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TEACHER PERSPECTIVES ON ADOLESCENT BEHAVIORS: IMPLICATIONS FOR DEVELOPING A SCHOOL-BASED SCREENING INSTRUMENT FOR EMOTIONAL AND BEHAVIORAL DISORDERS

by

Brittany Linn Schilling

A thesis prospectus submitted to the faculty of

Brigham Young University

In partial fulfillment of the requirements for the degree of

Educational Specialist

Department of Counseling Psychology and Special Education

Brigham Young University

August 2009

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BRIGHAM YOUNG UNIVERSITY

GRADUATE COMMITTEE APPROVAL

of a thesis submitted by

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This thesis has been read by each member of the following graduate committee and by majority vote has been found to be satisfactory.

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BRIGHAM YOUNG UNIVERSITY

As chair of the candidate's graduate committee, I have read the thesis of Brittany Linn Schilling in its final form and have found that (1) its format, citations, and bibliographical style are consistent and acceptable and fulfill university and department style requirements; (2) its illustrative materials including figures, tables, and charts are in place; and (3) the final manuscript is satisfactory to the graduate committee and is ready for submission to the university library.

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ABSTRACT

TEACHER PERSPECTIVES ON ADOLESCENT BEHAVIORS: IMPLICATIONS FOR DEVELOPING A SCHOOL-BASED SCREENING INSTRUMENT FOR EMOTIONAL AND BEHAVIORAL DISORDERS

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Universal screening is an emerging practice in the field of education to provide at-risk students with early intervention services. Currently there is not a universal screener specifically designed for the middle school population. Therefore, the purpose of this study was to obtain junior high and middle school teachers' perspectives on behaviors exhibited by students at risk for emotional and behavioral disorders in order to develop preliminary test items. Several themes were identified from the teachers' perspectives. Teacher perspectives noted that at-risk students displayed a variety of internalizing and externalizing behaviors. These issues included difficulty maintaining peer and teacher relationships, difficulty with hygiene and sleep, challenging home and school relationships, and noncompliant behaviors. From these themes, the researcher created an

initial item pool of 24 items, which can be used for future development of a screening instrument.

ACKNOWLEDGMENTS

There are many persons to thank who have contributed to this thesis and to my journey in writing it. To begin with, I am and will always be indebted to Dr. Ellie Young, my thesis chair, for her patience, her meaningful feedback, and her mentorship. The teachings she has imparted to me over these three years will continue to influence my practice as a school psychologist for years to come.

Next, I would like to thank my committee members. I am beholden to Dr. Paul Caldarella for the hours he dedicated to editing my literature review, which went above and beyond the scope of his position as a committee member. I am similarly grateful to Dr. Fischer for helping to improve my research design and narrow the scope of the project.

I am appreciative to the teachers who gave of their time and insight to contribute to this project. I know they make a difference in the lives of their students. I hope I have given their experiences a voice through this project.

If it had not been for Dr. Fulvia Franco, this project never would have moved forward. It was through her contacts and her willingness to solicit their help on my behalf that the focus groups were scheduled.

I thank my parents, John and Susan, for their encouragement, constant support, and faith in me. They are my biggest fans! I thank my siblings (Ryan, Jordan, and

Cameron) and their families, including my sweet nieces (Ayla, Dahlia, Sofia, and Marley) for their love and support. Lastly, I am grateful to my grandfather and grandmother (Joseph and Elizabeth) for encouraging me to pursue my graduate degree and for cheering me on every step of the way.

TABLE OF CONTENTS

List of Tables

INTRODUCTION

Comprehensive, school-wide screening has come to the forefront of educational discussions. Screening has become an integral part of the Response to Intervention model. Early identification of academic or behavior problems is focusing on providing early intervention services to children and adolescents in the United States. No Child Left Behind (2001) and the Individuals with Disabilities Education Improvement Act (IDEIA, 2004) which was reauthorized in 2004, are two specific governmental acts that have been passed in order to improve students' educational and performance experiences. IDEIA governs how states and public agencies provide early intervention, special education, and related services to more than 6.5 million eligible infants, toddlers, children and youth with disabilities (http://idea.ed.gov/). Currently, most of the special services require extensive documentation regarding educational deficits before recommending that services be provided; this is typically known as the wait-to-fail approach (Glover & Albers, 2007). Recent developments in special education law are attempting to address this inadequate approach by using a response to intervention model, which requires early identification through timely screening. The new method is a multi-tiered intervention approach (Glovers & Albers, 2007). With improved screening measures, it is intended that appropriate services will be provided to students earlier than previously available.

Students who are categorized under the Individuals with Disabilities Education Improvement Act with emotional disturbance (EBD; one of the 13 categories of educational disability) will also benefit from early intervention services (Cullinan & Sabornie, 2004). In order for students to meet the criteria for IDEIA's classification for

EBD, they must exhibit one or more of the five eligibility characteristics over a long period of time and to a marked degree. This disability must also adversely affect a child's educational performance, including inability to learn, relationship problems, inappropriate behavior, unhappiness or depression, and physical symptoms or fears. Once students have met the criteria for IDEIA, they then qualify for special education services. However, students must first be identified as having behaviors that negatively impact their access to the general education curriculum. Typically, these students have experienced a significant amount of educational failure by the time they are identified as a student with a disability (Cullinan & Sabornie, 2004). Prevention efforts are more likely to occur when students are identified as at risk for emotional and behavioral concerns. Prevention efforts can be targeted appropriately when valid screening measures are used to identify youth who need early and timely intervention. Universal screening is designed to provide a means of early identification and intervention for those at risk for academic, behavioral, or emotional difficulties (Glover & Albers, 2007).

Unfortunately there is a lack of EBD screening instruments specifically designed for use in middle school and junior high schools (Lane, Wehby, Robertson, & Rogers, 2007) that are also efficient in both time and cost. Given the need for EBD screening instruments at the middle and junior high school level, a goal of this study was to document behaviors displayed by students with, or at risk for, EBD as identified by middle and junior high school teachers. A second goal was to use these identified behaviors to develop possible items for a new screening instrument that could be used in middle and junior high schools to identify students at risk for EBD

LITERATURE REVIEW

There are numerous negative outcomes that have been associated students with EBD. The following literature review will explain the current literature on negative outcomes associated with students with EBD, new intervention models to provide services for such populations, and how an effective screener might identify students at risk for EBD in order design interventions for these students.

Characteristics of Students with EBD

The terms emotional and behavioral disturbance (EBD) is an educational classification under the U.S. Individuals with Disabilities Education Act (IDEIA, 2004). IDEIA has identified five core elements which may be exhibited by a student with EBD: inability to learn, inability to build and maintain relationships, the presence of inappropriate types of behaviors and feelings, the presence of unhappiness or depression, and a tendency to develop physical symptoms or fears related to school or personal problems. In order for students to meet the EBD criteria, they must exhibit one or more of these five eligibility characteristics over a long period of time and to a marked degree. These characteristics must also adversely affect a student's educational performance. EBD can be divided into externalizing and internalizing behaviors.

Externalizing behaviors. Early work by Horney (1945) classified the dichotomy between externalizing and internalizing behaviors as children either moving against the world (externalizing) or moving away from the world (internalizing). Behaviors that are disinhibited, antisocial, or aggressive in nature are called externalizing behaviors (Kovacs & Devlin, 1998). Externalizing behaviors include noncompliance, defiance, and aggression (Lane, Wehby, & Arwood, 2005). Externalizing behaviors are often disruptive

to other students and make it difficult for teachers to instruct (Lane, Gresham, & Shaughnessy, 2002).

Internalizing behaviors. Conversely, internalizing includes behaviors indicative of anxiety, withdrawal, or depression (McConaughy & Skiba, 1993). Internalizing behaviors and disorders such as overanxious disorder, social phobia, and depression are more prevalent with young teens and adolescents than with younger children, and these internalizing disorders tend to be persistent over time (Ollendick & King, 1994). Internalizing behaviors may be challenging to identify because they are not as overt and readily observable (Merrell, 1999). However, research indicates that teachers are aware of problem behaviors that internalizing students exhibit, even though those behaviors are often less imposing and dramatic than those that students with externalizing behaviors exhibit. Teachers' perceptions of internalizing behaviors still tend to be accurate (Kovacs & Devlin, 1998).

Outcomes for Students with EBD

Because students with EBD experience many negative educational outcomes, early identification and intervention are needed. This is especially true for adolescent students who must negotiate a variety of challenging transitions (Seidman, 1994). Early identification may need to focus on a variety of areas, given the fact that students with EBD often experience difficulties in many areas including academic, social, and emotional.

Academic. Researchers have often found that students with EBD exhibit academic achievement that is not commensurate with their chronological ages. For example, students with EBD have more problems in mathematics and reading than comparable

students without disabilities (Epstein, Kinder, & Bursuck, 1989). Researchers have also determined that in students with EBD in the age groups from ages 9 to 17, 58% were performing below grade level in reading and 93% below grade level in math (Greenbaum et al., 1996). Nelson, Babyak, Gonzalez, and Benner (2003) and Nelson, Benner, Lane, and Smith (2004) documented results from a cross-sectional study in of 150 students in Grades K through 12. Results indicated that high school students with EBD displayed substantial academic deficits in the areas of reading, math, and written language. Another study has reported similar results of low academic achievement among students with EBD. Coutinho (1986) documented academic deficits in the specific areas of reading comprehension and vocabulary among 45 adolescents with EBD, comparing them with same-age peers.

EBD may have more adverse effects on academic achievement over time than learning disabilities. In the realm of academic achievement, students with EBD have a tendency to fail courses more frequently than students without disabilities or students with learning disabilities (Nelson, Benner, Lane, & Smith, 2004). Similar results have been found in another study, which concluded that reading achievement among students with EBD did not improve over time; whereas the students with learning disabilities demonstrated improvement in the five years from intake to follow-up (Anderson, Kutash, & Duchnowski, 2001). Rogevich and Perin (2008) noted that some of the contributing factors regarding the low academic achievement for students with EBD may be externalizing behaviors such as impulsivity, lack of self-control, and aggression; however, it is unclear whether academic difficulties precipitate such behaviors or whether academic difficulties are the result of such behaviors. These factors may contribute to the

tendency for deficits to remain stable or to worsen over time in the area of mathematics (Nelson, Benner, Lane, & Smith, 2004).

Moreover, according to Cullinan and Sabornie (2004), deficits in academic performance and needed behavioral and emotional skills can often lead to trends of suspension, expulsion, and depleted graduation rates associated with students with EBD. For example, from 1991 to 2001, graduation rates for students in all disabilities categories rose in the United States except for students with EBD. As reported by Cullinan and Sabornie, students with EBD had the lowest graduation rate of all the students with disabilities, with only 42% graduating with a standard diploma. In summary, students with EBD frequently experience negative academic outcomes, which often have negative implications for their social outcomes.

Social. Students with EBD spend much of their school day apart from their peers, as over half of students with EBD between the ages of 12 and 17 spend 60% of their day outside of general education classrooms (Cullinan & Sabornie, 2004). Sabornie, Kauffman, and Cullinan (1990) found that adolescents with EBD were more likely to be peer rejected and less likely to be accepted than students without disabilities or students with learning disabilities. Similarly, students with EBD were also found by middle school general and special education teachers to exhibit less peer-preferred social behavior than students without disabilities, which may also be a significant contributing factor to negative social outcomes for such youth (Sabornie, Thomas, & Coffman, 1989). Another study conducted by Schonert-Reichl reports that boys with EBD had less empathy, less frequent contact with friends, and lower quality of peer relationships than their peers without disabilities (1993). For example, systematic playground observations

demonstrated that internalizing students spend 19.3% alone or in parallel play and 78.9% in social interactions with peers (Walker et al., 1998). In contrast, average students spend 8.4% of their time alone or in parallel play and interact with peers approximately 90.2% of the time (Kovacs & Devlin, 1998).

Peers are not alone in their challenging relationships with students with EBD; general education teachers have noted that students with EBD are among the least desirable to have in the general education classrooms (Soodak, Podell, & Lehman, 1998). All of the previous findings support research conducted by Epstein and Sharma (1998), which indicated that students with extensive emotional and behavioral disorders tend to exhibit few personal strengths and social resources.

More specifically, some of the social skills deficits identified in students with EBD may include limited pro-social interactions, tendencies to misinterpret neutral social cues as hostile, and behavioral patterns that impede teachers' abilities to conduct instruction effectively (Lane & Carter, 2006). In a similar manner, about one third of children and youth classified with EBD are reported by their parents to have trouble carrying on a conversation. A total of 44.2% of children at the elementary/middle school level and 29.4% of youth with EBD at the secondary school level have some trouble understanding what others say (Wagner et al., 2005). These data suggest that social skills deficits may be at the heart of many negative outcomes for students with EBD.

Perhaps compounding these students' difficulty in forming peer relationships and friendships may be the fact that students with EBD are more likely than students with other disabilities to have changed schools often; more specifically, about one third of elementary and middle school children classified with EBD and almost twice as many

secondary students (64.5%) have attended at least four schools since kindergarten (Wagner et al., 2005). Many of these school changes may be a result from having been reassigned by their school district to a new school, as EBD students are more likely than other students to be reassigned to a new school by the school district (Wagner et al., 2005). Additionally, students with EBD and students with other disabilities are more likely to have been retained than students in the general population, which may further impact a students' success at forming lasting peer relationships (Wagner et al., 2005).

The socially strained interactions seem to carry over into environments outside the classroom. Bullis, Nishioka-Evans, Fredericks, and Davis (1993) found relationship problems to be common among youth with EBD in work environments. Lane and Carter (2006) assert that it may actually be the lack of critical social, vocational, and self-determination skills that impedes youth with EBD in obtaining and maintaining employment. In addition, these researchers reported that many important adult outcomes such as work, college participation, and community engagement seem to be beyond the grasp of students with EBD. It seems to be a cyclical pattern of underachievement that many students with EBD experience; as they fail to complete high school, they often experience a revolving cycle of contact with the judicial system and remain disconnected from their communities (Lane & Carter, 2006). Students with EBD also experience negative long-term emotional and behavioral outcomes.

Emotional and behavioral. Students with EBD often exhibit or self-report high levels of negative emotion. Among the many varied emotions which many youth with EBD experience, depression ranks high for these students, as 20% of them have reported symptoms associated with depression (United States Public Health Service, 2000). In

1995, Newcomer, Barenbaum, and Pearson determined that adolescents with behavior disabilities were more depressed than peers with no disabilities. In this vein, research has indicated that many adolescents who experience symptoms of depression and moderate levels of distress in early adolescence will eventually become part of the 20% of children and adolescents who experience an episode of major depressive disorder by the age of 18 years (Lewinsohn et al., 1993). In a similar vein, research indicated that students with EBD have reported more suicide ideation and suicidal attempts than their peers without disabilities (Miller, 1994). In terms of anxiety, self-reports from students and teacher reports both confirm that adolescents with EBD were also found to be more anxious than their peers without disabilities (Newcomer et al.,1995). In addition to the negative emotions that students with EBD often report, Cullinan, Epstein, and Kauffman (1984) found results from teacher ratings of emotional and behavioral problems that students with EBD also display greater inappropriate behaviors (e.g., disruptiveness, fighting, disobedience, destructiveness) than their peers without EBD. It may be argued that the negative behavior many students with EBD exhibit may stem from the negative feelings that many of them experience; however, the results of the research is inconclusive (Cullinan, Epstein, & Kaufman, 1984).

Developmental declines for students with EBD also have been reported. Eccles, Lord, and Midgley (1991) report that declines have been documented for such motivational constructs as interest in school, intrinsic motivation, self-concepts and/or self-perceptions, and confidence in their intellectual abilities as students enter the early adolescent years. These declines often follow failure during early adolescence and include negative behavioral characteristics such as test anxiety, learned helplessness,

focus on self-evaluation rather than task mastery, and both truancy and dropping out of school. The negative outcomes for students with EBD are numerous; therefore, it is critical to identify the characteristics that indicate when these students are beginning to exhibit early warning signs so that responsive interventions can be implemented.

Students at Risk for EBD

Determining if a student is at risk for behavioral or emotional concerns involves multiple factors. To begin with, risk can be measured as a function of an individual, an environment, or an interaction between an environment, e.g., a disorder or disability interacting with home or school variables (Adelman, 1982; Fletcher et al., 2002). Furthermore, EBD could be viewed on a continuum, with more normal behavior on one end and formal EBD classification on the other. Being at risk for EBD could thus be defined by negative student outcomes, including academic performance deficits, emotional or behavioral maladjustment, and developmental delay (May & Kundert, 1997; McWirther et al.,1993).

Frequently students who have undergone a loss of support or status are at high risk for developing EBD; for example, students whose parents have recently divorced or died or those who experience a precipitous drop in grade point average (Vander Stoep et al., 2005). Specific behaviors that signal a student may be at risk for the development of EBD are aggression, peer rejection, academic failure, and affiliation with deviant peers (Farmer, Farmer, & Gut, 1999; Ialongo, Vaden, Kiernan, & Kellam, 1998; Kazdin, 1985, 1997; Walker et al., 1995; Walker et al., 1996; Walker et al., 1998), although family, community, and school factors additionally contribute to students being at risk and grade point average alone is not a singular risk factor for EBD.

Moreover, the causes of these negative, long-term outcomes appear to start much earlier than adolescence and may be attributed to specific factors. It appears that the seeds of EBD are often sown in childhood, while only emerging in adolescence. Researchers Conroy, Hendrickson, and Hester (2004) explain this trend:

> When followed longitudinally, Forness and his colleagues (1998) determined that many children displaying significant problem behaviors in early childhood were at high risk for school failure and later being identified as EBD. Campbell (1994) noted that preschool-age children who demonstrate significant problem behaviors have a 50% chance of demonstrating continued problems such as peer rejection, drug abuse, depression, juvenile delinquency, and school dropout during their adolescent years. Indeed, many of these high-risk children are likely to have problems well into adulthood (p. 200).

Given the negative outcomes for students with or at risk for EBD, schools have begun to construct three-tier frameworks to both prevent and intervene with students who display characteristics of EBD. One such framework is Positive Behavioral Support.

Introduction to Positive Behavior Support

The Positive Behavioral Support (PBS) model focuses on addressing systematic issues in schools, to help enact positive change in the areas of discipline, to increase academic performance, and to support social/emotional development (Walker et al., 2005). PBS is a model that integrates both a collaborative and assessment-based approach to creating individualized and systematic interventions for persons or groups with problem behavior (Lucyshyn, et al., 2002). Furthermore, in terms of goals, PBS focuses on creating positive expectations and then teaching those expectations. Teaching these

behaviors is an approach to help students meet the expectations of the educational system (Horner, Albin, Sprague, & Todd, 2000; Koegel, Koegel, & Dunlap, 1996).

An additional focus of PBS is to help parents, teachers, and other caregivers address youth behavior problems at several different levels of intervention (Lucyshyn, et al., 2002). A major construct of the PBS model is a tier system, which categorizes students into one of three tiers that ideally are aligned with a school's continuum of supports and interventions for youth with academic and behavioral concerns (Sprague, Sugai, Horner, & Walker, 1999; U.S. Department of Education, 2000; Walker et al., 1996). More specifically, the first level of supports is referred to as the primary or universal level. Therefore, systems at this level are designed to meet the needs of all students. An example of a primary support is teaching and reinforcing school-wide expectations of all students (Walker et al., 2005). Researchers generally indicate that 80% of students will need no further interventions or supports when systems at this level are positive, consistent, and well established (Horner & Sugai, 2002; Sprague et al., 1999; Sugai & Horner, 1999).

The secondary or targeted level provides specific services and supports for particular students with identified needs. The tier is usually comprised of about 10 to 15% of a school's population, who are considered to be at risk for developing significant emotional, behavioral, or academic problems. Targeted interventions within this tier would include social skills groups, school counseling programs, peer tutoring, and after-school homework clubs (Horner & Sugai, 2002; Sprague et al., 1999; Sugai & Horner, 1999).

Finally, the last level of supports is referred to as the tertiary or individual level and represents about 5% of a student body. Students at this level need more specific, individualized supports such as special education. Other supports may include individualized behavior contracts, systematic functional behavioral assessment and behavior support plans, wraparound services, and Individualized Education Programs (Horner, Sugai, Boland, & Todd, 2004; Horner & Sugai, in press; Sprague et al., 1999; Sugai & Horner, 1999).

However, despite the effectiveness of the three-tiered PBS model, in order for students to be properly included in the correct tier, students must first be identified through a universal screening process. PBS systems should include universal screening to determine needed services and the delivery of a continuum of services matched to the level of support indicated by screening and assessment. Such a screening model has been adapted to school-based programs by a number of researchers and practitioners focused on behavior change and academic improvement (McIntosh, Chard, Boland, & Horner, 2006).

Universal Screening vs. Diagnostic Assessment

School teams are able to respond more effectively if they screen and identify student needs early and carefully match and monitor the supports and interventions that are implemented (Walker et al., 2005). An effective screening system identifies students who are in need of secondary-level interventions, before their behaviors intensify and require tertiary-level interventions (Walker et al., 2005). School-based universal screening includes a consideration of the needs of all students in a school (Severson & Walker, 2002).

There are important differences between screening and diagnosis, with the first difference being the process by which screening is conducted (Severson & Walker, 2002). Diagnostic assessments are often conducted by those who have specific qualifications (e.g., school psychologists, reading specialists) in order to assess the nature of a particular student's academic or behavioral problems, and sequentially provide a diagnosis, which can often be a lengthy and comprehensive process (Satz & Fletcher, 1988). Conversely, universal screeners are usually administered by individuals from a variety of backgrounds to detect a potential need for an intervention or related services (Satz & Fletcher, 1988). Screening instruments are intended to measure constructs broadly and generally indicate if a student has some behaviors of concern that need further assessment or consideration (Glover & Albers, 2007).

School personnel typically use readiness assessments or diagnostic assessments in the school setting (Glover & Albers, 2007). School-based universal screening assessments are generally conducted in the classroom with all students in a school or school district to determine which students could benefit from more individualized interventions (Severson & Walker, 2002). Specialized instruments screen for a wide range of emotional and behavioral problems, syndromes, and diagnoses with greater detail than a broad screening instrument, and consequentially they often require more time to administer (Glover & Albers, 2007). In contrast, diagnostic assessments are administered on an individual basis to determine the nature and extent of students' academic or behavioral problems (Glover & Albers, 2007). Generally, universal screeners focus on the student's behavior or emotions rather than on environmental or cultural risk factors. It appears that broad, universal screeners may be more appropriate

for screening in schools, as research indicates that school personnel prefer time and cost efficient screeners that assess multiple target areas (Glover & Albers, 2007).

Characteristics of Effective Screening Instruments

Reliability. Effective screeners must yield scores that are reliable. In general, reliability refers to the consistency of scores when the testing procedure is repeated on a population of individuals or groups (American Educational Research Association, American Psychological Association, & National Council on Measurement in Education, 1999). Inter-rater reliability is a measure of an individuals' comparable performance on equivalent sets of assessment items, which may be administered at different times, by different individuals (Salvia & Ysseldyke, 2004). In terms of screening, inter-rater reliability is an important characteristic to determine if scores are consistent across scorers. This means that if different teachers rated the same person scores would be consistent. In addition, test-retest reliability is also a desirable characteristic. It is an indicator of how an individual rates on the same screening instrument over time. In summary, it is important in screening to check that measurement is consistent over time (Glover & Albers, 2007).

Validity. In addition to evidence of reliability, it is critically important that a screener yield scores that are valid. Validity is defined as the degree to which the screener measures what it is intended to measure (Glover & Albers, 2007). The process of validation is the accumulation of evidence to provide scientific basis for the proposed score interpretation. The interpretation of test scores required by proposed uses are evaluated, not the test itself (American Educational Research Association et al., 1999). Evidence based on validity is separated into five important types: (a) content, (b)

convergent and discriminant power, (c) internal structure, (d) the relationship with other performances, and (e) assessment consequences, which are divided into criterion-validity, construct validity, and content validity (Glover & Albers, 2007). In context of this discussion, construct validity is the main objective in developing a screening instrument. Construct validity is a determination of whether or not the test accurately measures its intended construct (American Educational Research Association et al., 1999).

Face validity is also important to the screening process. Face validity is a measure of whether the rater or user believes the instrument is effective in measuring what it purports to measure (Vander Stoep, 2005). It is also important to determine if the content is adequate and whether the domains sampled by the instrument are relevant to the screening instrument's purpose (Glover & Albers, 2007).

Moreover, researchers claim that perhaps the most important indicator of a screening assessment's technical adequacy is predictive validity. This type of validity is crucial in determining if a screening instrument will be effective in distinguishing between those who will and will not have subsequent performance or behavior difficulties (Glover & Albers, 2007). Predictive validity is related to the concept of false positives and false negatives discussed below.

Screening instruments and processes are intended to be a wide sweep of the population; hence, some false positives or false negatives may occur. False positives in terms of screening result in students being mistakenly identified as at risk when they are not actually at risk. Conversely, false negatives result in students being mistakenly assumed not to be at risk when in fact they are at risk (Kaufmann, 1999). Vander Stoep et al. (2005) assert that both false positives and false negatives may have some unwanted

outcomes. If a false positive occurs, then unnecessary concern may ensue or some low-level interventions may occur. In contrast, if a student is identified as a false negative then screening may result in unwarranted reassurance when the student may actually need further help, support, or professional attention. Kaufmann (1999) suggests that every intervention program in essence will yield false positives and false negatives, as no screener works in every instance.

Although there are no flawless universal screening systems or instruments, primary prevention is weighted toward false positives, as the intervention is assumed to be no risk or little risk (Kaufmann, 1999). However, unfortunately, as reported by Kaufmann, the American society has a tendency to prefer false negatives to false positives, thus making prevention more costly in both time and resources. Kaufmann further indicated that the educational culture has not yet integrated the value of prevention and early intervention into its systems of service. Kaufmann and others further assert that considering the overwhelming evidence of the underidentification of EBD in children and youth (Costello et al., 1998; Kaufman, 1997; Oswald & Coutinho, 1995), it is very plausible that many students who should be identified are not, thus resulting in a high rate of false negatives (Kauffman, 1999). Although a higher sensitivity of a screening instrument may be associated with higher false positives, there is greater confidence that students who are at risk will not be missed; thus, an effective screener should be weighted more toward false positives (Glover & Albers, 2007).

Developmental appropriateness. According to Vander Stoep and colleagues (2005), universal screening should take place during high-risk developmental periods, which may later inhibit the cognitive, emotional, and social development of young

adolescents. Moreover, research also has indicated that potentially stressful times such as the transition to middle school or from middle school to high school might be timely for universal screening (Vander Stoep et al., 2005). Many organizational and school cultural changes occur during the transitions from elementary to middle school. For example, Berk (2006) explained that middle school students report that their teachers care less about them, stress competition more and mastery and improvement less, are less friendly, and grade less fairly. Berk further indicated that an entry into a new school, in addition to a new teacher and peer expectations, may temporarily interfere with an adolescent's ability to make realistic assessments about their performance.

Furthermore, there are a number of other factors which also contribute to making adolescence a high developmental risk period especially regarding social and emotional issues. For example, adolescents who are highly dissatisfied with their parental relationships tend to be aggressive and antisocial (Berk, 2006). In a similar manner, adolescents who have low self-esteem in academics tend to be anxious and unfocused (Berk, 2006), while those who have negative perceptions of their peer relationships tend to be anxious and depressed (Leadbeater et al., 1999; Marsh, Parada, & Ayotte, 2004).

Cultural and gender appropriateness. In addition to other important characteristics, it is important that screeners are also cultural and gender appropriate. Conroy, Hendrickson, and Hester (2004) asserted that a screening measure needs to be multidimensional, taking into account child characteristics, as well as cultural expectations of the setting in which the students live and learn. Glover and Albers (2007) indicated that in order to make interpretations about a student's risk status, it is important to compare the individual's performance or behavior to a normative sample. A normative

sample is a similar group of peers. These researchers assert that one factor in determining if the norms are adequate is representativeness (i.e., the inclusion of individuals from the relevant gender, age, grade, race, ethnicity, socioeconomic status, geographic location, and disability status). Therefore, a screener with adequate norms is more likely to be culturally appropriate.

Furthermore, in terms of gender, boys are more likely than girls to exhibit academic and behavioral problems, and constitute 80% of the students who are classified with EBD (Wagner et al., 2005). Girls tend to experience difficulties in school transitioning, as their grade point average and self-esteem drops while feelings of anonymity increase after each transition (Berk, 2006). As a screening instrument is developed, the items and the instrument should be broad and far-reaching enough to capture these cultural and gender differences.

Practicality. Glover and Albers (2007) noted that some important pragmatic characteristics in screening instruments include: (a) time required to complete; (b) ease of scoring and interpretation; and (c) acceptability of the information sought to those who will be administering and completing the instrument. In addition, other important characteristics of an effective screener include: (a) compatibility with local service delivery needs, (b) alignment with constructs of interest, (c) theoretical and empirical support, (d) consistency in its measurement, (e) accuracy in its identification of individuals at risk, and (f) population fit.

One of the most important factors contributing to usability of an instrument is cost. Cost (i.e., time to administer and score personnel resources) must not outweigh the benefits (i.e., increased positive outcomes for at-risk students) associated with its

administration (Derogatis & Lynn, 1998; Flanagan, Bierman, & Kam, 2003). A screening instrument should be feasible for users to administer (Glover & Albers, 2007). Feasibility also means that the time required to administer the assessment should be appropriate for school scheduling (Glover & Albers, 2007).

The screening instrument should be appropriate to multiple stakeholders; this includes obtaining buy-in from stakeholders, which may increase the likelihood that an assessment is used over time and that it has meaningful impact on future instruction or service delivery. Equally vital is an infrastructure established to collect, manage, and interpret screening assessment data (Glover & Albers, 2007). It is also important that information afforded from the screening assessment be useful to stakeholders and ideally result in treatment utility (Hayes, Nelson, & Jarrett, 1987).

Research-based content. Additionally, it is essential that a screening instrument's content be supported by current research (Glover & Albers, 2007). Elliott and Busse (2004) asserted that without empirical and theoretical support for an instrument's content, it may be difficult to determine whether it is appropriate for its intended use. It is important to develop evidence by examining relevant literature and conducting logical analyses to evaluate each screening item (American Educational Research Association et al., 1999). Therefore, in developing new potential screening items for EBD, it is necessary that the item pool be consistent with the current research on behaviors displayed by students with or at risk for EBD.

Current EBD Screeners

There are two commonly used methods for universal screening of EBD, which include multi-gate and rating scale approaches. The *Systematic Screening for Behavior*

Disorders (SSBD; Walker & Severson, 1992) is a screening instrument that is considered to be universal because all students in a classroom are considered by the teacher for identification. The teacher writes the names of 10 students with internalizing and externalizing behaviors and then ranks those students. Instruments like the SSBD are particularly useful in that they allow for use of a multi-gated approach (i.e., students pass through more than one stage to be identified) as guided by teacher judgments. As teachers spend a significant amount of time with their students (more than most other adults in the school), they are potentially ideal candidates for identifying students who are at risk. In fact, Walker and Severson stated that teachers are an underutilized resource in assisting in the identification and referral of at-risk students for specialized services. Utilization of standardized screening instruments, such as the SSBD, is an effective procedure to access teacher knowledge of students (Walker & Severson, 1992). However, the multi-gate approach used in the SSBD could take a notable amount of time and resources in secondary school settings, since the instrument is only designed for use in grades K–6, where students typically have one teacher for most of the day; in comparison, secondary students usually have at least seven teachers.

There is another universal screening instrument called the *Student Risk Screening Scale (SRSS;* Drummond, 1993), but like the SSBD it has not been designed for use in middle and junior high schools. The SRSS requires at least five minutes to administer for each student. Screening a class of 25 students, rating each of them so as not to miss a student at risk, would require over two hours to complete. Moreover, the SRSS looks primarily at externalizing symptoms such as stealing, lying, cheating, behavioral

problems, peer rejection, negative attitude, and aggressive behaviors and not addressing important internalizing behaviors.

Summary

There is a significant need for screening instruments for use in middle and junior high schools. Any new screening instruments need to be universal, identify students with internalizing or externalizing behaviors, and result in scores that are reliable and valid. A new instrument also needs to be brief enough that educators consider them acceptable and feasible to use. The purposes of this study were to identify internalizing and externalizing behaviors exhibited by students with or at risk for EBD according to middle school teachers' perceptions, and to generate potential screening items that may be used for universal screening of early adolescent students. Two specific research questions were addressed in this study:

1. What internalizing and externalizing behaviors do middle school teachers identify as most commonly displayed by students with or at risk for EBD?
2. What possible screening items can be generated from the teacher-identified behaviors of students with or at risk for EBD?

METHOD

Research Design

This research project was designed to assemble a potential screening item pool to effectively screen for early adolescent students who may be at risk for emotional and behavioral disorders. The specific research method employed used focus groups to examine teachers' descriptions of internalizing and externalizing behaviors of youth whom they believe might have some factors of emotional and behavioral disorders. A focus group is a systematic discussion planned to elicit perceptions from a relatively homogenous group on a specific, defined topic of interest in a supportive, permissive atmosphere (Kruger, 1998). Focus groups have been used in identifying appropriate content for development of a structured instrument (Cary, 1994; Coˆte´-Arsenault & Morrison-Beedy, 1999; Sim, 1998). This group interview is flexible, relatively inexpensive, efficient, and data rich (Kennedy et al., 2001). Focus groups provide an opportunity for participants to elaborate on others' responses and for researchers to elicit cumulative data from several individuals at one time (Beyea & Nicoll, 2000; Morgan, 1997; Sim, 1998). During the group, participants hear a variety of views, and discussion is stimulated by views shared among participants (Charlesworth & Rodwell, 1997).

Some of the questions addressed internalizing and externalizing behaviors in the classroom. Therefore, a brief definition of these behaviors was given before the questions were posed to the group participants. The researcher used terminology with which the teachers were familiar; the goal of the focus groups was to isolate what teachers perceived as indicators of EBD risk factors. Some questions also addressed what behaviors teachers refer students for additional interventions, usually behavioral or

emotional services. The table in Appendix A illustrates a questioning route used in the focus groups.

Participants

Focus group experts Krueger & Casey (2000) recommended that three to four focus groups be formed, with approximately 4–10 participants in each group. In total, each group had 2–7 participants. The following table indicates the number of participants in each group and their gender:

Table 1

Participant Gender Information

Focus Group	*Female*	*Male*
1	5	2
2	5	2
3	4	0
4	2	0

General education teachers were selected because these teachers work most closely with students in the mainstream and who are usually not receiving interventions. They tend to be the school personnel that are first-responders to the needs of these students. Additionally, the screening instrument that will be designed will be for use in general education settings.

Current research indicates that there is no particular rule about the number of focus group interviews necessary in conducting research. According to Krueger & Casey (2000), the saturation of opinions is the principle for adding or reducing the number of

interviews. Saturation is defined as the point when the range of ideas is similar in each focus group (Krueger & Casey, 2000). After the fourth focus group was completed, the focus group moderator consulted with her thesis advisor to determine whether or not new themes and information continued to emerge and if additional focus groups should be conducted or if the groups had been sufficient. It was determined that while the last focus group enriched the data, there were not new themes emerging from the group that had not already been recorded.

Procedures

Participants, general education teachers in junior high and middle schools, were recruited from the Jordan School District due to the connections the researcher had as a district employee. The Nebo School District was also selected due to an established relationship that the faculty advisors have with this district. Ten letters were sent out in both the Jordan and Nebo School Districts to junior high and middle school principals explaining the purpose of the research and the focus groups. These names were obtained through the Jordan and Nebo School District Web sites after permission was obtained to conduct research in both districts. However, there were no positive responses in the Nebo School District. The procedures in the Jordan School District were determined in collaboration with the school district leadership. One week after the letters were distributed, the researcher made a phone call to the school principals to ascertain interest and availability for their schools' participation in the focus groups. There were no confirmed sites through these phone calls. However, the researcher obtained the name of two principals who were willing to conduct focus groups at their schools. With the principals' permission, the researcher recruited participants through an e-mail message,

posted signs in the faculty room, and visited teachers during their lunch breaks. Upon receiving verbal confirmation of a participant's willingness to participate, an e-mail was sent to confirm the location and time. Two focus groups were conducted in each school for both the junior high and middle schools in the afternoon when school was dismissed. The purpose of this location and time was for the convenience of the participants. Furthermore, an incentive of $25 cash was given to the participants.

The researcher moderated the group, being responsible for directing the discussion and keeping the conversation flowing. There were four different camera operators who ran the recording device and handled the environmental logistics that needed attention. Three of these operators were graduate students in school psychology at Brigham Young University. Once participants arrived, they were asked to sign the consent form that explained the research procedures and risks. The moderator provided a brief introduction before the group began, which included the following points: (a) welcome, (b) overview of the topic, (c) ground rules (or things that which helped discussion go smoothly), and (d) first question.

Data Analysis

The basic components of the interpretive process in this qualitative process were delineated as follows:

1) An unfocused overview of the text through recording procedures, which subjectively captured participants' experiences.
2) The researchers read the transcriptions for further interpretations looking for themes and patterns in order to reveal deeper, emergent concepts in the text.
3) Maintained similar semantics in the themes that teachers used when describing

specific behaviors students at risk for EBD engaged in.

The primary intent in the analysis of the focus group data was to summarize and bring significant meaning to the interviewers' and the researchers' experiences. Interpretation was not the final step in the research process but rather was a part of the research process itself (Seidman, 1998). Therefore, the most common data analysis method in qualitative research uses a simultaneous data collection and data analysis process. Beginning analysis after the first focus group was a technique used to improve data collection; this helped the researchers to determine the effectiveness of the questions posed. The moderator was then able to adapt the question for later groups and perform analysis as the study unfolded (Krueger & Casey, 2000).

The focus groups were videotaped and later transcribed by the researcher. The data were next coded by the researcher to identify themes, patterns, and major ideas, which were related to the research questions. An abridged version of the transcript was made, including only relevant and useful portions of the discussions. This process made the transcript and the analysis concise.

Further analyses were conducted by searching for themes and trends that emerged through the focus groups data. The emergent themes from the focus group data were recorded and condensed into succinct statements. As themes continued to resurface throughout the analysis, notations were made of their frequency and strength, in an attempt to uncover the most pressing, poignant themes. Themes that were continually supported by other focus group data were retained, while themes that did not demonstrate frequency or broad-based support were eliminated. The thesis advisor reviewed the initial findings after the analysis of the first focus group for validity and substantiation in the

research process. Only those themes and trends approved by the thesis advisor were included in the final report. From the themes, 25 initial items were created. These items were brief in nature, in order to use teacher time efficiently. Refer to the next section for the initial items table.

Lastly, in order to provide a reliability check, 6 participants in the focus groups were contacted to review the emergent themes that were recorded in the final report. However, only one participant responded with feedback. She was asked to indicate whether the themes were consistent with her experience in the focus groups. She was also given opportunity to provide open feedback and corrections she felt should be made to verify the themes reported.

RESULTS

The data from the focus groups were analyzed by the researcher and her thesis chair. The names of both the participants and the students they identified were changed to protect confidentiality. Teachers discussed some topics repeatedly throughout the focus groups as factors or behaviors which contribute to students being at risk for EBD. Therefore, themes that answer the research questions were identified according to frequency and strength. The following themes emerged from the data analysis.

Theme 1: Students who are at risk for EBD have difficulty forming relationships with peers. They tend to irritate, annoy, or pester their peers by touching them, tripping them, provoking them, or touching their things.

Respondents identified many externalizing behaviors associated with negative peer relationships including tripping, touching, hitting, touching the objects on their desk, taunting, and provoking other students. Teachers discussed how these students would pester other students repeatedly. Eventually, their peers would become upset and yell at them or demand that they stop. The instigating students would often say, "What?" and claim they had done nothing and refuse to take responsibility for their actions. As a result, other students would not want to be seated near these students.

> Participant 8: He's got a couple of friends in that class that, like they're his buddies, and they're like, we'll say his name is John; they'll say like, "John stop! Just go spit out your gum." They'll encourage him and yet he won't. It's like he does it out of spite. He won't do it, because other people want him to. That's what it appears to be. But um, most of his interactions I've seen have been very immature to other students.

> Participant 16: I would even say throwing things at people. I mean, I know it's not a form of actual touch, but it's to get someone else's physical, you know, attention, throwing things, or hitting their book off the desk, or to arouse somebody else's emotions as they walk by. You know, whether it's positive or

> negative, and it seems that they're not getting the teacher's attention. Then, it becomes, "I need somebody else's attention," and they'll get a student's attention.
>
> Participant 1: Provocative victims. They'll bring abuse on themselves on purpose. Over and over again, they'll irritate the people around them until somebody finally loses their cool and goes after them. He'll end up crying and going out in pain and agony.

The following quote is a conversation between participants discussing students' lack of physical boundaries. Participants discussed how students at risk for EBD often incite their peers by touching other students or their property.

> Participant 15: I do see a lot of the physical like touching though. The kids will go the long way around the room just to go by their friend, and just to hit them. You know like whatever just kind of hit them or whatever they'll do to bother somebody.
> Participant 16: Trip them.
> Participant 15: Yeah trip them.
> Participant 17: Sometimes it's not even a kind of. Sometimes, it's like a full on whack!
> Participant 16: Or I mean just definitely like, what was that? I mean like where did that come from? Whack upside their head, or steal their pencil, or push the other person's books off the desk or touching them or their other property.

For this theme, there appears there may be an underlying issue, that merits recognition. Teachers discussed that students at risk for EBD often formulated peer friendships with those younger than themselves. For example, students in ninth grade would be friends with students in the seventh grade. Teachers indicated that there are developmental differences between students in the ninth grade and students in lower grades; indicating that these students were less mature than other students with same age peers.

> Participant 1: Um, I see him commonly, he's a ninth-grader and I see him commonly hanging out with seventh-graders.
>
> Participant 1: But um, most of his interactions I've seen have been very immature to other students. He had a girlfriend that was a seventh-grader. Not that seventh-

> graders are bad, because I teach seventh-graders too. But maturity wise, they're completely different than a ninth-grader.

Theme 2: Students at risk for EBD also have difficulty forming positive relationships with teachers.

The participants discussed that the teacher-student relationships were often compromised because students would not follow teacher directions, showing defiant and noncompliant behaviors. In other instances, teachers expressed that students were aggressive towards them when they tried to help them or when correcting their behavior. While other students would respond to teacher redirection and intervention, participants reported that these students would lose emotional control when corrected by yelling, refusing to comply with teacher directives, throwing desks, and denying responsibility for their actions.

> Participant 9: I've got all my argumentative and angry and aggressive students, but I also have one student who's in eighth grade, thirteen—fourteen years old…And he—his behavior is kind of the opposite, like he acts almost like a six year-old, where he'll like pout. You know and get really like—like I'll look at him like, "Peter, like you know—seriously?" Like, he'll say something and I'll be like, "Peter you need to raise your hand." "Fine," (crosses arms haughtily across chest). Then, he won't talk, he won't answer a question. He is pouting. He is angry at me. He expresses it by refusing to participate the rest of class because I asked him to raise his hand. I mean something small. But he doesn't argue about it. He just like rolls his eyes and shuts down.

> Participant 4: So when I come over to encourage him to do his work, off the handles, off the rocker; just screaming "No, I won't" and "I wasn't doing anything wrong" and that kind of behavior.

> Participant 4: The constant talking out, talking to other students. And the thing that gets me is they're saying how they've just made a comment, you know inappropriate by that I mean off-task, off-topic. "I wasn't talking. What, what do you mean? Wasn't me." That makes me so irritated when they know they were the ones that were talking, and they have the gall to say, "Well, it wasn't me." Everyone in the class knows it was them, including them. That's what I, I get upset about is them denying it after they act out. That's what I'm trying to say.

> Participant 9: With a student who has emotional behaviors, they feel like it's a conversation between me and them; not me and the class when I am giving instructions. So if I say something to them like, "Alright we're going to watch a movie," it's always, "Well, can, can I do this? Can I…?" It's always me and this person talking and not that you know, be patient, I'm obviously going to address these issues. You know the routine. Everyday I tell you what's going to happen. You know, so it's the shouting out. They think no one else exists; it's just me and them talking in the classroom.
>
> Participant 9: And so that's what a lot of the students that I see having a lot of behavioral issues and emotional problems is that the, and it's just a thirteen-year old thing too (laughs), is that they're so argumentative about it. It's like, "Hey you weren't in trouble. I just said, stop talking. But then you wanted to argue, and you got angry or kicked this or slammed the door and threw your paper down as you were leaving, then it became a problem. You know, then your behavior became unacceptable. Before, I was just telling you to stop." So, I feel…they get very defensive when it wasn't a big deal. You know, a lot of anger.

The following quote is a conversation between participants discussing how students at risk for EBD often form negative relationships with teachers. Such students will ignore their teachers in a passive-aggressive manner to make a statement.

> Participant 2: I also had a student, who would, Oh, for maybe a quarter was mad at me. "Huhm" (crosses arms in perturbed manner), and would just sit here. And like he was mad at me and like, like you know.
> Participant 1: Stare you down.
> Participant 6: Stare
> Participant 2: Stare. You know "I'm just going to sit here, and you can't do anything." And never say anything, but it was, "You can't do anything about it and I'm just going to sit here." And after that didn't work so much, 'cause I don't care if she's mad at me, or not. Then, he had to sleep.

Theme 3: Students at risk for EBD often do not get their basic needs met; they frequently sleep in class and appear hungry.

These various issues included factors such as not getting enough food or adequate sleep. Teachers discussed the challenge of attempting to educate students whose primary needs were not being met and their frustration with this issue. Some teachers described how they became more empathetic towards students who were not academically engaged

when they learned that the students' primary needs of sufficient food and rest were not being met. Teachers said when students were in those circumstances, they were simply happy that they came to school at all.

> Participant 9: And through reading my students journals, it, it doesn't explain their behavior but you kind of see reasons why they are acting the way they are. Um, yeah, I mean horrible, horrible stuff that no human being should have to deal with, let alone a thirteen-year-old you know. And I'm expecting them to act the same way you know that Jane here acts, who has had the perfect life growing up; you know, loving family, food, electricity, and her own bedroom. You know how your other students are sleeping on the couch, dad's being mom, and you know all this horrible stuff. They come to school and they, you know, someone says one thing wrong to them, and they punch them. You know, cause they can't control that, and that's what's being modeled to them at home.

> Participant 9: Coming to school looking like they're just completely tired. I mean it's completely to a point where I don't even wake them up, because they're so out cold. The bell will ring, students will leave, and I have to go wake him up. They come in, they sleep, and I had a student actually say, "Will you wake me up when it's seven, so that I can go get breakfast downstairs?" Like he was just so tired, that he couldn't stay awake, but he wanted to get breakfast, because he was hungry. So I mean, just basic needs that aren't being met at home.

The following quote is a conversation between participants discussing students at risk for EBD sleeping in class. Several participants throughout the focus groups discussed this behavior exhibited by at-risk students.

> Participant 10: Another thing that I've seen in one of my students this year is sleeping; he sleeps a lot.
> Participant 12: Um huh.
> Participant 10: We do book work, we do group work, we do work on the computers, and he, he'll just sleep.

Theme 4: Students at risk for EBD often have parents who are less involved in the students' lives and who communicate on a less frequent basis with the school.

Teachers recounted memories of students whose parents were incarcerated, divorced, or whose attention focused on rebellious siblings. Some teachers recounted incidences when students would approach them one-on-one after class and tell them

difficult circumstances happening at home; this often included the parents divorcing, a sibling causing familial stress, or a parent who was currently in jail. Teachers discussed how these factors seemed to distract students from being able to perform adequately in school. Some students from these family situations acted out while others internalized their feelings.

> Participant 8: Well, he's got some, some history behind him you know; a brother that caused hell and then some. And I think Ryan has had to live through that and see what his brother is going through. And I think that the focus, and you guys tell me if you maybe think I am wrong, I think the focus has been so much on his brother that Mitch has maybe been lost under the; you know, kind of gone under the radar and kind of been lost. And so he's, he's flying under the radar. And his parents are so consumed with his older brother, that I think he gets lost. I don't know if you guys agree?
>
> Participant 3: The boy I'm thinking about is always in trouble. He was just suspended again today for an action yesterday. And he is literally crying out. The interesting thing was when the parent first came in to the last parent-teacher conference she said, "Well maybe if you would do more for him and get him more involved in the class and give him more responsibilities, he'd do some things for you." And I'm like (sighs), "I just need him to do the work." I mean, it's hard when you have forty students or thirty-something students to find special work for him to do just so he'll feel more needed, that kind of thing. But his parents are going through a divorce and she told me. And I honestly believe that he won't make it through to the ninth grade; that he'll drop out before then if it were up to him. He just doesn't care. His whole life I feel like is in such a rollercoaster between his parents, their divorce, and feeling like he's not important anymore in their lives. And what's going to happen to them? What's going to happen to him? He just—the only thing he can do is just get into trouble and take his fear out in inappropriate ways. I worry a lot about this student; that uh eventually, he'll feel like his only option is suicide. And I don't want to see that happen.
>
> Participant 9: An example of one student that we've had, the whole eighth grade team has had issues with. We've been trying to set up a meeting with the parents; the phone's been shut off. The principal's gone to the house. I mean, the student's been in fights; just disrespectful, can't sit still. It's always, I mean he's on (snaps fingers) 24-hours once he's at school. Today we're supposed to have a meeting at three o'clock, and they didn't show for the third time. So, this is the third and fourth time the parents aren't showing up. So, yes we want to hold them accountable for their actions, but how can we expect these kids to—not that I don't expect anything from them. I expect a lot of my students, however, I just

> feel for a lot them now. I'm not as idealistic, as I was when I first came in. Being like, "All my kids are going to succeed." It's like they've got the chips stacked against them from day one. It's, you know, the pull yourself up from your bootstraps kind of stuff.
>
> Participant 8: "Well, you know that poster that said 'my my mom—someone would be sad if their mom were in jail.' He's like, "That was me." And I was really surprised that he shared that with me. And ever since then, I've just watched him. My eyes were opened, and I could just maybe understand where he's coming from. He doesn't do any of his work ever. He's in my class this semester. He's probably been there three days—four days. And when he comes, he doesn't do anything.
>
> Participant 9: And no one's asking him what he's angry about and no one's listening to him. And like he needs someone, he needs an adult he can go to that he trusts, that he's going to be around long enough to like forge a relationship where he can like actually open up to someone. I feel like he had major trust issues; had a whole wall around him and it was him against the world. I mean bouncing from mom to dad from this state to that state.

The following quote is a discussion among participants regarding students at risk for EBD pushing boundaries. The participants indicated that such students are not disciplined at home, so they push the boundaries with their teachers.

> Participant 9: Well, their parents won't discipline them, so we have to.
> Participant 12: So we, so kids are pushing, and pushing, and pushing, until they find someone who finally says, "I love you enough to say stop," (group members agree).
> Participant 12: And I do care enough for you to say, "We're done."

Theme 5: These at-risk students frequently engage in internalizing and externalizing behaviors.

Unusual internalizing behaviors such as cutting, maintaining poor hygiene, refusing to speak, crying, appearing sad, and speaking negatively about themselves, make internalizing students stand out from their peers. Teachers discussed how students who internalize often fly under the radar, as opposed to externalizing students, who usually demand more attention.

> Participant 1: Some do a mild form of cutting in class. I mean, they'll take a safety pin and repeatedly do that (Participant 1 moves hand over opposite arm). And, and it's a form of cutting, but they can get away with it in class, because it's just a safety pin or even the back of an earring. They'll just sit and scratch, and scratch, and scratch, until they get a line, and then they'll do another one and another one.
>
> Participant 12: Oh, my gosh! They're hiding behind their hair! That has become so big these last few years. They just want to disappear behind their hair. It's the strangest thing. We call it the Utah surfer look, but literally, "I don't want to be seen." I know part of that is normal adolescent development, where you're not even comfortable in your own skin yet. But, you can just tell when those kids are hiding behind their hair there is something going on, and they're not going to talk about it.
>
> Participant 16: Using very depressing or depressed language. Or they're talking very negatively about themselves or negatively about life. Or maybe you don't see a lot of the signs of cutting or any of that stuff, but they have that thought process. Once again, go with consistency on that, because sometimes kids like to test the waters on your response and see how you respond to that, or look for you to say things like, 'What? No!" and then they kind of giggle go on to something else. If I saw consistency in, in those feelings and emotions, I would mention something.
>
> Participant 10: Crying, um, the girls, they, there's a lot of crying. And this was a couple of years ago, when I had a couple of girls that one day it was one or the other, that were always crying. I tried to talk to them, and it would seem like, at the time, looking individually at them, it seemed like, why are you getting so upset over it? But, then when I found out more about the background, it's like ok, I'm glad you're here at school. And so crying is definitely a big one that I see in the girls.

The following quote is a conversation among participants discussing a particular student's affect. Participants indicated that some students at risk for EBD had sad affects or appeared suicidal.

> Participant 8: He looks sad to me.
> Participant 9: Yeah.
> Participant 8: That was my comment before. I think they just look sad.
> Participant 11: He's, he's uh.
> Participant 12: And unkept. He looks like he could end it.
> Participant 9: Yeah, soon. He looks (shaking his head up and down)…we don't have any proof.

> Participant 11: He looked to me some days, I don't know. Just from—he looks suicidal some days, because he, he's got so much baggage it's unbelievable.

The following quote is a conversation among participants discussing the physical appearance of students at risk for EBD. Participants indicated that students at risk for EBD have poor hygiene and grooming habits.

> Participant 8: Parks (Participant 11) and I can tell you about him, because Parks made the comment when he first walked in, "That kid looks horrible." He stinks…I'm sorry, I don't mean to be rude, but he stinks. Um, he really needs a shower. He's got the long curly black hair.
> Participant 11: Matted, ugly, he needs a good hair cut.
> Participant 8: Matty. Acne, really bad and never says a word.
> Participant 12: Hides, hides.
> Participant 11: He hides.
> Participant 8: He's a good example.
> Participant 11: You know, you were talking about the hiding of the hair?
> Participant 12: There's our Brad.
> Participant 11: That's him. I don't think he's said two words all year.

The following quote is a conversation among participants discussing how students at risk for EBD often refused to speak in class. Some at-risk students completed basic work, but refused to participate most of the time.

> Participant 13: What about Brad Nielsen?
> Participant 12: Oh, he's another one.
> Participant 8: He's a good example.
> Participant 13: He came into my class—never said a word, unless I forced him to talk or I had to ask him a question. Other than that, never said a word; didn't talk to other kids in the class; just sat there. Pulled off a C, so basic work, but (shakes head back and forth).

Teachers discussed that students' externalizing behaviors are distracting to other students and frustrating to the instructor. Teachers recognized that some of the externalizing behaviors are likely related to students' low academic skills. Teachers admitted that externalizing students often occupied more of their time, because their

behaviors were so inappropriate. Some externalizing behaviors include vulgarity, profanity, sexual harassment, and explosive anger.

> Participant 15: One thing I've noticed too about my student that I was thinking about. A lot of his comments are very vulgar; very inappropriate in that sense that they're very vulgar. And manipulates words.
>
> Participant 9: Lots of hate language with him, and I've talked about that. Racial slurs, homophobic terms; even, you know, certain religions; certain words that he says that are not acceptable or not allowed in my classroom. It's been repeated. So, I've trapped it and it's not stopping. What do you do? And you know it's really frustrating as his teacher, because I am trying, but I've got a hundred and thirty some kids that come through every day. And this kid's definitely slipping through the cracks.
>
> Participant 20: I mean, sexual harassment too, where he'd kind of motion to his (motions to pelvic area) genitals and say certain things. And I can't remember exactly what he said, so I can't give him a quote. Something like, "Yeah right here," (pointing again to pelvic area) kind of pointing to himself. I'd just be like (shakes head), you know. Then, I'd, you know, ask him to leave and it would be "F*** you bitch," this and that and this.
>
> Participant 19: And he, the next thing I heard was the F bomb. And that word makes me angry, and so I and I don't get angry. It just frustrates me. And so I said to this student, "Please go stand in the hallway. I'll come talk to you in a minute." And he starts to freak out. So I go out and talk to him in the hallway, and he's got that same anger (snaps fingers). That first initial—he's like, "You're telling me this is crap. You're not going to…? They said this to me." I said, "Jacob, I didn't hear that. All I heard was that you said these choice words. I didn't say them. I said, "You said these words that aren't acceptable in my classroom." And he got very angry, very quickly.
>
> Participant 20: He—I've never had a student like him before. To the point where I went and talked to the counselor first hand and said, "something is not right." It got to the point, he called me a bitch in class. When I said, "Tyler sit up," he goes, "What?" like that and would get in my face (jerks body forward and moves hand toward self). Like physically getting in my space to the point where I went and spoke to my principal and said, "I don't feel safe in the classroom with him. He's the same size as me—bigger than me." He—there is no fear in him whatsoever. And he gets so angry that he cannot control himself.

Theme 6: Students at risk for EBD often display a pattern over time of internalizing or externalizing behaviors or demonstrated an abrupt, negative change in their behavior.

Teachers discussed how middle and junior high school students were very hormonal and emotional. They concluded that they were able to differentiate between those students who had a natural flux of hormones or emotions and those who were at risk for EBD by the frequency and duration of their behavior. Students who were at risk often displayed patterns of internalizing or externalizing behaviors over time. Some students exhibited extremes in behaviors or moods daily or hourly. Conversely, other students had a sudden, abrupt change in behavior. For example, a student earning average grades all year suddenly begins flunking their classes.

> Participant 8: It's always—like it could be, how's he doing today? When he walks in you know if it's going to be a good day with him or if he's going to be sleeping or completely out of control. And I feel like that's kind of the extremes too with these students. Either they come in and they're just dead to the world sleeping like they've had a rough night at home, who knows what happened. Or they come in and it's just like you know the 'Hugh show' for 45 minutes.

> Participant 3: Repeated behaviors. You can see all this stuff from most kids sometime. But, it's when it's repeated and it doesn't change. You can try different things and it doesn't change. And it's not just with you that they're having the same problem. But as he or she goes through the day, they have the same problem.

> Participant 17: Yeah, I think sometimes, and this goes kind of back to the extremes, we look at kids who are either consistently a problem, or sometimes there's the kid who like goes from like um perfect little angel child to the next day is a little devil (laughs). And it's like, what happened to this kid? And it's very inconsistent. And I think that sometimes that can mean, it can show either something has happened recently that a child has reacted to or something's been going on all along and some days are just better than others for this kid. But I have a student who was in honors citizenship an A student one quarter and then totally failed and blew it the very next quarter like within you know within a week's time just totally about-face. And come to find out later that some serious things had happened in his personal life, and he just fell apart, which is really sad.

The following quote is a conversation among participants regarding patterns of negative behavior displayed by students at risk for EBD over time. Participants explained that they would look for patterns over time, because sometimes middle school students just might have had a bad week. However, if patterns of negative behavior became imminent over time, participants knew there was a problem.

> Participant 13: Or the kid who is constantly out of his seat or constantly making the disruptions. You know, you got to give it a period of time. Maybe you know two weeks or something. And if that happens almost every single day, that's when we should start looking at it. You know, but as middle schoolers, maybe one week, they're having a bad week at home.
> Participant 12: Right.
> Participant 13: That might not be, uh something to send them down for. But if we start to see that, you have them all year long or the whole semester, you should start noticing these things.
> Participant 12: You notice a pattern.

Summary

The themes themselves are not separate entities, but rather, they are interconnected. Students who have difficulty forming relationships with their peers often engage in internalizing and externalizing behaviors in order to antagonize peers or separate themselves from their peers. Those who are unable to relate to their same age peers may then form friendships with younger peers. In a similar manner, students who engage in internalizing and externalizing behaviors have difficulty forming relationships with their teachers. These students' academic performance is compromised when they engage in these behaviors and therefore teachers get frustrated with these students, their low performance, and how distracting they are to other students. In a cyclical manner, students do not respond to teacher interventions and continue to fall farther and farther behind in their work. As they fall farther and farther behind, they are more likely to

engage in internalizing and externalizing behaviors to avoid their work, since they do not have the academic skills to perform the required work. Moreover, when students have parents who are less involved in their son's or daughter's education teachers feel that there is little accountability for students to perform at school. Moreover, students who are not getting their basic needs met at home of sleep and food are usually not able to keep up academically, because there is so much going on at home, they come to school tired and hungry. As a result, teachers often feel that the students need more than teachers are qualified to give them (i.e. therapy, residential treatment care). Therefore, each of these themes is interwoven with the other themes, creating a picture of what a student at risk for EBD may be like.

Preliminary Items

The researcher created 24 initial items, with 2–4 items being formed from each theme. The items have not been refined or tested. The researcher attempted to retain the same semantics the teachers used to describe student behaviors. The following list is a summary of the initial items:

- Irritates, annoys, or pesters other students
- Touches others' belongings
- Chooses mostly friends who are younger than himself/herself
- Provokes other students to anger
- Refuses to follow teacher directions
- Uses verbal or physical aggression towards the teacher
- Touches objects on other students' desks
- Denies responsibility for actions
- Yells in class
- Comes to school hungry
- Parents are non-responsive to phone calls

- Parents do not come or come late to meetings
- Parents appear unavailable to student
- Sleeps in class
- Cuts himself/herself or has cuts on body
- Hair often covers student's eyes and student seems to be "hiding behind hair"
- Appears sad
- Refuses to work in a group
- Completes little or no class work
- Uses profanity or vulgarity in class
- Sexually harasses teacher or peers
- Displays uncontrollable anger
- Shows sudden changes in behavior
- Exhibits a pattern of negative behavior over time

DISCUSSION

This study assessed middle school and junior high school teachers' perspectives on externalizing and internalizing classroom behaviors associated with students at risk for EBD. Focus groups were used to obtain teachers' perspectives on student externalizing and internalizing behaviors. Teachers' perspectives were sought as part of a process of developing a measure to develop a school-wide screening process to identify these at-risk students. Knowing the types and general categories of behaviors which teachers frequently observe in students they believe may be at risk for EBD is the first step in developing this screening instrument. Teachers' perspectives are important because students' at-risk behaviors are frequently observed in schools. Teachers also observe a wide range of behaviors in students and are reliable sources of information about youth (Severson & Walker, 2002). Furthermore, teachers come into contact with large numbers of students daily. For example, teachers may see 30 students an hour, which is a large base rate for understanding at-risk behaviors. Therefore, they are ideal candidates to participate in universal screening for students.

Themes Related to EBD At-Risk Behaviors

Teachers identified several categories of behaviors, which they associated with students being at risk for EBD. Although many different behaviors and scenarios were discussed across the four focus groups, specific overarching themes surfaced, which were consistent with previous research. The themes addressed a wide variety of behaviors but tended to align nicely into meaningful categories.

First, teachers described students who are at risk for EBD having difficulty forming relationships with peers. The at-risk youth tend to irritate peers, solve problems

aggressively, and act like provocative victims. Second, these students have difficulty forming positive relationships with teachers. They often respond defiantly to teacher requests, refuse to do their work, and lose control of their emotions in class. These students also tend to claim they are the victims when they are given an academic or behavioral request or when they are disciplined for their negative behavior. Moreover, participants across several focus groups identified out of school issues being a factor that negatively impacted students' education. These issues include parents' divorce, parents' unavailability to work with school personnel, inconsistent home settings, siblings with difficult behaviors, and poor home to school communication. Many teachers who had taken interest in a student and discovered more about their home life understood the child's behavior at school. Teachers discussed that they understood better why students struggle when having home life problems.

Next, students at risk for EBD often engage in externalizing and internalizing classroom behaviors, which negatively impact their educational performance. Students who externalize engage in disruptive behaviors such as, touching or tripping others as they walked by, calling others names, using profane language, calling out in class, and calling others names. Teachers discussed that internalizing behaviors were less overt, making interventions challenging for teachers. Internalizing behaviors included having a depressed or sad affect, wearing their hair in their eyes, cutting themselves, refusing to speak in class, and crying.

While most of the behaviors discussed in the focus groups centered on externalizing behaviors, internalizing behaviors were not frequently mentioned by the teachers unless prompted by the moderator. Therefore, fewer internalizing behaviors

emerged from the focus groups. There could be a few hypotheses about this outcome. The literature about externalizing and internalizing behaviors indicates teachers notice externalizing behaviors more due to the fact that they are often attention-seeking in nature (Merrell, 1999). Participants discussed the idea that students who internalize "fly under the radar." It is possible that if the researcher had given a more explicit definition of internalizing behaviors, then participants would have discussed them more fully. These descriptions may have included anxiousness, somatization, and depressive characteristics.

Another interesting idea emerged from the data; teachers reported that it was difficult to refer to the school psychologist or a school counselor because teachers perceived the students' issues were beyond the capacity of the staff to intervene or that the support staff was extremely busy, with an overwhelming caseload. Some teachers appeared frustrated with having to fill out several referral forms that resulted in little or no changes in the students' behavior. These teachers claimed they felt the professionals to whom they referred students were ineffective. Other teachers mentioned that they thought some students needed individualized, outside therapy to help them make important changes in their lives.

Additionally, several teachers discussed frustration with the accommodations they were given to simply put a student in the front row, give them more time, or read things out loud. Teachers explained that they did not feel adequately trained to make accommodations for students' emotional needs, as they are not trained therapists.

Connections with Current Research Literature

Teachers' responses and the emergent themes were largely consistent with the current research on at-risk behaviors. As noted earlier, externalizing behaviors are

disinhibited, antisocial, or aggressive in nature (Kovacs & Devlin, 1998). Many of the externalizing classroom behaviors identified by teachers were disinhibited, antisocial, or aggressive towards their peers or teachers, thus impeding their ability to form meaningful relationships with others at school. Teachers discussed students not having any friends, always bothering other students in class by touching their things as they walk by, making annoying noises, or tripping other students. Many teachers admitted to having difficulty forming relationships with such students, as students would often fly off the handle when teachers asked them to do something.

Furthermore, teachers identified internalizing behaviors, which were consistent with those described in the literature as overanxious, social phobia, and depression (Ollendick & King, 1994). Specific internalizing behaviors teachers identified included sleeping in class, rarely speaking, cutting themselves, reflecting a sad affect, hiding behind their hair, or refusing to complete classroom work. Teachers admitted that these behaviors tend to be less attention-seeking in nature, and therefore generally elicit little direct attention from the teacher.

Moreover, results in this study confirm research regarding students at risk for EBD having negative academic outcomes (Epstein, Kinder, & Bursuck, 1989; Greenbaum et al., 1996; Nelson et al., 2003; Nelson et al., 2004). Teachers discussed students having difficulty turning in work, talking with other students when they are expected to be doing their work, refusing to participate in group work, never speaking in class, and getting easily frustrated with assignments or teacher directives. Additionally, teachers discussed students' apparent difficult home lives. It appears that the quality of their class work suffered due to absences, lack of sleep, and other difficulties at home.

Limitations

One limitation was the limited sample pool from which the participants were drawn. All of the participants were teachers from the Jordan School District in Salt Lake City, Utah. While principals in the Nebo School District were also contacted, none were contracted for participation. It was a convenience sample that was homogenous in nature, consisting of mostly Caucasian females. This may have limited the participants from including a multicultural and non–gender-biased perspective. It also may have influenced how the teachers perceived the behaviors of diverse students. The behaviors of students with culturally different backgrounds may have been interpreted as difficult behaviors when the behaviors may have been culturally appropriate.

Additionally, the moderator at times interchanged the terms “with EBD” and “at risk for EBD” during the focus groups’ discussions. The interchange of these terms may have caused some confusion to the participants. The research questions were intended to access knowledge about students at risk for EBD and therefore should have always been framed that way.

Lastly, in the second focus group the camera operator was a school psychologist on staff at the school where the focus group was conducted. This may have been a conflict of interest for her to film the groups. Participants may not have felt comfortable expressing their opinions about making referrals to the mental health professionals when she was present. This may have limited the data in that particular focus group. This potential conflict of interest was avoided after the second focus group.

Suggestions for Future Research

This research project was conducted with the expectation that this data would be used to develop potential test items to be used in creating a screening instrument for identifying youth at risk for behavioral and emotional disorders. As previously discussed, entering middle and junior high schools can be a difficult transition for youth (Eccles, Lord, & Midgley, 1991). An age-appropriate screener would facilitate improved identification of students at risk for EBD. The next steps in test development involve forming current themes into items, refining those items, and contacting experts to evaluate their validity. Future researchers will additionally define the instruments' internal and external structure.

Furthermore, additional topics arose in the focus groups that may be helpful for further study. Teachers discussed their frustration with the system in their schools of receiving notices of students' needs and necessary accommodations late in the school year. Teachers discussed that they were not able to help the students until they themselves determined that a particular student probably had a disorder of some sort. Other teachers complained that the accommodations they were asked to make were all generally the same: seat them in the front row. They discussed that there were not enough individualized accommodations shared through the consultation with school psychologists, counselors, or other professionals in the school.

Another potential topic of future study is the lack of mental health personnel (school psychologists, school counselors, social workers) per student ratio in the schools. Many teachers indicated that they rarely referred students because the school psychologists were too busy or not helpful, or because they thought that the students

really needed outside therapy. Some teachers indicated that they would refer for self-harm or harm to others, but they generally would not refer for other reasons.

Summary

The study was conducted to access teachers' perspectives on students' at-risk behaviors for EBD. Results indicated that teachers saw several behaviors they identified as being at risk for EBD. Themes identified were consistent with current research about internalizing and externalizing behaviors manifested by students at risk for EBD. A practical implication of this study is to add to the richness of the existent literature on teachers' perceptions of student behaviors associated with EBD.

REFERENCES

Adelman, H. S. (1982). Identifying learning problems at an early age: A critical appraisal. *Journal of Clinical Child Psychology, 11,* 255–261.

American Educational Research Association, American Psychological Association, & National Council on Measurement in Education. (1999). *Standards for Educational and Psychological Testing.* Washington, DC: Author.

Anderson, J. A., Kutash, K., & Duchnowski, A. J. (2001). A comparison of the academic progress of students with EBD and students with LD. *Journal of Emotional and Behavioral Disorders, 9,* 106.

Bennett, K. J., Lipman, E. L., Brown, S., Racine, Y., Boyle, M. H., & Offord, D.R. (1999).Predicting conduct problems: Can high-risk children be identified in kindergarten and Grade 1? *Journal of Consulting and Clinical Psychology, 67,* 470–480.

Berk, L. E. (2006). *Child Development* (7th ed.). Boston: Allyn & Bacon.

Beyea, S. C., & Nicoll, L. H. (2000). Learn more using focus groups. *AORN Journal, 71,* 897–900.

Bullis, M., Nishioka-Evans, V., Fredericks, H. D., & Davis, C. (1993). Identifying and assessing the job-related social skills of adolescents and young adults with emotional and behavioral disorders. *Journal of Emotional and Behavioral Disorders, I,* 236–250.

Campbell, S.B. (1994). Behavior problems in preschool children: A review of recent research. *Journal of Child Psychology and Psychiatry, 36,* 113–149.

Carter E. W., Lane K. L., Pierson M. R. & Glaeser B. (2006). Self-determination skills and opportunities of transition-age youth with emotional disturbance and learning disabilities. *Exceptional Children, 72*(3), 333–346.

Cary, M. A. (1994). The group effect in focus groups: Planning, implementing, and interpreting focus group research. In J. M. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 225–241). Thousand Oaks, CA: Sage.

Charlesworth, L. W., & Rodwell, M. K. (1997). Focus groups with children: A resource for sexual abuse prevention program evaluation. *Child Abuse & Neglect, 21*, 1205–1216.

Cheng, Kai-Wen. (2007). A study on applying focus group interview on education. *Reading Improvement, 44*, 194–198.

Conroy, M. A., Hendrickson, J. M., & Hester, P. (2004). Prevention and intervention of emotional/behavioral disorders in young children. In R. Rutherford, S. Mathur, & M. Quinn (Eds.), *Handbook of research in behavioral disorders* (pp. 199–215). New York: Guilford Press.

Costello, E. J., Messer, S. C., Bird, H. R., Cohen, P, & Reinherz, H. Z. (1998). The prevalence of serious emotional disturbance: A re-analysis of community studies. *Journal of Child and Family Studies*, 7, 411–432.

Coˆte´-Arsenault, D., & Morrison-Beedy, D. (1999). Practical advice for planning and conducting focus groups. *Nursing Research, 48*, 280–283.

Coutinho, M. (1986). Reading achievement of students identified as behaviorally disordered at the secondary level. *Behavioral Disorders, 19*(4), 200–207.

Cullinan, D., Epstein, M. H., & Kauffman, J. M. (1984). Teachers' ratings of students'

behaviors: What constitutes behavior disorder in school? *Behavioral Disorders, 10,* 9–19.

Cullinan, D., & Sabornie, E. (2004). Characteristics of emotional disturbance in middle and high school students. *Journal of Emotional and Behavioral Disorders, 12,* 157–167.

Derogatis, L. R., & Lynn, L. L. (1998). Psychological tests in screening for psychiatric disorder. In M. E. Maruish (Ed.), *The use of psychological testing for treatment planning and outcomes assessment* (2nd ed.) (pp. 41–79). Mahwah, NJ: Erlbaum.

Drummond, T. (1993). *The student risk screening scale (SRSS)*. Grants Pass, OR: Josephine County Mental Health Program.

Eccles, J., Lord, S., Midgley, C. (1991). What are we doing to early adolescents? The impacts of educational contexts on early adolescents. *American Journal of Education, August,* 521–542.

Edgar, E. (1987). Secondary programs in special education: Are many of them justifiable? *Exceptional Children, 53,* 555–561.

Elliot, S. N., Haui, N., & Busse, R. T. (2004). Assessment and evaluation of students' behavior and intervention outcomes: The utility of rating scale methods. In R. B. Rutherford, M. M. Quinn, & S. R. Mathur (Eds.), *Handbook of research in emotional and behavioral disorders* (pp. 123–142). New York: Guilford Press.

Epstein, M. H., Kinder, D., Bursuck, B. (1989). The academic status of adolescents with behavioral disorders. *Behavioral Disorders, 14,* 157–165.

Epstein, M. H., & Sharma, J. (1998). *Behavioral and emotional rating scale: A strength-based approach to assessment.* Austin, TX: Pro-Ed.

Farmer, T. W., Farmer, E. M. Z., & Gut, D. (1999). Implications of social development research for school based interventions for aggressive youth with emotional and behavioral disorders. *Journal of Emotional and Behavioral Disorders, 7,* 130–137.

Flanagan, K. S., Bierman, K. L., & Kam, C. M. (2003). Identifying at-risk children at school entry: The usefulness of multibehavioral problem profiles. *Journal of Clinical Child and Adolescent Psychology, 32,* 396–407.

Fletcher, J. M., Foorman, B. R., Boudousquie, A., Barnes, M. A., Schatschneider, C., & Francis, D. J. (2002). Assessment of reading and learning disabilities: A research-based intervention-oriented approach. *Journal of School Psychology, 40,* 27–63.

Forness, S. R., Ramey, S. L., Ramey. C. T., Hsu, C., Brezausek, C. M., MacMillan, D. L., Kavale, K. A., & Zima, B. (1998). Head Start children finishing first grade: Preliminary data on school identification of children at risk for special education. *Behavioral Disorders, 23,* 111–124.

Gerber, M. M., & Semmel, M. I. (1984). Teacher as imperfect test: Reconceptualizing the referral process. *Educational Psychologist, 19,* 137–148.

Glover, T., & Albers, C. (2007). Considerations for evaluating universal screening assessments. *Journal of School Psychology, 45,* 117–135.

Goodman, R. (1997). The strengths and difficulties questionnaire: A research note. *Journal of Child Psychology and Psychiatry and Allied Disciplines, 38,* 581–586.

Greenbaum, P. E., Dedrick, R. F., Friedman, R. M., Kutash, K., Brown, E. C., Lardierh,

S. P., et al. (1996). National adolescent and child treatment study (NACTS): Outcomes for children with serious emotional and behavioral disturbance. *Journal of Emotional and Behavioral Disorders, 4,* 130–146.

Hayes S. C., Nelson, R. O, & Jarrett, R. B. (1987). The treatment utility of assessment: A functional approach to evaluating assessment quality. *American Psychologist, 42,* 963–974.

Horner, R. H., Albin, R. W., Sprague, J. R., & Todd, A. W. (2000). Positive behavior support. In M. E. Snell & F. Brown (Eds.), *Instruction of students with severe disabilities* (5th ed) (pp. 207–243). Upper Saddle River, NJ: Merrill.

Horner, R., & Sugai, G. (in press). School-wide behavior support: An emerging initiative. Journa*l of Positive Behavioral Support*.

Horner, R., Sugai, G., & Gresham, F. (2002). Behaviorally effective school environments. In M. R. Shinn, H. M. Walker, & G. Stoner (Eds.), *Interventions for academic and behavior problems II* (pp. 315–350). Bethesda, MD: National Association of School Psychologists.

Horner, R. H., Todd, A. W., Lewis-Palmer, T., Irvin, L. K., Sugai, G., & Boland, J. B. (2004). The School-Wide Evaluation Tool (SET): A research instrument for assessing school-wide positive behavior support. *Journal of Positive Behavior Interventions, 6, 3–12.*

Horney, K. (1945). *Our inner conflicts*. New York: Norton.

Ialongo, N. S., Vaden-Kiernan, N., & Kellam, S. (1998). Early peer rejection and aggression: Longitudinal relations with adolescent behaviors. *Journal of*

Developmental and Physical Disabilities, 10, 199–213.

Individuals with Disabilities Education Improvement Act of 2004. Retrieved May 31, 2008, from http://idea.ed.gov.

Jenkins, J. R. (2003, December). *Candidate measures for screening at-risk students.* Paper presented at the NRCLD Responsiveness To Intervention Symposium, Kansas City, MO.

Johnson, B., Christensen, L. (2004). *Educational research: quantitative, qualitative, and mixed approaches* (2nd ed.). Boston: Pearson Education.

Joseph, D. H., Griffen, M., & Sullivan, E. D. (2000). Videotaped focus groups: Transforming a therapeutic strategy into a research tool. *Nursing Forum, 35,* 15–20.

Kauffman, J. M. (1997). Characteristics of emotional and behavioral disorders of children and youth (6th ed.). Upper Saddle River, NJ: Prentice-Hall.

Kauffman, J.M. (1999). How we prevent the prevention of emotional and behavioral disorders. *Exceptional Children, 65,* 44–48.

Kauffman, J. M. (2005). *Characteristics of Emotional and Behavioral Disorders of Children and Youth* (8th ed.). Columbus, OH: Pearson Merrill Prentice Hall.

Kazdin, A. E. (1985). *Treatment of antisocial behavior in children and adolescents.* Homewood, IL: Dorsey Press.

Kazdin, A. E. (1997). Conduct disorder. In R. J. Morris & T. R. Krathwill (Eds), *The practice of child therapy* (3rd ed.) (pp. 199–270). Boston: Allyn & Bacon.

Kennedy, C., Kools, S., & Krueger, R. (2001). Methodological considerations in children's focus groups. *Nursing Research, 50,* 184–187.

Koegel, L.K., Koegel, R.L. & Dunlap, G. (Eds.) (1996). Positive behavioral support: Including people with difficult behavior in the community. Baltimore, MD: Paul H. Brookes.

Kovacs, M., & Devlin, B (1998). Internalizing disorders in childhood [electronic version]. *The Journal of Child Psychology and Psychiatry and Allied Disciplines, 39*(1), 47–63.

Krueger, R. A., & Casey, M. A. (2000). *Focus group—a practical guide for applied research.* Thousand Oaks, CA: Sage.

Krueger, R. A., & King, J. A. (1998). *Involving community members in focus groups.* Thousand Oaks, CA: Sage.

Lane, K. & Carter, E. (2006). Supporting transition-age youth with and at risk for emotional and behavioral disorders at the secondary level: A need for further inquiry. *Journal of Emotional and Behavioral Disorders, 14,* 66–70.

Lane, K. L., Gresham, F. M., & O'Shaughnessy, T. E. (2002). Identifying, assessing, and intervening with children with or at risk for behavior disorders: A look to the future. In K. L. Lane, F. M. Gresham, & T. E. O'Shaughnessy (Eds.), Interventions for children with or at risk for emotional and behavioral disorders (pp. 317–326). Boston: Allyn & Bacon.

Lane, K. L., Wehby, J. H. & Barton-Arwood, S. (2005). Students with and at risk for emotional and behavioral disorders: Meeting their social and academic needs. *Preventing School Failure, 49,* 6–9.

Lane, K. L., Wehby, J., Robertson, E. J., & Rogers (2007). How do different types of

high school students respond to schoolwide positive behavior support programs? *Journal of Emotional and Behavioral Disorders, 15,* 3–20.

Leadbeater, B. J., Kuperminc, G. P., Blatt, S. J., & Hertzog, C. (1999). A multivariate model of gender differences in adolescents' internalizing and externalizing problems. *Developmental Psychology, 35*, 1268–1282.

Lewinsohn, P. M., Hops, H., Roberts, R. E., Seeley, J. R., & Andrews, J. A. (1993). Adolescent psychopathology: I. Prevalence and incidence of depression and other DSM-III-R disorders in high school students. *Journal of Abnormal Psychology, 102*(1), 133–144.

Lichtensten, R., & Ireton, H. (1984). *Preschool screening*. Orlando, FL: Grune & Stratton.

Lucyshyn, J.M., Kayser, A.T., Irvin, L.R., & Blumberg, E.R. (2002). Functional assessment and positive behavior support plan development at home with families: Defining effective and contextually-appropriate plans. In J.M. Lucyshyn, G. Dunlap, & R.W. Albin {Eds.}. *Families, and positive behavioral support: Addressing problem behaviors in family contexts* (pp.97–132). Baltimore: Brookes.

Marsh, M.W., Parada, R.H., & Ayotte, V. (2004). A multidimensional perspective of relations between self-concept (Self Description Questionnaire II) and adolescent mental health (Youth Self Report). *Psychological Assessment, 16,* 27–41.

May, D. C., & Kundert, D. K. (1997). School readiness practices and children at-risk: examining the issues. *Psychology in the Schools, 34,* 73–84.

McConaughy, S. H., & Skiba, R. J. (1993). Comorbidity of externalizing

and internalizing problems. *School Psychology Review, 22,* 421–436.

McIntosh, K., Chard, D. J., Boland, J. B., & Horner, R. H. (2006). Demonstration of combined efforts in school-wide academic and behavioral systems and incidence of reading and behavior challenges in early elementary grades. *Journal of Positive Behavioral Interventions, 8,* 146–154.

McWhirter, J., McWhiter, B., McWhirter, A., & McWhirter, E. (1998). *At-risk youth: A comprehensive response*. Belmont, CA: Wadsworth.

Merrell, Kenneth. (1999). *Behavioral, social, and emotional assessment of children and adolescents [electronic version]*. Boulder, CO: Erlbaum Associates.

Miller, D. (1994). Suicidal behavior of adolescents with behavior disorders and their peers without disabilities. *Behavioral Disorders, 20,* 61–68.

Morgan, D., (1997). *The Focus Group Guide Book.* Thousand Oaks, CA: Sage.

Nelson, J. R., Babyak, A., Gonzalez, J., & Benner, G. J. (2003). An investigation of the types of problem behaviors exhibited by K–12 students with emotional and behavioral disorders in public school settings. *Behavioral Disorders, 28,* 348–359.

Nelson, J., Benner, G., Lane, K., Smith, B. (2004). Academic achievement of K–12 students with emotional and behavioral disorders. *Exceptional Children, 71,* 59–73.

Newcomer, P. L., Barenbaum, E., & Pearson, N. (1995). Depression and anxiety in children and adolescents with learning disabilities, conduct disorders, and no disabilities. *Journal of Emotional and Behavioral Disorders, 3,* 27–39.

Ollendick, T., & King, N. (1994). Diagnosis, assessment, and treatment of internalizing

problems in children: The role of longitudinal data. *Journal of Consulting and Clinical Psychology, 62.*

Oswald, D. P., & Coutinho, M. J. (1995). Identification and placement of students with serious emotional disturbance. Part I: Correlates of state child-count data. Journal of Emotional and Behavioral Disorders, 3, 224–229.

Rogevich, M., & Perin, D. (2008). Effects on science summarization of a reading comprehension intervention for adolescents with behavior and attention disorders. *Council for Exceptional Children,74,* 135–154.

Sabornie, E. J., Kauffman, J. K., & Cullinan, D. A. (1990). Extended sociometric status of adolescents with mild handicaps: A cross-categorical perspective. *Exceptionality, 1,* 197–209.

Sabornie, E. J., & deBettencourt, L. U. (1997). *Teaching students with mild disabilities at the secondary level.* Upper Saddle River, NJ; Merrill/Prentice Hall.

Sabornie, E. J., Thomas, V., & Coffman, R. M. (1989). Assessment of social/affective measures to discriminate between BD and nonhandicapped early adolescents. *Monograph in Behavior Disorders: Severe Behavior Disorders in Children and Youth, 12,* 21–32.

Salvia, J., & Ysseldyke, J.E. (2004). Assessment in special and inclusive education (9^{th}.ed.). Boston: Houghton Mifflin.

Satz, P., & Fletcher, J. M. (1988). Early identification of learning disabled children: An age old question revisited. *Journal of Consulting and Clinical Psychology, 56,* 824–829.

Schonert-Reichl, K. A. (1993). Empathy and social relationships in adolescents with

behavioral disorders. *Behavioral Disorders, 18,* 189–204.

Seidman, I. (1998). *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (2nd ed.). New York: Teachers College Press.

Seidman, E., Allen, L., Aber, J.L., Mitchell, C., & Feinman, J. (1994). The impact of school transitions in early adolescence on the self-system and perceived social context of poor urban youth. *Child Development, 65,* 507–522.

Severson, H. H., Walker, H. M., Hope-Doolittle, J., Kratochwill, T. R., & Gresham, F. M. (2007). Proactive, early screening to detect behaviorally at-risk students: Issues, approaches, emerging innovations, and professional practices. *Journal of School Psychology, 45,* 193–223.

Severson, H., & Walker, H. (2002). Pro-active approaches for identifying children at risk for socio-behavioral problems. In K. L. Lane, F. M. Gresham, & T. O. Shaughnessy (Eds.), *Interventions for students with or at-risk for emotional and behavioral disorders* (pp. 33–54). Boston: Allyn & Bacon.

Sim, J. (1998). Collecting and analyzing qualitative data: Issues raised by the focus group. *Journal of Advanced Nursing, 28,* 345–352.

Soodak, L., Podell, D., & Lehman, L. (1998). Teacher, student, and school attributes as predictors of teachers' responses to inclusion. *Journal of Special Education, 31,* 66–81.

Sprague, J., Sugai, G., Horner, R., & Walker, H. (1999). Using office discipline referral data to evaluate school-wide discipline and violence prevention interventions. *Oregon School Study Council, 42,* 4–18.

Sugai, G., Horner, R. (1999). Discipline and behavioral support, practices, promises, and

pitfalls. *Effective School Practices, 17,* 10–22.

U.S. Public Health Service. (2000). Report of the surgeon general's conference on children's mental health: A national action agenda. Washington, DC: Department of Health and Human Services.

Vander Stoep, A., McCauley, E., Thompson, K., Herting, J., Kuo, E., Stewart, D., et al. (2005). Universal emotional health screening at the middle school transition. *Journal of Emotional and Behavioral Disorders, 13,* 213–223.

Wagner, M., Kutash, K., Duchnowski, A. J., Epstein, M. H., & Sumi, C. (2005). The children and youth we serve: A national picture of the characteristics of students with emotional disturbances receiving special education. *Journal of Emotional and Behavioral Disorders, 13*(2), 79–96.

Walker, B., Cheney, D., Stage, S., Blum, C., & Horner, R. H. (2005). Schoolwide screening and positive behavior supports: Identifying and supporting students at risk for school failure [Electronic version]. *Journal of Positive Behavior Interventions, 7*(4), 194–204.

Walker, H. M., Colvin, G., & Ramsey, E. (1995). *Anti-social behavior in school: Strategies and best practices*. Pacific Grove, CA: Brooks/Cole.

Walker, H. M., Horner, R. H., Sugai, G., Bullis, M., Sprague, J. R., Bricker, D., & Kaufman, M. J. (1996). Integrated approaches to preventing antisocial behavior patterns among school-aged children and youth. *Journal of Emotional and Behavioral Disorders, 4,* 194–209.

Walker, H. M., Kavanagh, K., Stiller, B., Golly, A., Severson, H., & Feil, E. G. (1998). First step to success: An early intervention approach for preventing school

antisocial behavior. *Journal of Emotional and Behavioral Disorders, 6,* 66–80.

Walker, H. M., & Severson, H. H. (1992). *Systematic screening for behavior disorders: Users guide and administration manual*. Longmont, CO: Sopris West.

APPENDIX

Focus Groups Questions

Introductory questions

- What is the first thing that comes to mind when you hear the phrase “at risk for Emotional and Behavioral Disorders?”

Transition question

- What do you think are some of the keystone behaviors associated with risk for EBD?

Key questions

- In your role as teachers, what *specific* examples have you seen of this in the past?
- What have been your experiences with the behaviors of students who are at risk for school failure?
- Other than through the assessment process, how would you know if a child had EBD?
- Some students with EBD or who are at risk for developing EBD have internalizing behaviors, i.e., they turn their emotions and behaviors inward; they may be anxious, withdrawn, painfully shy, or sad. What do these behaviors look like in your classroom? How have you observed that these behaviors interfere with a student’s learning?
- What types of behaviors do you feel are appropriate to refer a child for further support and intervention from the school psychologist, school counselor, or other mental health specialist in the school for?

Ending questions

- Is there anything that we missed?
- Is there anything that you came wanting to say that you didn’t get a chance to say?