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### Cover Page Footnote

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## Efficacy of the Jesness Inventory-Revised Conduct Disorder and Oppositional Defiant Disorder Scales

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### *Abstract*

The authors investigated the Conduct Disorder (JR-CD) and Oppositional Defiant Disorder (JR-ODD) scales developed for the Jesness Inventory-Revised. Participants included 340 youth aged 12 to 18 seen at a juvenile court diagnostic clinic in Cleveland, Ohio. The authors also investigated the previously existing Social Maladjustment (JR-SM) and Asocial Index (JR-ASO) scales. Participants were independently diagnosed as having CD, ODD, Disruptive Behavior Disorder NOS (a milder behavioral disorder), or no diagnosable behavioral disorder. Mean scores varied across the groups in the expected directions for all four scales. JR-CD and JR-ODD were better able to differentiate between their target groups and the other groups than JR-SM and JR-ASO. However, sensitivities were low, and clinicians or researchers using the Jesness-R should note that while elevations strongly suggest the presence of the disorders, a lack of elevation does not imply the absence of the disorder.

**Keywords:** Jesness Inventory-Revised, Conduct Disorder, Oppositional Defiant Disorder, delinquency, scale efficacy

Perhaps the most common self-report instruments used in assessing youth with behavioral disorders and delinquency have been the Minnesota Multiphasic Personality Inventory - Adolescent (MMPI-A; Butcher et al., 1992), the Jesness Inventory (JI; Jesness, 1996), and the Millon Adolescent Clinical Inventory (MACI; Archer, 2006; Archer, Maruish, Imhof, & Piotrowski, 1991; Millon, Millon, & Davis, 1993; Pinkerman, Haynes, & Keiser, 1993). Although used to assist with diagnosis, none of these inventories contain scales which directly correspond to DSM-IV-TR behavioral disorder criteria (American Psychiatric Association, 2000). The MMPI-A has several scales known to be sensitive to Conduct Disorder (CD) and Oppositional Defiant Disorder (ODD), including Psychopathic Deviance (Pd), Mania (Ma), Conduct Problems (CON), and Cynicism (CYN); however, research has suggested that the instrument is not able to differentiate between these two disorders (Bannen, 2000). Similarly, the MACI has several scales that are sensitive to behavioral disorders in general, including Unruly (8A), Forceful (8B), Negativistic (8A), and Delinquent Predisposition (CC); however, research indicates the MACI is unable to differentiate youth who have CD from those who have ODD (Davis, 2007). The JI also has been shown to differentiate between delinquents and non-delinquents, particularly

the Asocial Index (ASO) and Social Maladjustment Scale (SM), but no research was found investigating its ability to differentiate CD youth from ODD youth or from other behaviorally disordered youth.

A growing trend in assessment devices used to assist with the diagnosis of children and adolescents is to tie the item content more closely to specific DSM-IV-TR criteria. The Diagnostic Behaviors Disorders Rating Scale (Pelham, Gnagy, Greenslade, & Milich, 1992) consisted of 36 items which coincided with DSM-III R diagnostic criteria for the disruptive behavior disorders. The Youth Inventory 4 (YI-4; Gadow & Sprafkin, 1999), the Conduct Disorder Scale (CDS; Gilliam, 2002), and the Adolescent Psychopathology Scale (APS; Reynolds, 1998) are all self-report inventories whose items specifically assess DSM criteria.

The revision of the Jesness Inventory took this approach. The Jesness Inventory Revised (Jesness, 2003) contains two scales not previously included in the Jesness Inventory - Conduct Disorder (JR-CD) and Oppositional Defiant Disorder (JR-ODD) - whose items were designed to correspond more closely to the diagnostic criteria of DSM IV-TR. In addition to 10 items included in the original Jesness, four new items were added to more completely assess the diagnostic criteria for CD. There is not a one-to-one correspondence between items and criteria, as four of the 15 criteria appear not to be tapped, and in other cases multiple criteria are tapped by a single item. However, all of the major areas of the diagnosis are tapped, including aggression to people and animals, destruction of property, deceitfulness or theft, and serious violation of rules. One new

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item was added to construct the new 16-item scale designed to assess the criteria for ODD, and it appears to tap all eight of the ODD criteria.

The Jesness-R manual (Jesness, 2003) offers what it describes as "a preliminary check of the validity of the CD and ODD scales" (p. 52). It reports a sensitivity of .77 and a specificity of .69 for delinquents vs. nondelinquents for the JR-CD scale and a sensitivity of .79 and a specificity of .64 for the JR-ODD scale for the same delinquent vs. nondelinquent samples. Unfortunately, the manual does not indicate what cutoffs yielded these figures. The manual also notes that the delinquent sample used in these studies did not necessarily merit diagnoses of either CD or ODD, and that further research with samples of diagnosed youth would be needed to validate the scales. The purpose of this study is to address this need by evaluating how well the new Jesness Inventory Revised scales identify youth who have been independently diagnosed as having either CD or ODD.

## Method

### Participants

Potential participants included all youth ages 12 to 18 adjudicated delinquent or unruly and evaluated for disposition at the Cuyahoga County Juvenile Court Diagnostic Clinic in Cleveland, Ohio between July 2, 2003, and April 14, 2010. These youths also received a Jesness-R as part of their court-ordered psychological evaluations, which were conducted by 12 Ph.D. or Psy.D. level licensed psychologists with an average of 14 years of experience in juvenile forensic evaluations and diagnosis. The range of experience was from 5 to 20 years. Several members of staff have made presentations in juvenile forensics at local, state, and national conferences as well as published articles in peer reviewed journals.

The psychological evaluation consisted of a semi-structured interview developed at the clinic which probed each of the criteria for CD and ODD, as well as more general information concerning family background, social history, developmental history, educational history, legal history, substance use history, and mental health history. A parent or parents, or other caretaker such as a grandmother, were interviewed by the clinician or probation officer or both. Other sources of information included a review of the youth's court record, educational record, mental health record and previous evaluations, and a mental status exam. Psychological testing was conducted by Master's level psychometrists and consisted of intelligence testing, achievement testing, and personality testing. The results of these tests were used by the doctoral level examiners to assist with diagnosis. Aside from the Jesness-R, the most commonly used personality instruments in the evaluations were the Millon Adolescent Clinical Inventory (Millon et al., 1993), the Minnesota Multiphasic Personality Inventory - Adolescent (Butcher et al., 1992), and the Rotter Incomplete Sentences Blank (RISB; Rotter, 1950).

Each psychologist produced a written report of the evaluation that included a diagnosis or diagnoses. These were made without scoring the Jesness-R for the JR-CD or JR-ODD scales and with the clinicians not having access to the individuals'

responses to the items in those scales. The report was reviewed by a second psychologist, one of the authors. Youth diagnosed as CD but whose report did not clearly identify a minimum of three criteria for that diagnosis were omitted from the study. Youth diagnosed as ODD but whose report did not clearly identify a minimum of four criteria for that diagnosis were omitted. The correlation coefficient for agreement between diagnoses was .96.

This yielded an initial sample of 402 youth - 281 males and 121 females. Mean age for the males was 14.7 ( $SD = 1.5$ ) and for the females was 15.1 ( $SD = 1.3$ ). Seventy-two percent were African American, 21% Caucasian, 4% Hispanic, and 2% Multi-racial. Sixty-two participants, 53 male and 9 female, were eliminated because they produced a Jesness-R with an elevated Variable Inconsistency Scale (J-VRIN) score, an elevated Variable Response Scale (J-VR) score, or an elevated True Response Inconsistency Scale (J-TRIN) score. These scales have been shown to be effective in detecting both random and partially random Jesness-R protocols (Pinsoneault, 1999, 2006; Trimble, 2005) and oppositional and acquiescent protocols (Pinsoneault, 1999). While in some settings, a 15% rate of invalid responding might be considered high, in a juvenile court setting where many of the respondents have a history of a lack of cooperation and an aversion to academically oriented tasks, such a rate is unsurprising. Retzlaff and Sheehan (1989) suggested that the expected prevalence rate for random responding in a forensic setting might be as high as 50%.

This resulted in a final sample of 340 youth, 228 males and 112 females, with a mean age of 14.8 ( $SD = 1.4$ ). Seventy-one percent were African American, 21% Caucasian, 4% Hispanic, and 3% Multi-racial.

### Procedure

Based on the diagnoses, participants were divided into five groups. Group 1 was diagnosed as having Conduct Disorder, Childhood Onset Type or Conduct Disorder, Adolescent Onset Type. It met from 3 to 9 of the diagnostic criteria, with a mean of 5.0. It also met from 0 to 6 additional partially documented criteria or documented criteria, which did not clearly meet the age of onset requirements, with a mean of 1.3.

Group 2 was diagnosed as having Oppositional Defiant Disorder. It did not meet sufficient criteria for a diagnosis of CD and met from 4 to 7 of the ODD criteria, with a mean of 5.2, and 1 to 3 additional partially documented criteria, with a mean of .73.

Group 3 was documented as having behavioral problems and met from 0 to 5 combined CD-ODD criteria with a mean of mean of 2.3 and an additional 0 to 5 partially documented criteria with a mean of 1.5, but not enough of either to merit a full diagnosis of CD or ODD. Group members were diagnosed as having Disruptive Behavior Disorder, Not Otherwise Specified.

Group 4 was documented as having milder behavioral problems and met from 0 to 5 combined CD-ODD criteria with a mean of 1.3 and an additional 0 to 4 partially documented criteria with a mean of 1.1. Group members were diagnosed as having Child or Adolescent Antisocial Behavior, Adjustment Disorder with Disturbance of Conduct, or Adjustment Disorder with Mixed Disturbance of Emotions and Conduct.

Group 5 did not meet sufficient criteria for diagnosis as having a behavioral disorder. It met from 0 to 5 combined CD-ODD criteria with a mean of 0.9 and an additional 0 to 4 partially documented criteria with a mean of 0.6. Group members were diagnosed as having no diagnosis or a mental health or substance abuse diagnosis. Common diagnoses included Parent-Child Relational Problem, Dysthymic Disorder or Depressive Disorder NOS, Cannabis Abuse or Cannabis Dependence, Sexual or Physical Abuse of Child or Neglect of Child, Borderline Intellectual Functioning or Mild Mental Retardation, and Attention Deficit Hyperactivity Disorder.

One hundred thirty-two youth were in Group 1, 55 in Group 2, 42 in Group 3, 50 in Group 4, and 61 in Group 5. Group 1 was termed the Conduct Disorder group (CD), Group 2 the Oppositional Defiant Disorder group (ODD), Group 3 the Otherwise Behaviorally Disordered group (OBD), Group 4 the Mildly Behaviorally Disordered group (MBD), and Group 5 the Non-Behaviorally Disordered (NBD) group.

The Jesness-R inventories were then re-scored for the JR-CD and JR-ODD scales. The primary Jesness-R scales orig-

inally designed to differentiate delinquent youth from non-delinquent youth, the Asocial Index (JR-ASO), and Social Maladjustment Scale (JR-SM), were also investigated to determine their effectiveness in detecting youth with CD or ODD, although they were designed to detect a broader group of unsocialized youth beyond those specific diagnoses.

**Results**

Table 1 shows the means and standard deviations for the scales for the various levels of delinquency. For the JR-CD scale, ANOVA yielded significant differences between the groups ( $F = 18.09, p < .01$ ), and a follow-up Fischer's LSD Test showed that the CD group was significantly elevated over the other four groups. The ODD and OBD groups were significantly elevated over the NBD group. Further examination with Cohen's  $d$  showed these differences to be moderate to large (see Table 2).<sup>1</sup> None of the other groups differed significantly.

Table 1.  
*Means and Standard Deviations*

Scale	CD Group		ODD Group		OBD Group		MBD Group		NBD Group	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
JR-CD	54.42	11.4	48.07	9.5	47.88	8.4	44.88	7.9	43.34	7.2
JR-ODD	55.40	9.8	53.13	10.5	49.74	9.4	47.24	10.4	45.62	10.1
JR-ASO	60.70	8.6	57.15	9.0	57.14	9.4	57.14	9.6	53.70	9.0
JR-SM	58.94	10.1	54.47	9.4	54.79	10.5	54.38	10.5	51.85	9.9

For the JR-ODD scale, ANOVA also yielded significant differences between the groups ( $F = 12.99, p < .01$ ), and a follow-up Fischer's LSD Test showed that the CD group was significantly elevated over the OBD, MBD, and NBD groups. The ODD group was significantly elevated over the MBD and NBD groups. Further examination with Cohen's  $d$  showed these differences again to be moderate to large (see Table 2). The OBD group was also significantly elevated over the NBD group, although Cohen's  $d$  showed this difference to be somewhat smaller. The CD and ODD groups did not differ significantly on the JR -ODD scale. This might be expected, as many youth who have CD also have characteristics of ODD. None of the remaining groups differed significantly.

Cohen's  $d$  for two independent means is defined as  $d = (M1 - M2) / \sigma$ . M1 = mean of first sample; M2 = mean of second sample;  $\sigma$  = population standard deviation.

For the ASO scale, ANOVA again yielded significant differences between the groups ( $F = 6.61, p < .01$ ), and a follow-up Fischer's LSD Test showed that the CD group was significantly elevated over the ODD, OBD, MBD, and NBD groups. Cohen's  $d$  showed the differences with the first three groups to be small, while the difference with the NBD group was moderately large (see Table 2). None of the other groups differed significantly.

For the SM scale, ANOVA also yielded significant differences between the groups ( $F = 5.99, p < .01$ ), and a follow-up Fischer's LSD Test showed that the CD group was again significantly elevated over the ODD, OBD, MBD, and NBD groups. Cohen's  $d$  showed the differences with the first three groups to be small-to-moderate, while the difference with the NBD group was again moderately large (see Table 2). None of the other groups differed significantly.

Table 2.  
Cohen's *d* Effect Size Difference Scores

Group	JR-CD Scale					JR-ODD SCALE				
	CD	ODD	OBD	MBD	NBD	CD	ODD	OBD	MBD	NBD
CD	--					--				
ODD	<b>.64</b>	--				.23	--			
OBD	<b>.65</b>	.02	--			<b>.57</b>	.34	--		
MBD	<b>.95</b>	.32	.30	--		<b>.82</b>	<b>.59</b>	.25	--	
NBD	<b>1.11</b>	<b>.47</b>	<b>.45</b>	.15	--	<b>.98</b>	<b>.75</b>	<b>.41</b>	.16	--

  

Group	JR-CD Scale					JR-SM Scale				
	CD	ODD	OBD	MBD	NBD	CD	ODD	OBD	MBD	NBD
CD	--					--				
ODD	<b>.36</b>	--				<b>.45</b>	--			
OBD	<b>.36</b>	.00	--			<b>.41</b>	.03	--		
MBD	<b>.36</b>	.00	.00	--		<b>.46</b>	.01	.04	--	
NBD	<b>.70</b>	.34	.34	.34	--	<b>.71</b>	.26	.29	.25	--

Note. CD = Conduct Disorder Scale; ODD = Oppositional Defiant Disorder Scale; ASO = Asocial Index; SM = Social Maladjustment Scale. Values in bold were statistically significant.

Table 3 shows specificity, sensitivity, positive predictive power (PPP), negative predictive power (NPP), and overall effectiveness for the JR-CD, JR -SM, and JR-ASO scales in differentiating the CD group from the other four groups. Scores of 60 or higher were quite suggestive of the presence of Conduct Disorder, but the sensitivity was low. With lower cutoffs many non-conduct-disordered youth would be flagged as resembling conduct-disordered youth. Scores of 70 or higher on JR-SM or JR-ASO are also indicative of the presence of Conduct Disorder, but the sensitivities were even lower.

Table 4 shows information for the JR-ODD, JR-ASO, and JR-SM scales in differentiating the ODD youth from the other groups. The CD group was not included in this analysis, as many conduct-disordered youth also have ODD, but the ODD diagnosis is subsumed by the more severe CD diagnosis. Scores of 60 or higher were somewhat suggestive of the presence of ODD, but the sensitivity was again low and a fair number of OBD, MBD, and NBD youth all produced elevations this high. Scores of 65 or higher were quite suggestive of the presence of ODD, but the sensitivity was even lower. As with the JR-CD scale, with lower JR-ODD cutoffs, many non-oppositional youth would be flagged as resembling oppositional youth. Scores of 70 or higher on JR-ASO or JR-SM were also indicative of the presence of ODD, but the sensitivities were again even lower.

Table 3.  
Scale Effectiveness in Detecting CD vs. ODD+OBD+MBD+NBD

Cutoff	Spe	Sen	PPP	NPP	Eff
JR-CD $\geq$ 50	.75	.59	.60	.74	.69
JR-CD $\geq$ 55	.82	.43	.60	.69	.67
JR-CD $\geq$ 60	.91	.33	.70	.68	.69
JR-CD $\geq$ 65	.96	.22	.76	.66	.67
JR-CD $\geq$ 70	1.00	.11	1.00	.64	.65
JR-CD $\geq$ 75	1.00	.05	1.00	.62	.63
JR-SM $\geq$ 50	.36	.80	.44	.74	.53
JR-SM $\geq$ 65	.53	.64	.46	.70	.57
JR-SM $\geq$ 60	.68	.48	.49	.68	.61
JR-SM $\geq$ 65	.87	.30	.59	.66	.65
JR-SM $\geq$ 70	.91	.18	.57	.64	.63
JR-SM $\geq$ 75	1.00	.06	.89	.63	.63
JR-ASO $\geq$ 50	.25	.89	.43	.79	.50
JR-ASO $\geq$ 55	.43	.73	.45	.71	.55
JR-ASO $\geq$ 60	.63	.57	.49	.70	.61
JR-ASO $\geq$ 65	.80	.38	.55	.67	.64
JR-ASO $\geq$ 70	.90	.13	.46	.62	.60
JR-ASO $\geq$ 75	1.00	.04	.83	.62	.62

Note. Spe = specificity; Sen = sensitivity; PPP = positive predictive power; NPP = negative predictive power; Eff = overall effectiveness.

Table 4.  
*Scales Effectiveness in Detecting ODD vs. OBD+MBD+NBD*

Cutoff	Spe	Sen	PPP	NPP	Eff
JR-CD <sub>≥</sub> 50	.75	.62	.34	.81	.58
JR-CD <sub>≥</sub> 55	.77	.49	.44	.81	.70
JR-CD <sub>≥</sub> 60	.85	.38	.48	.79	.73
JR-CD <sub>≥</sub> 65	.97	.13	.58	.76	.75
JR-CD <sub>≥</sub> 70	.99	.04	.67	.74	.72
JR-CD <sub>≥</sub> 75	1.00	.00	.00	.74	.74
JR-SM <sub>≥</sub> 50	.38	.69	.29	.77	.46
JR-SM <sub>≥</sub> 65	.54	.49	.28	.75	.52
JR-SM <sub>≥</sub> 60	.69	.33	.27	.74	.59
JR-SM <sub>≥</sub> 65	.88	.15	.30	.74	.68
JR-SM <sub>≥</sub> 70	.91	.07	.22	.73	.69
JR-SM <sub>≥</sub> 75	.99	.00	.00	.73	.73
JR-ASO <sub>≥</sub> 50	.27	.80	.28	.79	.41
JR-ASO <sub>≥</sub> 55	.44	.58	.27	.74	.48
JR-ASO <sub>≥</sub> 60	.65	.42	.30	.76	.59
JR-ASO <sub>≥</sub> 65	.82	.24	.32	.75	.66
JR-ASO <sub>≥</sub> 70	.91	.11	.30	.74	.70
JR-ASO <sub>≥</sub> 75	.99	.00	.00	.73	.73

Note. Spe = specificity; Sen = sensitivity; PPP = positive predictive power; NPP = negative predictive power; Eff = overall effectiveness.

**Discussion**

Results suggest that the new Jesness Inventory-Revised scales are useful in helping to detect youth with CD and ODD. Youth diagnosed independently with those disorders showed higher mean scores on the scales than youth with milder behavioral disorders or no diagnosable behavioral disorder. Youth with CD showed similar elevations on the JR-ODD scale to those diagnosed with ODD. This result is also in the expected direction, as many youth with CD also have the symptomatology of ODD.

The scales also showed higher specificities and sensitivities for the disorders than the previously existing JR-ASO and JR-SM scales. At a given specificity range, the new scales showed higher sensitivities, and at a given sensitivity range, the new scales showed higher specificities. This, again, might be expected as JR-ASO and JR-SM were developed to detect more general social maladjustment rather than these particular diagnoses.

JR-CD scores  $\geq 60$  strongly support a diagnosis of CD, while JR-ODD scores  $\geq 65$  strongly support a diagnosis of ODD. The traditional Jesness-R cutoff of 60 may over-diagnose ODD. Obviously, no diagnosis would be made based solely on a test score, and the cutoffs are offered only to assist clinicians in knowing what elevations are seen among CD or ODD youth but rarely seen among other youth who come to the attention of court clinics.

Users should note that the sensitivities of the scales were not strong at cutoffs with good specificities, and that they pro-

duced many false negatives. Many youth with the disorders do not endorse enough items to attain clinical elevations, and the lack of an elevation does not imply the lack of the disorder. Forty-one percent of the CD youth here produced JR-CD elevations below 50. Sixty-five percent of the ODD youth produced JR-ODD elevations below 50.

A primary strength of this study was that the sample consisted of members of the primary population for whom the Jesness-R is intended - juvenile delinquents. Diagnoses were made independently by Ph.D. or Psy.D. level licensed psychologists with many years of experience working in the field of juvenile forensics, and all diagnoses were reviewed by a second doctoral level psychologist. The independent diagnoses made by experienced psychologists in a juvenile forensic setting represents another strength of the study, particularly since the delinquent data used for the revision of the Jesness Inventory did not involve cases diagnosed with ODD or CD. The base rates of the different groups were the naturally occurring base rates in a court diagnostic clinic setting. All participants, however, came from the same urban setting, and the results need to be replicated in rural settings and other populations.

A limitation of the study is paradoxically embedded in its strength. This study looked only at a sample from a juvenile court setting where a high base rate of ODD and CD would be expected. A nondelinquent sample, consistent with a sample used in the data collection for the Jesness Inventory-R, would have enhanced the methodology of our study. Additionally, our sample consisted of 71% African American, 21% Caucasian, 4% Hispanic, and 3% Multicultural. This compares to the non-maternal delinquent data from the revision of the Jesness Inventory, which consisted of 53% African American, 26% Caucasian, 14% Asian, 2% Hispanic, 2% Native/Aboriginal, and 1% "Other". A more heterogeneous sample would have also improved the methodology of the current study.

Some of the weaknesses of the new Jesness-R scales observed here may be related to the item content. While the revision of the Jesness to the Jesness-R did increase the sampling of the criteria for CD, it is still not a one-to-one correspondence. Criteria of forcing someone into sexual activity or breaking into places are not assessed. The two items related to stealing tap attitudes of whether one considers stealing to be wrong and not whether one has engaged in stealing behavior. Some items suggest a person who might be perceived by others as threatening or intimidating, but no items directly query such behavior. A single item appears to assess both fire-setting and other deliberate destruction of property. Another single item assesses cruelty to both people and animals. Another single item is used to assess the triad of staying out at night, running away, and truancy.

The criteria for ODD appear to be better sampled; however, the items that relate to being touchy or easily annoyed appear to relate more directly to having one's feelings easily hurt rather than to being easily annoyed. Additionally, other criteria are assessed by only a single item. A future revision of the Jesness-R might further improve the scales' efficacies by addressing these limitations. However, the inherent difficulty in detecting the diagnostic criteria for these particular disorders through self-report is not easily overcome. Youth with ODD or CD often do not perceive themselves as having the problems

that are observed by others, or are aware of them but unwilling to overtly acknowledge them.

Finally, further research addressing the limitations of our study is needed to provide additional data on the validity of the Jesness-R ODD and CD scales. Specifically, and as noted above, a nondelinquent sample and more racial and ethnic heterogeneity in the sample would provide additional valuable data on the diagnostic utility of the ODD and CD scales. It should also be stated that a diagnosis of ODD and CD needs to be made from multiple sources of information and not just from one inventory such as the Jesness-R. Clinical interviews with the child, parent(s)/guardian(s), review of records, collateral contacts, and additional psychological testing should be included in a full diagnostic evaluation to confirm diagnoses of OD or CD and assess for other comorbid diagnoses. Future research is also needed to study the rates of comorbidity with the ODD and CD scales of the Jesness-R.

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