race, or sex, as well as mother education and marital status. The WNL sample mothers (M age = 38.4) was marginally older than the CLIN sample mothers (M age = 36.3).

Measures

Five primary measures were available for each mother-child pair. The MMPI was administered to all 223 mothers and scored on the 13 standard validity and clinical scales. MMPI F scale scores were below 100T for all subjects.

The T scores of the 16 full-length PIC profile scales, obtained from maternal response, were available for each child and adolescent. The PIC is an objective, multidimensional measure of child and adolescent behavior, affect, and ability. These profile scales, constructed using an empirical or rational/content scale strategy, include 3 scales that measure informant response set, Lie (L), Frequency (F), and Defensiveness (DEF); a general screening scale, Adjustment (AD); and 12 substantive clinical scales, Achievement (ACH), Intellectual Screening (IS), Development (DVL), Somatic Concern (SOM), Depression (D), Family Relations (FAM), Delinquency (DLQ), Withdrawal (WDL), Anxiety (ANX), Psychosis (PSY), Hyperactivity (HPR), and Social Skills (SSK).

Three separate objective behavior rating forms provided external criteria for each child or adolescent subject. One form was completed by each child’s mother and other relatives as part of the application to the clinic, another was completed by each child’s classroom teachers, and the final form was completed by a psychiatric resident or psychology intern who conducted the clinical evaluation. These three data collection forms are reproduced in Appendix A of Lachar and Gdowski (1979a). Rating form content was selected for source specificity to maximize accuracy and brevity. The items of each form were subjected separately to iterative common factor analysis by Lachar et al. (1984) within a sample of 691 children and adolescents that was demographically similar to the current sample. For each rating form, 4, 6, 8, and 10 factors were extracted by Lachar et
al. (1984), and all factors obtaining eigenvalues greater than 1 were subjected to varimax rotation and retained for further review if five or more items on each factor obtained a factor weight greater than 0.29. The most parsimonious solution was selected to represent the content of each form based on the stability and representativeness of the dimensions derived. Rating dimension scores were then developed by assigning unit weights to all items that obtained a factor weight greater than 0.29 on a given factor. Unit weighting systems generally perform well relative to more complex weighting schemes (Lessing & Clarke, 1982; Wainer, 1976, 1978) and offer inherent simplicity of application.

The Lachar et al. (1984) factor analysis of the parent form yielded five dimensions that incorporated 52 of 64 items, the teacher form yielded seven dimensions including 74 of 78 items, and the clinician form yielded seven dimensions incorporating 69 of 95 items. The five parent, seven teacher, and seven clinician dimensions obtained average intercorrelations of .27, .30, and .13, respectively, in the Lachar et al. (1984) sample. The complete specific item composition of these 19 rating form dimensions is presented in Lachar et al. (1984). The resulting rating form dimensions, number of items, and internal consistency coefficients (alpha) for each form are as follows:


2. Teacher dimensions: Hostility/Impulsivity (24/.94), Poor Study Skills (12/.89), Academic Delay (11/.89), Poor Classroom Adjustment (12/.87), Poor Self-Concept/Depressive Symptoms (11/.80), Social Withdrawal (8/.77), and Distractible/Motor Restlessness (9/.77).


Larger factor scores reflect greater pathology in the areas measured by these dimensions.

Statistical Analysis

An initial analytic approach provided the expected comparison of the PIC results obtained in the WNL and CLIN samples. It is important to note, however, that any differences revealed by such a comparison would not provide clear evidence of differential validity because the WNL and CLIN samples were not matched on type and degree of childhood psychopathology (e.g., Dahlstrom, Lachar, & Dahlstrom, 1986; Kline et al., 1985; Pritchard & Rosenblatt, 1980). For example, rather than concluding that maternal psychopathology compro-
mises PIC scale validity, equally parsimonious explanations for maternal MMPI/child PIC relationships would include a variety of experiential and genetic effects that have received empirical support in the study of parent-child characteristics.

A second statistical approach directly tests the issue of PIC differential validity. Two general multiple correlation methods were employed to investigate whether maternal psychopathology, as reflected by the MMPI, moderates the predictive accuracy of the 12 PIC clinical scales. The first method evaluated whether the magnitude of the correlations between PIC scales and external criteria differed across the WNL and CLIN samples. Within each of these two samples, all 12 PIC clinical scales were utilized as predictor variables of the 19 criterion dimensions with multiple regression. In addition, the PIC scales that obtained significant beta weights within each regression equation were identified by the “F-to-remove” test (Kenny, 1975). These analyses not only allowed comparison of the strength of the relationship between the PIC and the external criteria, but also whether the structure of these relationships, as indicated by the PIC scales obtaining significant beta weights, differed across the WNL and CLIN samples.

The second multiple correlation method evaluated the relative independence of maternal MMPI and PIC data in predicting the external child behavior rating dimensions. For the total sample (N = 223), the 12 PIC clinical scales were entered into multiple regression equations to predict each of the 19 external criteria. Additionally, the 10 MMPI clinical scales were entered into separate multiple regression equations to predict these same 19 criteria. These analyses allowed comparison of the relative efficiency of mothers’ reports of their own problems versus their reports of their children’s problems in predicting the external criteria. Following these separate PIC and MMPI regressions, a hierarchical multiple regression was conducted for each of the 19 criteria in the following manner: The 12 PIC clinical scales were entered simultaneously at the first step. Then the 10 maternal MMPI clinical scales were entered simultaneously at the second step. The multiple correlation values at each step were evaluated for significance, and the incremental validity that accrued by entering the MMPI scales was also tested for significance. These hierarchical analyses determined whether information about maternal personality integrity could contribute significantly to the prediction of child adjustment over the predictive value of the PIC scales alone.

RESULTS

To provide a summary index of the relationship between the degree of child and maternal psychopathology in this sample, a simple Pearson correlation coefficient was calculated between the number of maternal MMPI scales greater than 69T out of a possible 10 and the number of clinically elevated PIC scales out of a possible 12. This correlation was statistically significant, but it was of low magni-
tude and in the negative direction, $r = -.26$, $p < .05$. Thus maternal MMPI variance with regard to number of scale elevations accounted for less than 7% of PIC scale variance. This result indicated that the magnitude or heterogeneity of maternal psychopathology was not generally predictive of the magnitude or heterogeneity of child psychopathology as reflected by these measures. That is, mothers who ascribed a variety of personal problems to themselves via self-report appeared to be no more likely to do the same in the description of their problem children.

Multivariate comparison of the 12 PIC clinical scales for WNL and CLIN samples was significant, although the statistical effect was relatively small, Wilks' lambda $= 0.798$, $F(12, 211) = 4.46$, $p < .01$. Application of the index of redundancy statistic (Stewart & Love, 1968) demonstrated that the WNL–CLIN group contrast accounted for only 2.6% of the overall PIC scale variance. The means of all PIC profile scales and proportions of children who obtained clinical elevations on these scales for the WNL and CLIN samples are presented in Table 1. This table also reports the clinical range cutting $T$ scores for each PIC scale (Lachar & Gdowski, 1979a) and the results of univariate sample comparisons for PIC scale means and clinical range proportions. The mean PIC scale scores and

<table>
<thead>
<tr>
<th>Scale</th>
<th>Clinical Range</th>
<th>WNL (n = 108)</th>
<th>CLIN (n = 115)</th>
<th>Means</th>
<th>Proportions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$M$</td>
<td>%</td>
<td>$M$</td>
<td>%</td>
<td>$F(1, 221)$</td>
</tr>
<tr>
<td>L</td>
<td>&gt; 59*</td>
<td>44.2</td>
<td>3</td>
<td>40.1</td>
<td>0</td>
</tr>
<tr>
<td>F</td>
<td>&lt; 99</td>
<td>80.6</td>
<td>16</td>
<td>88.0</td>
<td>30</td>
</tr>
<tr>
<td>DEF</td>
<td>&gt; 69</td>
<td>44.6</td>
<td>5</td>
<td>43.4</td>
<td>2</td>
</tr>
<tr>
<td>ADJ</td>
<td>&gt; 59</td>
<td>86.9</td>
<td>89</td>
<td>91.4</td>
<td>97</td>
</tr>
<tr>
<td>ACH</td>
<td>&gt; 59</td>
<td>63.2</td>
<td>7</td>
<td>67.6</td>
<td>68</td>
</tr>
<tr>
<td>IS</td>
<td>&gt; 69</td>
<td>61.8</td>
<td>34</td>
<td>63.8</td>
<td>39</td>
</tr>
<tr>
<td>DVL</td>
<td>&gt; 59</td>
<td>79.3</td>
<td>7</td>
<td>67.6</td>
<td>58</td>
</tr>
<tr>
<td>SOM</td>
<td>&gt; 69</td>
<td>65.3</td>
<td>37</td>
<td>70.7</td>
<td>51</td>
</tr>
<tr>
<td>D</td>
<td>&gt; 69</td>
<td>73.0</td>
<td>52</td>
<td>75.8</td>
<td>68</td>
</tr>
<tr>
<td>FAM</td>
<td>&gt; 59</td>
<td>58.9</td>
<td>42</td>
<td>66.6</td>
<td>68</td>
</tr>
<tr>
<td>DLQ</td>
<td>&gt; 79</td>
<td>83.3</td>
<td>47</td>
<td>91.6</td>
<td>70</td>
</tr>
<tr>
<td>WDL</td>
<td>&gt; 69</td>
<td>66.7</td>
<td>32</td>
<td>65.4</td>
<td>33</td>
</tr>
<tr>
<td>ANX</td>
<td>&gt; 69</td>
<td>65.6</td>
<td>34</td>
<td>70.1</td>
<td>39</td>
</tr>
<tr>
<td>PSY</td>
<td>&gt; 79</td>
<td>78.4</td>
<td>40</td>
<td>80.7</td>
<td>46</td>
</tr>
<tr>
<td>HPR</td>
<td>&gt; 59</td>
<td>61.4</td>
<td>54</td>
<td>61.8</td>
<td>57</td>
</tr>
<tr>
<td>SSK</td>
<td>&gt; 69</td>
<td>68.9</td>
<td>53</td>
<td>70.3</td>
<td>58</td>
</tr>
</tbody>
</table>

*T-score units.

*p < .01.
proportions of children scoring in the clinically elevated range indicated significantly greater deviance on scales DLQ and FAM for the CLIN sample. (Results are reported at $p < .01$ because use of $p < .05$ resulted in mean differences as small as four $T$-score units attaining significance.) Over two thirds of the children in the CLIN sample obtained clinically elevated FAM and DLQ $T$ scores, as compared to under half of the children in the WNL sample, suggesting somewhat more severe examples of child externalizing behavior as well as greater evidence of familial, marital, and parental maladjustment within this sample. A greater proportion of clinically significant elevations was also obtained for scales F and ADJ among the CLIN sample; the mean SOM $T$ score was significantly greater in the CLIN sample, and the mean L $T$ score was significantly greater in the WNL sample. As documented in Table 1, only 2 of the 16 profile scales substantially varied according to respondent MMPI status. One of these PIC scales (FAM) specifically was designed to reflect, in part, the emotional adjustment of parents, whereas the other (DLQ) had been found in a large actuarial study to be related to ratings of parental inconsistency in setting limits with their children (Lachar & Gdowski, 1979a).

The results of the direct comparison of PIC predictive validity within WNL and CLIN samples using multiple regression analyses is presented in Table 2. A total of 12 of 19 multiple correlations obtained significance within the WNL sample, and 11 of the 19 multiple correlations attained significance within the CLIN sample. Seven criterion dimensions were significantly predicted by PIC scales in each MMPI-defined sample. Four parent dimensions (Hostility/Dyscontrol, Depressive/Somatic Symptoms, Antisocial Behavior, Developmental Delay), one teacher dimension (Hostility/Impulsivity), and two clinician dimensions (Hostility/Dyscontrol, Antisocial Behavior) were significantly predicted by PIC scales in both WNL and CLIN samples. The relative magnitudes of these correlations for each MMPI-defined sample were generally comparable, with the CLIN sample coefficients somewhat higher.

Examination of the individual PIC scales that obtained significant beta weights in their respective regression equations revealed similar patterns across both samples. The same PIC scales obtained significant beta weights in both samples in the prediction of the parent dimensions of Depressive/Somatic Symptoms, Antisocial Behavior, and Developmental Delay, and the clinician dimension of Antisocial Behavior. Even when the regression equations in these two samples did not obtain significant beta weights for the identical PIC scales, cross-sample comparison indicated that the PIC scales identified in each sample were conceptually consistent. For example, only PIC scales that reflect primarily externalizing symptomatology (DLQ and HPR) attained significant beta weights in both WNL and CLIN samples in the prediction of parent and clinician description of Hostility/Dyscontrol and clinician report of Emotional Lability/Impulsivity. Considering the expected statistical instability of the tests of individual beta weights across relatively small samples, these individual PIC scale
**TABLE 2**

Multiple Correlation of PIC and Maternal MMPI to Rating Form Factor Dimensions

<table>
<thead>
<tr>
<th>Rating Form Factor Dimension</th>
<th>Separate Sample</th>
<th>Whole Sample$^c$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WNL$^a$</td>
<td>CLIN$^b$</td>
</tr>
<tr>
<td>Parent Respondent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hostility/Dyscontrol</td>
<td>50$^*(DLQ)^d$</td>
<td>63** (DLQ, HPR)</td>
</tr>
<tr>
<td>Depressive/Somatic symptoms</td>
<td>48** (SSK)</td>
<td>55** (SSK)</td>
</tr>
<tr>
<td>Antisocial behavior</td>
<td>55** (DLQ)</td>
<td>69** (DLQ)</td>
</tr>
<tr>
<td>Developmental delay</td>
<td>47* (IS)</td>
<td>62** (IS)</td>
</tr>
<tr>
<td>Cognitive/Attentional deficits</td>
<td>33</td>
<td>55** (IS, DLQ)</td>
</tr>
<tr>
<td>Teacher Respondent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hostility/Impulsivity</td>
<td>52* (IS, DLQ)</td>
<td>51* (DLQ, HPR)</td>
</tr>
<tr>
<td>Poor study skills</td>
<td>42</td>
<td>40</td>
</tr>
<tr>
<td>Academic delay</td>
<td>56** (IS)</td>
<td>37</td>
</tr>
<tr>
<td>Poor classroom adjustment</td>
<td>44</td>
<td>47* (DLQ)</td>
</tr>
<tr>
<td>Poor self-concept/Depressive symptoms</td>
<td>43</td>
<td>21</td>
</tr>
<tr>
<td>Social withdrawal</td>
<td>27</td>
<td>54** (SOM)</td>
</tr>
<tr>
<td>Distractible/Motor restlessness</td>
<td>48* (IS, -SOM)</td>
<td>33</td>
</tr>
<tr>
<td>Clinician Respondent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hostility/Dyscontrol</td>
<td>47* (DLQ)</td>
<td>65** (DLQ, HPR)</td>
</tr>
<tr>
<td>Language/Motor deficits</td>
<td>60* (IS)</td>
<td>27</td>
</tr>
<tr>
<td>Emotional lability/Impulsivity</td>
<td>43 (DLQ)</td>
<td>53* (DLQ, HPR)</td>
</tr>
<tr>
<td>Disorganization/Limited reality</td>
<td>46* (IS)</td>
<td>38</td>
</tr>
<tr>
<td>Depressive/Somatic symptoms</td>
<td>40 (SSK)</td>
<td>34</td>
</tr>
<tr>
<td>Antisocial behavior</td>
<td>64** (DLQ, SSK)</td>
<td>66** (DLQ, SSK)</td>
</tr>
<tr>
<td>Social withdrawal</td>
<td>58** (SSK)</td>
<td>38</td>
</tr>
</tbody>
</table>

$^a$n = 108, $^b$n = 115, $^c$N = 223. $^d$Scales that obtained significant beta weights. $^e$p < .05. $^{**}$p < .01.

analyses are quite consistent and provide some evidence of the replication of PIC scale-to-external correlate relationships.

Results of the total sample multiple regressions with the PIC and MMPI scales are also presented in Table 2. Inspection of this table reveals that 15 of 19 multiple correlations of the PIC scales with the criterion dimensions achieved significance. In general, the magnitude of these correlations is greater than those obtained within the WNL and CLIN samples due to the larger sample size. In stark contrast to the PIC results, all multiple correlations of maternal MMPI scales with each of the 19 external dimensions were nonsignificant.

The multiple correlations predicting behavior rating dimensions using both the PIC and maternal MMPI are reported in Table 2. The multiple correlations derived from both PIC and MMPI scales are only marginally greater than those generated using only the PIC scales. In fact, all F-ratio tests of the incremental multiple correlation values obtained when maternal MMPI scales were added were nonsignificant. The range of these incremental multiple values was from .02
to .10, indicating that maternal MMPI variance accounted for at most 1% of unique criterion dimension variance not already explained by the 12 PIC clinical scales.

DISCUSSION

The results of this study do not support the assumption that maternal personality or psychopathology, as represented by MMPI scale elevations, moderates or limits the predictive potential of PIC scales. The magnitude of PIC scale co-variations with independent behavior ratings from parents, teachers, and clinicians was similar in two samples differing in degree of maternal psychopathology. In addition, the presence of significant PIC scale elevations within both maternal MMPI-defined samples seemed equally predictive of the attribution of problems by all three informant sources. Although the parent behavior checklist cannot be considered as a totally independent external criterion of the PIC, the emergence of this general pattern of results among the most PIC-independent ratings (i.e., those of classroom teachers and clinicians) enhances the confidence about the orthogonality of maternal psychopathology and the accuracy of PIC scale elevations generated by maternal response. In addition, the fact that the PIC significantly covaried with parent ratings of child developmental history and problem chronicity completed up to several weeks prior to clinic evaluations for both samples of mothers provides some evidence consistent with this conclusion (Lachar et al., 1985). Other analyses that have been presented are consistent with this conclusion. The addition of measures of maternal emotional status did not improve upon the predictive ability of the PIC, and substantial differences were not obtained across the 16 PIC profile scales between samples of mothers who had obtained within normal limits versus elevated MMPI profiles.

A case history further illustrates the relationship of parental global perception, parental response to PIC items, and actual child status: Interviews with parents concerning their 8-year-old son presented the clinical picture of chronic overactivity. In addition, temper tantrums, defiance and refusal to comply with parental requests, and aggressive behavior directed toward younger siblings were reported. He was in the fourth grade and achieving at grade level. Teachers documented some behavioral difficulties as well as problems with attention and concentration. An initial diagnostic impression of attention deficit disorder with hyperactivity led to a trial of psychostimulant medication.

His mother completed the PIC as part of the evaluation. The resulting profile demonstrated elevations in the clinical range for IS (72T), D (73T), and ANX (78T). In contrast, scales predictive of impulsivity and overactive behavior (HPR) and attention deficits (HPR, DVL) were not within the clinical range (cf. Lachar & Gdowski, 1979a). This profile was of clinical interest and specifically relevant to this present study's focus on PIC accuracy in that history obtained
from the parents and initial interview data did not indicate either significant internalizing pathology (D, ANX) or cognitive impairment (IS). Similarly, the information obtained in the initial interview appeared to be inconsistent with a within normal limits elevation of HPR.

Psychological assessment documented superior cognitive abilities (Wechsler Intelligence Scale for Children–Revised Full Scale IQ = 120). This performance was inconsistent with teacher report of only age-appropriate achievement. A neuropsychological assessment suggested temporal sequencing difficulties that were felt to be related to this ability/achievement discrepancy. Culbert and Gdowski (1981) have presented data suggesting that relatively moderate elevations on IS (70–79T) reflect specific cognitive deficits in a sample of reading disabled children of at least average intelligence. Psychostimulant medication proved ineffective for this child and was discontinued. Voelker et al. (1983) have suggested that the absence of clinical elevations on HPR, as obtained in this case, is contraindicative of a positive response to psychostimulants.

This child was continued in individual outpatient treatment. During the course of therapy, he described periods of sadness, loneliness, and fearfulness during which he would frequently withdraw to his room. He finally disclosed his concerns about his mother, her excessive use of alcohol, and his fear that she might injure herself. These concerns had been accurately reflected in the PIC elevations of scales D and ANX. This case presentation suggests that global maternal perceptions and their a priori categorization of child behavior are unlikely to affect response to molecular inventory items and that the resulting scale elevations may actually be accurate even when in apparent discrepancy with data obtained during diagnostic interviews.

Clinicians have relied and will continue to rely on parents as the major source of information about child behavior and development. The analyses presented in this article, in previously published literature, and in this case history clearly document the merits of transforming systematic parent responses into inventory items and the actuarial interpretation of the resulting scales.

REFERENCES


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