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The Relationship Among Self-, Teachers', and Peers' Perceptions of Competence for Children with Severe Behavior Disorders

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ABSTRACT

This study investigated the feasibility of Harter's multidomain perceived self-competence scales with children evidencing severe behavior disorders. Subjects were 46 children in a psychoeducational day treatment program. The younger group (n=29), ages 5--7 years, was administered Harter's Pictorial Scale of Perceived Competence and Social Acceptance for Young Children. The older group (g=17), ages 8--9 years, was administered Harter's Self-Perception Profile for Children. Additionally, the children rated their peers on a peer rating scale, and their teachers rated the children's competence using Harter's teacher rating scales. The resulting pattern of correlations among self-, teachers', and peers' ratings, and t tests comparing self- and teachers' ratings, were generally in accord with Harter's findings with nonclinical populations. Implications for further research on behaviorally disordered youngsters' competence are considered.

INTRODUCTION

Research on children's self-perceptions of competence has changed its focus considerably during the past two decades. Early researchers (e.g., Coopersmith, 1967) in the area regarded children's self-perceptions of competence as a global percept and consequently typically assessed it by means of one summary score on the particular measure being utilized, even though a variety of competence domains might have been surveyed. Others did not assess children's perceptions globally but rather concentrated on one domain of competence, most frequently social competence (Rolf, Sells, & Golden, 1972; Stipek, 1981). More recently, Harter (1982), questioning the validity of the first approach and advocating the importance of studying several areas at once, has developed children's self-assessment scales which sample several competence domains. Additionally, corresponding to these self-rating scales, she has developed scales on which students' competencies are rated by their teachers (Harter, 1982; Harter & Pike, 1984), thereby allowing teachers' and self-perceptions of the child's competence to be compared within and across domains.

While encouraging reliability and feasibility data for Harter's scales have been reported, the research involving these measures to date has been limited to nonclinical populations. Therefore, the present study was conducted to assess the validity of Harter's scales for children evidencing severe behavior problems. To assess the extent of the convergence of competence ratings from different sources, self-, teachers', and peers' ratings of competence were compared for a group of youngsters enrolled in a psychoeducational day treatment program.

Additionally, to evaluate developmental differences in perceptions of competence, two age groups were studied: one group of 5--7-year-olds, and a second of 8--9-year-olds. The particular age cutoff between the groups was chosen because of developmental changes theorized to occur in defining skills of competence and in children's understanding of, and ability to describe, the self and their perceived competence (Harter & Pike, 1984). Previous research has shown that, compared with younger children, older children (a) rely on relative comparison with others to a greater extent in their self-evaluations of achievement competence (Rubie, Boggiano, Feldman, & Loebel, 1980), (b) evidence more heterogeneity across various dimensions of social status (Coie, Dodge, & Coppotelli, 1982), (c) show greater agreement with teachers' ratings of competence (Landau,
Based on these findings, we hypothesized that (a) the younger children's self-ratings on the various subscales would intercorrelate more highly than the older children's since younger children differentiate less, (b) the younger children's self-ratings would be more positive than the older children's, and (c) the older children's self-ratings would show greater agreement with their teachers' ratings of them than would the younger children's self-ratings.

Finally, to examine differences in evaluations of competence between types of disorder, the children were grouped into those demonstrating externalizing disorders (conduct disorder, hyperactivity, or oppositional diagnoses) and nonexternalizing disorders (the remainder of the children). In several studies (Rolf, 1976; Rubin, 1983) of social competence, externalizing children have been rated more negatively by peers than have nonexternalizing youngsters. Consequently, in the current investigation, externalizing children were hypothesized to evidence less positive competence ratings by themselves, their teachers, and their peers than children with nonexternalizing diagnoses.

METHOD

Subjects

Forty-six children, comprising all pupils in five classrooms in a psychoeducational day treatment program for children with severe behavior disorders, took part in the study; their ages ranged from 5 years and 1 month to 9 years. The pupils in three of the classes (17 boys and 12 girls, \( n = 29 \)) were designated as the younger group; their mean age was 6-4 with a range from 5-1 to 7-9. The older group (mean age of 8-4, range from 7-10 to 9-0) consisted of the students in the other two classes (16 boys and 1 girl, \( n = 17 \)). The younger group's mean Stanford-Binet IQ was 80.10 (SD = 11.05), while the older group's was 88.35 (SD = 10.37). Because this IQ difference was significant, \( t(44) = 2.50, \ p < .02 \), subsequent comparisons between the two groups on the competence variables were analyses of covariance (ANCOVA), controlling for the contribution of IQ. The younger boys and girls did not differ significantly on IQ.

The children's DSM-III diagnoses, determined by the program's psychologists, included pervasive developmental disorder (11 children), oppositional disorder (9), attention deficit disorder without hyperactivity (9), attention deficit disorder with hyperactivity (3), expressive language disorder (4), atypical pervasive developmental disorder (1), adjustment disorder (2), adjustment disorder with disturbance of conduct (2), adjustment disorder with anxious mood (1), overanxious disorder (2), and conduct disorder-undersocialized aggressive (2). Three quarters of the children were black or Hispanic, and the remainder were white. Pupils in this program are mainly of low and lower-middle socioeconomic status, as determined by census tract median income figures (United States Bureau of the Census, 1983).

Instruments

Self-ratings. Each child completed the Harter scales of competence appropriate for his/her age. Three children in the younger group were administered the Pictorial Scale-of Perceived Competence and Social Acceptance for Young Children--Preschool and Kindergarten (P-K) (Harter & Pike, 1984), designed for youngsters ages 4 and 5. The remaining 26 pupils in the younger group were administered the Pictorial Scale of Perceived Competence and Social Acceptance for Young Children--First and Second Grade (1-2), designed for 6- and 7-year-olds (Harter & Pike, 1984). There are corresponding male and female versions for each of these pictorial scales. Both scales are composed of four domains: cognitive competence, physical competence, peer acceptance, and maternal acceptance. The scales contain 24 items (picture-plates), 6 for each domain. The child is shown a page with two pictures on it, told what each picture means (e.g., "This child is sad and this child is happy"), asked to choose which of the pictured
children is more like him/herself, and then asked whether the child in the picture is "a lot" or only "pretty much" like him/herself. Each of the four choices is assigned a numerical value from 1 (low perceived competence) to 4 (high perceived competence). The self-rating score for each subscale is determined by adding the scores of the 6 items for that subscale and dividing by 6.

Evidence for the scales' internal reliability was provided by Harter and Pike (1984), who reported alpha coefficients ranging from .62 to .83 for the four subscales for a sample of preschoolers and kindergartners, and a total scale alpha coefficient of .88. Alpha coefficients for a first- and second-grade sample were found by Harter and Pike (1984) to range from .53 to .79 for the four subscales, with a total scale alpha coefficient of .87. Factor analysis indicated that items loaded moderately to highly (i.e., in the .19 to .70 range) on their designated factors.

The children in the older group were administered the Self-Perception Profile for Children (Harter, 1985), which assesses six competence domains: scholastic competence (corresponding to cognitive competence on the younger children's scales), social acceptance (corresponding to peer acceptance), athletic competence (corresponding to physical competence), physical appearance, behavioral conduct, and general self-worth.

The scale contains 36 items, 6 for each domain, which are in a "structured alternative format." That is, for each item (e.g., "Some kids often forget what they learn BUT other kids can remember things easily") the child first is asked to choose the "kid" more similar to him/herself and then whether that is "really true" or "sort of true" for him or her. The four possible responses for each item are scored from 1 (low perceived competence) to 4 (high perceived competence). The self-rating score for each subscale is determined by adding the scores of the 6 items for that subscale and dividing by 6.

Alpha coefficients ranging from .71 to .88 were reported by Harter (1985) for samples of third through eighth graders.

Factor analysis evidenced substantial and appropriate factor loadings for each subscale; there were no cross-loadings larger than .18 (Harter, 1985).

Teachers' ratings. A rating scale paralleling the Pictorial Scales was used with the teachers of the younger group. The ratings were in a written format (e.g., "This kid often forgets what he or she learns, but this kid often remembers things easily"). Each of the teachers rated all children in his/her class on three domains (cognitive competence, physical competence, and peer acceptance); there were six items per domain.

For the teachers of the older children, a rating scale paralleling the Self-Perception Profile for Children was used. This measure is presented in the same format as the children's self-rating scale, but there are only three items per domain. Five domains or subscales (i.e., all but the global self-worth domain) are rated, for a total of 15 items. Harter (1982) reported internal consistency coefficients for the subscales to be .93 or above. Additionally, the factor pattern of the teachers' ratings was quite similar to the children's.

Peers' ratings. The peer rating measure, based on Vosk, Forehand, Parker, and Rickard (1982), consisted of one item asking if the child liked each named peer "a lot", "a little", or "not at all". For each child, the "a lot" scores were summed and multiplied by 3, the "a little" scores were summed and multiplied by 2, and the "not at all" scores were summed and multiplied by 1. The three weighted scores for each child were then summed and divided by the number of peers who had rated the particular child, to obtain an average peer rating. Such ratings of popularity have been found (Vosk et al., 1982) to correlate with teacher ratings, classroom behavior observations, and achievement test performance.

Procedure

The self- and peer measures were individually administered to each child in a private room. Procedures for administering the self-rating scales followed Harter
(1985), with the following modifications. To control for the wide range in the reading abilities of the children in the older group, the items were administered verbally rather than having the children read them independently. Following the completion of the self-perception scale, each child in the younger group was shown photographs of all peers from his/her classroom; each child in the older group was shown photographs of all the older children (i.e., the members of the two classrooms). The child was verbally asked about each child, "Do you like a lot, a little, or not at all?" During a two-week interval concurrent with the administration of the self- and peer scales, each teacher completed the appropriate rating scales for the pupils in his/her classroom.

RESULTS

For each age group a correlation matrix was calculated for the self-, teacher, and peer scales, and the two sociodemographic variables of age and IQ. Next, MANOVAs and t-tests were conducted comparing self- and teachers' ratings on the various competence domains. Finally, each age group was divided by two judges (a doctoral level clinical child psychologist and a graduate student in clinical child psychology) into children with externalizing diagnoses (i.e., conduct disorder, oppositional disorder, and hyperactivity) and those with nonexternalizing diagnoses; the intrarater reliability for this classification was 1.00. The self-, teachers', and peers' ratings of these two diagnostic groupings were then compared by means of MANOVAs and t-tests.

Results for the younger group

Means and standard deviations of variables. As Table 1 indicates, the children's self-ratings on all four subscales were positive, with means ranging from 2.90 to 3.19 for the various scales (2.5 being neutral). The teachers' ratings of the children, though, ranged from fairly negative for cognitive competence (1.90) to slightly negative for physical competence (2.21) to slightly positive for peer acceptance (2.73). The mean for the peer ratings (2.29) indicated that the children tended to regard their peers somewhat positively (2.0 = neutral like a little).

Reliability of self-ratings. With respect to internal consistency, coefficient alpha for the total score was .83. The individual subscales' reliabilities were: cognitive competence, .64; peer acceptance, .68; physical competence, .72; and maternal acceptance, .48.

Intercorrelations among the variables. The self-ratings were all significantly intercorrelated (correlations ranging from .46 to .55), but none of the variables...
teacher-self nor peer-self correlations were significant (see Table 2). There was a trend \( p < .06 \) toward a significant positive correlation, \( r(28) = .30 \) between self- and teachers' ratings of peer acceptance.

With respect to the intercorrelations among the teacher scales, physical competence ratings correlated significantly with ratings of both cognitive competence, \( r(28) = .33 \), and peer acceptance, \( r(28) = .60 \) (though no relationship was found between ratings of cognitive competence and peer acceptance). Teachers' peer acceptance ratings correlated significantly and positively with peers' ratings, \( r(28) = .26 \), while teachers' cognitive competence ratings correlated negatively with peer ratings, \( r(28) = -.34 \). None of the self-ratings correlated with age or IQ. Teachers' cognitive competence ratings correlated significantly with IQ, \( r(28) = .44 \), but not with age; none of the other teachers' ratings correlated with age or IQ. Peers' ratings correlated significantly and negatively with age, \( r(28) = -.31 \).

**Comparisons between self- and teachers' competence ratings.** A multivariate analysis of variance (MANOVA) comparing the three self-perception and the three teachers' perception scales was significant, \( F(3, 54) = 12.24, p < .001 \). \( t \) tests comparing the means of self- and teachers' ratings of cognitive competence, peer acceptance, and physical competence were all significant, with the children rating themselves more positively than did the teachers, \( t(28) = 5.03, p < .001 \) for cognitive competence; \( t(28) = 5.22, p < .001 \) for physical competence; and \( t(28) = 2.55, p < .05 \) for peer acceptance.
Comparisons between children with externalizing and nonexternalizing diagnoses. A MANOVA comparing the externalizing and nonexternalizing children on the various competence variables was significant, F(7, 23) = 14.03, p < .001. However, all t-tests comparing children with externalizing (n = 10) and those with nonexternalizing diagnoses (n = 19) with respect to self-, teachers', and peers' ratings were nonsignificant.

Sex differences in competence ratings. No significant differences between the younger boys and younger girls were obtained for any of the self-, teachers', and peers' ratings. A trend (p < .06) was found, though, for teachers' ratings of cognitive competence, with girls (M = 3.21, SD = 0.38) receiving higher ratings than boys (M = 2.79, SD = 0.54).

Comparisons with nonclinical youngsters' self-ratings. The current sample's self-ratings on the four subscales were compared with those of Harter and Pike's (1984) sample of first and second graders. Significant (p < .05) differences were found with respect to cognitive competence, t(92) = 9.46, and physical competence, t(92) = 2.36, with the nonclinical sample rating themselves more positively.

Results for the older group

Means and standard deviations of variables. The older children tended to rate themselves positively on all subscales (means ranging from 2.76 to 3.23). While these self-ratings were somewhat less positive than those of the younger children (see Table 1), the differences between the two age groups on the three subscales common to both (scholastic competence, athletic competence, and social acceptance) were nonsignificant when ANCOVAs controlling for the contribution of IQ were calculated. (A trend [p < .09] did exist for the difference between the younger and older children's self-ratings of peer/social acceptance.)

The teachers' ratings of the older children were less positive than the self-ratings, ranging from 1.88 to 3.02. The mean for the peers' ratings (2.06) was close to 2.00, the middle, neutral rating.

Reliability of self-ratings. Coefficient alpha for the total score was .80. Three of the subscales had reliabilities of at least .71 (scholastic competence, .73; behavioral conduct, .71; global self-worth, .71), with the other three subscales' reliabilities ranging from .40 (social acceptance) to .53 (athletic competence) to .57 (physical appearance).

Intercorrelations among the variables. The self-ratings for the older children generally intercorrelated less highly than did those of the younger group's (see Table 3). However, global self-worth correlated with both physical attractiveness, r(16) = .42, and behavioral conduct, r(16) = .42. Scholastic competence was the only self subscale to correlate with behavioral conduct, r(16) = .40, while physical attractiveness and athletic competence were the only self subscales that correlated with each other, r(16) = .56. As was true of the younger children, the social acceptance and athletic competence subscales were not significantly correlated with any of the teachers' or peers' ratings. The scholastic competence subscale, though, was significantly related to teachers' behavioral conduct ratings, r(16) = .51, and to peers' ratings, r(16) = .57; and the behavioral conduct subscale was significantly related to teachers' behavioral conduct ratings, r(16) = .54, teachers' athletic competence ratings, r(16) = -.61, and peers' ratings, r(16) = .43.

Similarly, the teachers' ratings for the older children intercorrelated less highly than those for the younger group. In fact, only teachers' athletic competence and teachers' social acceptance ratings correlated significantly, r(16) = .62, though a negative trend (r < .06) was found for the relationship between teachers' behavioral conduct ratings and teachers' athletic competence ratings, r(16) = -.41. The only teacher subscale to correlate significantly with peers' ratings was teachers' behavioral conduct ratings, r(16) = .57.
Several of the self-ratings were significantly related to the sociodemographic variables: age correlated with social acceptance, \( r(16) = .43 \), and behavioral conduct \( r(16) = .41 \), and IQ with physical attractiveness, \( r(16) = .57 \), and global self-worth, \( r(16) = .42 \). A negative trend \( (p < .06) \) was found for the correlation between teachers' social acceptance ratings and age, \( r(16) = -.39 \), while a positive trend \( (p < .08) \) was found for the relationship between teachers' scholastic competence ratings and IQ, \( r(16) = .37 \). Teachers' athletic competence ratings evidenced a significant negative association with age, \( r(16) = -.47 \), but was not related to IQ. Neither teachers' physical attractiveness ratings nor teachers' behavioral conduct ratings were significantly related to the sociodemographic variables. Finally, peers' ratings bore no significant association with age or IQ.

Comparisons between self- and teachers' competence ratings. A MANOVA comparing the five self-perception and five teachers' perception scales was significant, \( F(5,28) = 2.64, p < .05 \). Tests comparing the means of self- and teachers' ratings of scholastic competence, athletic competence, and physical attractiveness were all nonsignificant; also, a nonsignificant trend \( (p < .08) \) was found for social acceptance. The means of the self- and teachers' behavioral conduct ratings were significantly different, \( t(16) = 5.01, p < .001 \), the children rating themselves more positively.

Comparisons between children with externalizing diagnoses and nonexternalizing diagnoses. A MANOVA comparing the externalizing and nonexternalizing children on the various competence variables was significant, \( F(11.6) = 12.89, p < .01 \). The following self-domains showed nonsignificant differences between externalizing \( (n = 8) \) and nonexternalizing \( (n = 9) \) children: global self-worth, social acceptance, athletic competence, and physical attractiveness. However, the nonexternalizing children evaluated themselves significantly more positively than the externalizing children with respect to scholastic competence (means of 3.04 versus 2.52), \( t(16) = 2.76, p < .01 \), and behavioral conduct (means of 3.19 versus 2.48), \( t(16) = 3.48, p < .01 \). With respect to teachers' ratings, the externalizing children were perceived as more athletically competent (means of 3.09 versus 2.22), \( t(16) = 3.01, p < .01 \), and physically attractive (means of 3.21 versus 2.85), \( t(16) = 2.43, p < .05 \), than the nonexternalizing children, but less competent in their behavioral conduct (means of 1.29 versus 2.413, \( t(16) = 2.87, p < .01 \). Teachers' ratings of social acceptance indicated a nonsignificant trend \( (p < .06) \) for externalizing children to receive higher scores (2.60 versus 2.00) than nonexternalizing children. Lastly, the two diagnostic groups did not differ significantly with regard to peers' ratings.

Comparisons with nonclinical youngsters' self-ratings. The current sample's self-ratings on the six subscales were compared with those of Harter's (1985) sample of third through fifth graders. A significant difference was obtained only for the physical appearance subscale, with the current sample rating themselves more positively, \( t(51) = 2.38, p < .05 \).

DISCUSSION

The present study offers initial support for the utility of Harter's scales of self-competence with children evidencing severe behavior disorders, while also providing support for the hypothesized differences between younger and older children. The general agreement between the present study's results and those of Harter (1985), for both the younger and older groups, suggests that disordered and nondisordered children may not differ greatly in the cognitive bases and patterns of their self-perceptions of competence.

Younger Children

With the exception of maternal acceptance, the reliabilities of the younger children's self-ratings seem to be at least
marginally acceptable. However, they were generally somewhat lower than the following coefficient alphas for Harter and Pike's (1984) nonclinical sample: total score, .87; cognitive competence, .76; peer acceptance, .79; physical competence, .53; and maternal acceptance, .74. (The current sample's reliability for physical competence was actually considerably higher than that of Harter and Pike's pupils.) Thus, though the subscales were typically not as reliable as in the original normative sample, it appears that behaviorally disordered children of less-than-average IQ can understand the procedure and reliably respond to the Harter subscales.

For the younger pupils, the significant correlations among all the self-competence subscales suggest that the children may have a global, undifferentiated view of their competence. These findings and the magnitude of the intercorrelations are very similar to Harter and Pike's (1984) for their nonclinical population of the same age. The significant correlation between maternal acceptance and all of the other self-competence subscales may indicate that perceived maternal acceptance is an important component (and, one may speculate, perhaps a precursor) of children's positive self-regard. (This inference, though, must be tempered by the maternal acceptance subscale's rather low reliability.) Harter and Pike also reported significant relationships between maternal acceptance and each of the other three domains for preschool, kindergarten, and first grade nondisordered children.

In comparison with the children's self-ratings, teachers' ratings of the children were intercorrelated to a lesser extent, with the teachers differentiating somewhat among the domains and appearing to recognize that a child may vary in competence depending upon the domain under consideration. For example, unlike the children's self-ratings, the teachers' ratings of cognitive competence and peer acceptance did not evidence a significant association.

The correlations between self- and teachers' ratings within each domain were nonsignificant for cognitive competence and physical competence and evidenced only a trend toward significance for peer acceptance. This pattern differs from that uncovered by Harter and Pike (1984) and suggests that nondisordered school children may be more aware of, and/or more in agreement with, their teachers' perceptions of their abilities than are behaviorally disordered children. Interestingly, teachers' peer acceptance ratings were significantly positively associated with peers' ratings, while teachers' cognitive competence ratings were significantly negatively associated with peers' ratings. Thus the teachers (in their peer acceptance ratings) appeared to recognize which children were popular, and the children tended to prefer their classmates who were not the highest scholastic (i.e., cognitive) achievers.

The absence of significant correlations between any of the self- and peer ratings may indicate that young behaviorally disordered children's self-perceptions are not dependent upon how their peers view them. Ruble's (1983) finding that youngsters do not start using social comparison as a means of measuring their social competence until about 9 years of age supports this possibility.

Similar to Harter and Pike's (1984) results, the children rated themselves significantly more favorably than did their teachers. The teachers and children may have based their judgments upon different norms and criteria, with the teachers possibly comparing the program children to nondisordered ones and finding them lacking. Despite their relatively positive self-ratings, though, the current sample did rate themselves significantly less highly on cognitive and physical competence than did Harter and Pike's nonclinical sample. This may be due to the behaviorally disordered pupils still using nondisordered children—from whom they had only relatively recently been segregated—as their reference group.

The two sociodemographic variables of IQ and age entered into only two significant correlations with the self-, teachers', and peers' ratings. Not surprisingly, teachers' ratings of children's
cognitive competence were related to IQ (though children's self-ratings of their cognitive competence were not). Also, within this group of younger pupils, age had a negative association with peer ratings. Thus older behaviorally disordered children may be regarded more negatively by their classmates, perhaps because being bigger, they induce more fear and are more disruptive.

With respect to the subscales' validity, peer acceptance ratings would seem to be the most appropriate for use with this population, given (a) the relatively satisfactory reliability of self-ratings of peer acceptance, (b) the significant association between teachers' peer acceptance ratings and peers' ratings, and (c) the trend in the association between self- and teachers' peer acceptance ratings.

Older Children

For the older children's self-ratings, three subscales (scholastic competence, behavioral conduct, and global self-worth) demonstrated acceptable reliabilities, which were comparable to those of Harter's (1985) nonclinical sample (range of .71 to .80). However, for the other three subscales (social acceptance, athletic competence, and physical appearance) reliabilities were more problematic, suggesting caution in these subscales' use with this population. The long-standing nature of older behaviorally disordered pupils' difficulties may hinder their ability to comprehend the procedure and/or reliably respond to the instrument.

As hypothesized, unlike the younger group, few of the older group's self-ratings on the various subscales were significantly correlated with each other; indeed, two of the four significant relationships involved global self-worth, which is not a domain-specific area of competence. This pattern is consistent with Harter's (1982) finding that by 8 years of age children make meaningful differentiations among subscales. As was reported by Harter (1985), the scholastic competence and behavioral conduct subscales were significantly correlated. Additionally, the triad cluster of social acceptance, athletic competence, and physical attractiveness uncovered by Harter (1985) was partially replicated in the present study by the positive correlation between athletic competence and physical attractiveness.

Similarly, teachers' ratings of the various domains for the older group were generally less highly intercorrelated than were the ratings for the younger group. Thus not only younger and older children, but also the teachers of younger and older children, differ in the extent to which they differentiate among the various competence domains in pupils, perhaps due to a relative lack of differentiation in the actual competence of younger compared to older pupils; i.e., younger pupils who are skilled in one domain may be skilled in other domains.

The intercorrelations among the older children's self-, teachers', and peers' ratings evidenced a consistent pattern. Children's self-ratings of scholastic competence and behavioral conduct, teachers' ratings of behavioral conduct, and peers' ratings all intercorrelated significantly (except for a nonsignificant trend between self-ratings of behavioral conduct and peers' ratings). Peers preferred children who perceived themselves as scholastically competent and well-behaved and whose teachers perceived them as well-behaved. These findings suggest that behavioral conduct may be an important factor in the development of older behaviorally disordered children's peer acceptance and their self-perceptions of academic competence. (Relatedly, self-rating of behavioral conduct was one of only two domains that were significantly associated with global self-worth.)

Comparison of the t tests between self- and teachers' ratings for each domain conducted for the older and the younger groups indicates a possible developmental trend. While the younger children's self-perceptions were significantly more positive than their teachers' ratings for all domains, the older children's self-perceptions, as hypothesized, were generally not more positive than their teachers' ratings. Thus older children, even
behaviorally disordered ones, may evaluate their own competence quite similarly to their teachers' evaluations, perhaps indicating the children's internalization of their teachers' criteria for judging competence.

Interestingly, and in contrast to the younger group, there were almost no differences between the older children's self-ratings and those of Harter's (1985) nonclinical sample. Being older and in a segregated psychoeducational setting for a longer period of time, the older behaviorally disordered group may view their fellow classmates—rather than nondisordered pupils—as the appropriate comparison group and therefore regard themselves as relatively competent.

With respect to the sociodemographic variables, age evidenced a significant positive correlation with self-ratings of social acceptance and a trend toward a negative correlation with teachers' ratings of social acceptance. These seemingly discrepant results may partially reflect the lack of agreement between self- and teachers' ratings of social acceptance ($r=.17$). Age was also significantly positively related to self-ratings of behavioral competence. Regarding intelligence, there were significant positive correlations or trends between the older pupils' IQ and (a) self-ratings of physical attractiveness, (b) self-ratings of global self-worth, and (c) teachers' ratings of scholastic competence. Thus, more intelligent pupils generally possessed higher global self-esteem, regarded themselves as more physically attractive, and were viewed by their teachers (though, notably, not by themselves) as more scholastically competent.

Concerning the subscales' validity with the older children, behavioral conduct ratings would appear to be the most appropriate in light of (a) the acceptable reliability of self-ratings of behavioral conduct and (b) the significant correlations among self-ratings of behavioral conduct, teachers' behavioral conduct ratings, and peers' ratings.

**Externalizing and Nonexternalizing diagnosis**

The comparisons between the externalizing and nonexternalizing children's self-, teachers', and peers' ratings revealed no significant differences for the younger group. For the older group, as hypothesized, the nonexternalizing children rated themselves significantly more positively on scholastic competence and behavioral conduct than did the externalizing children. Similarly, the older group's teachers rated the nonexternalizing children's behavioral conduct significantly more positively than that of the externalizing children. However, the teachers perceived the former group as less athletically competent and physically attractive. These findings, which are consistent with the obtained negative correlations between perceptions (both self- and teachers') of behavioral conduct and teachers' ratings of athletic competence for the older group as a whole, indicate that children who act out may be viewed by their teachers as having more difficulty controlling their behavior but also as being more coordinated and motorically competent. The absence of a difference between the externalizing and nonexternalizing older children on peers' ratings failed to replicate Rolf's (1976) findings with a high-risk sample; within an entire sample of children evidencing long-standing disorders (such as the present one), acting out behavior may not serve as a negative influence on popularity.

Taken together, the comparisons between the externalizing and nonexternalizing pupils suggest the following: For the younger group, diagnosis (at least in the gross sense of externalizing and nonexternalizing) did not seem to bear a relationship to competence, perhaps because their behavioral patterns and disorders were less well-entrenched. For the older group, though, diagnosis did appear to bear a significant relationship to self- and teachers' perceptions. The greater length of time they had evidenced behavioral disorders (compared to the younger children) may have caused their behavioral problems to become more solidly established and a more salient factor.
in how they were regarded by themselves and their teachers (though not by peers).

Three aspects of the study's methodology and results merit comment. First, since somewhat different measures of perceived competence were employed for the two age groups, some caution is warranted in the conclusions regarding the comparisons between the younger and older children. To have employed just one of the measures, though, for all subjects would have been developmentally invalid, given the changes which children undergo from ages 5 to 9 in their cognitive and linguistic abilities and in the specific skills connoting competence and social acceptance (Harter & Pike, 1984). Also, it should be noted that the wording (i.e., sentence structure), format, and several of the constructs assessed are quite similar across the various measures.

Second, given the number of analyses conducted, one might speculate that some of the results achieved significance because of chance alone. The likelihood of this, however, is reduced due to (a) the significant MANOVAs; (b) the number of significant correlations and I tests exceeding that which would be expected solely by chance; and (c) the pattern of results, which largely supported the hypotheses and were consistent with previous findings.

Third, our conclusions comparing the present results with Harter's might be criticized due to our subjects' mean IQ being only in the 80s. Intelligence may be one contributor to perceived competence, and a few of the correlations between IQ and the competence variables in the present study were significant. Unfortunately, relatively few youngsters in urban settings who are certified as behaviorally disordered also achieve IQs in the average range. Indeed, the existence of a behavior disorder itself may interfere with intellectual performance and depress IQ scores. Thus, while not ideal, the current sample was not atypical with respect to clinical populations in the public schools.

In summary, the results of this study are generally in accord with Harter's findings with nonclinical populations and appear to support the scales' feasibility with behaviorally disordered children. Further research involving these scales with behaviorally disordered youngsters might profitably explore the possible correlates (e.g., academic performance, behavioral observations, other personality dimensions) of competence, as well as changes in competence over time as a function of treatment. Additionally, the scales' applicability to other clinical groups (e.g., children in residential care, youngsters with developmental and physical disabilities) would seem to warrant investigation as well.

REFERENCES


Author Notes
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