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## TEACHER EXPECTATIONS OF CHILDREN WITH MENTAL ILLNESS IN THE SCHOOLS

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ABSTRACT OF DISSERTATION

Jamie Lee Satterly Roig

The Graduate School  
University of Kentucky

2011

TEACHER EXPECTATIONS OF CHILDREN  
WITH MENTAL ILLNESS IN THE SCHOOLS

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ABSTRACT OF DISSERTATION

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A dissertation submitted in partial fulfillment of the  
Requirements for the degree of Doctor of Philosophy in the  
College of Education, Department of Educational, School, and Counseling  
Psychology at the University of Kentucky

By  
Jamie Lee Satterly Roig

Lexington, Kentucky

Director: Dr. H. Thompson Prout, Professor of School Psychology

Lexington, Kentucky

2011

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## ABSTRACT OF DISSERTATION

### TEACHER EXPECTATIONS OF CHILDREN WITH MENTAL ILLNESS IN THE SCHOOLS

Within an experimental vignette design, 224 certified teachers participated in this online study by completing a researcher created rating scale that assessed expectations for a child described in a randomly assigned vignette; a child without mental illness, a child identified with an emotional behavioral disorder, and a child identified as returning from acute psychiatric care. Results from the current study revealed reliable scales; learning, cooperation, self-control, and teacher self-efficacy. Findings indicated teachers reported significantly different expectations for children identified with mental illness in comparison to typical children in the areas of self-control and cooperation; specifically, teachers reported lower expectations for students to use self-control and cooperate if they have a history of the label Emotional Behavioral Disability (EBD). Further, teacher certification in the area of special education was a predictor for ratings of teacher self-efficacy to work with children labeled with EBD or a psychiatric hospitalization. In the whole sample, special education certification was a predictor variable for ratings of expectations for teacher self-efficacy. Years experience also predicted teacher self-efficacy. The results of the current study help support the argument for teachers to receive more training to assist children with mental illness and psychological problems, as participant responses clearly indicated a need for additional training and assistance when presented with challenging cases in the real world.

KEYWORDS: Teacher Expectations, Mental Health,  
Emotional Behavioral Disability, Special Education,  
Teacher Self-Efficacy

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Jamie L. S. Roig

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April 22, 2011

TEACHER EXPECTATIONS OF CHILDREN  
WITH MENTAL ILLNESS IN THE SCHOOLS

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\_\_April 22, 2011\_\_\_\_\_  
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DISSERTATION

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## TABLE OF CONTENTS

	Page Number
Acknowledgements -----	i
List of Tables -----	iv
1. Chapter 1 - Introduction and Literature Review -----	1
1.1. Existing Literature on Children and Adolescents with Mental Illness- -----	4
a. Classification in the School System -----	5
b. Labeling Controversy -----	7
i. Labeling -----	8
ii. Stigma -----	9
c. Characteristics of Students with Mental Illness -----	10
i. Prevalence in Children and Adolescents -----	10
ii. Common Deficits Associated with Mental Illness -----	12
1.2. The Teacher of a Child with Mental Illness -----	13
a. Teacher Attitudes, Attributions, and Behavior -----	13
b. Effect on Teacher -----	16
c. Teacher-Student Relationship -----	18
1.3. A Theoretical Perspective: Attribution Theory-----	19
a. Theoretical Conclusions -----	21
1.4. Research Approach -----	22
a. Teacher Expectations for Student and Self Scale -----	22
i. Learning -----	22
ii. Cooperation -----	23
iii. Self-Control -----	24
iv. Teacher Self-Efficacy -----	25
b. Analogue Research -----	26
1.5. Statement of Purpose and Hypotheses -----	27
2. Chapter 2 - Methodology -----	30
2.1. Participants -----	30
2.2. Measure -----	33
a. Instrumentation -----	33
i. Vignettes -----	33
ii. Rating Scale -----	34
b. Field Study -----	36
c. Item Analysis and Inclusion Rationale -----	38
2.3. Procedures -----	39

3. Chapter 3 - Results -----	43
3.1. Analysis to Test Research Questions and Hypotheses -----	43
3.2. Post Hoc Analysis -----	61
4. Chapter 4 - Discussion -----	66
4.1. Limitations -----	68
4.2. Implications -----	70
4.3. Future Research -----	71
a. Self-Fulfilling Prophecy -----	72
4.4. Conclusions -----	76
5. Appendixes -----	78
5.1. Appendix A -----	78
5.2. Appendix B -----	80
5.3. Appendix C -----	84
5.4. Appendix D -----	85
6. References -----	86
7. Curriculum Vita -----	100

## LIST OF TABLES

		Page Number
Table 2.1	Respondent Demographic Data -----	31
Table 2.2	Individual Item Means by Treatment Condition for TESSS -----	40
Table 3.1	Scale Cronbach’s Alpha Data -----	44
Table 3.2	Scale Means and Standard Deviation by Treatment Condition -----	46
Table 3.3	Learning Item to Scale Correlations -----	47
Table 3.4	Cooperation Item to Scale Correlations -----	47
Table 3.5	Self-Control Item to Scale Correlations -----	48
Table 3.6	Teacher Self-Efficacy Item to Scale Correlations -----	48
Table 3.7	Demographic Variable Correlations to Assess for Multicollinearity -----	51
Table 3.8	Standardized Regression Coefficients for Entire Sample with Teacher Self Efficacy as Dependent Variable -----	53
Table 3.9	Standardized Regression Coefficients for Condition 2 with Teacher Self Efficacy as Dependent Variable -----	55
Table 3.10	Anecdotal Data Themes Regarding Teacher Concern About Student in Scenario -----	57
Table 3.11	Anecdotal Data Reported Training to Work with Students with Psychological Problems -----	60
Table 3.12	Principle Component Analysis with Varimax Rotation on the TESSS Scale -----	62

## **Teacher Expectations of Children with Mental Illness in the Schools**

### **Chapter 1 – Introduction and Literature Review**

Throughout a typical school day, children are exposed to multiple factors that require interpersonal relationship skills, the ability to learn new concepts, and the ability to demonstrate learning. Classroom environments subject children to a variety of positive and negative experiences. Many children are able to cope and learn throughout the school day, but for some children who face mental illness, the stress of living up to teacher rules and expectations can lead to turmoil (Cooper & Tom, 1984). Children facing mental illness, who are considered to have poor mental health, in a school setting, find increased barriers to the achievement of good mental health due to placement in a stressful environment. The pressure to learn and perform well in academics often translates to stress and diminished academic potential for children facing mental illness. As a result, children with mental illness become susceptible to low educational success (Pullis, 1991). Within a school environment, outcomes from social interactions and academic success are clear stressors while other stressors such as teacher expectations and differential treatment may go unnoticed. To investigate stressors that often go unnoticed, it is critical to explore how and why teacher expectations emerge related to children with identified mental illness.

Working with children with mental illness is a complicated issue as society has created a “bad” picture of mental health labels, thereby creating a stigma. This stigma comes attached with fear, misunderstanding, and ignorance about how to help someone with mental illness (Hinshaw, 2006). The result often includes stereotyping and bias across environments, which leads to personal attitudes and expectations. Teacher expectations and attitudes are linked to student success in education. When expectations

are low and attitudes are negative, children tend to perform at a lower rate (Hughes, Gleason, & Zhang, 2005). The question is, are teacher expectations different towards children with mental illness when compared to children without mental illness and their expectations they change based on severity of mental illness? With the goal to optimize each child's learning potential, it is critical to understand how teacher expectations differ between a typical child and a child dealing with mental illness. This research study investigates whether teacher expectations differ towards children with mental illness when compared to children without mental illness. In this chapter, the literature regarding children with mental illness, the effects on teachers who work with them, and theories related to teacher expectations will be reviewed.

Children and adolescents dealing with mental illness spend the majority of each week at home and at school (Kurumatani, Ukawas, Kawaguchi, Miyata, Suzuki, Ide et al., 2004). In an ideal world, parents and teachers would have the supports and knowledge to make accommodations for a child with mental illness. It is expected that when a child is diagnosed with mental illness, parents will learn about the disorder and change the home environment. It is also expected teachers will do the same. Unfortunately, mental health issues are often neglected and have an attached stigma (Czuchta & McCay, 2001) resulting in stress for the child and a lack of formal diagnosing. The complex variables associated with mental illness leave school professionals with the delicate task of differentiating misbehavior from behavior that is related to a mental health problem. Teachers, for instance, are required to teach, manage behavior, be culturally sensitive, and deal with mental health problems (Baker, 2005). Educators are encouraged to leave bias at the door and treat all children the same. Many

teachers find this to be a challenging task. Most teachers also feel they have an obligation to help students with mental illness, but also feel burdened by the task (Roeser & Midgley, 1997). This reciprocal relationship creates a dynamic which may be detrimental to the learning process of children with mental illness because teacher expectations impact student behavior which may then alter students' future choices and levels of self-efficacy (Clark & Artiles, 2000). Teachers create expectations from a variety of sources. For the purpose of the present study, the term "expectation" will be utilized to describe teacher reports about student abilities. Teacher expectations are theoretically a response based on his or her attitude. In the literature, the terms attitude and expectation are often used interchangeably making it difficult at times to clearly understand each concept. Teacher expectations are defined as assumptions teachers make about student capabilities based on group and individual characteristics (Copper & Tom, 1984; Procter, 1984). For the purposes of this review, expectations are defined as beliefs about or attitudes toward future student performance based on various data (Chow, 1988; Jussim, 1986). Attitudes are defined as "learned cognitive, affective, and behavioral predispositions to respond positively or negatively to certain objects, situations, institutions, concepts, or persons" (Aiken, 2002, p.3). This research study was conducted with the assumption that expectations are a result of attitudes; however, due to the difficulty in assessing attitudes, teacher expectations will be measured (Prawat, Byers, & Anderson, 1983).

Within the current body of literature, few studies have emerged investigating teacher expectations of children with mental illness. The dynamics of the teacher-student relationship need to be explored in regard to identification of students with mental illness

in the school system, deficits associated with mental illness, and teacher characteristics. The relationship between labeling and teacher expectations will be discussed through attribution theory. Before delving into the current research on teacher expectations and attitudes, the problems associated with mental illness are important to understand.

### **Existing Literature on Children and Adolescents with Mental Illness**

Within the United States, the *Diagnostic and Statistical Manual of Mental Disorders fourth edition text revised (DSM-IV TR*, American Psychiatric Association, 2004) is used as a guideline for labeling mental illness by medical doctors, psychologists, and other mental health professionals. This manual outlines what constitutes disorders such as depression, anxiety, attention deficit hyperactivity disorder, bipolar disorder, and many others. DSM-IV TR terms are commonly used by teachers and other school professionals to describe student behavior (Baker, 2005). Select school professionals are trained to use the *DSM-IV TR*, but the disorders and terms are often misunderstood and misinterpreted by the majority of staff within the school system. Under the Individuals with Disabilities Improvement Education Act (IDEA), students are given specific rights and services if academic functioning is impaired based on mental illness (IDEA, 2004). A student may have a mental illness and not receive any support at school or in the community due to lack of identification. If this student does not require academic support, he or she may never be formally assessed by a qualified individual and have poor mental health that goes unnoticed. This system creates added pressure on the teacher to work with each child and notify other professionals if they see symptoms related to mental illness emerge, but teachers typically do not receive training on the *DSM-IV TR* and are not qualified to utilize its material (Baker, 2005). Teachers are



provided with minimal training in the identification of general childhood problems as they relate to educational outcome and can differentiate between the educational progress of children with and without mental illness (McElhany, Russell, & Barton, 1993). As a result, key markers of mental illness are often identified as intentional misbehavior. Thus, teachers are often the first people outside the home to notice a problem, but often are unsure how to proceed, leading to additional burdens for both teachers and students (Roeser & Midgley, 1997).

**Classification in the school system.** Under the current Individuals with Disabilities Education Improvement Act (IDEA) standards, children with mental illness may or may not qualify for special education based on social-emotional factors. Special services are only available through IDEA when mental illness results in academic problems. Children who qualify under IDEA for services with mental illness and academic impairment are usually evaluated and later grouped into one category called Emotional Behavioral Disorder (EBD). When a child is labeled as a student with EBD, the child is recognized as having a dual deficit with academic difficulties and severe emotional and/or behavioral disruption as typically recognized in the *DSM-IV TR* (Maras & Kutnick, 1999; Sutherland, Lewis-Palmer, Stichter, & Morgan 2008). Students who are labeled EBD often have characteristics associated with anxiety disorders, depressive disorders, obsessive compulsive disorder, Tourettes syndrome, attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder (CD), and/or psychosis (Wagner, Kutash, Duchnowski, Esptein, & Sumi, 2005). Due to the vast array of disorders categorized as EBD, it can be confusing to use this single label to define a child's impairment.

Part of the confusion lies in the difference between internalizing and externalizing disorders, which have varying sets of symptoms. Internalizing disorders typically refer to non-disruptive disorders such as anxiety or depression. Anxiety has noticeable effects, but is often subtle to outside observers with limited disruption to the environment. Externalizing disorders on the other hand, are typically disruptive in nature. Externalizing disorders are easily identified because children with this type of disorder disturb the surrounding environment (Levy, Hay, Bennett, & McStephen, 2005). The majority of students receiving services and labeled with EBD are typically diagnosed with externalizing disorders; students exhibiting characteristics of conduct disorder account for the highest percentage of EBD students served under IDEA (Cassidy, James, & Wiggs, 2001), which is an externalizing disorder. The current identification system labels all types of emotional and behavioral mental health disorders in the same category resulting in overgeneralization based solely on a generic label, teacher experience, and self-guided inquiry (Stinnet et al., 1999).

If a child is determined to have academic impairment due to mental illness, the child will begin receiving a variety of services through special education programs. Usually, students labeled EBD are included in the regular classroom, but it is common for teachers to lack the necessary supports to ensure effective learning. Sometimes, these children are separated into specialized classrooms or schools. Cassidy et al. (2001) studied a school designed for children labeled EBD. As expected, high levels of externalizing and internalizing disorders were identified. Interestingly, students were primarily referred to this school due to externalizing behaviors and internalizing disorders

were noted following further evaluation, indicating co-morbidity between internalizing and externalizing disorders in students identified with EBD.

Due to the classification system of IDEA, the category of EBD may not be useful in determining educational needs. Many teachers complain about disruptive behaviors associated with EBD (Infantion & Little, 2005) and frequently label externalizing behaviors as the worst type in the classroom. The very label of EBD creates specific attributions and expectations and can lead to negative outcomes while failing to discriminate type of disorder as all disorders are grouped in the same category. This system, as is the case when policy is implemented with the primary objective of compliance with federal law, creates a generalized stigma that lacks specificity based on type of mental illness. Understanding potential reasons for negative outcomes begins by understanding the controversy over labeling. If the label EBD does not appear to be an effective intervention, in part due to associated stigma, then why do we continue to use the label?

**Labeling controversy.** Labels are used to describe appearance, ethnicity, socioeconomic status, disabilities, and many other facets of life. Special education in the United States is driven by the use of labeling to identify students with disabilities that adversely impacts education (i.e., a student must have a diagnosis and demonstrate difficulties achieving while at school). Service delivery at schools depends on meeting the criteria for a labeled disability as provided in federal and state guidelines. The process of labeling mental illness both in and out of schools has been controversial due to overgeneralization and homogeneous grouping. Within special education, labels are associated with negative teacher attributions and expectations (Bianco, 2005; Stinnett,

Bull, Koonces, & Aldridge, 1999). Entry into the emotional behavioral disorder (EBD) category of special education requires the use of two labels, mental illness and special education, both of which are attached to negative consequences such as stigma and low expectations.

***Labeling.*** The fields of medicine and psychology have historically utilized the medical model for the purpose of identifying, defining, labeling, and treating disabilities (Stinnett et al., 1999). The assumption labeling is the most effective method of assisting students in the school setting has been a controversial subject within the field of education. Labels can be effective tools when they are linked to funding (e.g. special education funding, insurance, disability supplements, and social security) and assist with an individual's access to resources. Labels are also useful to assist in life and educational planning, to increase public awareness, provide others with starting places for future learning, and help labeled individuals relate with a group. EBD labels can be ineffective because they overgeneralize symptoms, do not lead to solutions for problems, do not automatically provide intervention, and are compounded by other labels such as race and socioeconomic status (Lauchlan & Boyle, 2007). Despite the many benefits of labeling, labels are associated with stigma, which leads to numerous attributions and expectations. For instance, teachers in one study reported treating students with disruptive behavior labels more negatively in comparison to typical peers (Wheldall & Merrett, 1988). In a survey assessing teacher beliefs about negative student behavior, Coleman and Gilliam (2001) found respondents were more concerned for children without special education labels, as students with labels were perceived as more serious cases and were assumed to be already getting services. In another study, students labeled in special education were

significantly more likely to have teacher-predicted behavior problems and negative expectations (Stinnett et al., 1999). Predictions and expectations based on labels appear to be the result of associated stigma.

*Stigma.* Labels are associated with detrimental attributions that lead to stigma (Day, Edgren, & Eshleman, 2007). Stigma is defined as “the co-occurrence of its components-labeling, stereotyping, separation, loss of status, and discrimination” in the presence of exercised power (Link & Phelan, 2001, p. 363) and is often discussed in regard to psychological disabilities (Hinshaw & Steier, 2008). From a sociological perspective, stigma occurs when: 1) a label is given; 2) negative stereotypes with a label are present (based on a negative attribute); 3) labeled people are segregated; and 4) status loss and discrimination occur (Link & Phelan). Studies evaluating stigma toward children and adolescents have revealed negative outcomes for stigmatized children (Hinshaw & Steier). In one study (Bianco, 2005), vignette methodology was used to examine teacher referrals for a gifted program comparing students with and without disabilities. Results demonstrated teachers were less likely to make a referral for a gifted program if the student was identified with a learning disability or an emotional and behavioral disability despite having gifted characteristics.

The negative connotation toward mental illness has increased in recent years due to a trend against mainstreaming individuals with psychiatric disabilities in the regular community, indicating stigma currently has more negative consequences than in previous years (Day, et al. 2007; Hinshaw & Steier, 2008). As individuals are stigmatized, they often have increased aggression, violence, and further mental health problems such as anxiety or depression (Hinshaw & Steier, 2008). Stigma and stereotyping can lead to

inappropriate assumptions and personal attributes (Hinshaw, 2006). Research indicates stigma can be worse than the disabling condition itself (Hinshaw & Steier, 2008), as it leads to the formulation of lower expectations. As low expectations and negative attributions are formed based on stigma, children achieve at a lower rate (Hughes, Gleason, & Zhang, 2005). In essence, the problems associated with labeling a child with EBD reside in the attached stigma. Unfortunately, despite knowledge of stigma, the tendency to create attributions and expectations related to stereotypes remains.

Awareness of characteristics of students with mental illness help highlight current problems and assist in focusing research to help teachers understand the difference between a behavior problem and mental health related issues. Due to minimal training, teachers often make the assumption that all children can control his or her behavior (Baker, 2006). Problems related to mental illness are often associated with impulse control deficits and an inability to control one's behavior (American Psychiatric Association, 2004) thereby making it critical to fully understand the symptoms and challenges a child with mental illness faces.

#### **Characteristics of students with mental illness.**

*Prevalence in Children and Adolescents.* Over the course of a lifetime, mental health disorders may emerge and recede. For many individuals the first experience with mental illness occurs before age 18 (Kessler, Berglund, Demler, Jin, & Walters, 2005; McElhany et al., 1993). Prior to adulthood, it can be extremely challenging to formulate a correct diagnosis. As a result, children and adolescents are often given multiple diagnoses over long periods of time. Lifetime prevalence of common disorders of children and adolescents include; Anxiety 28.8%, Mood disorder 20.8%, Impulse

disorder 24.7%, and substance abuse disorder 16.6% (Kessler, et al.). In general, determining prevalence of specific mental health disorders within any population is a challenge because not all instances are diagnosed. With children, the data become even more difficult to gather with approximately 25% of children ages 10-14 facing difficulties (Roeser, Eccles, & Sameroff, 1998a).

Comprehensive literature reviews have revealed poor information on prevalence rates, but what has been established is that somewhere between 5.4-21% of children and adolescents experience mental health problems (Costello, Angold, Burns, Stangl, Tweed, Erkanli et al., 1996; Lavigne, Gibbons, Christoffel, Arend, Rosenbaum, Binns et al., 1996; McElhany, et al.; Nimmo, 2000; Rosenblatt & Rosenblatt, 1999; Shaffer, Fisher, Dulcan & Davies, 1996) and 2-15% of children experience externalizing disorders (Infantino & Little, 2005). Estimates on the prevalence of internalizing disorders are hard to establish, but upwards of 29% of children will face this type of problem (Kessler et al., 2005) as female adolescents report more internalizing than their male peers (Roeser, van der Wolf, & Strobel, 2001). Approximately 7% of children will experience ADHD; 30.2 % of which will have a comorbid diagnosis of ODD. When looking at ODD alone, 2.8-4.9% of children are likely to be diagnosed (Costello et al., 1996; Wolraich, Hannah, Pinnock, Baumgaertel, & Brown, 1996). Similarly, 2.1-3.3% of children will be diagnosed with conduct disorder. It is also important to note males are far more likely to exhibit externalizing behaviors than females who are more likely to have internalizing disorders (Costello, et.al., 1996). Determining the prevalence of internalizing disorders is more challenging due to the nature of symptom discourse.

Many children who deal with depression, anxiety, and similar disorders go unnoticed thus complicating the identification and diagnosis of internalizing disorders.

Due to the high prevalence rates and the challenges individuals with mental illness face, it is critical to use prevention strategies. To help design effective treatment and prevention, it is critical that studies be conducted to determine areas of need. With the close link between mental health, social, and adaptive skills, it is critical we understand common deficits, how these students are received in the school system, and how to better prepare to help these children including those who receive no help under the provisions of IDEA.

***Common Deficits Associated with Mental Illness.*** Children with mental illness, labeled or not, face different challenges than their peers without mental illness as they often have inadequate functioning in many areas. Mental health related issues in adolescence are associated with low educational levels in adulthood and a general decreased quality of life (Koivusilta et al., 2003; McElhany et al., 1993). Children with the label EBD are also more likely to have deficits in social skills, cognitive and academic functioning, communication skills, motivation, and exposure to academic activities (Pullis, 1991). Students labeled with EBD are more likely to drop out of high school, be involved with the juvenile court system, be in foster care, have poor employment histories in adulthood, and have dysfunctional relationships (Bradley, Doolittle, & Bartolotta, 2008; Gagnon & Leone, 2006; Zigmond, 2006). In one study, only 51% of students identified with EBD finished high school (Wagner et al., 2005). Roeser, van der Wolf, and Strobel (2001) reported children in America who report emotional distress report more difficulty learning while at school.



Children who require hospitalization for mental health difficulties have even more academic and cognitive problems (Woolston, Rosenthal, & Riddle, 1989). In a more recent study, students identified as having trouble with mental illness demonstrated lower grade point averages, increased absences, lower motivation for school, and increased social problems (Suldo & Shaffer, 2008). Mental health has been established as a precursor to academic functioning and is important for determining readiness to learn and levels of emotional distress (Roeser et al., 1998a). What we can conclude is that emotional functioning and academic functioning are interrelated due to the social and academic demands presented at school (Roeser et al., 1998a). Teachers, however, have reported that academic and emotional functioning are separate processes (Bentz, Edgerton, & Miller, 1969). Just as teachers impact children, teachers with children with mental illness are affected by student behavior. This relationship variable may account for the interrelationship of emotional and academic functioning and also the teacher-student relationship.

### **The Teacher of a Child with Mental Illness**

**Teacher attitudes, attributions, and behavior.** Throughout the course of a school year, a child will spend countless hours with teachers and other educational professionals. For some children, this is even more time than spent with their parents. The role of the school system continues to change and requires a teacher to fill many roles in a child's life. Through the school day, most teachers will focus on externalizing behaviors (Repie, 2005) and often misinterpret or miss the hidden phenomenon of internalizing behaviors. When a teacher provides support (emotional and educational) for students, students have higher academic engagement, especially in middle school (Klem

& Connell, 2004). With a full classroom and many children to accommodate with limited supports, this is not a surprising finding (Repie). Within the school system, school psychologists and counselors are frequently the only professionals focusing on the problems associated with internalizing behaviors (Repie). Teachers who have received additional training as indicated by a higher degree tend to have more tolerance of disturbing behaviors and are better able to identify internalizing disorders (Johnson & Fullwood, 2006), which may lead to different attributions toward and expectations for students.

Coleman and Gilliam (2001) conducted a survey of teachers regarding their beliefs about negative and disruptive student behavior. Results were disturbing as most teachers “responded most negatively toward aggression rather than peer avoidance” (p.126), as avoidance is often a precursor to aggression. In addition, the respondents reported more concern for students in mainstream rather than those identified as having special needs. In another study, 45% of teachers admitted to bullying a student (defined as verbal threatening, misuse of power, physical violence, and/or racism) when students behaved poorly (Temlow, Fonagy, Sacco, & Brethour, 2006). The reality is teachers are faced with many challenges. When a child has disruptive behavior, it can be difficult to use reinforcement as an effective method of behavior management. Ineffective methods of discipline and praise are often implemented in the classroom (Infantino & Little, 2005). Teachers often report treating students with disruptive behavior differently than other children in the classroom and 55% of teachers feel they spend too much time on disruptive behavior (Wheldall & Merrett, 1988).

Algozzine and Curran (1979) theorized the degree to which teachers can tolerate poor behavior or emotional disturbance determines how they interact with the child and his or her attributions toward the child through an ecological theory. Within this theory, it is critical to understand the relationship between the environment and the disruptive child to anticipate possible negative outcomes. In essence, this theory proposes that a child with mental illness affects the teacher and changes his or her behavior. To further understand the relationship between teacher attributions and expectations and due to the lack of research investigating this relationship with children with mental illness, it is important to address findings in similar areas. Clark and Artiles (2000) conducted an experimental vignette study asking teachers to answer questions about children with and without disabilities (labeled with a learning disability or with no disability). Results indicated teachers self-reported behaving different around students with disabilities. This was indicated by teacher self-reports of consequences following student behavior, personal reactions to students, and expectation of student success. Similarly, when students with learning disabilities appear motivated to overcome challenges, teachers perceive them as more motivated and as more successful (Meltzer et al., 2004). In other areas, researchers have determined school climate and outside factors are critical to understanding teacher beliefs about students (Silva & Morgado, 2004). In several types of studies in different settings, the importance of understanding teacher attributions and expectations have emerged. For instance, Kenealy, Frude, and Shaw (1990) found teacher ratings of physical attractiveness (at age 11-12) predicted later academic achievement (age 14-15 and 19-20) in a longitudinal study. The same phenomenon occurs within a physical education classroom (Trouilloud, Sarrazin & Bressoux, 2006).

Other studies have reported a relationship between student culture, teacher perceptions, and academic performance (Love & Kruger, 2005; Tyler, Boykin, & Walton, 2006). Regardless of the areas of interest or setting, a relationship emerges between teacher expectations and attributions and student outcome (Schappe, 2005). Working with any population may have a profound effect on the teachers, especially working with students with externalizing behavioral disorders.

**Effect on teacher.** Student behaviors affect teachers in ways that may lead to stress, frustration, and loss of patience. When faced with ongoing behavior problems, teachers may bully students and ultimately treat them differently than their peers (Temlow et al., 2006). Many teachers leave their training feeling under prepared to deal with mental health issues (Baker, 2005). Roeser and Midgley (1997) administered surveys to teachers concerning beliefs about children with mental illness; 68% of teachers reported feeling burdened by such problems and as the school grew and became larger, teachers reported higher levels of burden. When asked about how they educated students with mental health issues, teachers reported they saw academics and emotional distress as separate issues. Despite the perceived separation of academic and emotional issues, 99% of teachers felt it was part of their professional role to help students with mental health problems. Teachers with high efficacy in helping students reported they needed to play a larger role in helping the child. Despite feeling an obligation, many teachers report dealing with behavior problems is stressful (Ho, 2004) and time consuming, leaving teachers to think students with serious problems are better served in a resource room rather than in the mainstream classroom (Lopes, Monteiro, Sil, Rutherford, & Quinn, 2004). Teachers see mental health, behavior, and academic functioning as separate

issues. This contradicts symptomology as noted in the DSM-IV TR that notes children with mental illness frequently manifest symptoms through disruptive behavior (American Psychiatric Association, 2004) and have academic difficulties. As a result, teachers tend to operate by making attributions to areas outside the classroom causing the behavior problem; home, social, etc. (Ho, 2004). In some instances, teachers may even make attributions about personal behavior based on the interaction with the environment. Based on review of the literature, several teacher variables appear to be related to extraneous variables such as sex, certification, experience, and training.

Multiple studies have concluded the majority of special education teachers certified to work with children identified with an emotional behavior disorder are male (Gagnon & Leone, 2006). Females, however, are most likely to work with children in the regular education setting. It has also been documented that teacher expectations are related to sex (Dupoux, Wolman, & Estrada, 2005), making certification(s) and sex critical components to assess within the sampled population. As type of certification is linked to education and training, certification type is also an important indicator of teacher skills, expectations, and education (Lane et al., 2003). Teachers' level of education has been cited as a key variable related to academic outcome for students identified with EBD (Wagner et al., 2006). As level of education increases (Bachelors, Masters, etc.), expectations for all students tend to increase (Dupoux et al.). As teachers receive more advanced training, they also have a higher tolerance for disturbing behaviors (Johnson & Fullwood, 2006). Experience has also been cited as important for investigating teacher expectations, as the two variables are shown to be related (Dupoux et al.). With increased experience, teachers are more likely to accept the concept of

mainstreaming and experience a change in expectations (Clark & Artiles, 2000). Due to the nature of the relationship between teacher and a child with mental illness, it has become critical to explore ways to ensure positive interactions that support good mental health.

**Teacher student relationship.** Research has indicated student achievement and teacher expectations are related (Hughes et al., 2005). Mihalas, Morse, Allsopp, & McHatton (2009) highlighted the importance of the student-teacher relationship to developing academic achievement. In one study, teachers and students were given self-report surveys asking about perceptions of relationship qualities and outcome variables. Results indicated that relationship variables, including parent and student interactions, predicted teacher perceptions of success (Hughes, et.al.). Schappe (2005) reported preschool performance and teacher expectations positively correlated. When teachers recently had a poor interaction with a student, they often have negative expectations that transfer to new students with similar characteristics (Lopes et al., 2004). This in turn may alter teacher self-efficacy, which can further alter attitudes and expectations as demonstrated by Caprara, Barbaranelli, Steca, and Malone (2006) who reported teacher self-efficacy was significantly related to student achievement. As attributions and expectations become more stable with low expectations, students tend to have negative outcomes (Juvonen, 1988). This is critical in understanding the impact of teacher expectations because academic achievement influences later academic choices and adjustment (Caprara et al., 2006). This is of concern as children with mental health problems often have low academic skills in adulthood (Koivusilta et al., 2003; McElhany et al., 1993). Vast amounts of research have demonstrated the effects of teacher

expectations and attitudes. The creation and effects of attributions and expectations can be explained through attribution theory.

### **A Theoretical Perspective: Attribution Theory**

By exploring attribution theory in regard to labels and attributions/expectations, we seek to understand the formulation and maintenance of attributions and expectations of teachers who interact with children identified with EBD. Attributions are defined as “the perception or inference of cause” (Kelley & Michella, 1980, p.458). Expectations, which according to attribution theory are created through attributions, are based on various sources of information (Chow, 1988; Jussim, 1986). Attribution theory proposes attributions are created when one’s reported or observed behavior is associated with some characteristic (Hinshaw & Steier, 2008). The characteristic can be either positive or negative. As attributions are formed, expectations are created for the individual in various domains (Kelley & Michella, 1980). Attribution theory is viewed as a progressive model that begins with an antecedent (such as the environment or pieces of information); an antecedent then leads to the creation of a consequence, defined as the formation of expectations, affective reactions, and behavior changes. According to attribution theory, three components are essential to determine how expectations are created: locus of control, stability, and controllability (Banks & Wollfson, 2008; Boysen & Vogel, 2008; Clark, 1997; Kelley & Michella, 1980).

Locus of control seeks to examine if the behavior is due to internal or external factors (Kelley & Michella, 1980). Internal factors refer to individual factors with a biological basis such as blurting out due to Tourettes Syndrome; whereas external factors refer to environmental characteristics such as blurting out due to being defiant. Teachers

often struggle to identify the classroom as an antecedent to behavior (Ho, 2004) thereby changing the locus of control. Both attributions and expectations have been theorized to vary based on locus of control. Specifically, expectations lower when the locus of control is considered to have an internal basis (Clark, 1997). In regard to labeling, the locus of control is identified at the antecedent stage altering the formation of expectations for students, teacher affect, and behavior for both teacher and student. The concept of stability assesses if the behavioral event is stable and likely to reoccur or unstable and inconsistent. Stable negative behaviors are often associated with lower expectations because the behavior is anticipated (Kelley & Michella, 1980). For example, if a child consistently argues with the teacher, the teacher is likely to expect this behavior to interfere with learning. Finally, the concept of controllability assesses if the child has control over his or her behavior. When the answer is “yes, the child has control,” and the behavior is deemed controllable, teachers tend to have higher expectations for the student (Clark, 1997).

The components of locus of control, stability, and controllability are pieced together to create expectations for students, teacher affect, and behaviors of both students and teachers. For instance, a teacher working with a child seen as having internal, stable, and uncontrollable behaviors is likely to develop low expectations for success, as opposed to a child with external, unstable, and controllable behaviors, whose teacher will likely develop higher expectations (Banks & Woolfson, 2008; Clark, 1997). In a vignette study, a student identified with an uncontrollable disability was significantly more likely to have lower expectations from a teacher in comparison to the expectations for the student’s typical peer (Sinnott et al., 1999). Likewise, stigma typically increases when



behavior is seen as outside a person's control (Hinshaw & Steier, 2008) and also leads to low expectations. Attribution theory is helpful in understanding how labels impact the formation of expectations, as the theory can generalize from an individual to a group and help identify the locus of control, stability, and controllability of the individual's behavior based on the label.

**Theoretical conclusions.** The use of labels has been reported as controversial. Although there are many benefits to using labels, labels often lead to stigma and the creation of premature teacher expectations which alters teacher behavior. Attribution theory helps to explain how expectations are created and impact students. To be identified as a student with an emotional behavioral disorder requires a mental health deficit that results in a diagnosis from the DSM-IV TR or a generalized diagnosis of an emotional behavioral disorder. Students labeled with an emotional behavioral disorder are grouped into an over generalized population and the nature of labeling inadvertently triggers stigma, stereotypes, and prejudice more so than accurate information to help them assist such students. Attribution theory assists in understanding how a label can lead to an incorrect attribution and later expectation based on a teacher's limited knowledge, information, and/or previous experience. It further explains how the minimal nature of information contributing to a label can create negative attributions and expectations before a child enters the classroom.

The overall picture indicates labels lead to expectations that are generalized to groups and fail to identify students as individuals with individual needs. Labels can be detrimental when associated with perceived locus of control, stability, and nature of the problem (internalizing or externalizing). It is important to note teacher education

programs are required to cover a vast array of topics and often lack the time to educate about mental health problems and EBD, which leads to frequently inaccurate assumptions about such problems and disorders. Attribution theory assists in understanding the effects of labeling and can lead to identifying points of intervention to decrease negative effects. When researching teacher attributions and expectations toward children with mental illness and discussing results in regard to attribution theory, a research approach must be designed to ensure the procedures are ethical and can decrease social desirability. Attribution theory is related to labeling as it facilitates the likelihood of making internal, stable, and controllable attributes toward misbehavior by employing an analogue research approach.

### **Research Approach**

This study was designed to utilize a researcher created rating scale entitled the Teacher Expectations for Student and Self Scale (TESSS). The TESSS was initially created based on literature review. Based on literature in the field of teacher expectations four scales were created to assess learning, cooperation, self-control, and teacher self-efficacy on the TESSS rating scale.

#### **Teacher Expectations for Student and Self Scale.**

*Learning.* Children who report emotional distress also report more difficulty learning while at school (Roeser et al., 2001). As a result, children with mental illness learn less information throughout formal education (Koivusilta et al., 2003; McElhany et al., 1993), leaving an achievement gap between their typical peers. Research has concluded emotional functioning and academic functioning are interrelated due to the context of school (Roeser, Eccles, & Sameroff, 1998a) and therefore must be studied

together. When a teacher meets a new student, he/she forms expectations about how the student will perform in the classroom and how he/she expects to be affected. Teacher expectations lead to differential treatment as demonstrated by Clark and Artiles (2000), who conducted an experimental vignette study asking teachers to answer questions about disabled (labeled with a learning disability) and non-disabled children. Results indicated teachers self-reported behaving differently (i.e., more negatively) around disabled students due to lowered expectations for learning. To be a successful learner in the classroom, teachers expect a student will produce work, receive good grades, (Beebe-Frankenberger, Lane, Bocian, Gresham, & MacMillan, 2005; Hersh & Walker, 1983; Kerr & Zigmond, 1986; Lane, Pierson, & Givner, 2003; Lane, Wehby, & Cooley, 2006), take responsibility for learning, be active in the learning process, self-monitor, have a positive attitude (Boers, 2001), and participate (Lane, Stanton-Chapman, Jamison, & Phillips, 2007). Thus, items on the learning scale asked teachers to rate their expectations for student learning, participation, desire to learn, general performance, and work completion.

***Cooperation.*** Students identified as mentally ill and/or EBD tend to have externalizing behaviors, leading teachers to complain such students are not cooperative (Infantion & Little, 2005), which can interfere with learning. Students identified as EBD typically have difficulty using effective social skills such as communication and active listening in order to be cooperative with peers and adults (Lane, Barton-Atwood, Nelson, & Wehby, 2008). Teachers expect all students will follow directions, comply with directives, attend to instruction, actively listen, use free time appropriately, and follow class rules (Hersh & Walker, 1983; Kerr & Zigmond, 1986; Lane et al., 2003; Lane et al.,

2006; Lane et al., 2007; Stephenson, Linfoot, & Martin, 2000). Teachers also expect students will put forth effort and respect authority (Boer, 2001; Clark, 1997; Clark & Artiles, 2000). For teachers to perceive students as cooperative, students must comply with rules and directives (Lane, Pierson, & Givner, 2003; Lane et al., 2007; Beebe-Frankenberger et al., 2005; Hersh & Walker 1983). Research has also shown teacher expectations are created based on perceptions of student perseverance and independence, where perceived absence of perseverance and independence leads to low expectations (Rubie-Davies, Hattie, & Hamilton, 2006). Thus, items were included to measure teacher expectations for cooperation for a student depicted in a written vignette.

*Self-control.* Rating scale items were included on this scale to measure out-of-control behaviors that lead to academic failure, including distractibility, impulsivity, arguing, fighting behaviors, disobedience, delinquency, and aggression (Stephenson et al., 2000; Wagner, Friend, Burslick, Kutash, Duchnowski, Sumi, & Epstein, 2006). Students are expected by teachers to control their tempers with peers and adults, respond appropriately to peer aggression, listen to classmates, and use acceptable language (Hersh & Walker, 1983; Kerr & Zigmond, 1986; Lane et al., 2003). Teachers operate on the assumption that all students can control their behavior and maintain attention (Lane et al.). Ignoring distraction and attending to instruction are important for academic success (Beebe-Frankenberger et al., 2005). Unfortunately, mental illness and EBD are associated with impulse-control deficits and an inability to control one's behavior (American Psychiatric Association, 2004; Lane et al., 2008). Teachers treat and perceive students with disruptive behavior differently than other children in the classroom. Fifty-five percent of teachers feel they spend too much time on disruptive behavior (Wheldall

& Merrett, 1988). Thus, items on this scale asked teachers about their expectations for a student in a written vignette to be non-aggressive, stay on task, display interpersonal skills, pay attention, and generally control his/her behavior.

***Teacher self-efficacy.*** Items were included to measure teacher self-efficacy for working with students described in the vignettes, as teacher self-efficacy is significantly related to student achievement and teacher expectations for students (Caprara et al., 2006). Self-efficacy is defined as the self perception of whether one can use his or her own abilities and skills to deal with a given situation (Bandura, 1977; Bandura & Adams, 1977; Bandura, 1982). Students have higher academic engagement when they perceive teachers are supportive (Klem & Connell, 2004), but studies have shown many teachers leave training feeling under prepared to deal with mental health issues (Baker, 2005) and have low self-efficacy for working with students with mental illness, leading to decreased levels of support for students. Teachers with high self-efficacy for helping students with mental illness reported they need to play a large role in helping the child (Ho, 2004). Furthermore, with increased support and increased self-efficacy, teachers report believing students with emotional and behavioral disorders have less control over behaviors (Liljquist & Renk, 2007), a belief which can lead to improved academic results with specified teacher training.

Students with a mental illness/EBD have historically been excluded from the regular classroom. In the last decade, however, schools have reinterpreted federal mandates to place these children in mainstream or regular education classrooms. For mainstreaming to be effective, teachers must have a positive attitude with cooperation and a commitment to provide additional supports for the student, as this will lead to high

teacher expectations, increased teacher self-efficacy, and greater student academic success (Dupoux et al., 2005). Teachers must have training and competence to make such inclusion successful (Hersh & Walker, 1983) and to achieve higher self-efficacy. Many teachers, however, find facilitating inclusion of students identified with EBD difficult due to the associated mental illness components, leading to teacher resistance and potential rejection of students (Cook, Tankersley, Cook, & Landrum, 2000; Cook, 2004; Dupoux, et al.). Teachers with low self-efficacy related to teaching EBD students have been shown to prefer the exclusion of EBD students, as they do not feel qualified to teach these students (Soodak & Podell, 1993) and have increased concerns about student aggression, defiance, and attention problems (Stephenson et al., 2000). Due to these factors, it is important to investigate how teacher self-efficacy differs between children identified with mental illness (by either doctor or school system label) and children identified without mental illness. Thus, items on this scale asked respondents to rate their expectations for their perceived ability (self-efficacy) to help the student.

**Analogue research.** Analogue research was first described in reputable psychology journals in the late 1960's as a means to analyze perceptions, attitudes, and reactions of psychotherapists toward fictitious scenarios/case studies that mimicked real clients (Kazdin, 1978; Mikton & Grounds, 2007; Munley, 1974). The use of analogue techniques have now broadened into several areas of social science research, including: counseling psychology, clinical psychology, school psychology, social psychology, sociology, social work, and education (Richman & Mercer, 2002). Analogue research, also called vignette research, uses researcher-created video, audio, or written vignettes designed to mimic realistic scenarios (Alexander & Becker, 1978; Cook & Rumrill, 2005;

Hueber, 1991) and to represent “an abstract from the real situation of interest” (Worell & Robinson, 1994, p. 464). Respondents are required to provide responses through rating scales, surveys, or interviews after exposure to a vignette. Analogue research frequently uses an experimental method, meaning multiple vignettes are created with manipulation of an independent variable (Cook & Rumrill). To effectively use experimental analogue research, vignettes must be constructed to be realistic (Cook & Rumrill), must control for extraneous variables, and only manipulated variables should vary (Gangong & Coleman, 2006; Huebner, 1991; Mikton & Grounds, 2007). Appropriate use of analogue technique can yield meaningful results. For instance, Prawat, Byers, and Anderson (1983) sought to assess teacher affect and attributions toward a student through the use of vignette methodology. Results indicated different types of vignettes elicited significantly different responses. Utilizing analogue research methodology, the present study is able to investigate specific research questions and hypotheses.

### **Statement of Purpose, Research Questions, and Hypotheses**

Although many studies have tapped into the existence of a relationship between mental health and academic functioning, there is not a clear understanding about how difficulties in academic functioning emerge (Roeser, Eccles, & Sameroff, 1998b). Aspects of teacher expectations and the outcomes for children with mental illness must be included as children with mental illness frequently experience decreased academic functioning. We will never learn how to help children in the classroom with mental health problems without better understanding how such problems relate to teacher expectations and academics (Roeser et al., 1998b). Additionally, it is important to identify variables that lead to high expectations as these will facilitate training and

support for teachers. Several limitations in the literature have emerged and warrant examination. First, a disconnect between the concepts of emotional and academic functioning is apparent. Teachers seem to view mental health issues as separate from academic issues. Another limitation involves the discussion of teacher attitudes toward children with mental illness; however, no studies were identified as specifically exploring this issue. As Roeser (2001) points out, this is another understudied area that could benefit from prolonged investigation.

The present design utilizes an analogue research design to assess if teachers respond to vignettes with different expectations for children labeled with mental illness in comparison to typical peers. A literature review was unable to identify existing rating scales designed to measure teacher expectations for children with mental illness.

Therefore, a researcher-created rating instrument was designed to be used in conjunction with the vignettes. An initial field study was conducted to ensure the researcher-created rating instrument provided meaningful results. The main study employed the researcher-created instrument to assess the areas of child mental illness and subsequent teacher expectations. Using attribution theory, the vignettes were designed to lead to attributions about locus of control, stability, and controllability of working with the student, thus resulting in expectations. The following key research questions and hypotheses were addressed:

#### Research Questions

1. Will teachers report different expectations for children with identified mental illness and/or the special education label EBD in comparison to typical peers?



2. How will teacher descriptive variables relate to expectations for students labeled with mental illness? Specifically, will descriptive variables predict teacher expectations?

#### Hypotheses

1. Teachers will respond with negative expectations for children labeled with mental illness/EBD in comparison to typical peers.
  - a. Teachers will respond with lower expectations for learning new content for children with identified mental illness or EBD label in comparison to typical peers.
  - b. Teachers will respond with lower expectations for cooperation for children with identified mental illness or EBD label in comparison to typical peers.
  - c. Teachers will respond with lower expectations for self-control for children with identified mental illness or EBD label in comparison to typical peers.
2. Teachers will report different expectations for themselves when presented with information about students identified with mental illness or a label of EBD in comparison to typical peers. Specifically, teachers will report decreased levels of self-efficacy when responding to items about their ability to help a child identified with mental illness or labeled with EBD in comparison to typical peers.
3. Teacher demographic variables (age, sex, teacher certification, education level, and years experience) will predict lower expectations on learning, self-control, and cooperation scales for students identified with mental illness and levels of teacher self-efficacy.

## **Chapter 2- Methodology**

The current body of literature suggests student labels lead teachers to have varying expectations in various domains. This research attempts to identify differences between the expectations teacher report, based on the label of a student, using teachers with current teaching certifications. A researcher-created rating instrument was developed through a literature review and field study for use in the present study, as a review of the literature revealed no existing measure of teacher expectations in regard to students with mental illness. The present study employed analogue methodology using a between-participants design with vignettes in conjunction with the Teacher Expectations for Student and Self Scale (TESSS) to measure teacher expectations. The methodology is designed to assess for statistically significant differences between treatment levels and demographic variables.

### **Participants**

With permission from a school district in the southeastern United States, data were collected via an internet survey sent to elementary school teachers. Three waves of data collection were employed. A total of 240 people participated in the study, yielding a 19.5% response rate. Sixteen respondents were excluded from data analysis due to one or both of the following reasons: they indicated did not have a teaching certification and/or did not provide answers to six or more rating scale items (making  $N=224$ ). Each individual was randomly assigned to one of three treatment conditions. The sample consisted of mostly female respondents (95%). The mean age of participants was 37.5 years. Participant age and years experience were recoded into groupings to represent subgroups within the sample and to allow for these variables to be used as dummy

variables in subsequent regression analyses. The demographic variable of teacher certification was coded in one of two ways; either regular education (0) or special education certification (1). Of the sampled population, 10% reported having dual certification in regular and special education. In this case, the respondent was coded as having a special education certification. Other participant demographics are located in Table 2.1.

*Table 2.1 – Respondent Demographic Data*

*Sampling Frame and Participant Descriptive Statistics*

	<i># (%) of Participants</i>
<i>Group Membership</i>	<i>N=224</i>
<i>Sex</i>	
<i>Male</i>	<i>11(5)</i>
<i>Female</i>	<i>213(95)</i>
<i>Age</i>	
<i>18-24</i>	<i>12(5)</i>
<i>25-35</i>	<i>103(46)</i>
<i>36-45</i>	<i>51(23)</i>
<i>&gt;45</i>	<i>58(26)</i>
<i>Education</i>	
<i>Bachelor's</i>	<i>19(8)</i>
<i>Bachelor's with Some Graduate Work</i>	<i>46(21)</i>
<i>Master's</i>	<i>98(44)</i>
<i>Master's with Post-Master's Work</i>	<i>59(26)</i>

Table 2.1 (continued)

<i>PhD or EdD</i>	2(1)
<i>Experience Teaching</i>	
<i>&lt;One Year – Five Years</i>	72(32)
<i>Six Years – Ten Years</i>	64(29)
<i>Eleven Years – Fifteen Years</i>	36(16)
<i>&gt;Fifteen Years</i>	52(23)
<i>Currently Teaching in Classroom</i>	
<i>Yes</i>	212(95)
<i>No</i>	12(5)
<i>Teacher Certification</i>	
<i>Regular Education Teacher Certification</i>	47(21)
<i>Special Education Teacher Certification</i>	177(79)
<i>History Teaching Students with</i>	
<i>Psychological Problems</i>	
<i>Yes</i>	212(95)
<i>No</i>	12(5)
<i>Currently Teaching Students with</i>	
<i>Psychological Problems</i>	
<i>Yes</i>	159(71)
<i>No</i>	65(29)

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*Note.* Age is coded 1=18-24, 2=25-35, 3=36-45, 4=>45; Education is coded 1=BA,

2=BA and some graduate work, 3=MA, 4=MA and some graduate work, 5=PhD, EdD;

*Years Experience is coded 1=<1-5 years, 2=6-10 years, 3=11-15 years, 4= >16 years; Teaching Certification is coded 1= Has a degree in SPED, 0= Does not have a degree in SPED, Regular Education; and Sex is coded 1=female 0=male.*

## **Measure**

The Teacher Expectation for Student and Self Scale (TESSS) was used to assess teacher expectations for students and self. The Teacher Expectation for Student and Self Scale (TESSS) is an unpublished examiner-created instrument. The TESSS includes items related to teacher expectations for student learning, cooperation, and self control, teacher-expected levels of self-efficacy, and demographic information. Open-ended questions are also included at the end of the instrument and were reviewed through content analysis for themes and information not assessed in the TESSS; results were used as anecdotal support for quantitative findings.

### **Instrumentation.**

**Vignettes.** Vignettes were prepared and piloted by asking advanced graduate students, faculty with survey and rating scale development experience, and practicing school personnel including teachers, counselors, and educational diagnosticians to complete the rating scale and respond to specific feedback question. Analogue research is characterized by the use of vignettes depicting real-life events when the actual event cannot ethically or reasonably be recreated to elicit a response from a participant (Gangong & Coleman, 2006; Kazdin, 1978). It is assumed respondents will respond the same as they would in a real-life situation (Worell & Robinson, 1994). Analogue research is best used when the goal is to isolate relationships between an independent variable and dependent variables (such as attitudes, expectations, perceptions, and other

non-observable traits), and when events cannot be simulated ethically in a real-life setting (Cook & Rumrill, 2005; Sumrall & West, 1998). This form of research is appropriate to use when seeking to measure expectations, perceptions, and attitudes, as people tend to make judgments based on familiarity with label characteristics rather than seek extra information (Stinnett et al., 1999). Although ideal for use with exploratory work, analogue research should be employed with attention to methodological weaknesses such as validity. To ensure a relationship between the independent and dependent variables is established, vignettes must be created with scientific rigor to make certain the description is accurate and realistic when read by respondents (Dixon & Dixon, 1993) as an unrealistic vignette will lead to unrealistic results.

Vignettes used in the current study were revised based on feedback to ensure the vignettes included realistic information and were not written in a persuasive manner. Participants received one of three vignettes focused on a child with no psychiatric history (control condition), a child labeled with an emotional behavioral disorder, or a child returning from inpatient psychiatric care (Appendix A) accompanied by the TESSS (Appendix B).

***Rating Scale.*** The Teacher Expectation for Student and Self Scale (TESSS) is an unpublished, researcher-created rating instrument. The instrument was developed after extensive review of the literature revealed no existing rating scale designed to measure teacher expectations and an initial field study. Consisting of 24 items, the TESSS is composed of questions to be answered using a six-point Likert-type format (strongly disagree, disagree, somewhat disagree, somewhat agree, agree, strongly agree). Due to results obtained in the initial field study, the TESSS collected demographic data and

obtained responses to open-ended questions to provide anecdotal support. The instrument was designed to reflect concepts related to teacher expectations for all students and for themselves, as found in the existing body of research literature.

Interest in teacher expectations as related to student outcomes has increased over the past several decades. Studies have found various student characteristics to be associated with teacher expectations and the prediction of academic outcome (Schappe, 2005), including: attractiveness (Kenealy, Frude, & Shaw, 1991; Trouilland, Sarrazin, Bressoux, & Bois, 2006), culture (Love & Kruger, 2005; Tyler, Boykin, & Walton, 2006), learning disability (Clark & Artiles, 2000), and socioeconomic status (Whelan & Teddlie, 1989). Teacher expectations are defined in the study as beliefs about or attitudes toward future performance based on various sources of information (Jussim, 1986). Teachers form expectations in several areas including: how students will perform as learners, how students will cooperate, how students will control their behavior, and teacher self-efficacy. Self-efficacy is defined as the self perception of whether one can use his or her own abilities and skills to deal with a given situation (Bandura, 1977; Bandura & Adams, 1977; Bandura, 1982). Teacher expectations play a large role in determining academic outcome (Schappe, 2005). Few studies have assessed teacher expectations toward students with mental illness (Roeser, Eccles, & Sameroff, 1998b). Mental illness in the study refers to students with a known diagnosis of a mental illness from a doctor and/or with a special education label of emotional behavior disorder (EBD). Children with mental illness have a poor prognosis for positive academic outcomes (see McElhany et al., 1993; Pullis, 1991; Roeser et al., 2001; Woolston et al., 1989). These findings warrant exploration into how teacher expectations vary between

children with mental illness (identified within or outside of the school system) and children without mental illness. In this study, teacher expectations were measured by asking respondents to complete a six-point Likert-type rating scale after reading a randomly assigned vignette.

The intention of TESSS items is to examine constructs within reliable, valid scales. Defined as the ability to measure a construct (Clark & Watson, 1995), construct validity is necessary to consider when developing rating scales to test hypotheses. To begin assessing construct validity during scale development, constructs were first defined (Clark & Watson, 1995; Saris & Gallhofer, 2007; Smith, 2005; Smith, 2005a) within the discussion of item inclusion. The instrument was field tested to assess both reliability and validity.

**Field study.** The field study was completed in two parts. First, vignettes were prepared and piloted with questions for feedback by ten advanced graduate students and psychology faculty with survey and rating scale development experience. Secondly, 40 pre-service and certified teachers responded to the TESSS after reading a vignette. Respondents were asked to write comments and suggestions throughout the materials (TESSS and vignette). Results indicated feeling responsibility to help was positively correlated with higher academic expectations for all students. A negative correlation was also found between ability to help this population and negative behavioral expectations. No significant differences in expectations and attitudes emerged between children with and without mental illness. Due to the sampling frame, these results are representative of individuals with limited experience in education, making generalizability to practicing teachers difficult. The field study provided critical information to aid further instrument



development and results suggested teachers need more training to assist children with psychological problems. Five scales that generated reliable scores were identified using rating scale items that were in conceptual groupings: academic expectations, behavioral expectations, excited to meet student and parents, feelings of responsibility to know how to help, and expectation of classroom disruption.

The study did not find a responding difference based on education or training. It is theorized this is due to the population sampled, as limited variability in education level emerged. The majority of the sample consisted of individuals in pre-service training that have yet to complete a college degree. It was also predicted that teacher ratings of ability to help, teacher perceptions of feelings of responsibility to help, and opinions of student placement would be related to academic and behavioral expectations. It was demonstrated that only perceived ability to help (self-efficacy) and behavior expectations were related. This may indicate training in behavior management played a role in participant reporting higher expectations for children with psychological problems. Field study results were used in addition to anecdotal data from respondents to continue to refine the TESSS. Revisions to the rating scale, based on feedback and analysis of results of this field study, included making questions clearer, providing more definitions of terms, and removing some items that seemed to be duplicates were implemented in future research. To ensure appropriate items are included, the literature on teacher expectation was also extensively reviewed a second time. It was also determined the number of response steps would be increased on the Likert-type scale to increase item reliability and prompt more accurate responding, as this will increase the validity and reliability of the scale (Anderson, 1997).

**Item scales, analysis and inclusion rationale.** Utilizing results from the field study, an additional review of the literature on teacher expectations was conducted. The review revealed four multidimensional concepts for investigation, including teacher expectations for: students to learn, students to cooperate, students to control their behavior, and teacher self-efficacy. Many of the items on the field study rating scale could theoretically be grouped to fit in one of the four concepts. Items were created to measure teacher expectations for a child identified with a mental illness via a recent psychiatric hospitalization, a child identified with EBD, or a child with no identified mental health concerns. To ensure the collection of reliable and valid data (Nardi, 2006), items were grouped into four scales based on four main concepts to measure expectations (student learning, cooperation, self-control, and teacher self-efficacy). The rating scale was designed to assess expectations for children with and without mental illness through four scales; learning, cooperation, self-control, and teacher self-efficacy. The learning scale asks teachers to rate their expectations for the student in the vignette to learn and participate. The cooperation scales asks a teacher to rate their expectations for the student in the vignette to follow rules and directives. The self-control scale asks a teacher to rate their expectation for the student described in the vignette to control his behavior. The teacher self-efficacy scale asks teachers to rate their perceived level of ability to help the student described in the vignette. The TESSS also asked several demographic questions to assess variables including the roles of practicing teachers, sex, certification, education, experience, and current placement.

## **Procedures**

Data were collected utilizing a nonprobability, purposeful sampling design targeting elementary school teachers in Central Kentucky via a web-based survey. Teachers were approached for participation through an email message sent to individual teacher email accounts (with school district permission). The email contained an introductory email (Appendix C), a link to access a web-based survey created through the online program Survey Monkey<sup>TM</sup> and an accompanying password. Teachers self-selected to participate. To begin participation, respondents were asked to access the link to Survey Monkey and enter the provided password. After entering the website, respondents were presented with an informational letter (appendix E); including an understanding that continuing to participate thereafter implies informed consent. Respondents then hit a next button and were presented with one of three randomly assigned vignettes. After reading the vignette, respondents were asked to complete the TESSS, answer open-ended questions, and enter demographic information. Those who completed the instrument were given the option to be entered in a drawing for one of two \$50 cash prizes by emailing the researcher. Requests and refusals to be entered in the drawing were not linked to respondent data. Respondents were also provided with a “Thank you” message and researcher contact information upon completion of the rating scale. Following the initial solicitation for participation, two reminder emails containing the same information were sent out on four day intervals. In total, respondents were approached for participation on three occasions. A total of 240 individuals participated in the current study; a 19.5% response rate. If a participant was missing six or more item responses and/or indicated he or she did not have a teaching certificate, data was

removed. A total of 16 respondent data sets were removed (eight due to more than six items missing and eight due to not having a teaching certificate). Respondents ( $N=224$ ) were included for data analysis. Data were obtained through Survey Monkey, were downloaded into an Excel file, and then were entered in to an SPSS on a computer protected by a password. Data were analyzed using SPSS to gather results related to the research questions and hypotheses. Eleven rating scale items were reverse coded before data analysis so that a higher rating indicates a positive expectation. Individual item means are presented in Table 2.2.

*Table 2.2 - Individual Item Means by Treatment Condition for TESSS*

	Control	EBD	Psychiatric
	Group Mean	Group	Hospital
	(Standard	Mean	Group Mean
	Deviation)	(Standard	(Standard
		Deviation)	Deviation)
Rating Scale Item	$N=67$	$N=90$	$N=67$
I expect this student will learn new concepts at a rate similar to typical students in my class.	4.74(1.04)	4.37(1.10)	4.40(.90)
This student will put forth effort on all tasks in class.	3.94(1.14)	3.68(1.23)	3.74(1.14)
I can help this student learn academic and social skills.	5.46(.79)	5.36(.60)	5.40(.65)

*Table 2.2 (continued)*

This student will behave aggressively toward others.^	4.92(.77)	4.22(1.01)	4.26(1.03)
This student will use independent time appropriately (as defined in our class rules).	4.12(1.06)	3.65(1.06)	3.66(1.03)
This student will verbally participate in class.	4.18(1.07)	4.34(.91)	3.87(.98)
It will be difficult for me to move through the core content with this student.^	4.88(.85)	4.78(.80)	4.5(.91)
This student will argue or fight with others.^	4.82(.78)	4.42(.95)	4.26(1.06)
This student will respond to redirection within one prompt.	4.18(.96)	3.55(.97)	3.66(.96)
This student will control his behavior by following classroom rules.	4.36(.85)	3.79(1.04)	3.97(.96)
This student will not perform to the level of my expectations in my class.^	4.71(1.06)	4.86(1.03)	4.69(.92)
I can effectively implement my training to help this student.	5.30(.3)	5.16(.75)	5.15(.72)
I expect this student to behave impulsively.^	4.5(.93)	3.66(1.10)	3.82(1.20)

*Table 2.2 (continued)*

I have learned how to work with this type of child through experience.	5.05(.77)	4.9(.92)	4.75(1.01)
This student will have problems completing work.^	4.25(1.05)	3.84(.97)	3.84(1.07)
This student will easily become distracted.^	4(1.07)	3.62(1.06)	3.65(1.09)
This student would be better taught by a different teacher.^	5.45(.57)	5.32(.75)	5.32(.75)
I expect this student will disrupt the learning of others students.^	4.86(.76)	4.16(1.03)	4.38(1.02)
This student will respond to peer aggression by seeking adult help.	3.65(1.06)	3.34(1.04)	3.24(.90)
I expect this student will have academic deficits.^	4.5(1.08)	4.11(1.11)	4.16(1.14)
This student will follow all class rules.	4.14(1.01)	3.67(1.24)	3.91(1.19)
This student will actively try to learn in class.	4.23(.96)	4.07(.86)	4.16(.94)
This student's level of cooperation will interfere with learning.^	4.20(1.03)	3.68(1.04)	3.78(.96)

\* Items scale, 1= Strongly Disagree, 2= Disagree, 3= Somewhat Disagree, 4= Somewhat Agree, 5= Agree, 6= Strongly Agree. Items marked with ^ indicate they reverse scored.

### **Chapter 3 – Results**

Data were prepared for analysis by reviewing appropriateness for inclusion in the study. Missing data were corrected by inserting the mean for the entire item (i.e., if a participant did not respond to item 4, the mean of item 4 was inserted). Next, descriptive information including frequency, skewness, kurtosis, and item means were run. Three survey items presented with skewness outside the parameters of +/- 2. The items included “Are you currently working within a K-12 classroom?,” “Have you previously taught students with psychological problems?,” and sex. Given the nature of these items, it was determined skewness was due to a floor effect and the items were not transformed.

#### **Analysis to Test Research Questions and Hypotheses**

Once data were deemed appropriate for use in analysis, scales were created based on previous field studies and theoretical concepts (Learning, Cooperation, Self-Control, and Teacher Self-Efficacy) by taking the mean of items. The reliability coefficient (Cronbach’s alpha) was utilized (Table 3.1) to assess if scales generated were reliable. The Learning, Cooperation, and Self-Control Scales generated reliable scores with all six items conceptualized to fit together. The Teacher Self-Efficacy Scale had one item removed to increase reliability. With all six conceptualized items included, Cronbach’s alpha=0.67. When the item “I can fulfill the needs of this student without extra support” was removed Cronbach’s alpha= 0.75. It was determined the item about support does not necessarily reflect teacher self-efficacy as support could be interpreted in various ways including administrative support, physically materials, teacher emotional support, etc. The item was written vaguely and thus it was removed from the scale. Descriptive statistics by treatment condition for each scale were run (Table 3.2).

*Table 3.1 – Scale Cronbach’s Alpha Data*

Scale Name	Included Rating Scale Items	$\alpha$
Learning	<p>I expect this student will learn new concepts at a rate similar to typical students in my class.</p> <p>This student will verbally participate in my class.</p> <p>This student will actively try to learn in class.</p> <p>This student will perform to the level of my expectations in my class.</p> <p>This student will have problems completing class work.</p> <p>I expect this student will have academic skill deficits.</p>	.80
Cooperation	<p>This student will follow all class rules.</p> <p>This student will respond to redirection within one prompt.</p> <p>I expect this student will disrupt the learning of others students.</p> <p>This student’s level of cooperation will interfere with learning.</p> <p>This student will put forth effort on all tasks in class.</p> <p>This student will use independent time appropriately (as defined in classroom rules).</p>	.87



*Table 3.1 (continued)*

Self-Control	This student will behave aggressively toward others. This student will respond to peer aggression by seeking adult help. This student will easily become distracted. I expect this student to behave impulsively. This student will argue or fight with others. This student will control his behavior by following classroom rules.	.88
Teacher Self-Efficacy	I can help this student learn academic and social skills. It will be difficult for me to move through the core content with this type of student. I can effectively implement my training to help this student. I have learned how to work with this type of child through experience. This student would be better taught by a different teacher.	.75

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*Table 3.2 - Scale Means and Standard Deviation by Treatment Condition*

	Control Group	EBD Group Mean	Psychiatric Hospital
	Mean (SD)	(SD)	Group Mean (SD)
	<i>N</i> =67	<i>N</i> =90	<i>N</i> =67
Scale			
Learning	4.44(0.70)	4.27(0.72)	4.19(0.74)
Cooperation	4.24(0.75)	3.73(0.85)	3.86(0.81)
Self-Control	4.38(0.63)	3.85(0.70)	3.87(0.80)
Teacher Self-Efficacy	5.23(0.53)	5.10(0.55)	5.02(0.56)

*\* Items were scale with 1 = Strongly Disagree, 2 = Disagree, 3 = Somewhat Disagree, 4 = Somewhat Agree, 5 = Agree, and 6 = Strongly Agree*

To assess for scale validity, a test of correlation was run between the items and each scale (see Table 3.3, 3.4, 3.5, and 3.6). The correlations indicate items within each scale are correlated to the scale score, thus suggesting valid scales were formed.

*Table 3.3 – Learning Item to Scale Correlations*

Scale Item	Learning Scale
I expect this student will learn new concepts at a rate similar to typical students in my class.	.71**
This student will verbally participate in my class.	.68**
This student will actively try to learn in class.	.68**
This student will perform to the level of my expectations in my class.	.74**
This student will have problems completing class work.	.71**
I expect this student will have academic skill deficits.	.74**

*\*\*p<.01*

*Table 3.4 – Cooperation Item to Scale Correlations*

Scale Item	Cooperation Scale
This student will follow all class rules.	.81**
This student will respond to redirection within one prompt.	.78**
I expect this student will disrupt the learning of others students.	.71**
This student's level of cooperation will interfere with learning.	.75**
This student will put forth effort on all tasks in class.	.78**
This student will use independent time appropriately (as defined in classroom rules).	.81**

*\*\*p<.01*

*Table 3.5 – Self-Control Item to Scale Correlations*

Scale Item	Self-Control Scale
This student will behave aggressively toward others.	.75**
This student will respond to peer aggression by seeking adult help.	.60**
This student will easily become distracted.	.71**
I expect this student to behave impulsively.	.75**
This student will argue or fight with others.	.80**
This student will control his behavior by following classroom rules.	.74**

*\*\*p < .01*

*Table 3.6 – Teacher Self-Efficacy Item to Scale Correlations*

Scale Item	Teacher Self-Efficacy
I can help this student learn academic and social skills.	.69**
It will be difficult for me to move through the core content with this type of student.	.64**
I can effectively implement my training to help this student.	.79**
I have learned how to work with this type of child through experience.	.74**
This student would be better taught by a different teacher.	.70**

*\*\*p < .01*

To test if treatment condition led teachers to respond significantly different to TESSS scales (learning, cooperation, self-control, and self-efficacy), a multivariate analysis of variance (MANOVA) was used with condition as the independent variable and the four outcomes entered as dependent variables. This method of analysis was appropriate because it allowed dependent variables that are conceptually related be evaluated for statistically significant differences based on the independent variable, condition. A MANOVA using Lambda was conducted to test for group differences with  $p < .05$  (the Box test was not significant). We expected that teachers in the control treatment condition would report higher expectations on all dependent variables. A linear contrast was examined comparing control group to the two experimental groups. A statistically significant main effect was found for treatment condition indicating scores differed based on condition,  $F(2,221)=4.79, p=.000$ . Statistically significant group differences were further evaluated through the use of univariate post-hoc analysis of variance to determine specific differences; univariate tests revealed significant main effects for cooperation and self-control based on condition; cooperation,  $F(2,221) = 7.89, p=.000$  and self-control,  $F(2,221) = 12.50, p=.000$  indicating significantly different responses on these scales based on treatment condition. An effect was not found for learning  $F(2,221) = 2.11, p=.124$  indicating condition did not result in significant different reporting of expectations for learning. An effect was also not found for teacher self-efficacy,  $F(2,221)=2.42, p=.091$  indicating different levels of teacher self-efficacy did not result in different responding based on treatment condition.

It was predicted respondents would respond with lower expectations for learning in conditions 2 and 3 in comparison to condition 1. This hypothesis was not confirmed.

As predicted, respondents reported lower expectations for cooperation in conditions 2 and 3 in comparison to condition 1. Thus, this hypothesis was confirmed. As predicted, respondents reported lower expectations for self-control in conditions 2 and 3 in comparison to condition 1. This hypothesis was confirmed.

To address research question 2: how will teacher descriptive variables relate to expectations for students labeled with psychological illness (i.e., EBD label or recent psychiatric hospital stay) and to address hypothesis 3, teacher demographic variables (age, sex, teacher certification, education level, and years experience) will predict lower expectations on the learning, self-control, and cooperation scales for students identified with mental illness and levels of teacher self-efficacy, a multiple regression was run ( $\alpha=.05$ ). A multiple regression was run as we had more than 20 cases per predictor variable on the whole group sample. A multiple regression was run rather than a Multivariate Analysis of Covariance (MANCOVA) because we were looking for predictor variables, not covariates. Before running a regression analysis, all predictor variables were coded into dummy variables and a correlation matrix (Table 3.7) was run to assess for extremely high correlations and multicollinearity. The predictor variable sex was removed from the analysis (even though it was stated in the hypothesis) due to the skewness of the sample; the sample was 95% female.

*Table 3.7 – Demographic Variable Correlations to Assess for Multicollinearity*

Scale	Age	Teacher Certification	Education Level	Years Experience
Age	--	.09	.41**	.76**
Teacher Certification	--	--	.07	.17**
Education Level	--	--	--	.50**

*Note. Age is coded 1=18-24, 2=25-35, 3=36-45, 4=>45; Education is coded 1=BA, 2=BA and some graduate work, 3=MA, 4=MA and some graduate work, 5=PhD, EdD; Years Experience is coded 1=<1-5 years, 2=6-10 years, 3=11-15 years, 4= >16 years; and Teaching Certification is coded 1= Has a degree in SPED, 0= Does not have a degree in SPED, Regular Education.*

*\*p<.01*

One correlation greater than  $r=.60$  was identified; age and years experience. Since this correlation makes intuitive sense (i.e., you would have more years experience with increased age), year experience and age were both used in the regression analysis. Items were evaluated for appropriateness in multiple regression; a multiple regression was run to explain the variance in the dependent variables on the whole sample and then by condition.

To determine predictor variables for learning (ratings of expectations for the student to learn), cooperation (ratings of expectations for the student to cooperate), self-control (ratings of expectations for the student to use self-control), and teacher self-efficacy (ratings of teacher self-efficacy to work with the student), four predictor variables were chosen (age, education, years experience, and teacher certification). The

regression model assessed if the above predictor variables predicted individual responses to the listed continuous variables. The multiple regression analyses using learning ( $R=.19$ ,  $F[4, 223]=2.06$ ,  $p=.09$ ;  $R^2=.04$ ), cooperation ( $R=.15$ ,  $F[4, 223]=1.18$ ,  $p=.319$ ;  $R^2=.02$ ), and self-control ( $R=.21$ ,  $F[4, 223]=2.55$ ,  $p=.065$ ;  $R^2=.04$ ) as dependent variables for the entire sample did not yield a statistically significant  $R$  ( $p>.05$ ). Multiple regression analysis using teacher self efficacy as the dependent variable yielded a significant  $R$ ,  $R=.34$ ,  $F(4, 223)=7.17$ ,  $p=.000$ . The overall adjusted  $R$  squared explained 11.6% of the variance (Table 3.8).



*Table 3.8: Standardized Regression Coefficients for Entire Sample with Teacher Self Efficacy as Dependent Variable*

Model	Unstandardized		Standardized	<i>t</i>	Sig.
	Coefficients		Coefficients		
	B	Std. Error	B		
(Constant)	4.78	.14		34.75	.000
Years Experience	.10	.05	.21	2.05	.042*
Ages	.09	.04	.06	.87	.385
Education	-.03	.06	-.04	-.45	.654
Teaching Certification	.31	.09	.23	3.51	.001**

*Note. Age is coded 1=18-24, 2=25-35, 3=36-45, 4=>45; Education is coded 1=BA, 2=BA and some graduate work, 3=MA, 4=MA and some graduate work, 5=PhD, EdD; Years Experience is coded 1=<1-5 years, 2=6-10 years, 3=11-15 years, 4= >16 years; and Teaching Certification is coded 1= Has a degree in SPED, 0= Does not have a degree in SPED, Regular Education.*

*\* $p < .05$ .*

*\*\* $p < .01$ .*

To compare relative effects, the  $\beta$  coefficient reports statistically significant differences on reports of teacher self-efficacy related to teacher certification,  $\beta = .23$ ,  $p = .001$  and years experience,  $\beta = .21$ ,  $p = .042$ .

To determine predictor variables for learning (ratings of expectations for the student to learn), cooperation (ratings of expectations for the student to cooperate), self-control (ratings of expectations for the student to use self-control), and teacher self-

efficacy (ratings of teacher self-efficacy to work with the student) in the control condition, four predictor variables were chosen (age, education, years experience, and teacher certification). The multiple regression analyses using learning ( $R=.30$ ,  $F[4, 65]=1.55$ ,  $p=.198$ ;  $R^2=.09$ ), cooperation ( $R=.21$ ,  $F[4, 65]=.68$ ,  $p=.609$ ;  $R^2=.04$ ), self-control ( $R=.28$ ,  $F[4, 65]=1.26$ ,  $p=.431$ ;  $R^2=.08$ ), and teacher self-efficacy ( $R=.31$ ,  $F(4,65)=1.59$ ,  $p=.189$ ;  $R^2=.09$ ) as dependent variables did not yield a significant  $R$  ( $p<.05$ ).

To determine predictor variables for learning (ratings of expectations for the student to learn), cooperation (ratings of expectations for the student to cooperate), self-control (ratings of expectations for the student to use self-control), and teacher self-efficacy (ratings of teacher self-efficacy to work with the student) in condition 2 (identified EBD condition), four predictor variables were chosen (age, education, years experience, and teacher certification). The multiple regression analyses using learning ( $R=.22$ ,  $F[5, 89]=1.08$ ,  $p=.373$ ;  $R^2=.05$ ), cooperation ( $R=.15$ ,  $F[4, 89]=.50$ ,  $p=.737$ ;  $R^2=.02$ ), and self-control ( $R=.15$ ,  $F[4, 89]=.50$ ,  $p=.739$ ;  $R^2=.02$ ) as dependent variables did not yield a statistically significant  $R$  ( $p<.05$ ). Multiple regression analysis using teacher self efficacy as the dependent variable yielded a statistically significant  $R$ ,  $R=.40$ ,  $F(4, 89)=4.05$ ,  $p=.005$ . The overall adjusted  $R$  squared explained 12% of the variance (see Table 3.9).

*Table 3.9: Standardized Regression Coefficients for Condition 2 (EBD) with Teacher Self Efficacy as Dependent Variable*

Model	Unstandardized		Standardized	t	Sig.
	Coefficients		Coefficients		
	B	Std. Error	B		
(Constant)	4.75	.21		22.22	.000
Year Experience	-.04	.10	-.07	-.44	.661
Ages	.34	.14	.25	2.39	.019
Education	.02	.07	.04	.34	.737
Teaching Certification	.14	.08	.30	1.68	.096
Sex	-.11	.27	-.04	-.41	.682

*Note.* Age is coded 1=18-24, 2=25-35, 3=36-45, 4=>45; Education is coded 1=BA, 2=BA and some graduate work, 3=MA, 4=MA and some graduate work, 5=PhD, EdD; Years Experience is coded 1=<1-5 years, 2=6-10 years, 3=11-15 years, 4= >16 years; and Teaching Certification is coded 1= Has a degree in SPED, 0= Does not have a degree in SPED, Regular Education.

\* $p < .05$ .

\*\* $p < .01$ .

To compare relative effects, the  $\beta$  coefficient reports significant differences on reports of teacher self efficacy related to teacher certification,  $\beta = .25$ ,  $p = .019$ .

To determine predictor variables for learning (ratings of expectations for the student to learn), cooperation (ratings of expectations for the student to cooperate), self-control (ratings of expectations for the student to use self-control), and teacher self-

efficacy (ratings of teacher self-efficacy to work with the student) in condition 3 (identified with psychiatric illness condition), four predictor variables were chosen (age, education, years experience, and teacher certification). The multiple regression analyses using learning ( $R=.19$ ,  $F[4, 67]=.58$ ,  $p=.679$ ;  $R^2=.04$ ), cooperation ( $R=.24$ ,  $F[4, 67]=.93$ ,  $p=.452$ ;  $R^2=.06$ ), self-control ( $R=.31$ ,  $F[4, 67]=1.62$ ,  $p=.179$ ;  $R^2=.09$ ), and teacher self efficacy ( $R=.27$ ,  $F[4,67]=1.28$ ,  $p=.287$ ;  $R^2=.08$ ) as dependent variables did not yield a significant R ( $p<.05$ ).

To add additional support to anecdotal data findings from this study, participants were asked to respond to two open ended questions; 1) What are your greatest concerns about working with a child similar to the child in the scenario? and 2) What kind of training have you had to work with children who have psychological problems? Data from question one were reviewed for themes presented in Table 3.10.

*Table 3.10: Anecdotal Data Themes Regarding Teacher Concerns about Student in Scenario*

<i>Theme</i>	<i>Condition 1: Control (percentage of sample) (n=67)</i>	<i>Condition 2: Identified EBD (percentage of sample) (n=90)</i>	<i>Condition 3: Identified with Psychiatric Hospitalization (percentage of sample) (n=67)</i>
Transitioning	15(22%)	6(6%)	4(6%)
Student Feeling Welcome	3(4%)	1(1%)	4(6%)
Forming Social Relationships	12(18%)	9(10%)	7(10%)
Student Level of Motivation	13(19%)	11 (12%)	8(12%)
Knowledge Gaps	5(07%)	2(02%)	4(6%)
Teacher Student Relationship	13(19%)	9(10%)	6(9%)
Disrupting/Distracting	3(4%)	8(9%)	1(1%)
Others			
Learning Class Expectations	4(6%)	4(4%)	2(3%)
Emotional Needs	1(1%)	1(1%)	2(3%)
No Concerns	7(1%)	5(6%)	3(4%)
Home Life	1(1%)	0(0%)	0(0%)
Defiance	0(0%)	1(1%)	0(0%)

*Table 3.10 (continued)*

Safety of Others	0(0%)	7(8%)	0(0%)
Supports Needed by Student	0(0%)	9(10%)	4(6%)
Need for One-on-One Assistance	0(0%)	5(6%)	2(3%)
Administrative Support	0(0%)	5(6%)	2(3%)
Not Having Enough Information	0(0%)	7(8%)	19(28%)
Parental Support	0(0%)	6(7%)	1(1%)
Teacher Lack of Experience/Training	0(0%)	3(3%)	5(7%)
Aggressive Outbursts	0(0%)	1(1%)	2(3%)
Safety of Student	0(0%)	4(4%)	0(0%)
Student Triggers	0(0%)	2(2%)	2(3%)
EBD Label	0(0%)	1(1%)	0(0%)

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Although statistical analysis was not conducted on the above anecdotal data, teachers reported different concerns based on student identification. For students in the control condition, teachers reported themes related to transitioning, forming social relationships, student level of motivation, and developing a student teacher relationship as the top areas of concern. For students identified with an EBD label, teachers' top concerns included student level of motivation, developing the student teacher relationship, the potential for students to disrupt the class, and having all supports needed for the student in place as top

concerns. For students identified with a recent psychiatric hospitalization, teachers reported concerns related to student level of motivation and not having enough information to help the child. Interestingly, teachers reported some similar concerns across conditions related to the student-teacher relationship. For students identified with an EBD label or a history of recent psychiatric hospitalization, several negative concerns were noted including defiance, safety of others, need for one-on-one assistance, administration support, not having enough information, parent support, lack of teacher training, aggressive behaviors, safety of the student, and student triggers that were not present for students without these identifying variables. This further supports that limited pieces of information can shape and alter the attributions and expectations teachers begin to form before students even walk into the classroom.

Question two was reviewed to assess types of training teachers have received to work with children with mental illness. Results are presented in Table 3.11.

*Table 3.11: Anecdotal Data Reported Training to work with Children with Psychological Problems*

<i>Type of Training</i>	<i>Total Sample (percentage) (N=224)</i>	<i>Condition 1: Control (n=67)</i>	<i>Condition 2: Identified EBD (n=90)</i>	<i>Condition 3: Identified with Psychiatric Hospitalization (n=67)</i>
Undergraduate Classes	55(25%)	17	27	11
Experience Working with Other Staff	105(47%)	32	38	35
Graduate Classes	20(9%)	8	6	6
Professional Development	18(8%)	10	4	4
No/Very Limited Training	47(21%)	9	22	16
Special Education Degree	37(17%)	12	16	9
Independent/ Personal Research	8(4%)	1	6	1
No Response to Item	25(11%)			



Findings from this open-ended item indicated that 20% of teachers reported having a lack of training to work with students with mental health needs. The majority of teacher training to work with children with mental health needs came through experience (47%), undergraduate training (25%), and professional development (21%). Given that the majority of reported training comes through experience, it indicates that years experience and higher levels of education would indicate a higher level of self-efficacy.

### **Post Hoc Analysis**

To further assess the validity of the scale scores on the TESSS, a post-hoc principle component analysis was conducted using 23 items from the TESSS. This analysis was not planned in the original study and results should be interpreted with caution as this statistic is not robust to small sample size and this data was gathered using an experimental design. The item “I can fulfill the needs of this student without extra support” was not included as it was not included in the reliability statistic and was determined to have multiple meanings. Results from the principle component analysis with varimax rotation indicated four factors. The results indicate that TESSS items loaded onto the four factors with eigenvalues for each the four factors greater than 1.00 and they explained over 60.7% of the variance in the items (see Table 3.12 for loadings).

Table 3.12: Principle Component Analysis with Varimax Rotation on the TESSS Scale

Rating Scale Item	Factor 1	Factor 2	Factor 3	Factor 4
I expect this student will learn new concepts at a rate similar to typical students in my class.	<b>.547</b>	-.007	.540	.192
This student will put forth effort on all tasks in class.	<b>.776</b>	.121	.264	.089
I can help this student learn academic and social skills.	.257	-.026	.421	<b>.582</b>
This student will behave aggressively toward others.^	.177	<b>.776</b>	.034	.115
This student will use independent time appropriately (as defined in our class rules).	<b>.710</b>	.249	.294	.103
This student will verbally participate in class.	<b>.551</b>	.106	.341	.127
It will be difficult for me to move through the core content with this student.^	.146	.344	<b>.548</b>	.300

*Table 3.12 (continued)*

This student will argue or fight with others.^	.320	<b>.706</b>	.132	.186
This student will respond to redirection within one prompt.	<b>.747</b>	.368	-.015	.070
This student will control his behavior by following classroom rules.	<b>.716</b>	.439	.065	.105
This student will not perform to the level of my expectations in my class.^	.219	.358	<b>.634</b>	.208
I can effectively implement my training to help this student.	.249	.097	.112	<b>.787</b>
I expect this student to behave impulsively.^	.236	<b>.668</b>	.089	.186
I have learned how to work with this type of child through experience.	.121	.140	-.026	<b>.765</b>
This student will have problems completing work.^	.288	<b>.601</b>	.387	-.018

*Table 3.12 (continued)*

This student will easily become distracted.^	.172	<b>.597</b>	.449	-.047
This student would be better taught by a different teacher.^	-.016	.222	.131	<b>.717</b>
I expect this student will disrupt the learning of others students.^	.222	<b>.712</b>	.260	.242
This student will respond to peer aggression by seeking adult help.	<b>.535</b>	.205	.154	.146
I expect this student will have academic deficits.^	.269	.232	<b>.683</b>	.025
This student will follow all class rules.	<b>.689</b>	.408	.097	.136
This student will actively try to learn in class.	<b>.676</b>	.186	.198	.128
This student's level of cooperation will interfere with learning.^	.376	<b>.573</b>	.332	.106

Results suggest four factors emerged, however, all items did not cluster as anticipated. Of the items conceptualized to fit for the learning scale, three items indicated high factor loadings on the same factor. Of the items conceptualized to fit for the cooperation and self-control scales, several items loaded on each factor. Of the items conceptualized to fit for the teacher self-efficacy scale, four items emerged with high factor loadings.

## Chapter 4 – Discussion

The purpose of the present study was to investigate teacher expectations for children with and children without mental illness (as defined in the current study by a child with a recent psychiatric hospitalization or the special education label EBD). Two research questions and three hypotheses were addressed using a researcher created rating scale: 1) Will teachers report different expectations for children with identified mental illness and/or the special education label EBD in comparison to typical peers?; 2) How will teacher descriptive variables relate to expectations for students labeled with mental illness? Specifically, the hypotheses evaluated if descriptive variables predict teacher expectations? 3) Teachers will respond with negative expectations for children labeled with mental illness/EBD in comparison to typical peers (teachers will respond with lower expectations for learning new content for children with identified mental illness or EBD label in comparison to typical peers; teachers will respond with lower expectations for cooperation for children with identified mental illness or EBD label in comparison to typical peers; and teachers will respond with lower expectations for self-control for children with identified mental illness or EBD label in comparison to typical peers); 4) Teachers will report different expectations for themselves when presented with information about students identified with mental illness or a label of EBD in comparison to typical peers. Specifically, teachers will report decreased levels of self-efficacy when responding to items about their ability to help a child identified with mental illness or labeled with EBD in comparison to typical peers; and 5) Teacher demographic variables (age, sex, teacher certification, education level, and years experience) will predict lower

expectations on learning, self-control, and cooperation scales for students identified with mental illness and levels of teacher self-efficacy.

Results from the current study revealed reliable scales; learning, cooperation, self-control, and teacher self-efficacy. Initial tests of validity indicated items grouped within each scale were related. Scale scores were used to test the research questions and hypotheses. Data indicated teachers reported significantly different expectations for children identified with mental illness (label with EBD or history of a recent psychiatric hospitalization) in comparison to typical children; specifically that teachers reported low expectations for a student to use self-control and cooperate. Further, teacher special education certification was a predictor for ratings of expectations for students labeled with EBD. Significantly different responses were indicated across treatment conditions; specifically the control condition reported significantly different expectations in comparison to conditions 2 and 3 (emotional behavioral disability and recent psychiatric hospital labels) on the ratings of cooperation and self-control. Teacher certification was a predictor variable for ratings of expectations for learning, self-control, and teacher self-efficacy. Years experience also predicted teacher self-efficacy.

The present student was designed using theoretical assumptions based on attribution theory. It did not test assumption theory. Rather it assessed teacher expectations for a student based on a vignette with limited information regarding a student and suggests the importance of considering attribution theory when examining teacher expectations. Results suggest that having a label leads to different attributions and responses from a group of certified elementary school teachers. Attribution theory purports that attributions are created based on associated characteristics and leads to the

formulation of expectations (Kelley & Michella, 1980). This study confirmed that expectations for a student labeled with a mental illness (either EBD or recent psychiatric hospitalization) are different thus inferring that the information provided to participants in the vignette (i.e., characteristics about a student) altered teacher attributions.

Teachers often complain about disruptive behaviors of students identified with emotional and behavior disabilities (i.e., mental illness; Infanton & Little, 2005). Results from the current study suggest any type of mental illness identification results in lower expectations for a student to control their behavior and to cooperate. This provides further support that labeling and the attached stigma leads to negative consequences (i.e., lower expectations) for students (Day, et al. 2007; Hinshaw & Steier, 2008). This study also confirmed that teacher certification had an impact on perceived teacher self-efficacy for working with a student labeled with an emotional behavioral disability (EBD). This provides further support to the findings in previous research that advanced training to work with a specified population leads to different expectations (Johnson & Fullwood, 2006).

### **Limitations**

The current study has potential weaknesses that are important to address, including threats to internal and external validity. Although many problems with analogue research can emerge, proper controls can limit their effect, thereby increasing the design's validity and the ability to generalize results. Analogue research has several strengths including decreased social desirability, high internal validity, high ethical standards, a low cost, and time efficiency. When analogue research methodology is carefully designed accounting for weaknesses, the researcher maximizes the strengths of



analogue technique and decreased weaknesses (Gangong & Coleman, 2006; Huebner, 1991; Mikton & Grounds, 2007). Weaknesses associated with analogue research include threats to external validity and creator bias. Awareness of threats to external validity and the possibility of creator bias can be controlled to provide the researcher with increased external validity with results that minimize social desirability toward stigmatized topics. The first step to addressing weaknesses begins by asking, “is this an appropriate method for my research?” If the goal is to measure differences in unobservable traits between controlled conditions that would be unethical to measure in other ways, analogue research is likely a good choice. Given the nature of the present study, this made vignette methodology a good choice.

The best way to target concerns of response bias is to use multiple vignettes with a changing independent variable (Worell & Robinson, 1994). Threats to external validity and creator bias must be examined. By simply choosing to use analogue research, external validity is threatened. To help increase generalizability of results, the research design must minimize creator bias and reduce respondent bias. An experimental method is also strongly encouraged to increase both internal and external validity (Dixon & Dixon, 1993). When implementing an analogue research technique, the aforementioned recommendations must be considered. By employing the cited recommendations, the weaknesses associated with analogue research were lessened, thereby increasing the usefulness of vignette research methodology in the current study. The present study controlled for possible weakness by field testing the instrument, revising the instrument, receiving feedback from various individuals on the ease of use, respondent understanding, and the real-life nature of the rating scale and vignette.

This study also used a researcher created rating scale as one could not be identified in the literature that targeted the areas of interest. Although the focus of this study was not rating scale develop, initial measures of reliability and validity indicated the created scales (learning, cooperation, self-control, and teacher self-efficacy) were appropriate for use in statistical analysis. A post hoc principle component analysis (PCA) revealed that some items did cluster as anticipated. This finding should be interpreted with cautions as a PCA is not robust to a small sample size.

Another potential weakness in the current student was the response rate of 19.5%. Without a 100% response rate, we cannot guarantee a representative sample was obtained. In compliance with recommendations from the internal review board (IRB) at the University of Kentucky, IP addresses were not tracked on the electronic software that ran the internet survey. Thus, we were unable to assess how many people began the survey, but did not complete the survey. It is possible that people started the survey and decided the topic was not relevant and stopped taking the survey. Participants were also solicited for participation in the month of February. During this month, the school system targeted for sampling had four snow days and one holiday. Thus, teachers were not in school with access to the internet everyday during the data collection period. This may have also impacted the response rate. In future research, the response rate could be increased by using a paper and pencil format, delivering rating scales in person, and providing a verbal invitation to participate.

### **Implications**

Results from this study suggest several considerations for teacher training and school staffing. Teachers reported different expectations based on minimal information

(i.e., a label). Review of anecdotal responses indicated teachers may not be aware that they have different expectations. Thus, an important contribution of the present study to the literature is to document teachers have different expectations based on mental health labels and help promote awareness of the different expectations. Another global implication of this study is that teachers need more training to work with students identified with mental health labels. Teachers reported very limited training to work with this population and noted anecdotally that experience and on the job training were their only form of training. This implies that additional school supports and training are needed to ensure all students are presented with the same expectations to maximize student achievement. This also implies that teachers early in their career will need more support and assistance to work with children with mental health labels. Teacher certification also played a role in the expectations reported for a child. Specifically, teachers certified in special education reported higher expectations for self-control and cooperation. Given this information, it reiterates the importance of hiring highly qualified teachers (i.e., teachers with certifications in special education) to work with child identified with mental health label. This also implies that these teachers should be utilized as a resource within the building to support fostering high expectations for all students.

### **Future Research**

Attribution was the underlying theoretical construct of this study, as it explains how minimal information such as a label can lead to negative attributions and expectations; attributions are based on environmental information, which lead to expectations (Chow, 1988; Jussim, 1986). Based on this theory, it was anticipated that treatment condition (i.e., information about student characteristics presented to the

respondent; a label) would lead to different attributions and thus expectations.

Attribution theory provided a foundation for the rationale and creation of the current study, but it failed to address factors related to misconception and how expectations change teacher behavior. To explore the impact of expectations on teacher behavior, self-fulfilling prophecy theory may assist in explaining how information can lead to changes in behavior.

*Self-Fulfilling Prophecy.* Rosenthal and Jacobson first discussed self-fulfilling prophecy in an article entitled *Pygmalion in the Classroom* in 1968 (Jussim, 1986). Self-fulfilling prophecy purports teacher expectations influence children's behavior in ways that fulfill the teacher's expectations further supporting teacher expectations for the student (Brophy, 1983; Tauber, 1998). Labeling, as discussed through attribution theory, creates expectations. Once expectations are formed, self-fulfilling prophecy contends students will be influenced to act in a certain way. The impact of self-fulfilling prophecies tend to have stronger effects for individuals in a stigmatized groups (Jussim & Harber, 2005), such as students labeled with mental illness and/or EBD. As children labeled with mental illness and EBD are stigmatized, it is anticipated they would experience a change of behavior based on teacher expectations. Proctor (1984) summarized Brophy and Good's model of self-fulfilling prophecy, indicating the process begins as information from many sources influences expectations, including direct contact and indirect contact such as talking with previous teachers or reviewing records. Once information is gathered, expectations are used to dictate teacher behavior, with different expectations leading to different behaviors. Teacher behaviors then lead to different levels of student achievement and behavior. The notions of self-fulfilling

prophecies have been challenged. Jussim, Eccles, and Madon (1996) noted that to say teacher expectations alone result in specific outcomes is an over simplification and there are various factors that need to be considered. Literature supports that a host of factors relate to student outcome including social perceptions (Jussim, 1986), which further supports the integration of attribution theory and self-fulfilling prophecy theory to explore the impact of teacher expectations. Jussim (1986) asserts self-fulfilling prophecy “refers to situations in which one person’s expectations about a second person lead the second person to act in ways that confirm the first person’s original expectations” (p. 429). He provides a model beginning with teacher expectations (based on stereotypes, status, reputation, standard test scores, early performance, and naïve predictions), proceeds to maintenance of expectations (by confirmatory bias, flexibility of expectations, and strength of evidence), and results in differential treatment driven by psychological, situational, and experiential factors. Due to a lack of training teachers tend to use experience rather than theory to guide intervention for students with EBD, leading to differential and unsubstantiated treatment (Maras & Kutnick, 1999). This finding was also supported through anecdotal data in the present study. Research supports race, socioeconomic status, and previous academic achievement are the most influential to developing teacher expectations (Jussim, Eccles, & Madon, 1996). Students labeled EBD typically have characteristics such as below grade level achievement and low levels of socioeconomic status. Exploring these characteristics through self-fulfilling prophecy further could provide additional insight into teacher expectations.

Taking a closer look at teacher expectations, higher expectations translate to teachers demanding better performance (Brophy, 1983). Low expectations lead to

decreases in instruction time, activities, questions, praise, and overall interaction, as well as increases in time spent trying to control behavior, discipline, and criticize the student (Proctor, 1984). Jussim (1986) went on to simplify the model reporting various factors that influence the creation of expectations. Jussim wrote “teachers develop expectations, teachers treat students differently depending on their expectations, and students react to this differential treatment in ways that confirm expectations” (p.429). Students labeled emotionally and behaviorally disabled reported less positive teacher attention and were more likely to fail to meet expectations in comparison to typical peers, which put them at risk for social and academic failure (Sutherland et al., 2008). In regard to mental illness, EBD labels, and teacher expectations, little research has been conducted to examine the role of self-fulfilling prophecy (Jussim & Harber, 2005). Still, self-fulfilling prophecy helps to explain how labels and stigma lead to differential treatment and how teacher expectations are confirmed and maintained toward labeled students, thus altering teacher expectations and potentially their behavior. Once a child is in the classroom, self-fulfilling prophecy theory explains how and why a student’s behavior reinforces teacher expectations, thus leading to future attributions. Self-fulfilling prophecy theory also helps to examine how a label and the attached stigma maintains expectations and influences teacher and student behavior, thereby confirming expectations. Although this study did not directly evaluate self-fulfilling prophecy, results suggest it may be helpful in understanding how expectations can alter behavior. Investigation of self-fulfilling prophecy in relation to the student teacher relationship and behavior change is an area for future research. Examining this was beyond the scope of the present study.

Results from the PCA should be used for further rating scale development and used in future research. Results from this study indicated that even with an experimental design, items many items clustered under the same factors suggesting valid scales were formed. Additional areas for future research including the evaluation of different expectations between internalizing and externalizing disabilities. Many of the open ended question responses indicated an expectation for out of control and/or aggressive behavior from students identified as a student with an EBD. Given that students identified under this label may have internalizing disorders (i.e., non-aggressive behaviors) it would be interesting to see how teachers respond to added information about type of mental health problem. It would also be interesting to investigate high school teacher responses to an older student (i.e., high school student). Given the nature of adolescent children and that mental illness becomes more prevalent in older children, results may be significantly different for this population. Running the same study with a different sample could provide specific information to plan training and system intervention for high school teachers. Another area for future research includes expectations between different types of special education identification labels (i.e., Specific Learning Disabilities, Autism, etc.). The current study did not assess for differences between types of special education labels. Understanding how teachers react and what they expect based on label could help facilitate training and system wide intervention. Also, significantly different responses were not identified in the area of learning. It is suspected that this could have been due to information presented in the vignette (“Alex has progressed through school with grade level scores on standardized assessment.”). In future research, it would be good to flush out capacity to learn and learning behaviors as separate constructs.

## **Conclusions**

Results from a literature review revealed teachers expect all students to learn, to cooperate, and to have self control. Teacher self-efficacy was also identified as a factor influencing expectations for student with special needs. The literature indicates that teachers frequently label behaviors associated with mental illness as the worst type of problem in the classroom in part due to the assumption all children can control their behaviors (Infantion & Little, 2005). The results of the current study will help support the argument for teachers to receive more training to assist children with mental illness and psychological problems.

As Kuperminc, Leadbeater and Blatt (2001) reported, the ultimate goal for a school is to prevent emotional disturbance (poor mental health) by looking through a wide lens at all students, not just those at risk. By accepting this approach, one can foster support for all students and help all children gain competence while developing positive relationships, which have been shown to be effective strategies to decrease the occurrence of mental health problems. Children with mental illness have broadened the purpose of the school system and in essence have necessitated a growing change in the roles of teachers, counselors, school psychologists, and other professionals (Braden, Dimarino-Linnen, & Good, 2001). This study explored teacher expectations of students and the differences between expectations that emerge for students with mental illness and students without mental illness. It also provides valuable information regarding ways to assist teachers in training and professional development to help increase self-efficacy for working with children identified with mental illness and/or EBD.



By understanding teacher expectations as they relate to the identification of a student with an emotional behavior disability and/or mental illness, we can better assist the student in the educational setting. Participant responses clearly indicated a need for additional training and assistance when presented with challenging cases in the real world. Awareness of these deficits can help teacher education programs and school districts to better train and support their staff.

## Appendices

### Appendix A - Vignettes

**Condition 1:** Next week, Alex Smith will be entering your classroom. Alex has progressed through school with grade level scores on standardized assessment. Previous teachers report Alex is sometimes hard to motivate and sometimes struggles to form relationships with other individuals in the school setting. A review of records indicates Alex is relatively normal in comparison to peers. Alex's favorite part of school is reported as lunch. Alex is currently attending a school in Northern Ohio and is moving into your district due to a parents change in employment and to be closer to family.

**Condition 2:** Next week, Alex Smith will be entering your classroom. Alex has progressed through school with grade level scores on standardized assessments. Previous teachers report Alex is sometimes hard to motivate and sometimes struggles to form relationships with other individuals in the school setting. A review of records indicates this student has been identified as a student with an Emotional Behavior Disorder (EBD) and will have an Individualized Education Plan (IEP). Alex's favorite part of school is reported as lunch. Alex is currently attending a school in Northern Ohio and is moving into your district due to a parents change in employment and to be closer to family.

**Condition 3:** Next week, Alex Smith will be entering your classroom. Alex has progressed through school with grade level scores on standardized assessments. Previous teachers report Alex is sometimes hard to motivate and sometimes struggles to form relationships with other individuals in the school setting. A review of records indicates this student was recently admitted to a psychiatric hospital for two days for unspecified reasons. Alex is currently attending a school in Northern Ohio, is moving into your district after the recent hospitalization, and he is moving into your district due to a parents change in employment and to be closer to family.

## Appendix B – TESSS Rating Scale

Thank you for agreeing to participate in this current research study. The intention of this rating scale is to examine your thoughts about a new student who will be entering your classroom. As you complete the rating scale, you will be asked to indicate your level of agreement with statements concerning a scenario.

### Insert Student Scenario

**DIRECTIONS:** You have just learned that a new student will be added to your classroom. Prior to the student’s arrival, you are given the information stated below from the school counselor. The information provided is limited and may make answering some questions difficult, but please read the scenario and complete the following statement ratings as if this student will be in your classroom next week and this is all you know. Please rate your level of agreement with each statement by selecting (1) Strongly Disagree to (6) Strongly Agree.

### Student Information (Insert one of three scenarios here):

Next week, Alex Smith will be entering your classroom. Alex has progressed through school with grade level scores on standardized assessment. Previous teachers report Alex is sometimes hard to motivate and sometimes struggles to form relationships with other individuals in the school setting. A review of records indicates Alex is relatively normal in comparison to peers. Alex’s favorite part of school is reported as lunch. Alex is currently attending a school in Northern Ohio and is moving into your district due to a parents change in employment and to be closer to family.

<b>Statement:</b>	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Somewhat Disagree</b>	<b>Somewhat Agree</b>	<b>Agree</b>	<b>Strongly Agree</b>
I expect this student will learn new concepts at a rate similar to typical students in my class.	○	○	○	○	○	○
This student will put forth effort on all tasks in class.	○	○	○	○	○	○
I can help this student learn academic and social skills.	○	○	○	○	○	○
This student will behave aggressively toward others.	○	○	○	○	○	○
This student will use independent time appropriately (as defined in our class rules).	○	○	○	○	○	○
This student will verbally participate in class.	○	○	○	○	○	○
It will be difficult for me to move through the core content with this student.	○	○	○	○	○	○
This student will argue or fights with others.	○	○	○	○	○	○

**DIRECTIONS continued:** Based on the scenario on page one, indicate your level of agreement with each statement below.

<b>Statement:</b>	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Somewhat Disagree</b>	<b>Somewhat Agree</b>	<b>Agree</b>	<b>Strongly Agree</b>
This student will respond to redirection within one prompt.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This student will control his behavior by following classroom rules.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This student will not perform to the level of my expectations in my class.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I can effectively implement my training to help this student.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I expect this student to behave impulsively.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have learned how to work with this type of child through experience.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This student will have problems completing work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This student will easily become distracted.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This student would be better taught by a different teacher.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I expect this student will disrupt the learning of others students.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This student will respond to peer aggression by seeking adult help.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I expect this student will have academic deficits.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This student will follow all class rules.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I can fulfill the needs of this student without extra support.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This student will actively try to learn in class.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This student's level of cooperation will interfere with learning.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Demographic Information:**

**DIRECTIONS:** Please answer all questions below to reflect your characteristics and experience.

What are your greatest concerns about working with a child similar to the child in the scenario?

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What kind of training have you had to work with children who have psychological problems?

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	<b>Yes</b>	<b>No</b>
Do you currently have student(s) with psychological problems in your classroom?	<input type="radio"/>	<input type="radio"/>
Have you previously taught students with psychological problems?	<input type="radio"/>	<input type="radio"/>
Are you currently working within a K-12 classroom?	<input type="radio"/>	<input type="radio"/>

How many years have you worked as a teacher in the K-12 school system? \_\_\_\_\_

Please indicate your current age? \_\_\_\_\_

What is the highest level of education you have obtained?

- Bachelors Degree
- Bachelors and Some Graduate School
- Masters Degree
- Masters with Post-Masters Work
- Ph.D. or Ed.D.

Please list your current teaching certifications.

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What is your sex?

- Female
- Male

**Thank you for taking the time to complete this rating scale!**

## **Appendix C: Introductory Email**

Hello,

You are being invited to take part in a dissertation research study designed to assess teacher expectations for a new student entering the classroom. If you volunteer to take part, you will be assisting us to learn more about teacher's expectations. The research will be collected via an internet rating scale that will require 10-15 minute of your time. You will be asked to log onto the internet site below, enter a password, read a scenario about a child, and complete a rating scale. If you decide to participate, you will receive entry into a raffle for one of two \$50 gift cards. We will make every effort to keep private all research records that identify you to the extent allowed by law. This study is anonymous. That means that no one, not even members of the research team, will know that the information you give came from you.

I would like to thank you in advance for your consideration to participate. If you have questions, suggestions, concerns, or complaints about the study, you can contact the investigator, Jamie Roig at [jlsatt2@uky.edu](mailto:jlsatt2@uky.edu). If you have any questions about your rights as a volunteer in this research, contact the staff in the Office of Research Integrity at the University of Kentucky at 859-257-9428 or toll free at 1-866-400-9428.

Thank you,

Jamie Roig, Ed.S.  
Doctoral Candidate  
School Psychology Program, University of Kentucky



## Appendix D: Participation Informational Letters

Dear Respondent,

You are being invited to take part in a research study designed to analyze a rating scale assessing teacher expectations for new students entering the classroom. If you volunteer to take part, you will be one of about 150 people to do so. The person in charge of this study is Jamie Roig (*Principal Investigator, PI*) of University of Kentucky Department of Educational and Counseling Psychology. She is being guided in this research by Tom Prout, Ph.D. (Advisor). By doing this study, we hope to learn if our rating scale measures teachers expectations.

The research will be collected via an internet rating scale that will require 10-15 minute of your time. You will be asked to log onto the internet site, read a scenario about a child, and complete a rating scale. To the best of our knowledge, the things you will be doing have no more risk of harm than you would experience in everyday life.

If you decide to take part in the study, it should be because you want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering. There are no costs associated with taking part in the study.

You will receive entry into a raffle for one of two \$50 gift cards for taking part in this study. We will make every effort to keep private all research records that identify you to the extent allowed by law. This study is anonymous. That means that no one, not even members of the research team, will know that the information you give came from you.

If you decide to take part in the study you still have the right to decide at any time that you no longer want to continue. If you have questions, suggestions, concerns, or complaints about the study, you can contact the investigator, Jamie Roig at [jlsatt2@uky.edu](mailto:jlsatt2@uky.edu). If you have any questions about your rights as a volunteer in this research, contact the staff in the Office of Research Integrity at the University of Kentucky at 859-257-9428 or toll free at 1-866-400-9428.

Thank you,

Jamie Roig  
Doctoral Candidate  
School Psychology Program, University of Kentucky

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