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SOCIAL SKILLS IN SPECIAL EDUCATION ADOLESCENT STUDENTS WITH OPPOSITIONAL DEFIANT DISORDER

by

VASILIOS SKOULOS

A dissertation submitted to the Graduate Faculty in Educational Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

The City University of New York

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Abstract

SOCIAL SKILLS IN SPECIAL EDUCATION ADOLESCENT STUDENTS WITH OPPOSITIONAL DEFIANT DISORDER

by

Vasilios Skoulos

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Social skills development has been an area of investigation for a long time. Studies have indicated that special education students have more social skills deficits than mainstream students. This is particularly true for "Emotionally Disturbed" students who seem to have the poorest social skills of all special education students (Gables, Hendrickson, & Rutherford, 1991). Recent educational reforms, supported by the re-authorization of the IDEA (P.L. 105-17) call for the mainstreaming of all special education students. Reaction to such mainstreaming efforts has been presented since the early 1980's. Gresham (1984) has advocated that arbitrary placement of special education students in mainstream classes is based on three faulty assumptions: a) social interactions between special education and mainstream students will increase, b) handicapped students will be accepted by their mainstream peers, and c) mainstream students will model appropriate behaviors to their special education peers. Gresham (1984) has recommended

social skills training prior to mainstream placement in order for mainstreaming efforts to be successful.

Although emotionally disturbed students have been viewed as having more social skills deficits than any other group of special education students, it is not clear which of the emotionally disturbed students actually have social skills deficits. This is because the emotionally disturbed category consists of students with various psychiatric disorders. The present study examined social skills deficits among special education students who met criteria for Oppositional Defiant Disorder (ODD; American Psychiatric Association, 1994). Twenty seven special education high school students diagnosed as ODD (experimental group) and 27 special education high school non-ODD students (control group) were rated by two sets of teachers along the three scales of the Social Skills Rating System-Teacher (SSRS-T; Gresham, & Elliott, 1990). Participants were matched on the following variables: age, gender, socioeconomic status, grade, learning disability. A modified version of the parent version of the Diagnostic Interview for Children and Adolescents-Revised (DICA-R; Reich, Leickock & Shanfeld, 1995) was used to determine the presence of ODD. The interview was modified to be used by teachers. Students' social skills were assessed via the SSRS-T. Three hypotheses were advanced: a) ODD students would be rated significantly lower on the Social Skills scale of the SSRS-T than non-ODD students, b) ODD students would be rated significantly higher on the Problem Behaviors scale of the SSRS-T than non-ODD students, and c) ODD students would be rated significantly lower on the Academic Competence scale of the SSRS-T compared to their non-ODD counterparts. Data were analyzed via three one-tail,

paired t-tests using the scores from the three sub-scales of the SSRS-T. The results supported the hypotheses. One unexpected finding was that the second group of teachers rated students significantly higher than the first group on the Problem Behaviors scale. It was assumed that the second group of teachers rated them higher because they had more time to observe inappropriate behaviors. Implications of these findings for social skills training and inclusionary efforts are addressed as well as limitations of the study and suggestions for future research.

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CHAPTER 1:

Overview

Several social reforms in the late nineteenth and early twentieth centuries were directed at children. Among these movements was compulsory schooling (Fagan, 1992). Compulsory education was accompanied by the need to provide services to children with handicaps. To deal with the various mental and physical conditions of handicapped students who were mandated to attend public schools, special education classes emerged in 1910. Despite compulsory schooling requirements, however, students continued to be excluded from school because of handicaps. Several landmark "right-to-education" lawsuits (Mills v. Board of Education, 1972; Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania, 1971, 1972) resulted in court rulings that handicapped children could not be excluded from public education.

As a result of such litigation, Public Law 94-142 was introduced in 1975 mandating education of students with special needs in the "least restrictive environment" Public Law 94-142 established criteria for classification of handicapped students into twelve categories (e.g., Learning Disabled, Emotionally Disturbed, Autistic, Speech Impaired). Students meeting criteria for one or more of these categories were eligible for special education services. The legislative requirement that handicapped children be educated in the least restrictive environment encouraged inclusion of special education students in mainstream classes with students without handicapping conditions. Mainstreaming efforts became more widespread following nationwide calls to include all students with disabilities in general education classes (Reynolds, Wang, & Walberg, 1987). For example, the Texas Education Agency issued a statewide leadership initiative

that proposed to educate all students, regardless of disability, in general education classes (Meadows, Neel, Scott, & Parker, 1994). By the late 1980's it was estimated that approximately half of all students with behavioral disorders were mainstreamed for at least part of their day in general education classes (U.S. Department of Education, 1989).

The most recent reauthorization of Public Law 94-142, the Individuals with Disabilities Education Act (IDEA) Amendments of 1997 (Public Law 105-17), calls for more "inclusion" into mainstream classes. "Inclusion" classes involve a regular education and a special education teacher teaching together a class that consists of mainstream and special education students. As such, "inclusion" can be viewed as a subset of the overall concept of mainstreaming. Consistent with nationwide mainstreaming efforts, the chancellor of the New York City Board of Education presented his Implementation Plan for Special Education on November 20, 1996, in an attempt to offer specific initiatives for reform with a primary focus on supporting students in general education instructional environments. Thus, the history of the education of students with disabilities has progressed from exclusion of some children with handicaps to instruction in special education classes to legislation stipulating mainstream instruction to the greatest extent possible.

The movement toward increased mainstreaming of special education students has elicited some cautionary reaction. Gresham (1984) protested the arbitrary placement of special education students in the mainstream. He argued that the concept of mainstreaming was based in part upon three faulty assumptions. The first assumption was that physical placement of special education children in regular classrooms would result in increased social interaction between regular and special education children. The second

assumption was that mainstream placement would result in social acceptance of handicapped children by their non-handicapped peers. The third assumption was that mainstreamed handicapped children would model or imitate the behavior of their nonhandicapped peers. Gresham (1984) presented evidence from several studies to support the position that these assumptions are faulty. Furthermore, he recommended the need for social skills training prior to the mainstreaming of special education students since special education students were found to have social skills deficits compared to regular education students.

More recently, Meadows, et al. (1994) concluded that the inclusion movement would pose a multitude of problems particularly for students whose handicapping conditions are classified under IDEA as Emotionally Disturbed. Research by Gable, Hendrickson, and Rutherford (1991) indicates that social skills among emotionally disturbed students are not as well developed as social skills of students with other handicapping conditions such as learning disabilities. These social skills deficiencies may present problems in mainstreaming of emotionally disturbed students (Gresham, 1984).

Study of factors, such as social skills, that may relate to mainstreaming success is further complicated by the undifferentiated nature of the "Emotional Disturbance" classification. The IDEA (1993) definition of "Emotional Disturbance" includes an inability to learn due to emotional disturbance, an inability to form satisfactory relationships, depression, fears and anxiety, and/or odd and unusual behavior. This definition clusters symptoms of various psychiatric diagnoses listed in the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV; American Psychiatric Association, 1994) together. For instance, inability to form satisfactory relationships may

be a symptom of Conduct Disorder (CD), depression may suggest Major Depression or Dysthymia, fears and anxiety may indicate one of the Anxiety Disorders while odd and unusual behavior could be a symptom of a Psychotic Disorder. As a result, frequently there is no way to determine specific symptom characteristics of research participants labeled as emotionally disturbed (Kavale, Fornes, & Alper, 1986). Thus behaviors displayed by subjects from one sample may vary greatly from those displayed by participants in another sample making comparison of results and generalization to other samples of emotionally disturbed students virtually impossible. Furthermore, researchers tend to use the terms "Emotionally Disturbed," "Behaviorally Disordered," and "Emotionally Handicapped" interchangeably. Singh, Deitz, Epstein, and Singh (1991) advocated the adoption of the DSM (American Psychiatric Association, 1994) classification system to deal with problems associated with the lack of specificity of the IDEA "Emotionally Disturbed" category.

To summarize, recent educational reforms require the placement of special education students into regular education classes, a practice called mainstreaming. However, there are two main concerns when dealing with mainstreaming. The first concern involves the arbitrary placement in the mainstream of special education students in general and those labeled as "Emotionally Disturbed" in particular. As noted above, there is some indication that such efforts may not succeed unless social skills training precedes mainstream placement. The second concern involves the defining characteristics of the "Emotionally Disturbed" group of students. The IDEA definition lacks specificity and therefore allows for inclusion of a very heterogeneous group of students under the classification category of "Emotionally Disturbed". As suggested above, researchers need

to delineate this classification category so that results of studies can enhance our understanding of the needs and deficits of different types of "Emotionally Disturbed" students. Study of children and adolescents with specific DSM-IV diagnostic labels will clarify whether all or just some "Emotionally Disturbed" students have social skills deficits. Furthermore, results of such studies will promote efforts for placement of these students in mainstream classes by providing specific suggestions for additional support for students with social skills deficits.

To address these two important concerns, the present study identified Emotionally Disturbed students whose behavior met criteria for a specific DSM-IV diagnostic category, Oppositional Defiant Disorder (ODD), and compared their social skills to those of special education students who did not meet these specific diagnostic criteria. In this way, a well defined group of students with specific characteristics was identified for examination of possible social skills deficits relative to other special education students.

Oppositional/Defiant Disorder was selected for study because the behavior of children and adolescents displaying ODD symptoms is disruptive to others. Diagnostic criteria for ODD include losing one's temper, arguing with adults, defying requests and rules, annoying others, and blaming others (American Psychiatric Association, 1994). These symptoms are indicative of social problems and may be associated with social skills deficits. Thus, children diagnosed with ODD were expected to have significantly lower social skills ratings by teachers than special education students who did not display ODD symptomatology.

Another group of "Emotionally Disturbed" students who have been shown to have social skills deficits relative to other special education students (Joffe, Dobson, Fine,

Marriage, & Haley, 1990) are those diagnosed as Conduct Disordered (CD). These students are generally sent to special schools and thus, are not often seen in a regular high school. Exclusion criteria were used to avoid participation in this study by students diagnosed with CD who may still have been in the regular high school.

CHAPTER 2:

Social Skills

Children's social development research has a long history. According to Hughes (1990), early theoretical developments occurred in the 1930's and 1940's (e.g., Koch, 1933; Piaget, 1932) but very little research took place during the next three decades. However, interest increased dramatically in the 1960's and continues to this date. Social skills research falls under the rubric of social competence which in turn is a subcategory of social development research.

Social competence in children, as one of the domains of social development, has attracted particular interest among psychologists and educators alike. There are several reasons for this interest: a) social interactions are important in everyday life because they enhance the quality of living, b) theoretical assumptions (e.g., Goleman, 1995) indicate that intelligence alone is insufficient to predict later success in life, and social competence has a better chance to accomplish this goal, c) some research evidence indicates that peer relationship problems in childhood predict various negative outcomes in adulthood. For example, unpopularity in childhood correlates positively with mental health problems in adulthood (Kohn, 1977) and discharges from the military service due to bad conduct (Roff, 1961), and d) there is some evidence that intervention focusing on enhancement of social skills in unpopular children has resulted in treatment gains on measures of specific social skills as well as measures of peer acceptance and teacher ratings (Conger & Keane, 1981; Gresham, 1985; Hughes & Sullivan, 1988).

Examination of the research literature reveals that the term "social competence" has been defined in many ways, reflecting the varying theoretical perspectives of

researchers. For instance, the following definitions of social competence have been proposed in some articles: "Effective response of the individual to specific life situations" (Goldfried & D'Zurilla, 1969, p. 158); "organism's capacity to interact effectively with its environment" (White, 1959, p. 297); "aspects of social behavior that are important with respect to preventing physical illness or psychopathology in children and adults" (Putallaz & Gottman, 1983, p. 7). DuBois and Felner (1996) raised concern about the lack of a consistent definition of the concept of "social competence". They indicated that "social competence" has emerged as an umbrella term to encompass such concepts as resiliency, protective factors, coping, life skills, social skills, mastery, hardiness, empowerment, and self-esteem. These authors outlined a complex positive-mental-health and adaptation model to define social competence and its component parts. Others also share the view that social competence is a complex multidimensional construct with specific components and outcomes (e.g., Merrell, Johnson, Merz, & Ring, 1992).

Social skills are thought to be a sub-domain of the broader construct of social competence (Gresham & Reschly, 1987). This latter view has gained support in recent studies (e.g., Merrell, et al., 1992). Hughes (1990) argues that "social competence" is an evaluative term referring to the overall effectiveness of social behaviors, while the term "social skills" refers to specific behaviors leading to judgments of social competence. "Social skills are behaviors that increase the probability that others (teachers, peers) will evaluate the individual as socially competent" (Hughes, 1990, pp. 424). Social skills are considered to be specific behavioral skills utilized by individuals when responding to social situations (Gresham, 1986). As Gresham and Elliot (1984) state:

Social skills are those behaviors which within a given situation predict important

social outcomes such as (a) peer acceptance or popularity, (b) significant others' judgments of behavior or (c) other social behaviors known to correlate consistently with peer acceptance or significant others' judgments (pp. 292-293).

Mathur and Rutherford (1996) define social skills as "socially acceptable patterns of behaviors that enable students to gain social reinforcement and acceptance and avoid aversive social situations". Along this line Walker, Colvin, and Ramsey (1995) define social skills as those factors necessary for students to initiate and maintain positive social relationships with peers and adults. This attention to interpersonal relationships is the cornerstone of most research studies on social skills. In fact, the purpose of most social skills training programs is to teach students ways to develop the necessary skills to establish positive relationships with peers and adults (Goldstein, 1988).

Social skills research has focused on two categories of special education students: the learning disabled and the emotionally disturbed. This research is reviewed below.

Learning Disabled Students

The federal definition of "Specific Learning Disability" refers to "a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, that may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or to do mathematics calculations" (34 C.F.R. § 300.7). The federal definition calls for a severe discrepancy between students' achievement and ability that is not correctable without special education and related services (34 C.F.R. § 300.543). Although some states use various formulas to demonstrate such discrepancies, the State of New York does not use a formula to determine a learning disability. However, the State law mandates a minimal discrepancy of 50 percent between expected

and actual achievement (New York State Department of Education, 1992). For example, a tenth grader whose reading skills fall in the fourth grade level is considered a learning disabled student in New York State. In the research literature, consistent criteria for classifying learning disabled participants are not used. Frequently, researchers (e.g., Deci, Hodges, Pierson & Tomassone, 1992; Costenbader & Keller, 1990) use learning disabled students as participants but do not specify criteria for selection. Thus, research results cannot be generalized with any confidence to other groups of students labeled as learning disabled.

Some social skills research with special education students has focused on those classified as learning disabled. Since learning disabilities are sometimes comorbid with ODD (Frick & O'Brien, 1994), samples of the studies reviewed below may contain learning disabled students with ODD. There has, however, been no research investigating social skills of students specifically diagnosed with ODD.

Dalley, Bolocofsky, Alcorn, and Baker (1992) examined differences in social competence of 147 adolescents classified as learning disabled-unsuccessful, learning disabled-successful, non-special education-low grade point average, and non-special education-high grade point average students. Social competence was measured by students' ratings of themselves and teachers' ratings of the students. The results indicated that learning disabled students rated themselves and were rated by their teachers as significantly less socially competent than mainstream students. It was also noted that successful learning disabled students (above average GPA and percentage of time spent in mainstream classes) did not differ from their non-successful learning disabled counterparts in their self-perceptions of social competence. Teachers of learning disabled students

perceived their students as less competent compared to mainstream teachers. Learning disabled students were more optimistic regarding their social competence than were their teachers.

Merrell (1991) compared the social competencies of learning disabled students with those of low achieving and typical students. Three groups of 40 elementary school students each, in grades 3 through 6, constituted the sample. The students' teachers offered ratings of the students using the Walker-McConnell Scale of Social Competence and School Adjustment (WMSSC; Walker & McConnell, 1988). Learning disabled and low achieving students were rated as having lower levels of social competence than the group of typical students. No significant rating differences between the learning disabled and low achieving students were noted. The author concluded that social skills deficits constitute an important characteristic of the leaning disabled population.

Similar findings were reported in another study comparing emotionally handicapped, learning disabled, and non-referred students (Costenbader & Keller, 1990). The sample consisted of 230 children between the ages of 6 and 11 years. Parents and teachers rated these students using the Child Behavior Checklist (Achenbach & Edelbrock, 1983) and the Conners Parent and Teacher Rating Scales (Goyette, Conners, & Ulrich, 1978). Within each source (parents and teachers) and each scale, emotionally handicapped children were rated as having more behavior problems and lower social competence than learning disabled children. Also, learning disabled students were rated as having more behavioral problems and lower social competence than the nonreferred children.

Kavale and Forness (1996) conducted a meta-analysis of 152 studies to investigate the nature of social skills deficits among students with learning disabilities. Participants' (n = 6,353) mean age was 10.75 years and the average IQ was 95. Quantitative synthesis shows that, on average, about 75% of students with learning disabilities can be differentiated significantly from comparison samples using measures of social competence.

Another meta-analysis of 39 studies (Swanson & Malone, 1992) concerning the social skills of learning disabled children revealed that such children were significantly less liked and were more likely to be rejected than were normal achieving children. Results also indicated that learning disabled students were rated as more aggressive and immature, and found to suffer personality problems when compared with non-handicapped children.

This brief review of the literature reveals that learning disabled students are generally found to have lower levels of social competence than non-learning disabled students. The only exception to this finding is a study by Vaughn and Haager (1994). They examined the social competence of students with learning disabilities from kindergarten through fifth grade and found that learning disabled students did not differ significantly from low achieving non-learning disabled students on social skills (Vaughn & Haager, 1994). Differences were noted, however, between learning disabled students and average/high achieving non-learning disabled students on social skills and behavioral problems.

Emotionally Disturbed Students

The federal definition for "Emotional Disturbance" calls for the presence of one or more of the following five characteristics over a long period of time, and to a marked degree which adversely affects educational performance: (a) an inability to learn which

cannot be explained by intellectual, sensory, or health factors; (b) an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; (c) inappropriate types of behavior or feelings under normal circumstances; (d) a general pervasive mood of unhappiness or depression; or (e) a tendency to develop physical symptoms or fears associated with personal or school problems.

The federal definition for "Emotional Disturbance" covers diverse psychiatric disorders. For instance, the first criterion may be due to any of several psychiatric disorders including anxiety, mood, disruptive behavior, personality, and psychotic disorders. The present study focuses on one of these psychiatric disorders, Oppositional Defiant Disorder (ODD), and examines social skills deficits among high school students identified as having ODD.

Social skill deficits for "Emotionally Disturbed" students, a population that includes students with ODD, may be the most critical deterrent to social acceptance (Schloss, Schloss, Wood, & Kiehl, 1986). Studies indicate that many students with behavioral disorders lack appropriate social skills (Gresham, 1986), are poorly accepted by their peers (Sabornie, 1985), and are rated by their teachers as having poor social skills (Gresham, 1984, 1986). Based on such findings, Meadows et al. (1991) recommended that, prior to placing behaviorally-disordered students in mainstream classes, educators need to look more closely at students' specific social skills deficits and levels of social competence.

A review of the literature on seriously emotionally disturbed students by Singh et al. (1991) revealed that most studies of these students have been based on the skills-deficit model of social skills acquisition. This model posits that such students lack certain

specific social responses in their behavioral repertoire, use inappropriate responses, or both. This implies that seriously emotionally disturbed students never learned appropriate social behavior or learned inappropriate social behavior. However, Singh et al. (1991) present another plausible explanation for poor social behavior of such students. Their argument is that the students' social environment reinforces either the absence of the correct social response or the presence of socially inappropriate responses.

Social competence was the focus of a study by Merrell et al. (1992) comparing students with mild handicaps and low achievement. The investigators used ratings of 362 boys and 204 girls from the Walker-McConnell Scale of Social Competence (WMSSC; Walker & McConnell, 1988). Comparisons were made across five groups: learning disabled, behaviorally disordered, mentally retarded, low achieving, and regular education students. Significant group effects were found on the three subscales and the total score of this instrument. All social competence scores of the regular education group were significantly higher than all other groups. Scores of the behaviorally disordered group were significantly lower than all other groups on the total score and subscale 1, a factor comprised of behavioral items related to empathy, self-restraint, and sensitivity.

There is some evidence that children with externalizing disorders (often classified as "emotionally disturbed"), who display symptoms of aggression, may have social problem-solving deficits (e.g., Richard & Dodge, 1982). Also, aggressive children of both sexes are prone to interpreting social situations as requiring aggressive behavior, and these children are more likely than non-aggressive children to react in a relatively reflexive and aggressive manner (Dodge & Newman, 1981; Steinberg & Dodge, 1983). More recently Joffe, et al. (1990) compared depressed, conduct disordered, and normal adolescents on

social problem-solving abilities. They found that the conduct disordered subjects were significantly less likely than their depressed and normal counterparts to: a) generate relevant means to a social end, b) anticipate obstacles to be dealt with in the pursuit of a social end, and c) generate directly assertive social responses to a difficult social situation. These findings were consistent with Kendall's (1985) hypothesis that externalizing disorders are related to a cognitive deficit. These studies reveal some very specific social skills deficits in students diagnosed with conduct disorder. This research can be viewed as an indication that a segment of "Behaviorally/ Emotionally Disturbed" students (namely those suffering from Conduct Disorder) have deficits in solving social problems.

In a more recent study (Gresham, MacMillan, & Bocian, 1996) using 136 students in grades 2 ($\underline{n}$ = 41), 3 ($\underline{n}$ = 50), and 4 ($\underline{n}$ = 45) referred for possible placement in special education, the participants were rated as high, moderate, and low risk for behavioral disorders. Their social competence was measured by the Social Skills Rating System-Teacher Form (SSRS-T; Gresham & Elliott, 1990). It was found that low risk students were rated by teachers as having significantly better social skills than moderate risk students, and moderate risk students had significantly better social skills than high risk students.

To summarize, it seems that relative to other students, students classified as "learning disabled" or "emotionally disturbed" suffer from social skills deficits. Whether all students classified as "emotionally disturbed" are equally deficient in social skills is not clear from the above studies. It is possible that only a segment of "emotionally disturbed" students suffers from social skill deficits or students who present with one type of pathology have more social skills deficits than students who present with another type of

pathology. To investigate these possibilities, it is necessary for students with emotional disturbances to be differentiated according to distinct diagnostic categories and assessed regarding social skills. This paper will identify "emotionally disturbed" students who meet DSM-IV criteria for Oppositional Defiant Disorder (ODD) and investigate social skill deficits among them relative to other students receiving special education, excluding students diagnosed with Conduct Disorder (CD). Students diagnosed as having ODD were chosen for study because their symptoms (e.g., defying rules, annoying others) are indicative of social problems and may be associated with social skills deficits.

CHAPTER 3:

Oppositional Defiant Disorder (ODD)

History of ODD

Children and adolescents who fail to conform to society's rules and expectations have been a concern for mental health professionals and the general public for a long time (Binder, 1987). At the turn of the nineteenth century psychiatrists were describing pyromania and kleptomania in terms of distorted personality constellations. In 1835, Pritchard described the phenomenon that he called "moral insanity" which matches in many ways what became known as the "psychopathic personality" much later (Binder, 1987). Martin and Hoffman (1990) also report the use of such terms as "constitutional psychopathic inferiority" and "moral imbecility" for both adults and older children who had severe and chronic anti-social tendencies. Several studies were conducted that evaluated the amount of mental deficiency among inmates. Based on the findings of these studies, Goddard (1914) argued that almost half of prison and reformatory inmates were feeble-minded.

Freud's concepts of id, ego, and superego influenced much of psychiatric thinking in the beginning of the twentieth century. Although he did not write about delinquency or criminality, it could be deduced from his theory that delinquency and inappropriate conduct were the result of deficits in superego (Vitiello & Jensen, 1995). It can further be deduced from Freud's theory that delinquents and criminals lack conscience. However, some psychoanalysts objected to the notion of lack of conscience and guilt among criminals (Zilboorg, 1954).

More recent formulations of the origin of ODD (Hanish, Tolan, & Guerra, 1996) emphasize the prevalence of parental antisocial personality disorder that is modeled and reinforced for the child coupled with parental marital discord and coercive family interactions. Thus, Patterson (1976) found that parents of oppositional children frequently punish or ignore socially appropriate behaviors and reinforce oppositional behavior.

In the beginning of the twentieth century, societal institutions and agencies were established in the U.S. for the purpose of remediating conduct problems in youths. William Healy established the Juvenile Psychopathic Institution in 1909 (Martin & Hoffman, 1990). The federal government developed correctional facilities and programs for juvenile offenders following the establishment of the U.S. Children's Bureau in 1912. However, it wasn't until 1974 when Congress enacted the Juvenile Justice and Delinquency Prevention Act that community-based alternatives to the institutionalization of non-violent and non-dangerous delinquent youths were mandated (Schwartz, 1989).

Borduin, Henggeler, and Manley (1995) traced the origins of the ODD diagnostic classification to a study by Jenkins and Hewitt (1944) that identified three behavioral syndromes among delinquent youths referred for treatment. These syndromes were called unsocialized aggressive, socialized delinquent, and overinhibited. Borduin et al. (1995) reported that these constructs along with those from studies by Quay (1964) led to the introduction of separate diagnoses of (a) Unsocialized Aggressive Reaction and (b) Group Delinquent Reaction in the second edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-II; American Psychiatric Association, 1968).

Psychoanalytic theorists also contributed to the identification of the disorder. For example, the symptom of oppositional behavior was presented by Levy (1955) following

the Jenkins and Hewitt (1944) study. Prior to Levy's "oppositional behavior", the term "passive-aggressive personality disorder" had been used (Lavietes, 1985). The Group for the Advancement of Psychiatry described children with oppositional disorder as "expressing their aggressiveness by oppositional patterns of generally passive character, although these patterns may have some actively aggressive implications" (Lavietes, 1985, pp. 1744).

The third edition of the DSM (DSM-III; American Psychiatric Association, 1980) included Oppositional Disorder as a diagnosis for the first time under the group "Other Disorders of Infancy, Childhood and Adolescence". The DSM-III described the disorder as:

> "A pattern of disobedient, negativistic and provocative opposition to authority figures ... The oppositional attitude is toward family members, particularly the parents, and teachers ... The continually confronting quality of these individuals is typical of their style and relationships ... Usually the individual does not regard himself or herself as "oppositional", but sees the problem as arising from other people who are making unreasonable demands" (American Psychiatric Association, 1980, pp. 63-64).

The revised edition of the DSM-III (DSM-III-R; American Psychiatric Association, 1987) renamed the diagnosis of "Oppositional Disorder" as "Oppositional Defiant Disorder" (ODD) and grouped it together with Conduct Disorder (CD) and Attention Deficit Hyperactivity Disorder (ADHD) under "Disruptive Behavior Disorders". As Husain and Cantwell (1991) noted, the revised diagnosis suggested a more active and aggressive stance with concomitant features of overt anger and hostility when the child is

confronted with external pressures and expectations. Cantwell (1989) indicated that both DSM-III and DSM-III-R require six months' duration of symptoms for the diagnosis of the disorder. The disorder is more detailed in the revised version with a greater number of possible symptoms (nine instead of five) and a greater number of symptoms needed for the diagnosis to be made (five instead of two). The age of onset that appeared in the DSM-III (3 years) was eliminated from the DSM-III-R. In addition, the DSM-III required the exclusion of any other DSM-III diagnosis before an ODD diagnosis was made. The DSM-III-R limited exclusions to certain specific diagnoses such as CD, a psychotic disorder, Major Depressive, Hypomanic, or Manic Episode.

The fourth edition of the DSM (DSM-IV; American Psychiatric Association, 1994) maintained the ODD diagnosis and grouped it under "Attention Deficit and Disruptive Behavior Disorders". In DSM-III-R, five out of nine criteria were needed to make a diagnosis. In DSM-IV four out of eight are required. The DSM-III-R criterion "often swears or uses obscene language" was dropped because of limited diagnostic utility (Vitiello and Jensen, 1995). The DSM-IV criteria appear in Table 1.

Differential Validity

The diagnosis of ODD raised controversy since its adoption as a psychiatric classification. The primary reason for the controversy originated from the assertion that it is difficult to distinguish between normal developmental, oppositional tendencies, and a pathological state (Schachar & Wachsmuth, 1990). According to Vitiello and Jensen (1995) developmental oppositional behavior should not cause substantial and persistent dysfunction. On the other hand, ODD should result in significant functional impairment.

Table 1

DSM-IV Diagnostic Criteria for Oppositional Defiant Disorder.

A. A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:

(1) often loses temper

(2) often argues with adults

(3) often actively defies or refuses to comply with adults' requests or rules

(4) often deliberately annoys people

(5) often blames others for his or her mistakes or misbehavior

(6) is often touchy or easily annoyed by others

(7) is often angry and resentful

(8) is often spiteful or vindictive

Note: Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. The behaviors do not occur exclusively during the course of a Psychotic or Mood Disorder.

D. Criteria are not met for Conduct Disorder, and, if the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

Note: Based on information from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Copyright 1994 American Psychiatric Association.

Rey (1993) also cautioned that normal developmental patterns need to be distinguished from a pathological state. According to this author negativistic and oppositional behavior are common during the preschool years and may lead to angry outbursts and conflicts with parental authority. Destructiveness, bullying, and fighting decrease after the preschool years (Rutter & Giller, 1983). Early adolescence is frequently associated with rebellious behavior (Looney & Oldham, 1989). Teachers report that most oppositional symptoms peak between the ages of 8 and 11 years and then decline in frequency (Achenbach & Edelbrock, 1986). Therefore, some oppositional behavior may be appropriate during the preschool and adolescent years. Pathological states, however, must extend beyond normal behavior and cause substantial and persistent dysfunction.

Controversy also exists regarding the differentiation of ODD from CD. This controversy was more pronounced when ODD was included in the DSM-III as evidenced by articles published at that time (e.g., Achenbach, Conners, Quay, Verhulst, & Howell, 1989; Costello, Edelbrock, Dulcan, Kalas, & Kloric, 1984). Researchers challenged the validity of the disorder and argued that the behaviors included in ODD are also likely to be evident in CD. In a review of factor analytic studies, Loeber, Lahey, and Thomas (1991) concluded that although ODD and conduct disorder are strongly and developmentally related, they are clearly different. Also they stated that the age of onset for ODD is earlier than for most CD symptoms. Nearly all youths with CD have a history of ODD, but not all ODD cases progress to CD. On the other hand, the authors noted that overt symptoms of CD (e.g., fighting and cruelty to animals) that involve direct interaction with a victim often correlate more strongly with ODD symptoms than with covert symptoms of CD. In reviewing the literature pertinent to specific symptoms of

ODD and CD, Rey (1993) concluded that developmental patterns of behavior in these two disorders appear to follow a different course, but a developmental progression from symptoms of ODD to CD cannot be ruled out. In addition, the author reported that lying is a common behavior during childhood but becomes increasingly associated with CD as the child becomes older.

The distinction between ODD and CD has been investigated by Lahey, Loeber, Quay, Frick, and Grimm (1992). These researchers examined statistical, hierarchical, and developmental relations between CD and ODD. Multidimensional scaling was used to summarize factor analytic literature that was reviewed previously by Lahey in an unpublished meta-analytic study. In that effort they summarized statistical patterns of co-occurrence among symptoms of ODD and CD in 64 factor analyses. When one dimension of co-occurrence was extracted, symptoms of ODD and physical aggression clustered on one pole, whereas covert symptoms of CD clustered at the other pole. When the second dimension of co-occurrence was extracted, the aggression items were separated from the symptoms of ODD. The authors concluded that this quantitative summary of factor analyses supported the hypothesis that ODD and CD are distinct syndromes by suggesting that the symptoms of ODD and CD are at least somewhat distinct in terms of co-occurrence.

On the other hand, the similarity between ODD and CD was supported by the results of a study on comorbidity of the Disruptive Behavior Disorders (Soltys, Kashani, Dandoy, Vaidya, & Reid, 1992). A sample of 100 children (ages 7-12) admitted to an impatient child psychiatry service of a community mental health center were identified as pure ADHD, ODD, CD, and combinations of ADHD and either ODD or CD using the

Diagnostic Interview for Children and Adolescents (DICA; Herjanic & Reich, 1982) and DSM-III criteria. The subjects were assessed with various anxiety, self-esteem, and depression instruments. The results supported more similarities than differences among the ODD and CD subjects. In fact, the only differences between the pure ODD and pure CD were the significantly lower threshold scores on the Dimensions of Temperament Survey (DOTS; Lerner, Palermo, & Spiro, 1982) in the ODD population.

Evidence for a hierarchical relation between ODD and CD was based on various studies reviewed by Lahey et al. (1992). For example, the Walker et al. (1991) study revealed that 96% of the clinic referred boys aged 7-12 years who met DSM-III-R criteria for CD also met full criteria for ODD. In addition, 84% of the clinic referred youths with CD in the DSM-III-R Field Trials also met criteria for ODD (Spitzer et al., 1991). Lahey et al. (1992) concluded that clinic referred youths with CD exhibit the same symptoms as youths with ODD and differ only by exhibiting more serious antisocial behaviors (i.e., that CD is a more severe form of ODD). As a result, a hierarchical order of these disorders was supported with ODD being at a lower level than CD.

Lahey et al. (1992) also demonstrated that subjects who were diagnosed with CD in the Developmental Trends Study had been diagnosed as ODD the previous year. Specifically, in year 1, 68 boys received a DSM-III-R diagnosis of CD. In year 2, 15 additional boys met criteria for CD. Of the 15 new cases, 13 (87%) had received a diagnosis of ODD in year 1. Seven more cases emerged in year 3. Of the 22 cases in years 2 and 3, 18 (82%) had received an ODD diagnosis in the preceding year. On the other hand, most boys with ODD in year 1 did not progress to CD in years 2 or 3. Fifty two percent of the boys in year 1 met criteria for ODD in years 2 and 3 while 23% did not

meet criteria for ODD or CD in years 2 and 3. These findings offer support for the developmental progression from ODD to CD in some children.

In a study examining the validity of ODD and CD, Russo, Loeber, Lahey, and Keenan (1994) compared ODD and CD diagnoses from the DSM-III-R to a developmentally-based option using 506 13-year-old boys. The study was carried out in an effort to integrate ODD and CD in a single, alternative, disruptive behavior syndrome for the DSM-IV edition. Under this alternative-diagnostic option ODD serves as a developmental precursor to the development of intermediate conduct disorder (ICD) and that in turn serves as the second stage of progression to the more severe form of advanced conduct disorder (ACD). The results of this investigation revealed that most DSM-III-R oppositional symptoms were more prevalent in boys diagnosed with ODD than in those diagnosed with CD. Also, they offered support for the progression from ODD to CD, since the more externalized symptoms (e.g., "breaking and entering" and "rape") were associated with CD.

These findings were supported by another study (Loeber, Keenan, Lahey, Green, & Thomas, 1993). Using a sample of 177 boys, followed over three years, the DSM-III-R constructs of ODD and CD were evaluated along three criteria: symptom discriminative validity, diagnostic external, and predictive validity. Most DSM-III-R criteria discriminated between ODD and CD. The CD symptom of "lying" had more in common with ODD symptoms. According to the researchers, "lying" is common in the preschool years and it is outgrown later by a portion of children. "Swearing" could be more suitably categorized as a CD symptom or even be eliminated. Regarding predictive validity, analyses over a period of three years indicated that about a third of the boys (32.4%)

diagnosed as ODD received the diagnosis of CD within 2 years. The Alternative Option was more successful than the DSM-III-R in predicting that half of those diagnosed as ODD later received a CD diagnosis.

Additional concerns about the validity of the DSM classifications were expressed by Ferguson and Horwood (1995) who assessed a birth cohort of 935 New Zealand children at the age of 15 for ODD, CD, and ADHD. A year later they reassessed the children on a series of measures including substance use behaviors, juvenile offending, and school dropout. The results revealed evidence of continuous and generally linear dose-response functions between symptom severity and outcome risks and that dimensionally scored variables were considerably better predictors of outcome than measures based on a diagnostic classification. The authors concluded that DSM-III-R diagnostic criteria may have considerable value and utility in diagnosing behavior disturbances that merit clinical attention, but the routine use of these criteria may result in a system of measurement that produces variables that have less than optimal predictive validity.

Loeber, Green, Keenan, and Lahey (1995) investigated some demographic and psychiatric predictors of the onset of conduct disorder and the role of physical fighting play in the transition from ODD to CD. Data were collected from 177 clinic-referred boys 7 to 12 years of age and continued for a period of six years. Information was collected from the parent, child, and teacher versions of the Diagnostic Interview Schedule for Children (DISC; Costello, Edelbrock, Dulcan, Kalas, & Kloric, 1987). It was found that the physical fighting discriminated between oppositional boys and boys with less serious conduct problems. In addition, low socioeconomic status, age of the mother at the birth of her first child, and boys' IQ were associated positively with the onset of CD between

the ages of 8 and 17. Also, parental substance abuse, the child's diagnosis of ODD, and his number of ODD and CD symptoms were significant discriminators between the two groups. The authors cautioned that this latter finding does not necessarily reflect processes leading to CD.

During the DSM-IV field trials it was decided to maintain four symptoms as the threshold for diagnosing ODD. This criterion optimized identification of impaired children, improved agreement somewhat with the clinician's validation diagnosis, and had somewhat better test-retest agreement than DSM-III-R (Lahey, Applegate, Barkley, Garfinkel et al., 1994).

In view of the issues discussed above it seems that the diagnosis of ODD requires the presence of symptoms that fall beyond normal developmental stages and cause substantial and persistent dysfunction. There is evidence that some of the children diagnosed with ODD outgrow it while others progress to CD. As a result, some researchers tend to view ODD as a milder form of CD and argue for changes in the diagnostic classification of these two disorders. These issues were considered during the field trials of the DSM-IV, but the decision was made to keep the two diagnoses separate since factor analytic studies supported such a distinction. However, the predictive validity of the DSM-III-R criteria for ODD has been questioned as it was presented in the studies above. It seems that the diagnostic criteria bear responsibility for this problem. Therefore, the diagnostic criteria need to be enhanced. Unfortunately, there are no studies conducted on the predictive validity of the DSM-IV criteria.

Comorbidity

Several studies have examined ODD as a comorbid disorder in the presence of other psychiatric disorders. A study of ADHD using 44 classroom teachers' ratings of 1077 elementary school regular education students in Germany examined the role of ODD comorbidity (Baumgaertel, Wolraich, & Dietrich, 1995). The results indicated a 7% ODD comorbidity among children diagnosed as ADHD-predominantly inattentive, 30% comorbidity in the predominantly hyperactive ADHD group, and 50% in the combined ADHD category. Overall, there was a 23.9% ODD comorbidity among children diagnosed with ADHD.

Barkley, Anastopoulos, Guevremont, and Fletcher (1991) examined ADHD adolescents and a control group using a comprehensive assessment battery. The subjects were 84 clinic-referred adolescents in treatment for ADHD and 77 community control adolescents. The age range was 12 to 17 years. ADHD teenagers were three times more likely to have an associated ODD (68%) than their control counterparts (22%) as measured by a structured interview made specifically for the purpose of this study.

Pelham, Evans, Gnagy, and Greensdale (1992) obtained teachers' ratings of 364 boys attending various part- or full-time special education classes for reasons other than mental retardation. The authors created a scale composed of 36 DSM-III-R diagnostic criteria for ADHD, ODD, and CD randomly ordered across diagnostic categories. The teachers' ratings revealed a prevalence rate of 36.5% for ODD in the age group of 15-19 years among Special Education students. Using the DSM-III-R criteria there was a comorbidity of 14% with ADHD on the overall sample, 1.4% with CD, and 5.8 with both ADHD and CD.

Angold and Costello (1993) reviewed the literature pertinent to depressive comorbidity in children and adolescents. They indicated that conduct/oppositional disorders showed a significant association with depression in every study. Rates of conduct/oppositional disorders were between 3.6 and 9.5 times higher in depressed than in non-depressed children. They argued that conduct or oppositional disorder is more common in depressed than non-depressed children and adolescents. However, they cautioned that the extent of such comorbidity for depression may be the result of subjects' ages as such disorders (oppositional and conduct disorders) are age dependent.

The above studies indicate the presence of ODD when other psychiatric disorders are diagnosed. This is especially true when dealing with Attention Deficit Hyperactivity Disorder which seems to have a particularly strong association with ODD.

Prevalence

The prevalence of ODD in adolescents is difficult to estimate because of the various diagnostic criteria utilized over the years. The DSM-IV reports rates from 2% to 16% depending on the nature of the population sample and methods of ascertainment. Anderson, Williams, McGee, and Silva (1987) report a rate of 5.7% in New Zealand while Kashani, McGee, Clarkson, Anderson, et al. (1987) estimated an 8.7% prevalence rate in the United States. These studies did not consider co-occurrence of conduct disorder and oppositional defiant disorder. As a result, some overlap between these two diagnoses may be possible.

August, Realmuto, McDonald, Nugent, and Crosby (1996) examined the prevalence of ADHD and comorbid disorders in a sample of 7,231 first through fourth grade children. The study was part of a longitudinal project aimed at the prevention of

serious and chronic disruptive behavior disorders including conduct disorder and substance abuse. The Diagnostic Interview for Children and Adolescents-Revised-Parent Version (DICA-R-P; Reich, Shayla, & Taibelson, 1992) was used to generate child psychiatric diagnoses. The results revealed that ODD was present in 13 students (4.2%) who did not have ADHD and 37 students (12%) with ADHD. The authors noted that their results are consistent with results of other studies using populations from the community. Clinic-referred samples tend to reveal higher prevalence rates.

Russo et al. (1994), using a community sample of 506 13-year old boys and following DSM-III-R diagnostic criteria, reported a 10% prevalence rate for ODD. This rate dropped to 7.4% when the Alternative (to the DSM-III-R) Option was employed. Parent reports of the presence or absence of ODD and CD symptoms were attained using the adult-caretaker version of the DISC and the parent version of the Child Behavior Checklist (CBCL; Achenbach, & Edelbrock, 1983). However, the authors cautioned against the lack of generalizability of the findings in view of the sample's make-up.

McDermott's (1996) nationwide study on gender prevalence for psychopathology in childhood and adolescence used a sample of 1400 students between the ages of 5 and 17. Behavior pathology was measured through the Adjustment Scales for Children and Adolescents (ASCA; McDermott, Marston, & Scott, 1993). The ASCA is a standardized observation/ rating device for completion by classroom teachers. The results revealed the following percentage prevalence for ODD in the 15 to 17 year old cluster: Males, 14.4%; Females, 21.3%, and Total 17.3%.

Lahey, Loeber, Stouthamer-Loeber, et al. (1990) compared prevalence rates between selected DSM-III and DSM-III-R diagnoses. Towards that end, they used a

sample of 177 boys (7 to 12 years of age) referred to an outpatient clinic. The boys qualified for diagnoses of disruptive behavior disorders. The children, their parents, and teachers were administered the DISC (Costello, Edelbrock, Kalas, & Dulcan, 1984). The DSM-III-R ODD criteria resulted in diagnosing 25.5% fewer subjects with ODD, compared to the DSM-III ODD criteria.

Fergusson, Horwood, and Lynskey (1993) examined the prevalence and comorbidity of a number of DSM-III-R diagnoses in a birth cohort of 1,265 15-year old New Zealand children. These children were part of a longitudinal study, known as the Christchurch Health and Development Study (CHDS). Born in 1977, they were studied at birth, 4 months, and annual intervals to the age of 15. Oppositional/defiant disorder was assessed through the child version of the DISC (Costello, Edelbrock, Dulcan, Kalas, & Kloric, 1982). Maternal reports were obtained through the Revised Behavior Problems Checklist (RBPC; Quay, & Peterson, 1987). The authors noted marked discrepancies in the prevalence estimates based on maternal and child reports. Regarding ODD, self-report revealed a 5.1% rate while maternal report indicated an 1.8% rate. The authors then combined maternal and child reports to obtain the "best" estimate of the overall prevalence of the disorder in the sample. Two approaches were used: Optimal Informant and Latent Class. The difference in the prevalence rate between the two approaches was minimal. For the conduct disorders the optimal informant approach yielded a rate of 10.8% while the latent class method revealed an 8.1% rate. The authors did not report on ODD rates separate from those of CD.

Purpose of the Study

Recent educational reforms call for the placement of special education students into mainstream classes. For some students, there are suggestions that social skills training needs to precede such placement efforts (Gresham, 1984). Social skills training may be particularly important among "Emotionally Disturbed" students. Since the "Emotionally Disturbed" category includes students with various psychiatric disorders, the present study focused on students identified as ODD because these students' symptoms would seem to place them at risk for social skills deficits. Specifically, the purpose of the study was to compare teacher-rated social skills deficits of two groups of high school special education students: students whose behavior met DSM-IV criteria for ODD and a matched comparison group of students whose behavior did not qualify them for an ODD diagnosis.

Hypotheses

Gresham (1984) has suggested that social skills training should precede the placement of some special education students into mainstream classes. Diagnostic criteria for ODD include behaviors that are disruptive to others and indicative of social problems. Therefore, it seemed plausible that students with ODD would have social skills deficits relative to other special education students without disruptive symptomatology. In view of this, the following hypotheses were advanced:

HO1: Adolescents with an ODD disorder will score significantly lower on the Social Skills scale than the control group of special education students without ODD.

This would be suggestive of the ODD students' poor social skills. Some of the studies reviewed above indicated that emotionally disturbed students lacked

appropriate social skills (Gresham, 1986), and, furthermore, parents and teachers rated emotionally handicapped children as having lower levels of social competence than learning disabled students (Costenbader, & Keller, 1990). The ODD students, as a subcategory of the emotionally disturbed group, were expected by virtue of the nature of their symptoms to have significantly lower social skills than other special education students when students with CD are excluded from study.

HO2: Adolescents with an ODD disorder will score significantly higher on the Problem Behaviors scale than the control group students.

A study by Richard and Dodge (1982) found that emotionally disturbed students have social problem-solving deficits. In addition, compared to depressed, students with CD have been found to experience difficulties in generating relevant means to a social end and anticipating obstacles to be dealt with in the pursuit of a social end (Joffe et al., 1990). Since a great number of ODD students progress to CD, it was expected that ODD students would experience more difficulties in dealing with social problems compared to other special education students.

HO3: Adolescents with an ODD disorder will score significantly lower on the Academic Competence scale than the control group students.

There has been some evidence that behaviorally disordered students (ODD is a subcategory of this group) are distinctly different from other comparison groups, such as low achieving-mainstreamed, learning disabled, and mentally retarded, in terms of social skills deficits (Merrell et al., 1992). Furthermore it has been noted that the emotionally disturbed perform much lower in school

adjustment behavior (Merrell et al., 1992). Thus it was expected that the ODD students would score lower than the non-ODD control students on the Academic Competence scale.

CHAPTER 4

Methodology

Population

Participants were drawn from self-contained special education classrooms of an urban academic high school in a metropolitan area in the northeastern region of the United States. According to school statistics, students had the following ethnicities: 16 % White (non-Hispanic), 29 % Hispanic, 47 % African American, 8 % Other (Chinese and Arab). The special education department of this school served 198 different students during the two semesters of the study. Most of the students had been attending self-contained special education classes since early elementary school. They ranged in age from 14.3 to 19.3 years and were in classrooms in grades 9 through 12. They took seven classes daily with different teachers.

The 198 special education students were classified by the department as follows: Emotionally Disturbed (ED, $\underline{n}$ = 39), Learning Disabled (LD, $\underline{n}$ = 124), Mentally Retarded (MR, $\underline{n}$ = 26), Speech Impaired (SI, $\underline{n}$ = 8) and Traumatic Brain Injured (TBI, $\underline{n}$ = 1). Participants were drawn from the group of 163 students with ED or LD classifications. It should be noted that students were classified as LD either according to New York State guidelines conforming with IDEA that mandate a discrepancy of 50 percent or greater between potential and actual achievement (New York State Department of Education, 1992) or according to less stringent criteria under section 504 of the Rehabilitation Act of 1973 that does not stipulate specific discrepancy guidelines.

Students classified with MR, SI and TBI were not included since it appeared that their disabilities might confound social skills results. Of the 163 students classified as

either ED or LD, 115 (70.6%) were males, and 48 (29.4%) were females. To further control for the possibility that social skills deficits were due to possible MR, students with IQ scores below 70 were not included in this study. To control for possible effects of gender, ethnicity, learning disability, and socioeconomic status, participants were matched on these variables. Criteria for inclusion in groups are presented in Figure 1.

Diagnostic Measures

Diagnostic Interview for Children and Adolescents-Revised (DICA-R). The DICA-R is a structured clinical interview. Structured interviews in general include a broad range of disorders and can be applied to a fairly wide age span and facilitate standardization of diagnosis (Boyle, Offord, Racine, Sanforde, et al., 1993). The diagnosis of ODD and the identification of comorbidities were accomplished using the parent version of the Diagnostic Interview for Children and Adolescents-Revised (DICA-R-P; Reich et al., 1995) modified for use with teachers. The parent version rather than the adolescent one was selected on the basis of findings that adolescents are less reliable informants than their parents when dealing with externalized disorders such as ADHD, ODD, and CD (e.g., Hart, Lahey, Loeber, & Hanson, 1994). The decision to use a modification of the parent version for teachers was based on three assumptions. First, because parents of children and adolescents diagnosed with ODD often believe that it is acceptable to defy authority (Hanish, Tolan, & Guerra, 1996), they may not have cooperated in answering the DICA. Second, students may demonstrate inappropriate behaviors in schools but may not do the same at home. Third, it has been recommended that where teachers' and parents' ratings are available, teachers' ratings should be given more weight because teachers are less biased than parents, and teachers have a more

Figure 1

Criteria for inclusion in groups

Group Characteristics

	Experimental	Control
ODD Diagnosis[1]	Yes	No
IQ above 70[2]	Yes	Yes
In Self-Contained, Special Education Classroom	Yes	Yes
Reading Scores[3]	Match	Match
Math Scores[3]	Match	Match
CD Diagnosis[4]	No	No
ADHD Diagnosis[5]	No	No

[1]Assessed using the DICA Oppositional Defiant Disorder module.
[2]Assessed using the Wechsler Intelligence Scale for Children-Third Edition.
[3]Assessed using the Woodcock Johnson-Revised.
[4]Assessed using the DICA Conduct Disorder module.
[5]Assessed using the DICA Attention Deficit Hyperactivity Disorder module.

accurate norm reference than do parents (Conners, 1990).

The DICA-R consists of modules that classify child and adolescent psychiatric disorders. There are three versions: One for children 6-12 years of age, one for adolescents aged 13 to 17 and a parent version that covers the 6- to 17-year-old age span. This study employed a modification of the DICA-R-P for adolescents modules for Oppositional Defiant Disorder (ODD), Conduct Disorder (CD), and Attention Deficit Hyperactivity Disorder (ADHD) so that it could be used with teachers. For instance, Item B3 "Does (s)he often refuse to do things that you, the teachers or other adults ask him/her to do? I mean refuse to do it, not just put it off." was presented as "Does (s)he often refuse to do things that you, or other adults ask him/her to do? I mean refuse to do it, not just put it off".

The modules follow closely the DSM-IV criteria for the various disorders. However, evidence about their reliability and validity is incomplete. A review of the literature did not provide information on the psychometric properties for this latest version of the DICA. One of the authors (Dr. Reich) has forwarded some kappa values for the DICA-R (personal communication, July 1997). Based on data collected from 48 subjects between the ages of 13 and 17 the kappa values were: 0.56, 0.78, 0.82 for the ADHD, ODD and CD diagnostic categories respectively. A comparison of a previous version of the DICA to the Child Assessment Schedule, the Interview Schedule for Children, and the Schedule for Affective Disorders and Schizophrenia revealed weaker validity data for the DICA (Hodges, 1993). Despite the limited psychometric evidence, the DICA-R-P was selected because, of all available instruments at the time of the study, DICA items corresponded to the DSM-IV criteria.

Items on the DICA are scored as follows: No (1), Rarely (2), Sometimes or Somewhat (3), Yes (5). There is also coding for "I don't know" and "Always" responses. The authors also offer a set of probes for positive answers. In addition, there is the option of skipping certain items.

The ODD diagnosis was made when the following three criteria were met: a) There were "Yes" (5) responses in four or more of the items B1, B2, B3, B4, B5, B6, B7, and B8; b) the responses to item B10b were 3, 4, or 5; c) the responses to items B9, or B10a were either 3 or 4.

Wechsler Intelligence Scale for Children-III (WISC-III). The WISC-III was used to assess the participants' intelligence levels. This instrument has been used extensively in the identification of special education populations. The reliability coefficient for the Full Scale IQ is .96 (Wechsler, 1991) while the stability coefficient ranges between .90 and .95. The manual lists correlations of the WISC-III with the WPPSI-R, WAIS-R, DAS, Stanford-Binet Intelligence Scale-Fourth Edition, K-ABC, and Woodcock Johnson-Revised to document evidence for concurrent validity. The Full Scale IQ correlations range between .65 (Woodcock Johnson-Revised) and .91 (WAIS-R). Tables C1 through C12 (Wechsler, 1991, pp. 270-281) in the manual present correlations among the various subtests and scales. The verbal subtests correlate higher with each other than with performance subtests. The performance subtests correlate more highly with each other than with verbal subtests. This pattern of correlation is used as evidence of convergent validity. The WISC-III was not administered in this study. However, students' WISC-III scores from their records were used.

Woodcock Johnson Psychoeducational Battery-Revised (WJ-R). Data from the Woodcock Johnson-Revised (Woodcock & Mather, 1990) were used to determine the presence of learning disabilities. This instrument consists of various achievement tests intended to measure reading, mathematics, and writing skills as well as school-related knowledge. Each subtest yields a standard score as well as age equivalent and grade equivalent scores. Although this instrument yields various scores, broad scores were utilized in this study because this is the traditional way of reporting scores during students' evaluations. Specifically, the letter-word identification and the passage-comprehension scores were used to calculate the broad reading score. Similarly, the broad math score was used. The broad math score was derived from the calculation and applied problems scores. The broad reading and the broad math scores were used for matching participants in the two groups according to their learning disability.

Internal consistency reliability coefficients range between .731 (Writing Fluency) and .968 (Applied Problems) with the majority of scales in the high .80s and low .90s. The content validity of the test was examined by using item validity studies and expert opinion. Most items are open-ended or free-response in nature. This parallels the requirements of scholastic performance in real life situations and eliminates guessing as a confounding factor in scores. Concurrent validity was assessed as well. For a group of 51 subjects of approximately 17 years of age the correlations between the Woodcock Johnson-Revised and other instruments' achievement scores ranged as follows: Reading .362 to .684; Math, .648 to .736; and Written Language: .476 to .627. The authors summarized their extensive data on construct validity as "one of moderate intercorrelations" (p. 104). As with the WISC-III, the Woodcock Johnson-Revised was

not administered. Instead, Woodcock Johnson-Revised scores were used from the records.

Social Status Measure

Four Factor Index of Social Status. Participants in this study were matched according to socioeconomic status (SES). The assessment of SES was accomplished with the Four Factor Index of Social Status (Hollingshead, 1975). This scale evaluated SES along four factors: occupation, education, gender, and marital status. The occupational factor is determined from a list provided by the author. Various types of occupations fall into one of nine possible categories yielding a scale score ranging from 1 to 9. Higher scale scores pertain to higher paying (and more prestigious) jobs. The occupational factor is calculated by multiplying the scale score by 5.

The educational factor is determined using a 7-point scale score multiplied by 3. Higher scores indicate higher educational status. For example, the score of 1 refers to less than seventh grade education while the score of 7 refers to graduate degree. The estimation of status of a family of two working parents is calculated by adding these two factors for each parent and dividing the grand total by two.

Dependent Variable

The dependent variable was measured with the Social Skills Rating System (SSRS). The SSRS (Gresham & Elliott, 1990) is an expansion of a research instrument, the Teacher Ratings of Social Skills, developed by the authors in 1984. The SSRS underwent a "tryout" test in 1987 and a nationwide standardization in 1988 (Gresham & Elliott, 1990). The SSRS is useful in settings where information from a teacher, a parent, and a child is desired for screening, classifying, or making intervention plans. The

instrument has eight forms. There are three teacher forms (Preschool, Elementary, and Secondary Level), three parent forms (Preschool, Elementary, and Secondary Level) and two student forms (Elementary and Secondary Level). The teacher form consists of three scales (Social Skills, Problem Behaviors, and Academic Competence) while the other two types of forms consist of two scales each (Social Skills and Problem Behaviors). Each of the scales has subscales. Although the authors of this instrument have made an effort to make the forms similar across the main three domains (Teacher, Parent, Student), not all scales contain all subscales under each of the three domains.

For the purpose of this study, the Teacher form (Secondary Level) was used. The decision to use the Teacher form instead of the other two forms was based on a recent critique of instruments that measure social competence. Hughes (1990) has indicated that ratings taken from parents, teachers, and students have low agreement rates. Furthermore, he asserts that assessment results obtained in one setting cannot be generalized to a different setting. In view of this latter assertion it may be that teachers' and parents' ratings differ because they assess children's social skills in different situations. Since the present research focused on social skills manifested in school, it was considered appropriate to use teachers' rather than parents' ratings.

The SSRS-T is a norm-referenced instrument designed for screening and classification of students' social behavior. The Social Skills Scale measures positive social behaviors in three areas: Cooperation, Assertion, and Self-Control. The Problem Behaviors Scale measures behaviors that interfere with the development of positive social skills using three subscales: Externalizing Problems, Internalizing Problems, and Hyperactivity. Finally the Academic Competence Scale provides a quick estimate of

academic functioning. Teachers rate reading and mathematics performance, general cognitive functioning, as well as motivation and parental support. Teachers rate the frequency of a specified behavior (e.g., "Finishes classroom assignments within time limits") on a 3-point scale (0, Never; 1, Sometimes; 2, Very Often). In addition, they rate the importance of the behavior (0, Not Important; 1, Important; 2, Critical). The Academic Competence Scale is rated on a 5-point scale (Lowest 10%; Next Lowest 20%; Middle 40%; Next Highest 20%; Highest 10%). All ratings are converted to standard scores with a mean of 100 and a standard deviation of 15.

The scale was standardized on 299 teachers' ratings. The authors report internal consistency coefficient alphas for all forms ranging from .73 for the Problem Behaviors Scale to .95 for the Academic Competence. Test-retest reliabilities for a 4-week period for the teacher form were: .85 for the Social Skills Scale; .84 for the Problem Behaviors Scale; and .93 for the Academic Competence scale. The authors cited a number of studies in which SSRS scores correlated highly with other similar measures (e.g., Social Behavior Assessment, Hater Teacher Rating Scale, Piers-Harris Children's Self-Concept Scale, and the Child Behavior Checklist) in an effort to demonstrate content validity. Also, they presented several methods to establish evidence for the construct validity of SSRS. These methods were developmental changes and sex differences, internal consistency, correlations with other tests, factor analyses, convergent and discriminant validity, and group separation. The construct validity of the Teacher version was supported by moderate to high loadings on factor analyses ranging between .45 and .92.

Participant Selection and Descriptive Information

A database list was created of all 198 special education students in self-contained classrooms from the computer database program that the Special Education Department used to generate Individualized Education Programs (IEPs) for its students. The list included students' names, classification labels, IQ scores, and Reading and Math scores as well as the dates that these scores were obtained. Students who had been classified as ED and LD were identified for possible inclusion in the study, decreasing the potential subject pool to 163. The next step involved a screening for IQ below 70 to eliminate the possibility that social skills deficits were due to low IQ. This reduced the potential subject pool to 132.

After this initial screening of the database, the parents of potential control and experimental participants were contacted and asked to sign consent forms allowing their children to participate in the study (see Appendix A). Student assent was also obtained. Parents completed The Four Factor Index of Social Status (Hollingshead, 1975) that was used to assess socioeconomic status (SES).

Next, teacher participation was solicited. Twelve teachers who taught potential study participants were approached, and all signed consent forms (Appendix A). Two teachers for each potential participating student were interviewed using the ODD, CD, and ADHD modules of the parent version of the DICA-R that was modified for use with teachers. A requirement was set that each teacher had to have known the students he or she rated for a minimum of two months. Arrangements for these interviews followed this order: The experimenter obtained each student's program. Then he asked two of each student's six teachers to meet with him in his office in a mutually agreed upon time in

order to conduct the DICA interview. The selection of these teachers was not random. It was based on the teachers' ability to meet with the examiner during their free period. Only teachers who taught academic subjects (e.g., English, Math, Science, Social Studies) were offered the opportunity for an interview. All 12 teachers were interviewed with the DICA.

If students met criteria for CD or ADHA, they were eliminated from the study. Students identified as meeting ODD diagnostic criteria according to both teachers' DICA-P answers were the experimental subjects. Students who met ODD criteria by one teacher only were dropped from the study. Twenty-seven students met criteria for ODD exclusively. Students not meeting criteria for ODD, CD, or ADHD became potential candidates for the control group.

Next, the 27 experimental participants were matched with control group students who met the following criteria: a) same gender, b) age, c)same ethnicity, and d) Reading and Math scores within ± 1.0 grade levels of each other on the WJ-R. Then experimental and control participants were matched according to IQ scores. A ten IQ point discrepancy (less than 1 standard deviation) was the maximum permitted for each pair. (WJ-R and IQ scores were no more than three years old.) Finally, the groups were matched according to SES scores. Thus, as indicated in Figure 1 (see page 37), control and experimental groups were composed of participants matched according to SES, IQ, Reading and Math scores, ethnicity, and gender. Experimental participants met DSM-IV criteria for an ODD diagnosis; control participants did not.

Student participants were drawn from the Learning Disabled and Emotionally Disturbed classification categories. Whereas the Emotionally Disturbed students met

IDEA criteria for this classification label, the Learning Disabled met either IDEA or Section 504 criteria. Table 2 indicates the number of experimental and control group participants who were classified previously by the Committee on Special Education as either a) LD according to IDEA or Section 504, or b) ED. Both control and experimental participants could have had other emotional disturbances (e.g., depression, anxiety) that were not assessed in this study.

Table 2

Number of Participants Drawn from the Two Classification Categories

	Learning Disabled		Emotionally Disturbed	Total
	IDEA	Section 504		
ODD	5	2	20	27
Non-ODD	6	9	12	27
Total	11	11	32	54

A total of 40 male and 14 female students participated in this study with each group containing 20 males and 7 females. The sample included 10 White, 20 African American, 22 Hispanic and 2 Arab students with an equal number of students of each ethnic background in control and experimental groups. Table 3 presents the means, standard deviations, and results of t-tests for independent samples for control and experimental participants' ages, IQs, Reading scores, Math scores, and SES scores. Most participants came from single parent homes with mother as the head of the household who in turn was either unemployed or worked as an unskilled worker (Hollingshead, 1975).

IQs were in the low average range. As would be expected from matching participants, there were no between group differences for descriptive variables.

Table 3

Means, standard deviations, and results of t-tests for independent samples for control and experimental participants' ages, IQs, Reading scores, Math scores, and SES scores

	Group					
	Experimental (ODD)		Control (Non-ODD)		t	p
Variables	M	SD	M	SD		
Age	16.35	1.17	16.50	1.15	.46	.65
IQ	83.67	7.12	83.00	7.51	-.33	.74
Reading	6.16	2.17	6.09	1.99	-.11	.91
Math	6.17	1.52	6.30	1.84	.28	.78
SES	18.96	7.70	21.41	9.24	1.06	.30

Students were not matched in terms of their grade. Table 4 presents the number of students from each grade that participated in each of the two groups. The interaction of Grade X Group was evaluated via a chi-square test. The Pearson chi-square value was 1.679 ($p = .641$) indicating that grade and group were not significantly related.

Table 4

Number of Students per Grade by Participating Groups

	Group	
Grade	ODD	Non-ODD
9	3	6
10	5	6
11	9	8
12	10	7

Twelve teachers participated in the interviews with the DICA. All of them taught academic subjects: Science, Math, English and Social Studies. All teachers but one taught five classes. There were three teachers assigned to each of the four academic subjects. Five of the teachers were male, and seven were females. In terms of ethnicity, two of them (a male and a female) were Hispanic and the remaining were Whites.

Procedure

Following the matching of the 27 experimental participants to their control counterparts, two special education teachers were selected from each adolescent's program of classes and administered the Social Skills Rating Scale-Teacher (Secondary Level) form. If a teacher had a DICA interview for a particular student, that teacher did not rate that student's social skills. The average of the two teachers' scores from the three

SSRS-T subscales made up each student's scores on these subscales. The same two teachers did not rate each student. In total eleven of the twelve teachers described above rated the students on the SSRS. The twelfth teacher was not selected for the SSRS rating because she taught only three classes (the other teachers taught five classes) and had provided DICA information for 38 of her 45 students. Of the 11 teachers, 1 rated 16 students, 3 rated 12 students each, 2 rated 10 students each, 3 rated 8 students each and 2 rated 6 students each. This study was completed over a period of two terms (Spring 1999 and Fall 1999 school terms).

Data Analysis

The collected data were analyzed via three one-tailed *t*-tests for independent samples. Each *t*-test compared the experimental to the control group along each of the three dependent variables: Social Skills, Problem Behaviors, and Academic Competence. A .05 level of significance was used in this study.

Design

A two-group design was used. A sample size analysis (Cohen, 1992) indicated that 26 subjects was the minimum number of subjects per cell required to detect statistically significant results at the $p < .05$ level. The first group ($n = 27$) was composed of special education students who qualified for an ODD diagnosis. The second group ($n = 27$) did not qualify for an ODD diagnosis. The ODD diagnosis vs. non-ODD diagnosis was the independent variable, and it was established using the Diagnostic Interview for Children and Adolescents-Revised (DICA-R; Reich, Leacock, & Shanfeld, 1995). The dependent measures were the three scales (Social Skills, Problem Behaviors, and Academic Competence) of the Social Skills Rating System (Gresham & Elliott, 1990).

CHAPTER 5

Results

This chapter presents analyses of the relationship between teacher SSRS ratings, SSRS descriptive statistics for experimental and control groups, and tests of the hypotheses. Data were analyzed using SPSS for Windows (version 6.1.3).

Every student received SSRS ratings from two teachers. Because student participants had classes with different teachers, the teacher ratings were not provided by the same two teachers for each student. Table 5 presents the means and standard deviations for teacher 1 and teacher 2 ratings.

Table 5

Means and Standard Deviations for Teacher 1 and Teacher 2 SSRS Ratings of the Total Sample

	Scale					
	Social Skills		Problem Behaviors		Academic Competence	
Teacher	M	SD	M	SD	M	SD
Teacher 1	31.96	(12.09)	8.20	(3.96)	25.50	(8.84)
Teacher 2	31.61	(12.29)	10.35	(5.75)	24.98	(7.92)

Since every student received ratings from two teachers, a correlation was run on

the two teachers' ratings to detect the degree of association in the ratings of the students. The results appear in Table 6 and reveal high, positive significant correlations between the

Table 6

Correlations Between the Two Sets of Teachers on the Three SSRS Dependent Variables

SSRS Scale	SSRS Scale		
	Social Skills 1	Problem Behaviors 1	Academic Competence1
Social Skills 2	.8824 (p = .000)		
Problem Behaviors 2		.8277 (p = .000)	
Academic Competence 2			.7978 (p = .000)

raters. However, correlations cannot detect discrepancies in teachers' ratings of the same student. To deal with this shortcoming, three paired t-tests were conducted on the three dependent variables to examine possible differences in the scoring of the two sets of teachers that were not evident from the correlations. Table 7 presents the t-values and probabilities for each of the three t-tests for paired samples. The results indicate an unexpected significant difference on teachers' ratings along the Problem Behaviors subscale but no significant differences on the other two subscales. The second set of teacher raters rated students higher on Problem Behaviors than did the first set of teachers raters. Table 5 (see page 45) presents the means and standard deviations for the two groups of teachers. Individual teacher ratings for Problem Behaviors are presented in Appendix B. A visual inspection of the SSRS protocols did not suggest any consistent pattern of discrepant ratings by particular individual teachers. Specifically 10

discrepancies were noted with a minimum difference of 6 points. Visual inspection revealed that a total of 7 different teachers were involved in these 10 discrepancies. Subsequent data analyses utilized the average scores of the two teachers' ratings for each student.

Table 7

t-values and Probabilities for Teachers' Ratings along the Dependent Variables

SSRS Scale	t	p
Social Skills	.44	.664
Problem Behaviors	-4.75	.000
Academic Competence	.71	.484

Before the three t-tests for independent samples were carried out in order to examine differences between the ODD and the non-ODD group on the three dependent variables, Levene's tests for equality of variances were conducted to determine equality of variance for each variable. Table 8 presents the results of these analyses. Only Problem Behaviors yielded a significant F value. This indicates that equal variances cannot be assumed for this variable and as a result, an unequal variances t-test was used for this variable. On the other hand, the Levene's test for equality of variance on the social skills and academic competence did not yield significant F-values and as a result the equal-variances-assumed t-tests were used for these variables.

Table 8

Levene's Test for Equality of Variances on the Three Dependent Variables

SSRS Scale	F	p
Social Skills	1.836	.181
Problem Behaviors	10.588	.002
Academic Competence	0.595	.444

The first hypothesis of this study was that adolescents with an ODD diagnosis would score significantly lower on the Social Skills Scale than the non-ODD students. Table 9 presents support for this hypothesis as the non-ODD students were rated higher than the ODD ones and the difference was significant.

Table 9

Mean Scores, Standard Deviations, t-value and Probability for ODD and non-ODD Subjects on the Social Skills Scale

Group	M	SD	t	p
ODD	27.00	9.11		
Non-ODD	36.57	12.43	3.23	.001

The second hypothesis stated that adolescents with ODD would score significantly higher on the Problem Behaviors scale than the control group students. This hypothesis was also supported by the data. Table 10 indicates that the mean rating for the ODD group was about twice the mean rating for the non-ODD group.

Table 10

Mean Scores, Standard Deviations, t-values and Probability for ODD and non-ODD Students' Ratings on the Problem Behaviors Scale.

Group	M	SD	t	p
ODD	12.46	4.18		
Non-ODD	6.09	2.34	-6.91	.000

Lastly, the third hypothesis that ODD adolescents would be rated significantly lower on the Academic Competence scale than their control counterparts, was examined. Table 11 indicates a significant difference between the two groups and offers support for the proposed hypothesis.

Table 11

Mean Scores, Standard Deviations, t-values and Probability for ODD and non-ODD Students' Ratings on the Academic Competence Scale.

Group	M	SD	t	p
ODD	22.83	6.64		
Non-ODD	27.65	8.52	2.32	.013

CHAPTER 6

Discussion

This study was an initial effort to investigate whether some special education students in self-contained classes have social skills deficits that may require intervention before they can be included in mainstream classes. Results showed that special education students in self-contained classes who met DSM-IV criteria for ODD were perceived by their teachers as having fewer social skills (i.e., cooperation, assertion, and self control), lower academic competence, and more problem behaviors than other special education students whose behavior did not meet criteria for an ODD diagnosis.

These findings offer support for the assertion that ODD students have social skills deficits compared to non-ODD students and are consistent with previous findings (Merrell et al., 1992) that children with behavioral disorders receive the lowest scores on social competence and school adjustment when rated by their teachers. Merrell et al. (1992) found that behaviorally disordered students were rated the lowest on empathy, sensitivity, and self-restraint when compared to learning disabled, mentally retarded, low achieving, and regular education students using the Walker-McConnell Scale of Social Competence and School Adjustment (SSCSA; Walker, & McConnell, 1988). The Social Skills subscale of the SSRS -T measures students' cooperation with teacher's directives in class, assertion of appropriate interpersonal skills particularly when treated unfairly, and self-control of impulsivity. These constructs appear to be similar to those measured by the SSCSA. It seems then that ODD students are perceived by their teachers as less capable in a) cooperating with teacher directives, b) asserting themselves in social situations with others in a socially acceptable manner, and c) exercising self-control.

Similarly the finding that ODD students were rated significantly higher than non-ODD ones by their teachers on the Problem Behaviors subscale of the SSRS-T is consistent with evidence that children with externalizing disorders who display symptoms of aggression may have problem-solving deficits (Richard & Dodge, 1982). Gresham and Elliott (1990) indicate that the Problem Behavior scale consists of two subscales. One measures externalizing while the other measures internalizing problems. The externalizing problems subscale includes such items as "Argues with others", "Talks back to adults", "Has temper tantrums", "Fights with others". The internalizing problems subscale includes such items as "Likes to be alone", "Has low self-esteem", "Acts sad or depressed" and "Is easily embarrassed". ODD as a subcategory of the disruptive behavior disorders is associated with externalizing (e.g., "Fights with others", "Argues with others") rather than internalizing symptoms (e.g., "Likes to be alone", "Acts sad or depressed"). Thus, it can be argued that ODD students are viewed by their teachers as more confrontational and therefore more likely to display inappropriate behaviors when having disagreements with their peers.

Teachers offered quite discrepant ratings for students who met ODD diagnostic criteria and those who did not on the Problem Behaviors subscale. The mean rating for the ODD group was double that for the non-ODD group on this subscale. This may indicate that students in the ODD sample were substantially more disruptive in class than special education students without ODD symptoms.

Data indicated that the two teacher raters differed significantly in their ratings of all students in the sample on the Problem Behaviors subscale. The second set of teacher raters rated students higher on Problem Behaviors than did the first set of teacher raters.

This may be due to the time of the rating. The second set of teachers rated students later in the term than the first set and therefore had the opportunity to observe problem behaviors for a longer period of time. This longer exposure to students may have been responsible for the higher ratings.

The third hypothesis that ODD students would be rated lower by their teachers on the Academic Competence scale than their non-ODD peers was supported by the data as well. The Academic Competence scale of the SSRS calls for an overall comparison of a student to other students in the class with respect to intellectual functioning, overall academic performance, reading and math abilities, overall motivation for success and parental encouragement. The findings of this study with regard to academic achievement are consistent with research indicating that academic achievement is positively related to social competence (Harvilchuck-Laurenson, 1997; Malecki, 1998). Also, there has been some evidence that ADD students are rated lower than non-ADD ones on their academic competence by their teachers (Friedman, 1998). In addition, rejected students were rated by their teachers lower on academic achievement compared to popular and controversial groups (Frentz, Gresham, & Elliott, 1991). A recent study has also shown that children with high levels of aggressive-hyperactive-impulsive-inattentive behavior were more likely to have ADHD, ODD and CD than control children, more symptoms of general psychopathology, greater social skills deficits, more parental problems and lower levels of academic achievement skills (Shelton et al., 1998).

Implications

The results of this study indicate that ODD students have lower social skills, lower levels of academic competence and higher levels of problem behaviors than non-ODD

students. Traditionally students with such profiles have undergone social skills training to address their deficiencies (Rutherford, Quinn, & Mathur, 1996). Smith-Christopher, Nangle and Hansen (1993) have identified four different social skills intervention procedures: a) Group training,

b) Social problem-solving training, c) Peer-mediated interventions and d) Training individuals in the natural environment. Typically, interventions with adolescents consist of a combination of several procedures. Plienis et al. (1987) used both conventional-skills training and social problem-solving skills training with a group of three ED students. Improvements were noted in unstructured conversations with unfamiliar adolescents, responses to scenarios of social problems, teacher's ratings of adjustment and interactions during informal class parties. In another procedure referred to as "reciprocal social skills training" Serna, Schumaker, Hazel and Sheldon (1986) had delinquent youth learn to give positive and negative feedback, accept negative feedback, negotiate, resist peer pressure, follow instructions and use problem solving skills. Their parents were taught reciprocally complimentary social skills. Results indicated an improvement in social skills for both parents and students. Maintenance of these skills was evident 10 months later.

A recent meta-analytic study (Quinn, Kavale, Mathur, Rutherford, & Forness, 1999) indicated that social skills training might be more effective for promoting pro-social behaviors, but not very successful with disruptive behaviors which may be more resistant to change by social skills training alone. Despite this finding, social skill training programs did not seem to be effective overall. The researchers reported that the limited effectiveness of the social skills training programs might be due to the failure of group-based interventions to assess and address the variation in the types of social skill deficits

evidenced by individual students within the group. Arnold and Hughes (1999) caution that homogeneous group treatment of at-risk youth opens up the possibility of reinforcement of deviant values, affiliation with peers that model antisocial behavior and stronger identification with a delinquent subculture.

It seems then that social skill training is educators' and therapists' way to address social skill deficits in children. However, it might be more effective if offered individually rather than in a group. The addition of parent training might yield better results than student social skills training alone as indicated by research (Serna, et al., 1986). Since many ODD children are diagnosed as CD later on in their lives (Loeber, et al., 1991), social skills training might prevent the transitioning to CD. Progression from ODD to CD implies deterioration in individuals' mental health as CD includes more serious antisocial behaviors than ODD. Therefore, identifying ODD students early and offering them social skills training might prevent the transition to CD.

The treatment of ODD has been the focus of considerable research. Hanish, Tolan and Guerra (1996) recommend parent management training as the most effective way to treat the disorder. They highlight the need for teaching parents social learning principles and behavior management skills so that parents can increase positive behaviors and decrease negative behaviors in their children. These suggestions are based on evidence that parents of non-compliant children tend to reinforce oppositional behavior and ignore or punish positive social behaviors (Patterson, 1976). Barkley, Edwards, and Robin (1999) have created a program called Problem-Solving Communication Training (PSCT) where parents of ODD children are taught to pay attention to their children's good behavior, give their children effective commands, and create a behavior contract and a

point system with clearly specified rewards and punishments. The family engages in problem-solving exercises while the therapist helps the parents to identify unreasonable beliefs and at the same time improve their communication skills.

Recent educational reforms call for greater efforts to mainstream as many special education students as possible. Many school districts throughout the country have already engaged in this practice that is known as "inclusion". However, adaptation of full inclusion without empirical support for its success is especially troublesome to parents and professionals who provide services to students with emotional and behavioral disorders (Braaten, Kauffman, Braaten, Polsgrove, & Nelson, 1988; Council for Children with Behavioral Disorders, 1989). Proponents of inclusion argue that Special Education students with social skills deficits will benefit from mainstream placement since such students will have the opportunity to imitate their mainstream classmates' appropriate behaviors. MacMillan, Gresham and Forness (1996) expressed their serious concern about inclusionary efforts in the absence of empirical evidence for its success. They cited a study by Farmer and Hollowell (1994) where it was found that behaviorally disordered children in regular classrooms tended to gravitate toward other nonidentified peers with more equal levels of aggressive and disruptive behaviors rather than mainstream students who displayed appropriate behaviors. Furthermore, they question the effectiveness of modeling because it had not helped ED students when they were in mainstream classes prior to their classification. In another study, Arnold and Hughes (1999) stated that once the child's level of antisocial behavior is accounted for, the deviancy of his or her friends would not make an independent contribution to the child's current or future level of delinquency or aggression. This implies that students who engage in antisocial behaviors

cannot deteriorate by mere interacting with peers that display antisocial behaviors as well. Therefore, their placement alone in self-contained classes will not exacerbate their behavior while their placement in inclusion classes will not bring any benefits to them either. These findings suggest that the placement alone in self-contained or inclusion classes will not enhance their social skills nor curtail antisocial behavior. On the other hand, social skills training might help (Serna, Schumaker, Hazel, & Sheldon, 1986).

Lewis, Chard and Scott (1994) reviewed the literature with regard to mainstreaming of ED students and noted that the most effective mainstream teachers were the least tolerant of behavioral non-compliance and the most reluctant to have a child with disabilities in their classrooms. These researchers also cited studies suggesting that ED students would have difficulty meeting the behavioral expectations in most general education classes.

Smith-Harvey (1996) surveyed self-contained teachers in 1989 and 1994 and mainstream teachers in 1994 when the school district in that study engaged in the utilization of either a self-contained program in 1989 or a mixed self-contained and inclusion program in 1994. She found no significant differences in students' progress in school or aggression in either setting and so failed to support or refute those who advocate a policy of inclusion.

In view of the limited benefit of inclusion to ODD students, it may make more sense to offer social skills training prior to inclusionary efforts so that mainstreaming can be more successful for ODD students and their mainstream peers and more rewarding for the receiving mainstream teachers.

Limitations

Studies (Jacobsen, Lahey, & Strauss, 1983; Lefkowitz & Tesiny, 1985; Shah & Morgan, 1996) have shown that elementary school children who scored higher on self-rated depression were rated by teachers as less socially competent than children who scored lower on depression. While this study controlled for symptoms of other externalizing disorders (i.e., ADHD and CD), it did not control for or assess internalizing symptoms, such as depression and anxiety. It is possible some students with ODD symptoms were also depressed, and that this related to their social skills deficits. Depression has been found to co-occur with a diagnosis of CD (another disruptive disorder; Harrington, Fudge, Rutter, Pickles, & Hill, 1991). Angold and Costello (1993) reviewed the literature relative to depressive comorbidity in children and adolescents. They indicated that conduct/oppositional disorders showed a significant association with depression in every study. Others (Rodriguez & Routh, 1989) have found a positive association between LD and depressive symptoms. So it is possible that the present control group that consisted mostly of LD adolescents also had depressive symptoms that may have been related to teachers' social skills ratings.

A second limitation has to do with the gender composition of the ODD and non-ODD groups. Males ($n = 40$) outnumbered females ($n = 14$). Due to this under-representation of females the results may not be truly representative of females. However, studies in the area of externalizing disorders typically include more males than females (e.g., Soltys et al., 1992; August et al., 1996) because males tend to display these disorders at a much higher frequency than females (e.g., McDermott, 1996).

Another limitation involves the socioeconomic status of the sample. Almost

exclusively, participants came from the low socioeconomic strata and lived mostly in single parent homes. Although the sample of this study is considered to be representative of the special education population of the high school from which it was drawn, it may not be representative of special education students in the United States as a whole. Furthermore, the overwhelming majority of students were of minority origin. This limitation may not allow for generalization of findings to other ethnic groups.

This study did not examine ethnic nor gender differences between students and teachers. It should be noted that the majority of students were of minority descent whereas the overwhelming majority of teachers were Whites. It is possible that cultural differences may have played a role in the teachers' evaluations of students' social skills. Perhaps, some of the behaviors viewed as problematic by these White teachers may have been viewed as more normative by African American or Hispanic teachers. Furthermore, the study did not control for same or opposite gender pairs of students and teachers. It is possible that students may respond differently to male than female teachers, and that teachers' ratings may be influenced by this.

Finally, the experimenter and the investigator of this study were the same person. This situation may have created an investigator or experimenter bias effect (Barber, & Silver, 1968).

Suggestions

To address the above limitations the current study should be replicated with some changes. Future studies should control for depressive-symptoms when examining social skills deficits of students with externalizing symptoms. A larger sample of participants from various ethnic groups and diverse socioeconomic statuses would be desirable. In

addition, the interviews with the DICA and all interactions with the teachers should be conducted by experimenters who are not investigators in the study. Also hypotheses can be tested about students responding differently to male or female teachers and how such differences affect teachers' ratings of students in terms of ODD and social skills deficits. Lastly, future research needs to investigate the effectiveness of social skills training programs for Special Education students diagnosed as ODD prior to their placement in inclusion or mainstream classes.

Appendix Listing

Appendix A - INFORMED CONSENT FORMS

THE
GRADUATE SCHOOL
AND
UNIVERSITY CENTER
THE CITY UNIVERSITY OF NEW YORK

PH.D. PROGRAM IN EDUCATIONAL PSYCHOLOGY
33 WEST 42 STREET, NEW YORK, NY 10036-8099
212 642-2281

PARENT CONSENT FORM

Dear _____

My name is Vasilios Skoulos and I am a school psychologist. I am completing my doctorate in Educational Psychology at the Graduate School and University Center of the City University of New York. I am doing a dissertation on the social skills of high school students who receive special education I anticipate that the results of the dissertation will help educators know if it would benefit some special education students to receive social skills training. So while the results may not directly benefit your child, they may help other children in the future.

If you volunteer to have your child participate in the study, I will ask you to participate in a brief questionnaire regarding your education and job. Your child's teachers will be asked questions about your child's behavior, activity level, and social skills. Therefore, assessment will be done indirectly on your child. The results of these interviews and your questionnaire will not be reported to Lafayette school officials or kept in your child's school records. They will be used for the purpose of this study only and will be kept confidential in a locked file cabinet by me. If you wish, I will share your child's results with you upon request.

I will also need your permission to use the results of your child's Committee on Special Education evaluation to determine if your child meets requirements for participation in this study. Please be assured that I will keep all information confidential. The names of students who participate in the study will not be mentioned in any report or publication.

This study should pose minimal risk for your child, but if you or your child become uncomfortable with participating for any reason, you may withdraw your child from this study at any time without penalty There are no negative effects from this study, but if a situation arises, there is a school psychologist available Your child's participation in this study will in no way affect his or her standing as a student at Lafayette High School.

If you agree to volunteer your child for participation, please read and sign the attached consent form If you have questions during the course of this study, please call me during the day at (718) 372-3480, ext 4771 or contact my dissertation advisor at CUNY Graduate School, Dr Tryon (212-642-2270) If you have questions concerning your rights as a participant in this study, please call Ms Hilry Fisher at Sponsored Research, Graduate School and University Center CUNY at (212) 642-2059

Graduate School & University Center CUNY
IRB
Approved
Approved. Expires 4/19/99 To 4/19/00

_____ I agree to allow my son/daughter participate in this study
_____ I don't agree to allow my son/daughter participate in this study

_____ _____ _____
Student's Name Parent/Guardian's Signature Date

THE
GRADUATE SCHOOL
AND
UNIVERSITY CENTER
THE CITY UNIVERSITY OF NEW YORK

PH.D. PROGRAM IN EDUCATIONAL PSYCHOLOGY
33 WEST 42 STREET, NEW YORK, NY 10036-8099
212 642-2261

STUDENT ASSENT FORM

Dear _____

My name is Vasilios Skoulos and I am a school psychologist. I am completing my doctorate in Educational Psychology at the Graduate School and University Center of the City University of New York. I am doing a dissertation on the social skills of high school students who receive special education. I anticipate that the results of the dissertation will help educators know if it would benefit some special education students to receive social skills training. So while the results may not directly benefit you, they may help other children in the future.

If you volunteer to participate in the study, I will ask one of your parents to participate in a brief questionnaire. Your teachers will be asked questions about your behavior, activity level, and social skills. The results of these interviews and questionnaire will not be reported to Lafayette school officials or kept in your school records. They will be used for the purpose of this study only and will be kept confidential in a locked file cabinet by me. If you wish, I will share the results with you and your parent upon request.

I will also need your permission to use the results of your Committee on Special Education evaluation to determine if you meet requirements for participation in this study. Please be assured that I will keep all information confidential. The names of students who participate in the study will not be mentioned in any report or publication.

This study should pose minimal risk to you, but if you become uncomfortable with participating for any reason, you may withdraw from this study at any time without penalty. Your participation in this study will in no way affect your standing as a student at Lafayette High School.

If you agree to participate, please sign the consent form. If you have questions during the course of this study, please call me during the day at (718) 372-3480, ext. 4771 or contact my dissertation advisor at CUNY Graduate School, Dr. Tryon (212-642-2270). If you have questions concerning your rights as a participant in this study, please call Ms. Hilry Fisher at Sponsored Research, Graduate School and University Center/CUNY at (212) 642-2059

_____ I agree to participate in this study.
_____ I don't agree to participate in this study

_____ _____
Student's Signature Date

Graduate School & University Center / CUNY
IRB
Approved
Approved: #/19/93 Expired: To #/15/94

Student's Signature

THE
GRADUATE SCHOOL
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THE CITY UNIVERSITY OF NEW YORK

PH.D. PROGRAM IN EDUCATIONAL PSYCHOLOGY
33 WEST 42 STREET, NEW YORK, NY 10036-8099
212 642-2261

TEACHER'S CONSENT FORM

Dear _____:

As part of my training as a school psychologist, I am pursuing a doctorate in educational psychology at the City University of New York. Currently I am working on my dissertation which involves a study of the behavior and interactions of special education students. I would like to ask for your cooperation to participate in my dissertation study. This will involve your participation in an interview or a questionnaire about the behaviors and interactions of some of your students in your class. I would like to assure you that all collected information about your students will be kept confidentially in a locked cabinet and will not be shared with others. Instead they will be used only for the purpose of this study. The results of my study may be published in a scientific journal but the names of the participating students, families and teachers will not be released. Your participation in the study is voluntary and you may withdraw at any time without penalty.

If you have questions about this research, you can call me at (718) 372-3480 ext. 4771 or my advisor, Dr. Georgiana Shick-Tryon at (212) 642-2270. If you have questions about your rights as a participant in this study, you can contact Hilry Fisher, Sponsored Research, Graduate School, City University of New York, 212-642-2059.

Thank you in advance for your consideration.

Vasilios Skoulos
School Psychologist

I understand my rights and agree to participate in Mr. Skoulos' dissertation study.

Graduate School & University Center / CUNY
IRB
Approved
Approved Expired
4/19/99 To 4/18/00

_____ _____
Teacher's Signature Date

Appendix B - INDIVIDUAL TEACHER RATINGS FOR PROBLEM BEHAVIORS

INDIVIDUAL TEACHER RATINGS FOR PROBLEM BEHAVIORS

Student	Teacher 1	Teacher 2
1	7	5
2	5	7
3.	2	3
4	15	23
5	14	22
6	8	4
7	15	17
8	8	14
9	7	4
10	4	4
11	11	17
12	6	4
13	10	13
14	6	6
15	12	18
16	7	17
17	8	12
18	4	5
19	12	15
20	16	20
21	4	13
22	15	19
23	15	14
24	5	4
25	5	15
26	7	4
27	15	18
28	7	7
29	11	17
30	9	9
31	7	12
32	2	5
33	10	17
34	1	3
35	8	7
36	16	18
37	8	8
38	12	15
39	13	15
40	12	15
41	7	6
42	4	5

INDIVIDUAL TEACHER RATINGS FOR PROBLEM BEHAVIORS Cont'd

Student	Teacher 1	Teacher 2
43	4	7
44	6	8
45	5	6
46	5	4
47	4	5
48	8	10
49	8	8
50	7	8
51	5	3
52	5	6
53	6	9
54	10	9

Appendix C - HOLLINGSHEAD SES DETERMINATION WORKSHEET

HOLLINGSHEAD SES DETERMINATION WORKSHEET

ID: _____

Student's Initials _____ DOB: _____

Mother at home? Y or N Father at home? Y or N

Mother's occupation _____ Father's occupation _____

Occupation scaled score _____ Occupation scaled score _____

CIRCLE ONE:

Mother's education:	Score	Father's education:	Score
< 7th grade	1	< 7th grade	1
9th grade	2	9th grade	2
10th or 11th grade	3	10th or 11th grade	3
HS grad	4	HS grad	4
> 1 yr. college	5	> 1 yr. college	5
college or university grad	6	college/univ grad	6
graduate degree	7	graduate degree	7

Head of house ever married? Y or N

Separated or divorced? Y or N

If separated-divorced, does head receive support payments? Y or N

Father's scoring:

Factor	Scaled score	Factor weight	Score x weight
Occupation	____	5	_____
Education	____	3	_____

Mother's scoring:

Factor	Scaled score	Factor weight	Score x weight
Occupation	_____	5	_____
Education	_____	3	_____

If appropriate: Father's score _____

Mother's score _____

Total scores = _____ divided by 2 = _____

Family Total Score

Appendix D - DICA - R

Student's Name:_____ ID#_____

Teacher's Name:_____

B1. Does he/she often lose his/her temper, shout or yell at adults or his/her friends?

NO RARELY SOMEWHAT YES

B2. Does (s)he get into arguments with you, or other adults?

NO RARELY SOMEWHAT YES

B3. Does (s)he often refuse to do things that you or other adults ask him/her to do? I mean refuse to do it, not just put it off.

NO RARELY SOMEWHAT YES

B4. Does (s)he often do things on purpose to annoy people? For example, does (s)he act silly or make fun of people, or do things that (s)he knows will get on their nerves?

NO RARELY SOMEWHAT YES

B5. When (s) makes mistakes or gets into trouble, does (s)he tend to blame him/herself, others or both?

NO RARELY SOMEWHAT YES

B6. Do things people say or do get on her/his nerves a lot?

NO RARELY SOMEWHAT YES

B7. Does (s)he often feel that people are unfair to her/him or that they don't take her/his feelings into account?

NO RARELY SOMEWHAT YES

B8. When (s)he is angry with someone, does (s)he often try to get back at them in some mean or spiteful way? For example, telling things about them that aren't true, breaking confidences, or even making up lies about people.

NO RARELY SOMEWHAT YES

B9 Have these behaviors caused problems with how this child gets along with her/his friends?

NOT AT ALL NOT TOO MUCH SOMEWHAT QUITE A BIT

B10a Have these behaviors caused problems with how this child gets along at school?

NOT AT ALL NOT TOO MUCH SOMEWHAT QUITE A BIT

B10b When was the last time that (s)he had any of these problems? Was it

within the past two weeks? 1

within the past month? 2

within the past six months? 3

within the past year? 4

Over a year ago? 5

B11 Has (s)he caused any of the following things to happen?

-(S)he lost friends?

NO RARELY SOMEWHAT YES

-You were angry and frustrated with her/him a lot of the time?

NO RARELY SOMEWHAT YES

- (S)he felt very sad?

NO RARELY SOMEWHAT YES

- Grades were poor NO RARELY SOMEWHAT YES

- Teachers angry with her/him a lot of the time?

NO RARELY SOMEWHAT YES

- (S)he has an attitude problem?

NO RARELY SOMEWHAT YES

- (S)he was frequently punished (physical/Grounded/Lost money)?

NO RARELY SOMEWHAT YES

- (S)he was beaten up?

NO RARELY SOMEWHAT YES

- (S)he was sent to see a counselor/doctor?

NO RARELY SOMEWHAT YES

- (S)he was kicked out of the house?

NO RARELY SOMEWHAT YES

- (S)he was sent somewhere else to live?

NO RARELY SOMEWHAT YES

- (S)he was referred to juvenile court?

NO RARELY SOMEWHAT YES

A1a Is it hard for this student to do the school work slowly and carefully? Is the work messy and careless?

NO RARELY SOMEWHAT YES

A1b Does (s)he make a lot of mistakes in school work or homework because (s)he rushes through them without checking?

NO RARELY SOMEWHAT YES

A2a Does (s)he daydream a lot, or have a hard time concentrating when (s)he is trying to work at school or at home?

NO RARELY SOMEWHAT YES

A2b In any kind of activities such as sports or games, does this child have a hard time remembering what to do next, or does (s)he have trouble paying attention to the rules?

NO RARELY SOMEWHAT YES

A3 Do you often feel that the child doesn't seem to be listening to you even when you are speaking directly to her/him?

NO RARELY SOMEWHAT YES

A4a Does (s)he have difficulty in school because even after you explain the lesson, (s)he is still not sure what (s)he is supposed to do?

NO RARELY SOMEWHAT YES

A4b If you ask him/her to do something, does (s)he forget to do it, or does (s)he forget exactly what to do?

NO RARELY SOMEWHAT YES

A5a Does (s)he have a hard time getting organized? Is (s)he always without pens, papers and other items (s)he needs to complete a task? Does (s)he lose things, or break things?

NO RARELY SOMEWHAT YES

A5c Is it hard for her/him to find anything (s)he needs, because (s)he leaves her things scattered around the floor, or piled up in a heap?

NO RARELY SOMEWHAT YES

A6a Does (s)he hate doing school work or homework because (s)he finds it very hard to sit still and pay attention?

NO RARELY SOMEWHAT YES

A6b Does (s)he find any excuse to get out of doing school work or homework because (s)he finds it so hard to stay focused on what (s)he is doing?

NO RARELY SOMEWHAT YES

A7a Is (s)he continually losing things like pencils, notebooks, papers from school, the pieces for a game, or other items required for an activity?

NO RARELY SOMEWHAT YES

A8a Is it hard for him/her to do work when something else is going on in the same room? Is (s)he distracted by any little thing?

NO RARELY SOMEWHAT YES

A9a Is (s)he often forgetful in her/his day to day activities? For example, does (s)he forget to bring his homework to school?

NO RARELY SOMEWHAT YES

A11a Does (s)he have a very hard time sitting still? Does (s)he squirm and fidget in her/his seat?

NO RARELY SOMEWHAT YES

A12a Does (s)he have a hard time staying seated at school? Is (s)he in and out of her/his seat?

NO RARELY SOMEWHAT YES

A13a Is (s)he continually running around, or climbing on things at times when (s)he shouldn't be?

NO RARELY SOMEWHAT YES

A14a Is it really hard for her/him to do anything quietly either by herself/himself or with kids?

NO RARELY SOMEWHAT YES

A15a Do you feel that (s)he just can't slow down; that (s)he is continually moving or doing something?

NO RARELY SOMEWHAT YES

A16a Does (s)he often seem to talk "non-stop"? Does (s)he frequently talk "on and on"?

NO RARELY SOMEWHAT YES

A17a Does (s)he often start answering a question before it has been completed?

NO RARELY SOMEWHAT YES

A18a Is it hard for her/him to wait her/his turn in games, or in sports? Does (s)he find it very difficult to wait in line?

NO RARELY SOMEWHAT YES

A19a Does (s)he often jump in and start talking to you at the inappropriate times? For example, when you are busy or you are talking to someone else?

NO RARELY SOMEWHAT YES

A19b When other kids are involved in an activity, is (s)he likely to butt in without being asked?

NO RARELY SOMEWHAT YES

Have these behaviors caused problems with how this child gets along with people at home? Y N

Have these behaviors caused problems with how this child gets along with her/his friends? Y N

Have these behaviors caused problems with how this child gets along with her/his teachers? Y N

Have these behaviors made it difficult for this child to get good grades in school?

Y N

C3a Does (s)he like to "outsmart" other people so that (s)he gets them to do what (s)he wants, or so (s)he can put something over on them?

NO RARELY SOMEWHAT YES

C3b Does (s)he like to think of her/himself as pretty good at "outsmarting" other people like that?

NO RARELY SOMEWHAT YES

C3c Does (s)he get into trouble because people say (s)he lies or that (s)he puts things over on other people?

NO RARELY SOMEWHAT YES

C5 Has (s)he ever stolen anything from someone when the person wasn't looking or wasn't around?

NO RARELY SOMEWHAT YES

C6 Has (s)he bullied or picked on someone, or done things to make someone afraid of her?

NO RARELY SOMEWHAT YES

C7a Has (s)he been in fights with other kids? (Fights in which they hit one another, not just yelling and screaming.)

NO RARELY SOMEWHAT YES

C7b Has (s)he started any of these fights? That is, (s)he threw the first punch?

NO RARELY SOMEWHAT YES

C8 When (s)he's been fighting, has (s)he ever used other things besides her/his hands? For example a stick, a rock, a bat, a knife, a broken bottle or a gun.

NO RARELY SOMEWHAT YES

C9 Other than when fighting, has (s)he ever done anything on purpose to hurt another person or to cause them physical pain?

NO RARELY SOMEWHAT YES

C10 Has (s)he ever hurt or killed a small animal like a cat, a dog, a squirrel, a hamster or a gerbil? Has (s)he tried to hurt a larger animal, like a horse or cow?

NO RARELY SOMEWHAT YES

C11 Has (s)he ever mugged someone or held them up and robbed them? Has (s)he ever bullied other people to give her/him something that was theirs?

NO RARELY SOMEWHAT YES

C12a Has (s)he ever set any fires that (s)he wasn't supposed to set?

NO RARELY SOMEWHAT YES

C12b Did (s)he set the fire on purpose, or by accident?

DELIBERATE ACCIDENT

SOME DELIBERATE/SOME ACCIDENTAL

C12c Did (s)he set any fires on purpose because (s)he wanted to wreck or destroy something or burn something up?

NO RARELY SOMEWHAT YES

C13 Has (s)he ever wrecked someone else's property on purpose (without setting fires)?

NO RARELY SOMEWHAT YES

C14 Has (s)he ever broken into someone's house or car, or has (s)he ever broken into a building?

NO RARELY SOMEWHAT YES

C15a Has (s)he ever stayed out at night on purpose when (s)he was told to be in?

NO RARELY SOMEWHAT YES

C15b How many times has (s)he stayed (sneaked) out like that? _____

C15c How old was (s)he the first time (s)he stayed (sneaked) out?_____

C15d When was the last time (s)he did this?

PAST 2 WEEKS PAST MONTH PAST 6 MONTHS PAST YEAR

OVER A YEAR AGO

C16a Has (s)he run away from home overnight or longer?

NO RARELY SOMEWHAT YES

C16b How many times has (s)he run away like that? _____

C16c Did (s)he ever go back home? _____

C16d How old was (s)he the first time (s)he ran away? _____

C16e When was the last time (s)he did this?

PAST 2 WEEKS PAST MONTH PAST 6 MONTHS PAST YEAR

OVER A YEAR AGO

C17a Has (s)he ever skipped school?

NO RARELY SOMEWHAT YES

C17b How often has he skipped school? _____

C17c How old was (s)he the first time (s)he skipped school? _____

C17d When was the last time (s)he skipped school?

PAST 2 WEEKS PAST MONTH PAST 6 MONTHS PAST YEAR

OVER A YEAR AGO

C18 Has (s)he ever forced anyone to do sexual things with her/him? Not just intercourse, but forcing them to be touched where they didn't want to be touched, or forcing others to do things to her/him?

NO RARELY SOMEWHAT YES

C19 Have these behaviors caused problems with how this child gets along with the family?

NOT AT ALL NOT TOO MUCH SOMEWHAT QUITE A BIT

C20 Have these behaviors caused problems with how this child gets along with her/his friends?

NOT AT ALL NOT TOO MUCH SOMEWHAT QUITE A BIT

Appendix E - APA PERMISSION FOR CITATION

American Psychiatric Association

1400 K Street, N. W.
Washington, D. C. 20005
Telephone 202.682.6000
Fax 202.682.6850
E-mail apa@psych.org
Internet: www.psych.org

January 20, 1998

Vasilios Skoulos
28 Curtis Place
Lynbrook, NY 11563-2010

Dear Mr. Skoulos:

I am responding to your recent request to **reprint diagnostic criteria for Oppositional Defiant Disorder for your dissertation** from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.

Permission is granted under the following conditions:

- Permission is nonexclusive and limited to the single use specified in your letter;
- Use is limited to the English language only; and
- Permission must be requested for subsequent uses (including subsequent editions)

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Sincerely,

Ronald E. McMillen/RM

Ronald E. McMillen
Director of Publications

Enclosure

Appendix F - STUDENT DATA WORKSHEET

STUDENT DATA WORKSHEET ID:_____

STUDENT INITIALS: _____ SEX: M or F

DOB: __/__/__ AGE:___ yrs., ___ mos.

RACE: 1 White

2 African-American

3 Hispanic

4 Asian-American

5 Other: _____

DICA CRITERIA MET: circle Yes or No

ADHD	Yes	**DROP**	No
CD	Yes	**DROP**	No
ODD	Yes		No
Learning Disability	Yes	**MATCH**	No

SSRS Scores:

Social Skills: _____ _____

Problem Behaviors: _____ _____

Academic Competence: _____ _____

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