

# Clinician to Clinician

## When Parents and Teachers Disagree

by Frank M. Gresham, Ph.D.



#### **Editor's Note**

This column is a new feature of Attention!\* providing practical information for professionals who teach, treat or coach individuals with AD/HD.

MANY CHILDREN AND YOUTHS WITH AD/HD have significant deficits in social competence and peer relationships (Barkley, 1990; Guevremont, 1990). It is estimated that over 50 percent of children with AD/HD have substantial difficulties in establishing and maintaining satisfactory interpersonal relationships and social acceptance with peers and teachers. Children with AD/HD often evoke negative responses from their peers. This reaction causes them to be rejected based primarily on their impulsive and oppositional behavior patterns coupled with social skills deficits (Landau & Moore, 1991). One investigation showed that a group of 25 boys with AD/HD (ages 6 to 12-years-old) had much higher rates of aggression and noncompliance that led to peer rejection compared to a group of 24 boys without AD/HD in a 5-week summer camp (Erhardt & Hinshaw, 1994). Other studies have also consistently shown that children with AD/HD rapidly attain a rejected peer status that is difficult to change without rather high intensity inventions.

This article describes the use of parent and teacher ratings of AD/HD children's social skills. Consistent with past research using behavior-rating scales, there are often relatively low agreements between different sources of information regarding children's social behavior (Achenbach, et al., 1987). One conclusion from the Multimodality Treatment of AD/HD (MTA) Study from the National Institutes of Health Consensus Conference was that there is often a "disconnect" between educational assessments and health-related services. That is, there is often a lack of agreement between those conducting diagnoses of AD/HD and those who monitor and implement treatments in school settings (Swanson et al., 1999). This lack of agreement between raters does not necessarily mean that either source of information is erroneous or invalid. When one finds such discrepancies, the task of the clinician is to collect additional information that will serve to confirm or disconfirm hypotheses about the nature and causes of social skills deficits in specific settings (Gresham, 2001).



**Social Skills Assessment Considerations** 

The previously mentioned MTA Study used more than 50 instruments in its assessment battery. In the data reduction process, the MTA Group identified 13 measures from six key instruments that were selected as marker variables. Specific domains of behavioral functioning measured by these instruments and the sources of this information were represented in a Source X Domain matrix. Social skills were assessed using parent and teacher ratings from the Social Skills Rating System (SSRS, Gresham & Elliott, 1990). The SSRS provides a comprehensive assessment of social skills and also measures problem behaviors (internalizing, externalizing and hyperactivity) as well as teacher ratings of academic competence. Each item on the SSRS is rated on a 3-point scale (0 = Never, 1 = Sometimes, or 2 = Very Often) based on the rater's perceived frequency of the behavior.

The SSRS was standardized on a national sample of 4,170 children and adolescents in ages 3–18 years and was stratified by race/ethnic group, gender and geographic region. Table 1 shows the domains assessed by the SSRS.

#### **Discrepancies Between Parent and Teacher Ratings**

Consistent with past research using different informants, there are sometimes rather large discrepancies between parent and teacher ratings of children's social skills and problem behaviors. Based on the standardization sample of the SSRS, the correlation between teacher and parent ratings of social skills and problem behaviors was .36. There are several reasons why this might be the case. One, behavior ratings are summaries of observations of the *relative frequency* of specific behaviors. The precision with which behavior is measured with rating scales is relative and not exact.

Two, behavior ratings are influenced by differential task demands that might be present in home versus school settings. For example, paying attention and sitting still are often much more difficult during protracted periods of seatwork in school than during an equal amount of time playing video games at home. Three, behavior ratings may be greatly influenced by differential *tolerance levels* of different raters. That is, one often finds different tolerance levels for behavior between parents and teachers, between different teachers, and between mothers and fathers.

Four, the observability or salience of behavior can affect the agreement between different raters of behavior. For instance, raters often disagree on the occurrence of internalizing behaviors (e.g., anxious, depressed, lonely) and agree more highly on the occurrence of externalizing behaviors (e.g., fidgets, disobeys rules, acts impulsively). Five, different raters may mistake behavioral frequency with behavioral intensity. For example, the behavior of fighting is a high intensity behavior that may occur once a month and one rater might rate it as occurring "Very Often" (using an intensity criterion) whereas another would rate it as occurring "Sometimes" (using a frequency criterion). Six, behavior ratings are often influenced by Halo Effects in which the salience of one behavior may influence the perceived frequency of other behaviors. A good example of this is when low ratings of cooperation social skills inadvertently create low ratings of assertion social skills when, in fact, these may not be deficient.

#### Discrepancies: What to Do?

One way that a clinician might handle discrepancies between parent and teacher sources of information would be to conduct a side-by-side comparison as a basis for planned discussions with the discrepant sources of information. *Swanson et al.* provide general principles for these discussions that are summarized below.

- What are the differences in task demands between home and school settings that might explain discrepancies in ratings?
- Are differences in ratings explained by the child's behavior in a one-to-one situation versus the child's

TABLE L SSRS Domain Description

The wise clinician will collect as much information as possible from multiple sources to assist in a more accurate characterization of the child with AD/HD's level of social competence.

IADLE I 33K3	Sky Domain Descriptions		
Domain	Description		
Cooperation	Behaviors facilitating academic performance and success		
Assertion	Behaviors involving initiation of social interactions or expression of opinions		
Responsibility	Behaviors related to following rules in home/community settings (Parent Scale only)		
Self-Control	Behaviors that involve inhibition impulses or acting-out behavior pattern		
Academic			
Competence	Academic and related behaviors involving reading, mathematics, motivation, intellectual functioning and parental support (Teacher Scale only)		
Externalizing	Behaviors representing undercontrolled or acting-out behaviors		
Internalizing	Behaviors representing overcontrolled or inhibited behavior pattern		
Hyperactivity	Behaviors representing inattention, impulsivity, and overactivity		

36 attention@chadd.org / April 2002 / attention@chadd.org 37

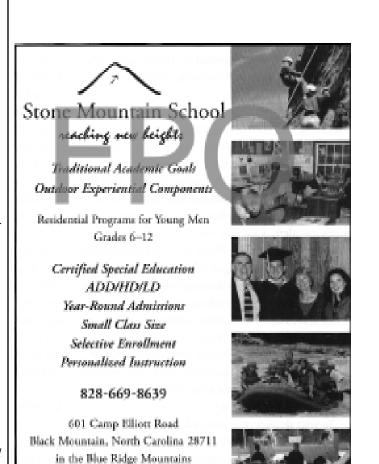
### Clinician to Clinician, continued

behavior in a large group situation?

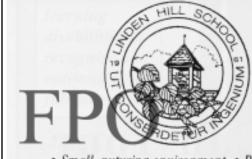
- Are differences in ratings due to differences in perceptions of raters regarding social skill acquisition (can't do) versus performance (won't do) deficits?
- Is the disparity in social skill ratings between raters due to differences in the number of opportunities to perform the social skills in question in school versus home settings?
- Is the disparity between raters due to the more frequent presence of competing problem behaviors in one setting versus another setting?

The assessment of the social skills of children with AD/HD often relies on the use of behavior rating scales collected from parent and teacher informants. The MTA Study used parent and teacher ratings of the social skills of children with AD/HD using the Social Skills Rating System (SSRS) and found relatively low agreements between parent and teacher ratings. Based on the MTA Study, it seems wise to telephone the child's teacher to inquire about any discrepancies between parent, teacher and clinician impressions of a child's social skills. It should be noted that the SSRS could yield a large number of social behavior patterns given the number and type of raters completing the instrument, variability in scale and subscale patterns, and the age of the child being rated. For example, the Elementary SSRS has three scales (Social Skills, Problem Behaviors and Academic Competence), three raters (Parent, Teacher and Student), and three levels (More, Average and Fewer). At the subscale level, there are five social skill subscales (Cooperation, Assertion, Responsibility, Empathy and Self-Control) and three Problem Behavior subscales (Externalizing, Internalizing and Hyperactivity). The potential for disparities among raters is great given the number of scales, subscales and raters involved. Moreover, teacher or parent ratings of a child's social skills may not be corroborated by direct observations of the child's peer interactions on the playground or the home with friends. The wise clinician will collect as much information as possible from multiple sources to assist in a more accurate characterization of the child with AD/HD's level of social competence. ■

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