ABSTRACT

HEAD START TEACHERS’ INTENTIONS TO IMPLEMENT SUGGESTIONS FOLLOWING MENTAL HEALTH CONSULTATION: AN INVESTIGATION OF THE ROLES OF WORKING ALLIANCE AND TEACHER EFFICACY

by Kathryn A. Conaway

The purpose of the present study was to test the hypothesis that teacher efficacy would mediate the relationship between the consultation working alliance and teachers’ behavioral intentions to implement the consultants’ suggestions. Surveys were administered to Head Start teachers subsequent to mandated, biannual mental health consultations conducted by graduate student consultants working under faculty supervision. Multiple regression tests for mediation were used to analyze the data. Results of the analyses failed to support the study hypotheses. However, post hoc analyses revealed significant relationships. The discussion of the results focuses on possible explanations for the significant and nonsignificant findings, limitations of the study, and directions for future research.
HEAD START TEACHERS’ INTENTIONS TO IMPLEMENT SUGGESTIONS FOLLOWING MENTAL HEALTH CONSULTATION: AN INVESTIGATION OF THE ROLES OF WORKING ALLIANCE AND TEACHER EFFICACY

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Introduction

This study investigated the consultant-consultee relationship from an across-models, relational-perspective, focusing on the working alliance within the interaction. The purpose of the present study was to investigate Head Start teachers’ perceptions of the working alliance during mental health consultations, as well as the relationship between these perceptions of the consultant-teacher alliance and teachers’ intentions to implement the consultants’ suggestions. In addition, this study examined teachers’ professional efficacy as a potential mediator of teachers’ intention to implement the recommendations.

To introduce the rationale for this study, I will first review the need for mental health consultation services in Head Start programs. Next, I will provide an overview of consultation and the three primary models used in school-based consultation. I will follow this with a presentation of consultant roles and the empirical studies investigating the consultation relationship. The working alliance will be introduced as a useful lens through which to view the consultant-consultee relationship. Finally, I will discuss the construct of teacher efficacy and present the implications of this construct for consultation.

Head Start Population

Head Start is a federally funded preschool program designed to provide comprehensive services to impoverished children and their families. One challenge that arises from targeting this socio-economically disadvantaged population is that children from impoverished environments display higher rates of problematic behavior than their peers. In fact, approximately 10% of U.S. children in general display problematic behavior, whereas the percentage of low-income children displaying problematic behavior is approximately 27% (Raver & Knitzer, 2002). Head Start populations often exhibit high rates of inattentive and aggressive behavior (Webster-Stratton & Hammond, 1998). Head Start teachers have indicated that problem behaviors in this population are increasing over time, with children displaying higher levels of emotional distress, such as depression and withdrawal, as well as aggressive behaviors (Yoshikawa & Knitzer, 1997).

Moffitt (1993) posits that children’s negative behavior may be due to a lack of alternative behavioral options. For example, a child may forcefully take a toy from a peer because the child’s behavioral repertoire does not include the prosocial options of asking nicely, waiting and taking turns, or sharing. In consequence, children who are unable to choose situationally appropriate prosocial behavior are frequently rejected by peers and adults; experiencing this
rejection often results in the development of additional problem behaviors such as aggression or withdrawal. These problem behaviors limit opportunities to interact with prosocial peers that could provide modeling of important skills and reinforcement for appropriate behaviors. In addition to inadequate social skills, children who demonstrate problematic behavior often experience learning difficulties and underachievement in academic settings, which in turn narrows their future educational and occupational options (Prinz & Miller, 1991; Moffitt, 1993).

Teachers play an important role in the management of behavior problems in preschoolers. However, young children who display antisocial behavior receive less teacher instruction and less positive feedback from teachers (Kupersmidt & Coie, 1990, cited in Raver & Knitzer, 2002). More disturbing are findings that suggest that certain teacher behaviors can actually perpetuate a child’s disruptive behavior. Arnold, McWilliams, & Arnold (1998, as cited in Raver & Knitzer, 2002) found that teachers who fail to respond to problem behavior or react harshly might actually increase the child’s disruptive behavior. In addition, a national survey found that teachers of primarily low-income children “used significantly more harsh, detached, and insensitive behaviors with children than teachers serving middle and upper income children” (Phillips, Voran, Kisker, Howes, & Whitebrook, 1994, as cited in Raver & Knitzer, 2002, p. 13).

Thus, socioeconomically disadvantaged children not only are at increased risk for developing problematic behavior, they also face higher chance of their problematic behavior being perpetuated by the behavior of teachers. Noting these patterns, Head Start teachers have recently recognized a need for more training regarding effective methods for handling children's challenging behavior (Yoshikawa & Zigler, 2000). This training is particularly necessary given that many preschool teachers report feeling overwhelmed by the emotional distress of some children, and report that they do not feel adequately trained to deal effectively with the needs of emotionally distressed children (Knitzer, 1996).

Head Start mental health consultation. The federally mandated mental health consultations can assist with this need. Governmental regulations require Head Start organizations to contract outside consultants to conduct biannual mental health consultations. One purpose of these consultations is to “design and implement program practices responsive to the identified behavioral and mental health concerns of an individual child or group of children” (U.S. Department of Health and Human Services, 1998, section 1304.24). In addition, these consultations provide an avenue for sharing information with teachers and parents on childhood
behavioral and developmental issues, mental health issues, and available community resources (U.S. Department of Health and Human Services, 1998). Moreover, Head Start directors and mental health coordinators report many benefits associated with providing staff with support and training in mental health related skills. These benefits include staff members’ increased skill repertoire, improved problem-solving skills, increased confidence in dealing with difficult situations, and the formation of a safe place for teachers to vent frustrations and share successes (Yoshikawa & Knitzer, 1997).

The potential benefits of providing effective mental health consultations to Head Start teachers are significant. Children who experience adverse circumstances within the home, such as poverty, single-parent families, and family physical and mental health problems are more likely to evidence negative adolescent and adult outcomes, including negative self-concept, poor social/emotional competence, and school failure (Murray, 2003). Studies have shown that children’s problematic behaviors become progressively more fixed, with the most behavioral malleability prior to the age of eight (Huesmann & Guerra, 1997). One study suggests that children under eight might be more responsive to behavioral interventions because their thinking patterns, actions, and reputations have not yet fully formed (Webster-Stratton, Reid, & Hammond, 2001). Early intervention is essential in fostering the development of prosocial skills. Positive interventions during the preschool years can have a life-altering affect on an individual, opening up social, academic, and career possibilities. In fact, research has demonstrated that poor children who participate in quality preschool programs, such as Head Start, experience greater success in school and beyond (Raver & Knitzer, 2002; Zigler & Styfco, 2003).

The system of mental health consultation with Head Start classrooms provides an opportunity for teachers to receive information and support on the particular issues that they are encountering. The preventative, indirect structure of the Head Start’s mental health consultation system provides assistance for individual children of concern, while maximizing the number of children who can benefit from mental health services. This structure is consistent with the general structure of school-based consultation, in which the goals are to offer immediate remedial strategies as well as preventative strategies for future similar problems (Gutkin & Curtis, 1999). The following section delineates the primary models of consultation used in schools and provides an overview of each.
Consultation Models

*Mental health consultation.* Three primary models of consultation have historically existed within school settings: mental health consultation, behavioral consultation, and organizational development. Mental health consultation is one of the earliest forms of consultation. Gerald Caplan developed mental health consultation following World War II, when he and a small clinical staff provided mental health care to 16,000 immigrant children, housed in over 100 separate sites. Due to the large number of referrals and limited staff, provision of traditional services to individual children was not possible. Therefore, Caplan provided consultation to caregivers in order to enhance their effectiveness in working with the immigrant children and consequently decrease the need for direct service referral. In addition to addressing mental illness, Caplan’s model promoted mental health in a preventative way. This system proved effective; the indirect service approach had the potential to influence many more children than would have been possible through direct service (Caplan & Caplan, 1993; Caplan, Caplan, & Erchul, 1995).

Caplan and Caplan (1993) describe mental health consultation as a triadic relationship in which the consultee seeks the expert assistance of an external consultant in order to solve a consultee-identified work-related problem. The relationship between the consultant and consultee is coordinated and nonhierarchical. The consultee is free to accept or reject the consultant’s suggestions and maintains full responsibility for client outcomes. The goals of the mental health consultation are twofold: to address the consultee’s current difficulty and to increase the consultee’s capability to handle similar problems in the future. This model of mental health consultation conceives consultee inefficacy to result from one or more of four inherent “lacks:” lack of knowledge, lack of skill, lack of confidence, and/or lack of objectivity. Lack of objectivity, resulting from unconscious themes, seems to be the most common deficit, making salient the psychodynamic underpinnings of the model (Caplan & Caplan, 1993; Caplan, Caplan, & Erchul, 1995).

The consultant-consultee relationship is a key component of mental health consultation. According to Caplan and Caplan (1993), the relationship should be a non-hierarchal partnership in which consultees feel safe to discuss professional issues. It is important for consultees to be active participants, educating the consultant about their professional world so that the consultant is able to provide pertinent input. Developing solutions jointly increase the consultees’ sense of
ownership and in turn, the likelihood that they will act. In addition, a strong positive relationship may facilitate the consultant’s position as a role model. According to this consultation model, consultants should possess three traits: empathy, tolerance of one’s own and other’s feelings, and the belief that human behavior is understandable with enough information (Caplan & Caplan, 1993; Brown, Pryzwansky, & Schulte, 2006).

Behavioral consultation. Similar in some ways to mental health consultation, behavioral consultation is a problem-solving process that seeks to assist the consultee and third party client. It is appropriate for individual cases and programs, and consultation goals can be both remediation and prevention-focused (Dougherty, 2000). Behavioral consultation differs from mental health consultation in that it is based on behavioral and social learning theory rather than on psychodynamic theory. This consultation model focuses on observable behaviors such as skills and knowledge rather than unconscious themes (Bergan, 1977, as cited in Erchul & Conoley, 1991).

The aim of behavioral consultation is to cooperatively problem-solve with the consultee with the aim of effecting positive change in the third-party client, as well as to increase the knowledge and/or skill of the consultee (Bergan & Kratochwill, 1990; Erchul & Conoley, 1991; Zins, Kratochwill, & Elliott, 1993; Kratochwill, Elliott, & Carrington-Rotto, 2002). The emphasis of behavioral consultation is on behavioral observation and assessment, with problems conceptualized in relation to the environment and the functionality of behavior-environment interactions (Gresham, 1991, as cited in Bramlett & Murphy, 1998). The framework for this model consists of four stages: problem identification, problem analysis, plan implementation, and problem evaluation (Bergan & Kratochwill, 1990).

During the problem identification stage the following tasks occur: the consultee’s concerns are assessed; the target problem area is identified; the target behavior is described in objective and concrete terms; the behavior’s frequency, intensity and duration are estimated; provisional goals are discussed; environmental conditions surrounding the target behavior are tentatively identified; and data collection procedures are established (Bergan & Kratochwill, 1990; Erchul & Conoley, 1991; Zins, et al., 1993). Bergan and Tombari (1976, cited in Erchul & Conoley, 1991) found this stage, problem identification, to be the single best predictor of intervention implementation by a consultee. This finding speaks to the importance of early agreement on the goals and tasks of the consultation process. The second stage in behavioral
consultation is problem analysis. At this point, adequacy of baseline data is determined, goals for change are established, environmental conditions surrounding the target behavior are analyzed, an intervention plan is designed, and data collection procedures are reaffirmed. During the third stage, the consultee implements the intervention plan that has been created in the previous stage. The fourth and final stage is problem evaluation. This phase features the determination of achievement of intervention goals, evaluation of the plan efficacy and discussion of the next steps in the intervention plan (Bergan & Kratochwill, 1990; Erchul & Conoley, 1991; Zins, et al., 1993).

The behavior model of consultation is widely utilized and adaptable to a broad range of settings (Zins, et al., 1993). Several model elements, such as the inclusion of caregivers in intervention implementation, the incorporation of environmental factors in the conceptualization of behavioral problems, and the capacity for provision of services to large numbers of children in natural settings, facilitate ease of integration into school systems (Zins, et al., 1993). In addition, behavioral consultation, as compared with mental health consultation, is likely to be more easily accepted, and as a result, adopted in schools, because the behavioral focus is less threatening than mental health consultation’s psychodynamic focus (Erchul & Conoley, 1991).

Within the behavioral model of consultation, the consultant and consultee relationship is essential; however, behavioral theorists have not reached a consensus on the best term to describe this relationship. Zins and Erchul (1995) use the term “cooperative partnership” to describe the manner in which consultants and consultees work jointly together in order to problem solve for the benefit of a third party client. Erchul, et al. (1992) use the term “teamwork,” and Kratochwill et al. (2002) refer to the consultant-consultee relationship as “collaborative.” Regardless of the term used, it is clear that the consultant-consultee relationship involves mutual contributions to accomplish goals.

Organizational development consultation. Similar to the mental health and behavioral models of consultation, one of the basic tenets of the organizational development model of consultation is the necessity of developing a strong relationship between the consultant and consultees (Schmuck, 1995; Curtis & Stollar, 1996). However, the organizational development model of consultation differs from the previous two models in that the client is the system rather than an individual child or classroom; the focus of organizational development consultation is on groups within a system or on the entire organizational system itself (Schmuck, 1995; Gutkin &
Curtis, 1999). Another point of divergence is the focus; mental health and behavioral consultation focus on behaviors, whereas the focus of organizational consultation is on process—the way that individuals and groups interact-instead of on specific problem behaviors (Schmuck, 1995). The underlying assumption for use of the organizational development model in school-based systems is that “healthy” systems are more likely to facilitate “healthy” psychological and educational experiences for students and teachers (Schmuck, 1990, as cited in Gutkin & Curtis, 1999). This style of consultation is applicable to numerous important organizational issues such as program evaluation, dissemination of new programs, within group and between group communications, and group conflict (Gutkin & Curtis, 1999). The organizational change process includes several interrelated phases, each having a specific evaluative component: problem diagnosis, planning, initiation, implementation, and institutionalization (Fullan, 1982, as cited in Zins & Illback, 1995). Working through these phases in a way that will facilitate lasting change can take time, generally a minimum of 2-3 years (Fullan, 1982, as cited in Zins & Illback, 1995).

Not surprisingly, the consultant-consultee relationship is an essential element in successful organizational consultation. Schmuck (1995) identifies the following three important precepts in the organizational development consultation relationship: (1) authentic interpersonal relations; (2) collaboration based upon respect, inclusion, and mutual control; and (3) commitment and participant ownership of the educational improvement process. In this consultation model, organizational change is attained through the process of stakeholders collaboratively working together to systematically identify areas for improvement, plan, problem solve, implement change, and evaluate their change efforts.

**Effectiveness of consultation models.** Numerous studies have investigated consultation effectiveness in relation to the model of consultation used. In 1985, Medway and Updyke conducted a meta-analysis to examine the effectiveness of mental health, behavioral and organizational development consultation. The analysis was comprised of 54 studies conducted between 1958 and 1982; 44% (N = 24) used a mental health model of consultation, 33% (N = 18) used a behavioral model of consultation, and 22% (N = 12) used an organizational development model of consultation. The results of the investigation supported the effectiveness of consultation overall, demonstrating that consultation participants evidenced more positive outcomes than approximately 68-76% of individuals who did not participate in consultation.
researchers found consultation to have a generally positive effect on both the consultees and the third party clients. However, the results of the meta-analysis did not provide evidence for the superiority of one consultation model over the others. Based upon this finding, the authors suggest the selection of the model of consultation according to consultation goals. The study results suggested that mental health consultation was more effective in facilitating consultee change, whereas behavioral and organizational development models were more effective in bringing about change in the third party clients. In a review of previous literature, Gresham and Kendall (1987) noted that these findings were not consistent with previous reviews, in which there was more support for behavioral models of consultation than for mental health or organizational development models.

Sheridan, Welch, and Orme (1996) conducted a follow-up meta-analytic review of consultation outcome studies between 1985 and 1995. The overall findings were similar to those of Medway and Updyke (1985), with some beneficial outcomes resulting in 76% of the studies. According to Sheridan and colleagues (1996), the majority of consultation outcome research reported between 1985 and 1995 (46%, N = 21) used a behavioral consultation model or a variation of a behavioral model. Behavioral consultation models produced the most consistently positive results, with 89% of the studies evidencing positive outcomes, 11% showing neutral outcomes, and none of the behavioral studies reporting negative results. However, interpreting differences between consultation models should proceed cautiously, given that there were over four times as many studies of behavioral consultation as any other model included in the meta-analysis. Only five of the studies in this meta-analysis used a mental health model of consultation. Of those, 57% of the studies evidenced positive outcomes and 43% showed neutral outcomes; there were no negative outcomes reported for the mental health consultation model. Due to the low number of studies using an organizational development model of consultation (N = 2) included in this review, limited support for the effectiveness of this consultation model could be found. For studies that used “other” models, the researchers found that 29% evidenced positive outcomes, 65% evidenced neutral outcomes, and 6% showed negative outcomes. For the five studies that did not specify a model, 67% reported positive outcomes and 33% reported negative outcomes.

A common criticism with model-specific consultation outcome studies has been the lack of data detailing the methods employed during the consultation and insufficient monitoring of
the consultation process fidelity (Gresham & Kendall, 1987; Kratochwill, Sheridan, & VanSomeren, 1988, as cited in Sheridan, et al., 1996; Gresham, 1989; Gresham & Noell, 1993; Sheridan et al., 1996). Although it appears that the empirical evidence leans in favor of using behavioral consultation, for the majority of studies there is no documentation delineating the specific consultation processes. Gresham and Kendall (1987) stated that “most consultation research can be described as limited in scope, univariate in nature, non-experimental, devoid of a strong theoretical base, and unsophisticated in terms of research design and statistical treatment of data” (p. 313). In a subsequent review, Sheridan and colleagues (1996) reported some improvement in the methodological rigor of the consultation research, with one third of the studies in the review delineating the specific consultation strategies used. However, few monitored the actual consultation processes in order to ensure that the consultation process was following the described strategies (Sheridan et al., 1996). The authors recommended that future consultation researchers adopt a clearly defined, research-valid model, either mental health, behavioral, or organizational development, based upon “a sound match between practitioner, need, and model” (Sheridan et al., 1996, Implications for Practice, ¶ 1).

Although some researchers (Sheridan et al., 1996) have recommended strict adherence to one model, others have espoused alternative views. Maital (1996) argues for benefits of integrating various aspects of differing consultation models. According to this author, integration may decrease resistance and thus facilitate increased levels of collaboration between consultant and consultee. Martin (1987) presents a developmental perspective of consultation, stating that as the relationship between the consultant and the system grows, so too does the depth and complexity of consultation services requested. He describes a progression moving from case consultation to program consultation, and finally, to organizational consultation. As the field of consultation continues to grow and develop, the boundaries between these three models of consultation become increasingly more blurred. All consultation occurs within some type of organization, affects the mental health of the consultee and/or the client either directly or indirectly, and aims to facilitate a form of behavioral change (Dougherty, 2000).

Many experts in the field of consultation posit that there are far more similarities than differences between consultation models (Mannino & Shore, 1985; Erchul & Conoley, 1991; Zins, et al., 1993; Gutkin, 1996a; Gutkin & Curtis, 1999; Brown, et al., 2006). Common elements include working with the consultee in order to assist the third-party client, and presenting the consultee
with information that can enhance their ability to address proactively similar situations in the future. However, one of the single most important common elements is the interpersonal relationship between the consultant and the consultee. This element is an essential component of consultation (Rosenfield, 1991; Conoley & Conoley, 1992; Henning-Stout, 1993; Kratochwill, et al., 1995; Zins & Erchul, 1995; Gutkin, 1996 Gutkin & Curtis, 1999). The importance of the consultant-consultee relationship speaks to the necessity of understanding their respective roles in their work together.

**Consultant Roles**

In the consultation relationship, each individual brings her or his own personality, knowledge, skills, and resources. A consultant interacts with the consultee in a particular way based upon the unique goals of the consultation interaction, as well as the personal uniqueness of each member of the dyad. The way that a consultant interacts with the consultee is referred to as the consultant’s role. Depending on the situation, a consultant can adopt a number of roles (Lippitt & Lippitt, 1986, as cited in Dougherty, 2000; Brown et al., 2006). Each of these roles affects both the content and the process of consultation. For example, at times it is most beneficial for the consultant to observe and discuss processes with the consultee, whereas at other times, it may be most appropriate for the consultant to share expert knowledge with the consultee. Dougherty (2000) presents a modified version of the Lippitt and Lippitt (1986, as cited in Dougherty, 2000) categorization scheme for consultant roles. This rubric places consultant roles along a directive-nondirective continuum. The most directive role is that of the **advocate** and the least directive is that of a **process specialist**. Falling between these two poles are the roles of **expert**, **trainer/educator**, **collaborator**, and **fact-finder**. The consultation relationship is multidimensional and as with all interpersonal interactions, a constant give-and-take and balancing of needs is necessary for an effective interaction. Thus, there is a need for consultants to adopt multiple roles. The give-and-take between each particular pair of individuals will automatically differ because they are bringing their own unique needs, expectations, frames of reference, and abilities with them to the relationship. While the particular interaction between individuals will vary, there is continuing debate in the literature about the general role of the consultant

**Consultant as expert.** Graham (1998) noted that although a consultant can take on numerous roles, the two most common types of consultation roles discussed in the literature are
the roles of “expert” and “collaborator.” These two roles are often presented as mutually exclusive, either as a collegial and collaborative relationship or as an authoritarian expert approach. The “expert” approach has often been conceptualized as “that which is not collaborative” (Graham, 1998, p. 156). Thus, this approach has been perceived as being uncooperative and dictatorial (Graham, 1998).

Historically, reliance on the expert knowledge of a consultant has been common. In many fields, consultants worked within the “expert” paradigm (Gallessich, 1982, as cited in Schulte & Osborne, 2003). An organization would call in expert consultants to diagnose a problem and prescribe a means of remedying the difficulty. Consultants generally worked alone as they diagnosed the problem and developed remediation plans. When the assessment and plan development were complete, the organization received the information in a one-way form of communication, such as a written report (Schulte & Osborne, 2003). In a review of related literature, Schulte and Osborne (2003) found documentation identifying a critical problem with the expert model of consultation; that is, it often did not result in targeted change. Schulte and Osborne (2003) present three interrelated problems considered by model critics to be responsible for the ineffectiveness of the expert approach. First, there was no consultee input in this model. As a result, consultees often rejected the consultant’s expert advice, perceiving the remediation plans to be a poor fit for their particular setting. Second, the expert model was hierarchical and placed the consultee in a subordinate position. Many thought that the differential status increased consultee resistance to change, lowered consultee self-efficacy, and impeded remediation plan ownership. Finally, the lack of involvement during the problem identification and plan development stages had the potential to lead to misunderstandings in the interpretation of the consultant’s recommendations, thus jeopardizing correct implementation.

It is important to note that the aforementioned criticisms referred to an “expert model” of consultation that is characterized by a hierarchal structure and a one-way channel of communication. The criticisms are by no means referring to a consultant’s possession of expertise and the sharing of expert knowledge with a consultee. Generally, consultation interactions begin because of an immediate problem that the teacher (consultee) is facing; often, the teacher has tried everything s/he could think of in order to solve the problem on her/his own and contacts the consultant because s/he has run out of ideas and needs assistance (Gutkin, 1996a). The consultant’s expertise is the reason that the consultant was contacted.
Consultant as collaborator. In this role, the question for the consultant is how best to share her/his expertise in order to assist the consultee and third party client. Originally, collaboration was seen as a means to an end—a way to empower teachers to help themselves (Meyers, 1973, Williams, 1979, as cited in Gutkin, 1999a). In a review of relevant literature, Gutkin (1999a) presents the assumptions that have underlain this approach. First, psychologists were aware that teachers possessed important insights about their particular environments and that they could provide valuable assistance in developing interventions that would be effective within their classrooms. Second, psychologists realized that the interventions that were developed would most likely be implemented by the teacher and therefore it was the psychologist’s role to facilitate an atmosphere in which they could “give psychology away” (Miller, 1969, as cited in Gutkin, 1999a) to the consultees. Third, with the emphasis on prevention rather than remediation, it became necessary for psychologists to garner the support and cooperation of the community agencies with which they worked, such as schools. Finally, psychologists realized that teachers choose what they do in their own classrooms and therefore teacher buy-in to the intervention plan is essential.

For these reasons, collaboration was seen as crucial to effective consultation practice. Furthermore, all the consultation research until the late 1980s supported the assumption of the vital importance of the collaborative construct (Wenger, 1979; Babcock & Pryzwansky, 1983; Gutkin, 1980, Hinkle, Silverstein, & Walton, 1977, Maitland, Fine, & Tracy, 1985, Reinking, Livesay, & Kohl, 1978, all cited in Gutkin, 1999a). For example, Babcock & Pryzwansky (1983) found that teachers preferred a collaborative approach to an expert model at every stage of the consultation process. In addition, survey studies have suggested that teachers find interventions that have been collaboratively developed by the teacher and the consultant to be more acceptable than interventions that were developed by the consultant alone (Fairchild, 1976, Reinking, Livesay, & Kohl, 1978, as cited in Graham, 1998). Studies also suggest that consultants who requested teacher input on intervention development were more effective than consultants who simply informed the teacher of the proper implementation of the intervention (Bergan & Neumann, 1980, as cited in Knoff, McKenna, & Riser, 1991).

“Collaboration Debate.” Within the field of school psychology, the need for collaboration between consultant and consultee was an unquestioned element of the service process (Reschly, 1976, as cited in Gutkin, 1999a). The necessity and value of this assumed
foundational element was not challenged until the late 1980s. Witt (1990) issued this “wake-up call” (Gutkin, 1999a) to professionals and scholars working in the field of school-based consultation following a study by Erchul (1987). Erchul (1987) reported a positive relationship between the consultant’s dominance (control of the consultation process) and the consultee’s evaluation of the effectiveness of consultation. Based upon his research results, Erchul (1987) concluded that, “behavioral consultation is not typified by a coequal, nonhierarchical relationship between participants” (p. 122). Thus, the longstanding assumption of the essential quality that collaboration played in effective consultation was brought into question. Following from this interpretation, Witt (1990) pointed out that there was little research support for the collaborative construct in consultation and that the work of Erchul (1987) suggested the opposite might actually be the case: that is, that collaboration may lessen the effectiveness of consultation. Witt (1990) concluded that collaboration was a “myth in need of data.”

Gutkin (1999a) argues that the need for consultants to choose between a collaborative and a directive/prescriptive/expert approach is a “false dichotomy” resulting from definitional problems in collaborative research. These definitional problems have spurred the “collaboration debate” over whether collaboration is useful in the consultation process (Gutkin, 1999a). In fact, Erchul (1992) reinterpreted the findings of his earlier study (1987), stating, “the presence of consultant dominance does not signal the absence of collaboration” (p. 365). Interpretations of the data from studies conducted within the past fifteen years are consistent with this reinterpretation. That is, consultant directiveness/prescriptiveness or the “expert” role does not preclude a collaborative interpersonal working relationship between the consultant and the consultee (Erchul, Covington, Hughes, & Meyers, 1995; Erchul, et al., 1992; Hughes and DeForest, 1993; Gutkin, 1996; Busse, et al., 1999; Houk and Lewandowski, 1996, as cited in Busse, et al., 1999).

The confusion over collaborative and expert roles may be illuminated by a brief analysis of how terms are used to convey meaning. Bachrach (1981, as cited in Erchul, 1999) describes levels of definitions: daily, poetic, and scientific. A daily definition is the meaning that is commonly accepted and understood. A poetic definition may not be commonly accepted, but it represents a distinctive and often creative way of viewing the phenomenon. A scientific definition is explicit, specific, fixed, and limited. A major error found in psychological research is the use of daily definitions for scientific purposes (Bachrach, 1981, as cited in Erchul, 1999).
In an effort to conduct sound research, some early researchers of the collaborative construct (Erchul, 1987; Erchul & Chewning, 1990; Witt, et al, 1991) operationalized the collaborative phenomena according to the measures used to code the verbal interactions. Terms such as dominance, domineeringness (Erchul, 1987), topic determination, and topic continuation (Witt, et al., 1991) were used as the operational constructs in these studies. However, the scientific definitions and daily definitions of the terms used in the three “seminal” (Gutkin, 1999a) collaborative studies (Erchul, 1987; Erchul & Chewning, 1990; Witt, et al., 1991) are incongruent. Because psychologists study constructs that are “almost always part of the daily fabric of everyday human life” (Gutkin, 1999b, p. 231), unintended outcomes often result when the definition of variables are inconsistent with the common meanings of terms (e.g. negative reinforcement, intelligence; Gutkin, 1999b; Schulte & Osborne, 2003). Therefore, although the scientific definition of dominance in Erchul’s (1987) study is harmonious with collaboration, the daily definition is not. The “collaboration debate” (Gutkin, 1999a) is a result of this definitional incongruence (Gutkin, 1999b; Schulte & Osborne, 2003). Erchul (1999) questions whether the collaboration-expert debate (Gutkin, 1999a) would have developed had there been a verbal interaction coding system that measured elements of relational communication, such as trust, intimacy, inclusion-exclusion, and similarity, that could have been used in the investigation of collaboration rather than the measures that examined elements of control, dominance, and submission.

In an effort to address this vital construct and avoid the “sticky term” (Erchul, 1999) of collaboration, researchers have used several synonyms that also rely on daily meanings such as cooperation (Erchul & Chewning, 1990) teamwork (Erchul, et al., 1992), partnership (Gutkin, 1996) and complementarity (Erchul, 1987), thus exacerbating the problem. Scholars have called for the development of a “comprehensive operational definition of collaboration” (Kratochwill, 1991; Erchul, 1999, p. 194; Gutkin, 1999b). In the meantime, however, Gutkin (1999b) asserts that it would be a mistake to avoid the collaborative construct in consultation research because years of research indicate that most psychologists believe that collaboration during consultation is crucial to the consultation relationship (Idol, 1990; Gutkin & Conoley, 1990; Gutkin & Curtis, 1999; Kratochwill, et al., 1995; Erchul & Martens, 2002; Gutkin, 1996a).

An additional concern with the research on collaboration is the narrow lens through which the construct often is viewed. Hughes, Erchul, Yoon, Jackson, and Henington (1997)
concluded that studying isolated consultant behaviors is of limited usefulness and that consultation outcomes are dependent upon how the consultant responds in an ongoing way. Although research on effective consultation verbalization skills informs practice, there are many more factors that impact the dynamic and complex consultant-consultee relationship, such as the context in which the consultation occurs and the situation that is being addressed (Sheridan, Salmon, Kratochwill, & Carrington-Rotto, 1992).

In addition, a comprehensive review of the consultation literature elucidated a major empirical gap in that the majority of the research failed to address the inherent uniqueness of each consultation dyad (Fuchs, Fuchs, Dulan, Roberts, & Fernstrom, 1992). There was a call for research that would increase knowledge about the type of consultation that was most effective in particular settings and in particular types of interactions (Fuchs, et al., 1992). Hughes (1994) recommends that we replace the question “Does consultation work?” with the question “What consultation approaches result in what effects with which clients and consultees?” (p. 82)

Sheridan (1992) asserts that collaboration is a multidimensional, ever-changing, dyad-specific, and unique interactional process. “It is a dynamic process that enables educational personnel to access and develop new, creative alternatives. It is not an end, but a means to an end” (Sheridan, 1992, p. 90). Collaboration may take many forms and be operationalized in numerous ways (Sheridan, 1992). Regardless of definitions, however, the working relationship between the consultant and the consultee is central to the concept of consultation. “After all, one cannot consult without the participation of the consultee” (Sheridan, 1992, p. 91). Ultimately, the consultee has control over the consultation outcomes and whether and how interventions are implemented. Gutkin and Conoley (1990) have coined the phrase the “paradox of school psychology” to describe this phenomenon of indirect service delivery, in which effective interventions for children are the result of the consultants’ ability to serve adults effectively. As noted by Gutkin & Curtis (1981):

Once the door to the classroom is closed, there is little that any of the educational specialists can do to insure the occurrence of any event that the teacher does not want to occur…. We must recognize that if a teacher decides that a remedial program is inappropriate, it is highly likely that the plan will not be implemented. This would be true regardless of the actual quality of the particular program. (pp. 220-221)
Thus, third-party clients are served through the development of an effective consultant-consultee relationship.

*Importance of process and content skills.* Within consultation, an effective consultant needs both interpersonal skills and understanding along with expert knowledge (Sheridan, et al., 1992; Idol, 1990; Rosenfield, 1991; Knoff, Sullivan, & Liu, 1995). Idol (1990) offers an alternative way of conceptualizing consultation. Idol separates the content from the process of consultation, differentiating these two elements as the scientific base and the artful base of classroom consultation. She defines the scientific base as the knowledge that the consultant brings to the consultation process; the possession of this knowledge is generally the reason that the consultant was initially requested to work and problem-solve with the consultee. Idol (1990) defines the artful base of consultation as the way a consultant works and problem-solves with a consultee—in other words, the consultant’s process skills. “It is a demonstrable knowledge of how to bring about effective decision making, how to solve problems with others, and how to interact and communicate effectively with others” (Idol, 1999, p. 5). The scientific base is the *what* of consultation, whereas the artful base is the *how*. Effective consultants need both. In addition, consultants need to be able to draw upon these bases, as needed, during complex consultation interactions in order to evidence positive outcomes (Idol, 1990). A dual focus on attending to both the content of the presenting problems and possible solutions, as well as to the relationship issues within the dynamic consultation process, is essential to successful consultation interactions (Rosenfield, 1991; Idol, 1990). The psychotherapeutic construct of working alliance incorporates both the artful and the scientific base within the therapeutic interaction. In the following section, I will present the applicability of the working alliance construct for the field of consultation.

*Working Alliance*

Although research on the collaboration within the consultation relationship has encountered numerous impediments in the form of both methodological and definitional flaws, the importance of this construct is still widely acknowledged within the field (Sheridan, 1992; Erchul, 1999; Gutkin, 1999a; Gutkin, 1999b). Progress has been slow in the areas of conceptualization and measurement of collaboration within consultation, largely as a result of the aforementioned methodological and definitional difficulties. However, the sophistication that is lacking in the consultation literature can be found in the psychotherapeutic literature. Concurrent
with the consultation research on collaboration, psychotherapy researchers have investigated the construct of working alliance. Researchers have studied extensively and carefully the working alliance and have made significant gains in both the conceptualization of this construct and in techniques to measure it.

The working alliance is a multidimensional construct that possesses congruent daily and scientific definitions, which thereby precludes the need to address the “false dichotomy” (Gutkin, 1999a) of either providing services with an expert or collaborative approach. Horvath and Greenberg (1994) provide the following definition of working alliance:

Through development and maintenance of the alliance, the therapist can simultaneously attend to the content of the client’s relational difficulties and foster a process conducive to client change. A unique feature of the alliance concept is that it integrates the relational and the technical aspects of treatment into an overarching model of the therapeutic working alliance. From the perspective of the client’s change process, it seems unlikely that there are actually two distinct mechanisms (a technique element and a relationship component); it is more probable that these factors are interdependent and catalytic to each other. The emphasis on these two features—the interactive nature of the relationship and the integration of the technical and relational aspects—sets the alliance apart from other constructs. (pp. 1-2).

As can be seen from this definition, the working alliance construct possesses elements consistent with Idol’s (1990) formulation of the artful and scientific base of consultation.

Bordin (1979) expanded the application of the working alliance construct to include all change relationships. Collaboration within the consultation relationship fits well within this expanded framework. The idea of collaboration is central to the current formulation of the working alliance (Horvath & Greenberg, 1994); in fact, Bordin (1983) refers to the working alliance as “collaboration for change” (p. 35). Bordin emphasized that in building the alliance, it is important for there to be active collaboration between the client and the therapist in developing the goals and tasks (Bordin, 1994). Although the concept of working alliance has primarily been associated with psychotherapeutic relationships, Bordin (1979) defines the terms more generally and proposes that the working alliance construct is “universally applicable” (Bordin, 1979).
Bordin (1979) viewed his formulation of the working alliance to be relevant to all forms of therapy and to most forms of change relationships:

A working alliance between a person seeking change and a change agent can occur in many places besides the locale of psychotherapy. The concept of the working alliance would seem to be applicable in the relation between student and teacher, between community action group and leader, and, with only slight extension, between child and parent. (p. 252).

Thus, working alliance is seen as facilitating change across many different types of interactions.

In the 1970’s, Edward Bordin presented his conceptualization of this important construct. Bordin built on the work of Greenson (1967, as cited in Bordin, 1994) and his theory was consistent with Greenson’s in that the working alliance was seen as a foundational element of effective change interactions, that is, existence of a strong working alliance was viewed as a facilitator for intervention. Bordin (1979) presents an integrated, three component model of working alliance that consists of mutual agreement on goals, mutual agreement on tasks to achieve those goals, and a relational bond. According to Bordin’s (1979) model of working alliance, a basic level of understanding and agreement on the goals for change is essential. The strength of the working alliance is impacted by the clarity of the established goals and the mutuality with which the goals are decided upon (Bordin, 1983). The second component, tasks, are those activities that are determined to be the relevant and effective steps leading to goal attainment; responsibility to perform these tasks must be accepted by both parties (Horvath & Marx, 1990, as cited in Dykeman, 1995). The strength of the alliance depends on a goodness of fit between tasks relevant to specific goal achievement and the client or consultee’s level of ability and efficacy to perform the tasks. The third component of working alliance, the relational bond, refers to the mutual feelings of liking, caring, and trusting between each part of the dyad. Bordin (1979) considered all three components, agreement on goals and tasks and a relational bond, as necessary for a strong working alliance and the facilitation of change.

Agnew-Davies, Stiles, Hardy, Barkham, and Shapiro (1998) furthered the conceptualization of the working alliance by defining more specifically the boundaries of the working alliance and delineating additional alliance dimensions. The authors synthesized alliance elements from the various theories and alliance measures using a combination of
conceptual and empirical strategies and developed the Agnew Relationship Measure (ARM), a trans-theoretical model for measuring alliance. The ARM contains five scales: bond, partnership, confidence, openness, and client initiative. Bond, according to Agnew-Davies et al. (1998), is similar to the bond element detailed by Bordin (1979) and represents the qualities of friendliness, support, understanding, and acceptance. The partnership scale encompasses the pragmatic aspects of Bordin’s (1979) second and third elements, which are the mutual determination of and mutual working on tasks and goals. Confidence, an element not explicitly discussed in Bordin’s (1979) conceptualization, concerns optimism and respect for the professional competencies of the therapist. Identification of this dimension elucidates the important role of the consultant’s professional content and process expertise. Openness concerns the client’s comfort in disclosing personal information. Finally, Client Initiative refers to the client’s willingness to take responsibility for guiding the direction of therapy.

Many features of the working alliance make it especially relevant to the consultant-consultee relationship in mental health consultation. The multidimensionality of the construct—encompassing interpersonal connectedness, collaboration, and expertise—allows researchers to focus on the gestalt of the consultation relationship. In addition, the assertion that different types of change collaborations require differential amounts of relational depth and positive regard (Bordin, 1979) is also quite salient for the consultation field. That is, the change collaboration of consultation would naturally require less relational depth than would long-term therapy relationship. Further, within the realm of teacher consultation, differing recommendations may require a stronger working alliance between the teacher and the consultant than others may. For example, consultation with a teacher regarding responding to an individual child’s fearful behavior may not require the level of depth and positive regard in the consultant-consultee relationship as would consultation with a teacher regarding her/his general teaching or disciplinary style. The strength of the working alliance is a result of the fit between the personalities of the two parties and the needs of the working alliance (Bordin, 1979). It is not the use of specific behaviors per se, but rather the relevance of the behaviors employed by the therapist, and as I propose, the consultant, that impact the quality of the alliance (Horvath & Greenberg, 1994). These points relate to the issue of fit between consultant and consultee and to the relevance of the services to the consultee’s needs.
Applying the concept of working alliance to the consultant-consultee relationship may also be useful for the prediction of outcomes. Treatment outcome studies have consistently found a link between the strength of the working alliance and psychotherapy outcomes (Horvath & Symunds, 1991; Martin, Garske, & Davis, 2000), with the strength of the alliance early in the therapeutic relationship being a stronger predictor of outcomes than the strength of the alliance in mid or late sessions (Horvath & Symunds, 1991). In addition, the link between working alliance and psychotherapy outcome is not associated with length of treatment (Horvath & Symunds, 1991). Applied to the field of consultation, these two points, the predictive quality of early working alliance strength and its relation to treatment effectiveness across various lengths of treatment, are significant. School-based consultation is often time-limited. However, these findings suggest that short-term consultation has the potential to evince positive outcomes. Further, the construct of working alliance has been shown to apply across diverse theoretical orientations. Regardless of psychotherapeutic model used in treatment, the strength of the working alliance has been shown to be a major factor in the degree of change achieved by the client (Bordin, 1979; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Therefore, it seems plausible that the quality of working alliance could predict outcomes across models of consultation as well. The formation of a strong alliance between and consultant and consultee, regardless of the type of consultation (e.g. mental health, behavioral, organizational development) could be one important factor in evincing positive consultation outcomes.

Teacher Efficacy

From the perspective of social learning theory, the working alliance facilitates change within the therapeutic relationship in several ways. First, it increases the therapist’s power of verbal persuasion, or reinforcement value, which translates into increased power to influence the client’s behavior. As a result of this greater reinforcement value, therapists can also influence clients by modeling behaviors, which are more likely to be imitated by clients when the working alliance is strong. Finally, a strong working alliance facilitates the therapist in promoting positive expectancies, that is, it encourages the client to believe that s/he can succeed at a particular behavior (Raue & Goldfried, 1994). The aforementioned change processes delineate means of increasing clients’ sense of self-efficacy, and they can be applied to the consultation process toward increasing teachers’ sense of professional efficacy.
Teacher efficacy is a context-specific extension of the self-efficacy construct delineated in social learning theory. According to Bandura (1997), self-efficacy is a future-oriented belief in one’s ability to organize and execute necessary actions to produce specific attainments. Accordingly, teacher efficacy is defined as “the teacher’s belief in his or her capability to organize and execute courses of action required to successfully accomplish a specific teaching task in a particular context” (Tschannen-Moran, Woolfolk Hoy, & Hoy, 1998, p. 233). Efficacy is informed by and informs an individual’s thoughts, feelings, level of motivation, and choice of behavior. An individual’s efficacy beliefs influence her/his choice of behavior, amount of effort expended, level of perseverance and resiliency, amount of stress or depression experienced, and level of achievement (Bandura, 1997).

An important distinction is that self-efficacy refers to an individual’s perceived level of competence rather than her/his actual level of competence (Bandura, 1997). Individuals frequently misestimate their own personal competence, which has significant effects on their subsequent performance. Bouffard-Bouchard, Parent, & Larivee (1991) found students with high self-efficacy to perform significantly better than peers with the same-skill and with low self-efficacy. Higher efficacy students were more consistent in applying their knowledge and more persistent in solving math problems. In general, maximum performance is realized when one slightly overestimates personal abilities (Bandura, 1997). The concept of reciprocal determinism (Bandura, 1997) is particularly relevant to the discussion of teacher efficacy. Reciprocal determinism is a triadic model that consists of the reciprocal interrelation between behaviors, personal factors, and the environment. According to this theory, an individual’s actions, the environmental response to these actions, and an individual’s interpretation of her/his performance all informs and alter subsequent actions, environmental responses, and personal interpretations. For example, in response to a child’s inattentive behaviors during a reading assignment, a teacher chooses to implement a consultant’s recommended intervention to reengage the student. Her decision to implement the intervention was spurred by the inattentive child and based on her self-efficacy to perform the action. When she performs the intervention, she affects her environment; if the child becomes re-engaged, she perceives a positive change in her environment. The positive environmental change reinforces her sense of efficacy for performing the intervention as well as her beliefs in the benefits of the action.
Within the consultation relationship, collaboration facilitates enhancement of teacher efficacy in several ways. During a typical consultation interaction, the consultant and consultee (teacher) dialogue about various challenges that the teacher faces. During this verbal exchange, the consultant has the opportunity to utilize verbal persuasion to present possible solutions that are within the scope of the teacher’s capabilities and resources. In addition, the consultant has the option to model the suggested behavior, so that the teacher can see what it entails. If this dialogue results in a favorable response by the teacher and s/he decides to try the suggestion, the consultant can assist in facilitating a mastery opportunity in the classroom, that is, the consultant can help to arrange an actual trial of the behavior that was verbally discussed and modeled. In these ways, consultation fosters improved teacher efficacy. Hughes (1992, p. 270, as cited in Hughes & DeForest, 1993, p. 360) accurately sums up the multiple factors involved in achieving positive consultation outcomes:

Teacher behavior is largely determined by what they think, and what they think is determined by a myriad of variables, including their attributions for pupils’ behavior, personal sense of competency, implicit theories of teaching, and perceptions of the consultant’s motives, credibility, and trustworthiness. Influencing the teacher to implement a specific strategy with a child is more is more than a matter of accurately diagnosing the child’s problem and prescribing a technically “correct” intervention. Rather the consultant must carefully attend to a host of interpersonal, intrapersonal, and situational variables that determine the success of the consultant’s efforts to influence the teacher to adopt a particular approach with a child (p. 270).

Teachers’ beliefs in their abilities have powerful effects on multiple areas of education. Teachers’ sense of professional efficacy influences their general educational orientation, as well as their instructional processes (Bandura, 1997). Teachers with high teacher efficacy spend more time on planning and organization (Allinder, 1994), utilize effective classroom management techniques (Woolfolk, Rosoff, & Hoy, 1990), maintain an openness to implementation of innovative classroom practices (Guskey, 1988; Stein & Wang, 1988), devote more time to academic activities (Gibson & Dembo), interact more positively with students when they make errors (Ashton & Web, 1986; Gibson & Dembo, 1984), and possess an increased willingness to
work with students experiencing difficulties and develop programs for special pupils (Podell & Soodak, 1993).

Not surprisingly, teachers with high teacher efficacy who demonstrate positive teaching practices have a positive influence on student outcomes. Teachers who have high teacher efficacy promote student autonomy (Midgley, Feldlaufer, & Eccles, 1988), motivation (Midgley, Feldlaufer, & Eccles, 1989), achievement (Armor et al., 1976; Berman et al., 1977), and students’ personal self-efficacy (Anderson, Greene, & Loewen, 1988). Clearly, beliefs in their own capabilities lead to positive action by teachers. According to Bandura (1997), teacher efficacy influences student achievement and behavior, indirectly, through the mediational impact on teaching behaviors (e.g., effort and perseverance).

The Present Study

The present study investigated the consultant-consultee relationship from a relational perspective, focusing on the working alliance within the interaction. The construct of working alliance encompasses the multiple relational factors discussed in the consultation literature. Although the working alliance construct has been effectively studied across various change relationships (Bordin, 1979), no study has measured working alliance within the field of consultation. This study undertook this task.

Within the field of consultation, development of a strong working relationship is foundational for effective consultation (Rosenfield, 1991; Conoley & Conoley, 1992; Henning-Stout, 1993; Kratochwill, et al., 1995; Zins & Erchul, 1995; Gutkin, 1996; Gutkin & Curtis, 1999). The consultant-consultee relationship includes elements of the psychotherapeutic working alliance (Agnew-Davies, et al., 1998), such as the relational bond, agreement on the goals and tasks of the consultation process, and the consultee’s confidence in the expertise of the consultant. The achievement of the preventative and remediation goals of consultation occurs through change (i.e., implementation of consultant recommendations). In order for teachers to implement the recommendations of the consultants, teachers must understand the content of the suggestions, possess the motivation to put the suggestions into place, have the skill to perform the suggested behaviors, and believe that they can successfully execute the recommended behaviors (Bandura, 1997). Forming a working alliance with the teacher precedes and encompasses the work of consultation that increases the teacher’s sense of professional efficacy. That is, in order for the consultant to engage the consultee in a conversation in which verbal
persuasion or modeling increase teacher efficacy, the consultant and consultee must have mutual positive regard and agreement on which tasks and goals are realistic for a given consultee in a particular context (Raue & Goldfried, 1994). Thus, it seems plausible that the working alliance must come first and the consultant must focus recommendations on areas in which the teacher’s efficacy can be increased to a point at which the teacher is willing to try the suggestions. If the teacher possesses the requisite knowledge and skill but lacks the confidence to execute the recommendations, it is likely that the teacher will not attempt to employ the consultant’s suggestions.

The current study examined the mediational role played by teachers’ perceived efficacy and the effects of teacher efficacy on teachers’ implementation intentions. This line of research has promise for increasing our understanding of the most efficacious ways of conducting mental health consultations. The investigation of this hypothesis will be helpful for determining whether increased collaboration within the consultation process, mediated by the teacher’s sense of efficacy, will increase the likelihood that the teacher will implement the consultant’s suggestions. If this is the case, it implies that a primary focus should be placed on increasing teachers’ sense of professional efficacy during mental health consultations.

**Hypotheses**
- Perceived working alliance is related to increased behavioral intention to implement the consultant’s suggestions.
- Perceived teacher efficacy mediates the relationship between perceived working alliance and behavioral intention to implement the consultant’s suggestions.

**Method**

**Participants**
Participants included Butler County Head Start lead teachers who received mental health consultations during the spring of the 2005/2006 school year. Data were collected during a Butler County Head Start staff meeting on April 28, 2006. There were 24 lead teachers present during the meeting (96%) and 100% of lead teachers in attendance participated in the study. Of the lead teachers in attendance, 22 had received mental health consultations during the spring. Participating teachers completed surveys, which took approximately 30 minutes. All participants signed a
consent form (Appendix A). Subsequent to completing the survey, a debriefing form describing the study was distributed and reviewed (Appendix B).

Of the lead teachers, 72.7% were Caucasian/white, 22.7% were African American, and 4.5% were Asian/Pacific Islander. All respondents were female. Table 1 presents the years of general teaching experience, years of experience teaching in Head Start, and time in current position of study participants. The educational attainment of participating teachers varied. Table 2 presents the educational attainment of teachers in the current study and the mean of years at Head Start for each educational level. The educational attainment of lead teachers in the present sample ranged from holding a Child Development Associate (CDA) certification to holding a master’s degree. The majority of teachers completing this survey worked in typical classrooms (n = 16), fewer worked in inclusion (n = 4) and TIPP (n = 2) classrooms.

Procedure

Mental health consultation process. Miami University and the Center for School-Based Mental Health Program’s (CSBMHP) team of graduate student mental health consultants, under faculty supervision, provided bi-annual federally mandated mental health consultations to Butler County Head Start teachers during the 2005/2006 school year. Consultants worked with teachers to highlight the teachers’ strengths in promoting children’s emotional and behavioral health, as well as attempted to collaboratively problem solve with teachers to address particular classroom challenges. For the 2005/2006 school year, a team of six Miami University clinical psychology graduate student consultants, under faculty supervision, provided the consultations to 25 lead teachers in 49 Butler County Head Start classrooms. The process contained the following stages: the introductory visit, a presentation of the consultation process to staff, completion of the goals, strengths, and challenges form by teachers, classroom observation, and the teacher consultation.

The initial interaction with the teachers provided the consultants with an opportunity to introduce themselves to the teachers, provide an overview of the mental health consultation process, and schedule the observation. At a subsequent teacher meeting, a more detailed review of the consultation process was given and various handouts of proactive teaching strategies were provided (e.g., setting up the physical environment, building positive relationships with children, etc.). In addition, at the teacher meeting, teachers were asked to complete a form detailing their classroom goals, strengths, and challenges (Appendix C). Consultants used this information to fit the consultation to the needs of each classroom teacher.
The next stage of the process was the classroom observations. Consultants observed each classroom for approximately one hour. Observations provided a snapshot of the physical classroom environment and teacher-student interactions, as well as provided an opportunity to identify children who may have been in need of further support or assessment (Appendix D). Following the observations, a report was prepared based upon a template that prompted for teacher-identified goals, classroom strengths, and recommendations to address teacher-identified challenges and goals (Appendix E). Consultants were trained to frame suggestions positively and constructively within the current classroom resources. Support materials were supplied to the teacher during the consultation. Faculty supervisors reviewed all paperwork and discussed each classroom prior to the graduate student consultant providing the mental health consultation.

During the mental health consultation, the consultant first reviewed the report with the teacher. Next, the consultant and teacher discussed children in the classroom who might benefit from additional support. The consultant and teacher, then, collaboratively problem-solved and identified possible interventions for these children. During this phase, the teacher and consultant utilized a template that prompted for observed behaviors, possible environmental adjustments, and next steps (Appendix F). This process was meant to empower the teacher to assume principal responsibility for behavior modifications with these children, while supplying the teacher with ideas for successful interventions.

Measures

Participants provided demographic information (Appendix G). In addition, each teacher completed measures to assess working alliance, teacher efficacy, and behavioral intentions. The instruments are listed below. Table 3 presents a summary table of all items on each measure.

Working Alliance. Selected scales of the client version of the Agnew Relationship Measure (ARM; Agnew-Davies, Stiles, Hardy, Barkham, & Shapiro, 1998) were adapted and used to measure the teachers’ perceptions of the consultant-consultee working alliance (Appendix H). The ARM is composed of five scales designed to measure the following dimensions of the working alliance within the therapist-client relationship: bond, partnership, confidence, openness, and client initiative. Each of the items is measured on a seven point Likert scale from “strongly disagree” (1) to “strongly agree” (7). Higher scores are representative of a stronger working alliance.
The scales of bond, partnership, and confidence were selected as particularly appropriate to this study. The bond scale measures the client’s perceptions of the therapist’s friendliness, acceptance, understanding, and support. The partnership scale measures the client’s perception of working jointly on therapeutic tasks with the therapist. The confidence scale concerns the client’s level of optimism and respect for the professional competence of the therapist. In the client version of the ARM, these three scales loaded on a common factor (Agnew-Davis et al., 1998). Previous research evinces good internal consistencies for the three aforementioned scales, (bond $\alpha = .82$, partnership $\alpha = .80$, and confidence $\alpha = .87$ (Agnew-Davies et al., 1998).

For the current study, items from the bond, partnership, and confidence scales were adapted to the consultant-consultee relationship and combined to form an overall measure of working alliance. For all items on this measure, the word “consultant” replaced the word “therapist” and the word “suggestions” replaced the word “techniques.” Each of the scales contained one item that was removed as inappropriate for the current study; these included the item “My therapist accepts me no matter what I say or do” from the bond scale, the item “My therapist and I are willing to work hard together” from the partnership scale, and the item “I feel optimistic about my progress” from the confidence scale. The resulting adapted measure of working alliance contained 14 items (five items from the original bond scale, three items from the original partnership scale, and six items from the original confidence scale). In the present sample, the adapted working alliance measure showed good internal consistency, $\alpha = .78$.

**Efficacy. Teachers’ Sense of Efficacy Scale** (short form; Tschannen-Moran, & Woolfolk Hoy, 2001). The Teachers’ Sense of Efficacy Scale—short form (TSES) was used to measure the efficacy construct (Appendix I). The measure is a 12-item scale designed to capture a broad range of teaching tasks. The TSES is comprised of three 4-item subscales that measure teachers’ perceptions of their ability to affect student engagement, classroom instruction, and classroom management in a positive way. Responses are rated on a nine-point Likert scale anchored from “nothing” (1) to “a great deal” (9). Higher scores are representative of higher teacher efficacy. The TSES correlates well with other measures of teacher efficacy, providing evidence of its construct validity. Previous reliabilities were $\alpha = .90$ for the full scale, $\alpha = .81$ the engagement subscale, $\alpha = .86$ for the instruction subscale, and $\alpha = .86$ for the management subscale (Tschannen-Moran, & Woolfolk Hoy, 2001). In the present study, full-scale scores were used as an overall measure of teacher efficacy. The overall measure evinced good internal consistency with $\alpha = .92$. 

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Intention to Implement Consultant Suggestions. Head Start teachers’ intentions to implement the suggestions made by the mental health consultants were measured using a three item behavioral intention scale (BIS) constructed for this study (Appendix J). This scale was modeled after the Theory of Planned Behavior (TPB; Ajzen, 2005) behavioral intention scale (Francis et al., 2004). Responses were rated on a 7-point Likert scale, with higher ratings indicating stronger intentions to implement the consultant’s suggestions. Studies utilizing similar behavioral intention scales have shown good internal consistency, e.g. $\alpha = .84$ (Armitage & Conner, 1999). In the present study, the scale evinced good internal consistency with $\alpha = .82$.

Data Analyses

SPSS was used to perform all statistical analyses. The study hypotheses were tested using multiple regression to test for mediation, following Baron and Kenny (1986). As illustrated in Figure 1, a mediational model is comprised of three variables with two causal paths leading to the dependent variable: the direct path ($c$), which is the relationship between working alliance and the teacher’s intention to implement the consultant’s suggestions, and the indirect paths ($a$ and $b$), which are the relationships between working alliance and teacher efficacy and between teacher efficacy and intention to implement suggestions respectively. In a mediational model, the significance of the direct path ($c$) is reduced significantly by the inclusion of the mediator ($c'$). According to Baron and Kenny (1986), several requirements must be satisfied to establish a mediational relationship. A series of multiple regressions were conducted to test the requisite relationships.

1. Working alliance (independent variable) must be significantly associated with intention to implement the consultant’s suggestions (dependent variable). For this test, the dependent variable was regressed on the independent variable ($path c$).
2. There must be a significant relationship between working alliance (independent variable) and teacher efficacy (mediator). This test was accomplished by regressing the mediator on the independent variable ($path a$).
3. There must be a significant relationship between teacher efficacy (mediator) and intention to implement consultant’s suggestions (dependent variable). For this test, the dependent variable was regressed on the mediator ($path b$).
4. The significance of the relationship between working alliance and intention to implement consultant suggestions should be reduced when teacher efficacy is added.
to the model and simultaneously used to predict teacher’s intention to implement the consultant’s suggestions. This test was accomplished by regressing the dependent variable simultaneously on the independent variable and the mediator (path \( c' \)).

**Results**

The data from the current study contained six missing values: four on the ARM, one on the TSES, and one on the BIS. Due to the small sample size, the mean of the completed measure items for the participant was calculated and used to replace the missing values. This study contained one outlier for the category of years of Head Start teaching experience; one teacher in the current sample had 37 years of Head Start teaching experience (\( z = 3.05 \)). The data from this respondent was retained. Analyses involving this variable should be interpreted with caution.

The relatively small sample of lead teachers (N = 22) completing this survey has resulted in low power for the current analysis. Power is the probability of correctly rejecting a false null hypothesis (\( H_0 \)). As power increases, the chances of correctly rejecting a false \( H_0 \) increase. According to Cohen (1992), a mediational analysis with three variables and a medium effect size would require a sample size of 76 in order to have sufficient power. Therefore, the results of the current study were interpreted with the awareness of the limits imposed by a small sample size and low statistical power.

Table 4 presents the descriptive statistics for the non-standardized values of study variables. Cronbach’s (1951) alpha was acceptable for all variables, with no alpha less than .78. According to Baron and Kenny (1986), correlations among variables are expected in a mediational model due to the presumption that the independent variable causes the mediator. In the present study, there were no significant correlations between the independent variable (working alliance) and the mediator (teacher efficacy). Table 5 presents the correlations among study variables.

All analyses were run using standardized values for each of the variables. Mediational analyses followed the procedures described by Baron and Kenny (1986). The first criterion, that working alliance is significantly related to teachers’ decision to implement the consultants’ suggestions (path \( c \)), was not supported (\( t (20) = .83, p > .05 \)). According to Baron and Kenny (1986), if the analysis in the first step fails to show a relationship between the independent and the dependent variable, mediation cannot occur and therefore there is no reason to continue the
analyses. However, if the first criterion had been supported, analysis would proceed to investigate the relationship between the independent variable, working alliance, and the mediator, teacher efficacy (path a). In the present study, this step also failed to show a significant relationship between teacher efficacy and working alliance ($t (20) = .59, p > .05$). The third step would be to investigate the relationship between the mediator, teacher efficacy, and the dependent variable, intentions to implement suggestions (path b). The results of this analysis demonstrated a significant relationship between a teacher’s sense of efficacy and his or her decision to implement the consultant’s suggestions ($t (20) = 2.56, p < .05$). As shown, teachers’ sense of professional efficacy accounts for 25% of the variance in the decision to implement suggestions made by the mental health consultant. The final step in the Barron and Kenny (1986) method would be to regress the dependent variable, teachers’ intentions to implement consultants’ suggestions, on the independent variable, working alliance, and the mediator, teacher efficacy (path c'). The results of this step were not significant. ($t (19) = .60, p > .05$). The full model accounted for 26% of the variance, which is only a slight improvement to the 25% of variance accounted for by teacher efficacy alone. Table 5 presents the analyses results.

The Baron and Kenny (1986) criteria for a mediational model require working alliance to predict behavioral intention (step 1), for working alliance to predict teacher efficacy (step 2), for teacher efficacy to predict behavioral intentions (step 3), and for the significance between working alliance and behavioral intention to be greatly reduced by the inclusion of teacher efficacy (step 4). The current data do not support the mediational model in the first two, prerequisite steps. Therefore, the current data do not support the proposed mediational model.

Post Hoc Analyses

Baron and Kenny (1986) state that a moderator is generally introduced when an unexpectedly weak relationship exists between the independent and the dependent variable. A moderator is a variable that affects the direction and/or strength of the relationship between the independent and the dependent variable (Baron & Kenny, 1986). Figure 2 depicts the moderation model. A third variable moderates the relationship between an independent and a dependent variable if the effect of the independent variable is different for varying values of the moderator. According to Baron and Kenny (1986), a moderation model is composed of three causal paths that feed into the outcome variable. A moderation analysis examines the impact of the independent variable on outcomes (path a), the impact of the moderator on outcomes (path b),
and the interaction of the moderator and the independent variable on outcomes (path c). The interaction term is the product of the independent variable and the moderator. The significance of a moderational model is determined by the significance of the interaction term on outcomes (path c).

Post hoc analyses examined two potential moderators of the relationship between working alliance and teachers’ behavioral intentions to implement consultants’ suggestions: years of Head Start teaching experience and educational attainment of Head Start teachers. The first moderator considered was teacher experience. In the field of school-based consultation, researchers have found that the older and more experienced a teacher is, the less likely consultation will have successful outcomes (Martin & Curtis, 1980). Therefore, it seems plausible that the level of teacher experience may moderate the relationship between consultant-teacher working alliance and consultation outcomes, that is, that the effect of working alliance on teachers’ behavioral intentions to implement consultants’ suggestions may vary according to the level of teacher experience. Level of teacher experience was measured as the length of time the teacher had held a teaching position with Head Start. Length of time teaching at Head Start varied widely for this sample (see Table 1), with a range from 5 months to 37 years. The method for testing moderation followed Baron and Kenny (1986). A series of simple linear regressions tested each of the causal paths. The first path (a), the impact of the independent variable, working alliance, on outcomes, teachers’ behavioral intentions to implement consultants’ suggestions, was not significant (t (20) = .83, p > .05). The second path (b), the relationship between years of experience (moderator) and outcomes, was significant (t (20) = -3.25, p < .01). However, the third path (c), which is the effect of the interaction of the moderator and the independent variable on the outcome, in this case the interaction of working alliance and duration of Head Start teaching experience on teachers’ behavioral intentions to implement consultants’ suggestions, was not significant (t (18) = -.75, p > .05). According to Baron and Kenny (1986), moderation is determined by the significance of the interaction term (path c). Although the results revealed a significant main effect, i.e. teacher experience on teachers’ behavioral intentions to implement consultants’ suggestions, the results fail to support the moderational model due to the lack of significance of the interaction term on the outcome (path c). Intercorrelations for this analysis are presented in table 7. Results of this analysis are presented in Table 8.
A second moderational analysis was undertaken to investigate the effect of teachers’ level of educational attainment on the relationship between working alliance and teachers’ behavioral intentions to implement consultants’ suggestions. Research suggests that a relationship exists between teacher effectiveness and the level of teacher education (National Research Council, 2001, as cited in U.S. GAO, 2003). Therefore, it seems reasonable that increased knowledge of “best practices” in early childhood education would impact the working alliance with the consultant due to an increased likelihood for the teacher and consultant to agree on the problem, goals, and subsequent tasks for an intervention. A regression analysis examined this supposition. The first path (a), the effect of working alliance on teachers’ behavioral intentions to implement consultant suggestions, was not significant ($t(20) = .83, p > .05$). The second regression analysis tested the significance of teachers’ educational level on teachers’ behavioral intentions to implement consultants’ suggestions (path b); this analysis was significant ($t(20) = 2.48, p < .05$). The final analysis measured the effect of the interaction of teachers’ educational level and working alliance on teachers’ behavioral intentions to implement consultants’ suggestions (path c). The results of this step were not significant ($t(18) = -.07, p > .05$). Therefore, the moderation model was not supported despite the main effect for path b, teachers’ educational level on teachers’ behavioral intentions to implement suggestions. Table 9 presents the intercorrelations of model variables. Table 10 presents results of this moderational analysis.

The results of the previous analyses suggest that teacher experience as well as teachers’ level of educational attainment may have an impact on teachers’ decision to implement consultants’ suggestions. Post hoc analysis investigated the possibility of a relationship between these two factors, teacher experience, and teachers’ level of educational attainment. Recent federal mandates established higher educational requirements for Head Start teachers, with 50% of teachers nationally required to have a minimum of an Associate’s degree (U.S. GAO, 2003). The need for Head Start administrators to comply with this mandate may result in newly hired teachers possessing higher levels of education than those who have been in their positions for longer. An examination of the relationship between teaching experience and teacher educational level evinced a significant negative correlation, with teachers who taught the least amount of time possessing higher levels of education ($R^2 = -.43, p < .05$). Interestingly, an investigation of the relationship between teacher experience and teacher efficacy revealed a negative correlation that showed a trend toward significance ($R^2 = -.38, p < .10$). This result suggests that newer
teachers, who according to the previous results also have higher levels of education, reported higher levels of teaching efficacy than did teachers who had more years of experience.

Previous analyses uncovered another significant finding in relation to teacher efficacy. In the a priori mediational analysis, a main effect of teacher efficacy on teachers’ behavioral intentions surfaced ($t (20) = 2.56, p < .05$). This finding indicated that teachers with higher levels of professional efficacy were more likely to implement consultants’ suggestions than teachers who reported lower levels of professional efficacy. Based upon the effect of teacher experience on professional efficacy as well as the effect of teacher experience on teachers’ behavioral intentions to implement consultants’ suggestions, post hoc analyses were ran to determine if teacher efficacy mediated the effects of experience on teachers’ behavioral intentions. The analyses supported the mediational model. The method for mediational analysis followed the Baron and Kenny (1986) steps, previously outlined. The first criterion, that teacher experience is significantly related to teachers’ decision to implement the consultants’ suggestions ($path c$), was supported ($t (20) = -3.25, p < .01$). The second criterion, that teacher experience is significantly related to teacher efficacy ($path a$) revealed a result with a trend toward significance ($t (20) = -1.84, p < .10$). The third step was to investigate the relationship between the mediator, teacher efficacy, and the dependent variable, intentions to implement suggestions ($path b$). The results of this analysis demonstrated a significant relationship between teacher efficacy and decision to implement consultants’ suggestions ($t (20) = 2.56, p < .05$). The final step in the Barron and Kenny (1986) method was to regress the dependent variable, teachers’ intentions to implement consultants’ suggestions, on the independent variable, teacher experience, and the mediator, teacher efficacy ($path c'$). The results of this step were consistent with mediation, showing that the relationship between teacher experience and behavioral intention was no longer significant when teacher efficacy was included in the equation ($t (19) = 1.71, p > .10$), Table 11 presents the intercorrelations of model variables and Table 12 presents the results of the mediational analyses.

Discussion

The purpose of the present study was to investigate the relationship between consultant-teacher working alliance, teachers’ sense of professional efficacy, and teachers’ intentions to implement suggestions made by the mental health consultants. It was hypothesized that teachers’
intentions to implement consultants’ suggestions would be significantly related to the strength of the consultant-teacher working alliance. It was also hypothesized that the consultant-teacher working alliance and teachers’ intentions to implement consultants’ suggestions would be mediated by teachers’ level of professional efficacy. Analyses failed to support the hypotheses. Multiple regression tests for mediation following Baron and Kenny (1986) revealed no support for the mediation model due to a lack of significance between the independent variable, working alliance, and the dependent variable, teachers’ behavioral intentions to implement consultants’ suggestions.

Speculations can be made for the lack of significance between working alliance and teachers’ behavioral intentions to implement consultants’ suggestions. First, the study sample was small, 22 participants. The small sample size resulted in low power for the analysis. With low power, it is difficult to detect an effect even if one is present and particularly if the effect size is small. In the present study, more than three times as many participants would have been needed to establish sufficient power and for the study to have a reasonable chance of detecting a medium effect size of working alliance on teachers’ behavioral intentions to implement consultants’ suggestions. An additional factor that may have impacted the a priori analyses was the relative lack of variance in the independent variable. The standard deviation for teachers’ reported behavioral intentions was nearly two times the standard deviation of teachers’ reported working alliance. The relative lack of variance of working alliance compared with behavioral intentions may have precluded the variables from varying together, which is necessary for prediction (i.e. the prediction of behavioral intentions from the working alliance ratings).

Alternatively, speculations could be made for the lack of significance, between working alliance and teachers’ behavioral intentions to implement consultants’ suggestions, to be a result of a failure to incorporate a moderator into the model. Although working alliance and behavioral intentions did not show a direct relationship, perhaps a relationship between these factors did exist and was visible only at particular levels of a third factor. Post hoc analysis investigated two possible moderators: teacher experience and level of teacher education. Informed by previous research, it was hypothesized that working alliance would show a relationship with teachers’ behavioral intentions to implement consultants’ suggestions based on differential levels of teacher experience or teacher education. However, results of post hoc moderation analyses revealed no support for either model.
The results of a priori and post hoc analyses involving working alliance and teachers’ behavioral intentions to implement consultants’ suggestions were puzzling, as it would have been expected that increases in working alliance (i.e., consultant-teacher rapport, agreement on problems and next steps, along with teachers’ perception of consultants’ level of knowledge and skill) would have resulted in teachers’ reporting stronger intentions to implement consultants’ suggestions. Alternative explanations of this counterintuitive finding include the potential effects of the mandated consultation structure and/or the possible methodological limitations of the evaluation process.

That teachers were not engaging in consultation out of their own volition may have affected the study findings. It is theorized that teachers who engage in the consultation process voluntarily are more likely to take ownership of the intervention derived during the consultation and the subsequent implementation of that intervention (Henning-Stout, 1993). Although voluntary participation by teachers in the consultation process is the ideal, it is generally not the reality (Harris & Cancelli, 1991, as cited in Gutkin & Curtis, 1999). The initiation of many school-based consultations originates from a source other than the teacher (Gutkin & Curtis, 1999). A demonstration of resistance to the consultation process by teachers would seem understandable under these mandated conditions (Gutkin, 1996a). Teachers demonstrating resistance to the consultation process may not work with the consultant to plan appropriate interventions or take ownership of the implementation of the interventions. Thus, teachers who were not engaging positively in the consultation process would be less likely to develop or report a strong working alliance with the consultant.

Although the mandated nature of consultations can be posited (Gutkin, 1996a) to result in a lack of working alliance between the consultant and teacher, this same factor may also result in teachers’ reports of a strong working alliance with the consultant. That is, the mandated nature of the mental health consultations may have a positive impact on the reported working alliance. Because the biannual consultations are a required part of the teachers’ jobs, willingness to engage in the consultation process may be a reflection of teachers’ acceptance of their job requirements. Thus, teachers’ reports of strong working alliances with consultants may have resulted from their acceptance of the consultation aspect of their jobs.

Perception of an alliance between the survey administrator and the Head Start administration may have also affected teachers’ responses on survey items. Teachers filled out
surveys during a mandatory staff meeting. At the time of the survey administration, the Head Start educational manager provided an introduction for the survey administrator, in which she expressed her enthusiasm about the consultation services and the relationship of the local Head Start with the University. This introduction may have swayed teachers into providing more positive responses than they otherwise would have provided. For example, teachers may have responded more positively on the measure of working alliance in order to mirror the sentiment of the administration.

Additionally, methodological limitations may have affected the teachers’ responses on the measures. For instance, consultations occurred between January 31, 2006 and March 7, 2006, yet the surveys were not administered until April 28, 2006. The time span between the provision of consultation services and the administration of the survey may have affected the way teachers responded to items. More specifically, it would have been possible for teachers to have rated their levels of professional efficacy based upon current classroom experiences; however, rating the working alliance with the consultant and rating behavioral intentions to implement consultants’ suggestions would have required teachers to reflect back on situations that occurred 1 ½ to 3 months earlier. This gap in time had the potential to affect teachers’ responses on measures of working alliance, teacher efficacy, and behavioral intentions.

Despite the fact that analyses from the current study failed to support relationships involving the working alliance variable, the analyses did reveal several significant relationships not involving the working alliance variable. Post hoc analyses revealed a relationship between teacher experience and teachers’ behavioral intentions to implement consultants’ suggestions, between teachers’ level of education and behavioral intentions to implement consultants’ suggestions, and between teachers’ level of education and years of Head Start teaching experience. In addition, a priori analyses, revealed a relationship between teacher efficacy and teachers’ behavioral intentions to implement consultants’ suggestions.

Post hoc analyses of moderation evinced two main effects. The first main effect revealed a negative relationship between teacher experience and teachers’ behavioral intentions to implement consultants’ suggestions. Teachers with more experience reported lower behavioral intentions to implement consultants’ suggestions. Previous research supports this finding, e.g. Martin and Curtis (1980) found a negative relationship between teachers’ experience and consultation outcomes. One possible explanation for this finding is that teachers with more
experience also possess more confidence in their teaching abilities. Research has found an inverse relationship between teacher-reported confidence and the implementation of new instructional methods, with teachers who chose not to implement the new method having a higher level of confidence than those teachers who did implement the new method (Guskey, 1984). This finding suggests that teachers who choose not to implement consultant recommendations might do so because they have the confidence to reject them.

The second main effect, revealed during post hoc moderation analyses, was a significant positive effect of teachers’ levels of education on their behavioral intentions to implement consultants’ suggestions. Teachers with higher levels of education were more likely to report behavioral intentions of implementing consultants’ suggestions. Perhaps, the overarching teaching philosophy of more educated teachers aligns more closely with the consultants’ philosophies of “best-practices” within a classroom. Congruence on best practices in the classroom may increase the likelihood that more educated teachers implement consultants’ suggestions. Research suggests that teachers with higher levels of education are more effective in numerous domains (e.g. National Research Council, 2001, as cited in U.S. GAO, 2003). For example, in a review of relevant literature, Barnett (2003) stated that consistent links have been found between preschool teachers’ qualifications and the quality of care and education provided to students. Studies have shown that teachers with more education have more positive, warm, and responsive interactions with their students, use more proactive classroom management techniques, and provide richer cognitive and language experiences. Thus, teachers with higher levels of education are more effective in supporting children’s social, emotional, and academic growth. It seems plausible that consultants’ suggestions would be more likely to coincide with the teaching practices of more educated teachers’ because of this common focus on social and emotional development. This mutuality may be one factor involved in the higher frequency with which teachers with higher levels of education reported behavioral intentions of implementing the consultants’ suggestions.

Another interesting finding involving teachers’ educational level was the significant negative correlation between years of Head Start teaching experience and teachers’ level of education. In other words, the current data showed that newer teachers possessed higher levels of education than did teachers who were more experienced. One possible explanation for this finding is the 1998 federal Head Start Act’s mandated increase in the educational level of
According to this act, 50% of Head Start teachers nationwide were required to possess a minimum of an Associate’s degree in early childhood education or in a related field with preschool teaching experience by September 30, 2003 (U.S. GAO, 2003).

Paralleling the finding of the current study that showed that newer teachers possessed higher levels of education, analyses revealed that newer teachers tended to report higher levels of professional efficacy as well. An examination of teachers’ levels of experience and teachers’ reported levels of professional efficacy evinced a trend toward significance. This finding supports previous research, which found that newer teachers reported higher levels of professional efficacy (Hoy & Woolfolk, 1990; Pigge & Marso, 1993, as cited in Tschannen-Moran, Woolfolk-Hoy, & Hoy, 1998; Ghaith & Yahgi, 1997). This suggests that the longer a teacher is in the field, the lower her/his reported level of professional efficacy will be. Furthermore, Bandura (1979) suggests that efficacy may become less malleable over time. The implications of this being that the longer a teacher teaches, the lower her/his professional efficacy will be, and the more difficult it will be to alter her/his sense of professional efficacy. In other words, when consultants are working with more experienced teachers, not only might they be facing the problem of consulting with a teacher with lower efficacy, but also the additional challenge of trying to transform more inflexible efficacy beliefs.

The present study evinced a connection between consultation outcomes and teacher efficacy. A priori analyses revealed a significant main effect between teachers’ reported levels of professional efficacy and teachers’ intentions to implement consultants’ suggestions. Teachers who reported higher levels of professional efficacy were more likely to report behavioral intentions of implementing the consultants’ suggestions. This finding is consistent with previous research, which found that teachers with higher efficacy were more likely to view consultants as effective and interventions as acceptable (DeForest and Hughes, 1992).

To summarize, results of the current study revealed the following: teachers who had higher levels of education were more likely to implement consultants’ suggestions than teachers with lower levels of education, newer teachers tended to have higher levels of education and higher levels of professional efficacy, and teachers with higher levels of professional efficacy were more likely to report behavioral intentions of implementing the consultants’ suggestions. Inferring from these findings, the hypothetical “best consultee” would be a newer teacher.
because s/he would be likely to have more education, higher professional efficacy, and a greater probability of implementing the consultant’s suggestions.

Results of analyses from the current study, as well as previous research findings, pointed toward a possible connection between teacher experience, teacher efficacy, and behavioral intentions. Post hoc analyses investigated the potential mediating effect of teacher efficacy in the relationship between years of Head Start teaching experience and teachers’ behavioral intentions to implement consultants’ suggestions. Previous research (Martin & Curtis, 1980) and current analyses showed that the longer a teacher teaches, the less likely s/he was to implement the consultant’s suggestions. In addition, previous research (e.g. Hoy & Woolfolk, 1990) and current analyses revealed that the longer a teacher teaches, the lower her/his reported level of professional efficacy. Moreover, mediation analyses indicated a significantly stronger relationship when teachers’ level of experience and teachers’ reported level of professional efficacy were used simultaneously to predict teachers’ behavioral intentions to implement consultants’ suggestions. This finding suggests that positive consultation outcomes (i.e. teachers’ intentions to implement consultants’ suggestions) could result from focusing consultation efforts on increasing the teacher’s sense of professional efficacy. Further, the impact of increasing the teacher’s sense of professional efficacy has the potential to attenuate the negative effect that teachers’ increasing level of experience has on consultation outcomes.

As can be seen, the royal road to positive consultation outcomes may well be through the enhancement of teachers’ professional efficacy. Practice implications naturally follow. Consultation will be most effective when services are tailored to a teacher’s particular level of professional efficacy and level of experience. Perhaps newer teachers’ sense of efficacy will be altered more easily by verbal persuasion techniques (Hagen, Gutkin, & Palmer-Wilson, 1998) common in traditional mental health consultations and teachers who have been on the job for longer may benefit most from more intensive methods of efficacy enhancement, such as modeling or facilitated mastery experiences. Further, the finding that increases in teacher education lead to increased teacher efficacy points to the potential benefits of enhancing teachers’ professional developments, possibly through additional in-service training or small group workshops. In a similar manner, Head Start’s federal mandate of higher levels of teacher education may assist mental health consultants working with Head Start teachers, as higher
levels of teacher education result in higher levels of teacher efficacy and more positive consultation outcomes.

Limitations of the Study

In addition, to the aforementioned limitations, such as sample size, power, relative lack of variance in the working alliance variable, and timing of survey administration, several other factors limited the findings in the present study. First, there were potential limitations of the abbreviated scale used to assess the dependent variable. The three questions that made up the dependent variable of behavioral intentions were part of a larger 13-item measure that also assessed attitudes toward behavior, subjective norms, and perceived behavioral control. The wording of this scale was similar for all 13 items. The seemingly repetitive nature of this series of questions could have been frustrating for participating teachers.

Second, the current study lacked information regarding the actual recommendations made to each teacher. We know that the realm of the recommendations were similar for each teacher; however we do not have information about how many recommendations were made to each teacher or about the teachers’ perceptions of the level of difficulty and importance of each recommendation. Mann (1986, as cited in Guskey, 1988) suggested that teachers who need the least improvement are the first to implement, while those teachers, whose classrooms could benefit most, often remain uninvolved. Perhaps fewer recommendations were made to teachers who reported higher levels of education and higher professional efficacy, as these teachers may have already been incorporating a number of proactive and prosocial methods in their teaching practices.

A third factor that may have limited the study was the level of teacher motivation in the absence of cash incentives. Teachers who completed surveys the previous year were provided a small cash incentive for their participation. No cash incentives were provided for participation in the current study. Finally, this study did not collect data of actual teacher behaviors following consultation; rather, teachers were asked to provide self-reports of their behavioral intentions. As Witt and colleagues (1996) have noted, there is no way of knowing the accuracy of self-report data. Whether teachers will actually implement their reported behavioral intentions is uncertain.

Future Research

According to Ajzen (2005), behavioral intentions mediate the relationship between a person’s perceptions of relevant factors and her/his actual behavior. Therefore, a reasonable next
step would be to look at the actual post-consultation behaviors of teachers. Future research that explored the actual behaviors of teachers before and after consultation instead of, or in addition to, their reported behavioral intentions, would be beneficial.

Given that a teacher’s level of professional efficacy has been found to be one factor that is involved in positive consultation outcomes (e.g. high teacher efficacy leads to an increased likelihood of teachers implementing consultants’ suggestions), logical next steps would be to consider the possible reasons for teachers’ decreasing efficacy as they gain years of experience and possible ways that teachers’ sense of professional efficacy could be enhanced for various reasons and at differing levels of experience. DeForest and Hughes (1992) suggest providing low efficacy teachers with additional guidance and assistance in implementing recommended interventions, such as through modeling and facilitated mastery experiences. Perhaps future investigations could examine the potential benefits of providing technical assistance that would offer increased facilitation of modeling and mastery experiences.

Additionally, it would be useful to consider if the provision of in-service presentations or small group trainings, in combination with the one-on-one consultation services, could increase the likelihood of positive consultation outcomes (e.g. increased teacher efficacy) in a more cost effective way. Finally, an investigation of consultation effectiveness with differential amounts of time in the classroom along with the respective teacher and classroom characteristics could shed light on the qualities of teachers and classrooms that require more or less time for effective consultation.
References


Table 1

Teaching Experience of Head Start Lead Teachers

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>General teaching experience</td>
<td>13.46</td>
<td>10.58</td>
</tr>
<tr>
<td>Head Start teaching experience</td>
<td>9.73</td>
<td>8.93</td>
</tr>
<tr>
<td>Time in current position</td>
<td>6.28</td>
<td>7.71</td>
</tr>
</tbody>
</table>

*Note. N = 22 Head Start teachers.*
Table 2

Educational Level of Head Start Lead Teachers and Relation of Educational Level to Years of Head Start Teaching Experience

<table>
<thead>
<tr>
<th>Education</th>
<th>N</th>
<th>Percentage</th>
<th>Mean years at Head Start</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDA</td>
<td>3</td>
<td>13.6</td>
<td>11.33</td>
<td>6.0</td>
<td>20.0</td>
</tr>
<tr>
<td>Two-year college degree</td>
<td>8</td>
<td>36.4</td>
<td>15.38</td>
<td>4.0</td>
<td>37.0</td>
</tr>
<tr>
<td>Four-year college degree</td>
<td>10</td>
<td>45.5</td>
<td>5.60</td>
<td>.42</td>
<td>15.0</td>
</tr>
<tr>
<td>Master’s degree</td>
<td>1</td>
<td>4.5</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Note. CDA = Child development associate certification
Table 3

Survey Items for Working Alliance, Teacher Efficacy, and Behavioral Intentions Measures

<table>
<thead>
<tr>
<th>Variable</th>
<th>Items on measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working alliance (ARM)</td>
<td></td>
</tr>
<tr>
<td>Bond scale</td>
<td>I feel friendly towards my consultant.</td>
</tr>
<tr>
<td></td>
<td>My consultant finds it hard to understand me (r).</td>
</tr>
<tr>
<td></td>
<td>My consultant is supportive.</td>
</tr>
<tr>
<td></td>
<td>My consultant is warm and friendly with me.</td>
</tr>
<tr>
<td></td>
<td>My consultant seems bored or impatient with me. (r)</td>
</tr>
<tr>
<td>Partnership scale</td>
<td>My consultant follows his/her own plans, ignoring my views of how to proceed. (r)</td>
</tr>
<tr>
<td></td>
<td>My consultant and I agree about how to work together.</td>
</tr>
<tr>
<td></td>
<td>My consultant and I have difficulty working jointly as a partnership. (r)</td>
</tr>
<tr>
<td>Confidence scale</td>
<td>I have confidence in my consultant and his/her suggestions.</td>
</tr>
<tr>
<td></td>
<td>I feel critical or disappointed in my consultant. (r)</td>
</tr>
<tr>
<td></td>
<td>My consultant's professional skills are impressive.</td>
</tr>
<tr>
<td></td>
<td>My consultant tries to influence me in ways that are not beneficial to me. (r)</td>
</tr>
<tr>
<td></td>
<td>My consultant does not give me the guidance I would like. (r)</td>
</tr>
<tr>
<td></td>
<td>My consultant is confident in him/herself and his/her suggestions.</td>
</tr>
</tbody>
</table>

(Table 3 continues)
<table>
<thead>
<tr>
<th>Variable</th>
<th>Items on measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher efficacy (TSES)</td>
<td>How much can you do to motivate students who show low interest in schoolwork?</td>
</tr>
<tr>
<td></td>
<td>How much can you do to get students to believe they can do well in schoolwork?</td>
</tr>
<tr>
<td></td>
<td>How much can you do to help your students’ value learning?</td>
</tr>
<tr>
<td></td>
<td>How much can you assist families in helping their children do well in school?</td>
</tr>
<tr>
<td>Student engagement scale</td>
<td></td>
</tr>
<tr>
<td>Instructional strategies</td>
<td>To what extent can you craft good questions for your students?</td>
</tr>
<tr>
<td>scale</td>
<td>How much can you use a variety of assessment strategies?</td>
</tr>
<tr>
<td></td>
<td>To what extent can you provide an alternative explanation or example when students are confused?</td>
</tr>
<tr>
<td></td>
<td>How well can you implement alternative strategies in your classroom?</td>
</tr>
<tr>
<td>Classroom management scale</td>
<td>How much can you do to control disruptive behavior in the classroom?</td>
</tr>
<tr>
<td></td>
<td>How much can you do to get children to follow classroom rules?</td>
</tr>
<tr>
<td></td>
<td>How much can you do to calm a student who is disruptive or noisy?</td>
</tr>
<tr>
<td></td>
<td>How well can you establish a classroom management system with each group of students?</td>
</tr>
<tr>
<td>Behavioral intentions (BIS)</td>
<td>I intend to implement the consultant’s suggestion in my classroom within the next three months.</td>
</tr>
<tr>
<td></td>
<td>I plan to implement the consultant’s suggestion in my classroom within the next three months.</td>
</tr>
<tr>
<td></td>
<td>I expect to implement the consultant’s suggestion in my classroom within the next three months.</td>
</tr>
</tbody>
</table>

*Note.* ARM = Agnew Relationship Measure. TSES = Teacher Sense of Efficacy Scale. BIS = Behavioral Intentions Scale. (r) = reversed.
Table 4.

Descriptive Statistics for Non-standardized Study Variables of Working Alliance, Teacher Efficacy, and Teachers’ Behavioral Intentions to Implement Consultants’ Suggestions

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Standard Deviation</th>
<th>Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARM</td>
<td>6.53</td>
<td>5.14</td>
<td>7.0</td>
<td>.52</td>
<td>.78</td>
</tr>
<tr>
<td>TSES</td>
<td>7.66</td>
<td>5.67</td>
<td>9.0</td>
<td>.85</td>
<td>.92</td>
</tr>
<tr>
<td>BIS</td>
<td>5.77</td>
<td>3.67</td>
<td>7.0</td>
<td>1.01</td>
<td>.82</td>
</tr>
</tbody>
</table>

*Note.* N = 22. ARM = Agnew Relationship Measure. TSES = Teacher Sense of Efficacy Scale. BIS = Behavioral Intentions Scale.
Table 5.

Pearson Product-Moment Correlations for Working Alliance, Teacher Efficacy, and Behavioral Intentions Measures

<table>
<thead>
<tr>
<th></th>
<th>TSES</th>
<th>BIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARM</td>
<td>.13</td>
<td>.18</td>
</tr>
<tr>
<td>TSES</td>
<td></td>
<td>.50*</td>
</tr>
</tbody>
</table>

Note. ARM = Agnew Relationship Measure. TSES = Teacher Sense of Efficacy Scale. BIS = Behavioral Intentions Scale.

* p < .05, 2-tailed
Table 6.

Tests for Mediation: Multiple Regressions Statistics for the Model of Working Alliance (Independent Variable), Teacher Efficacy (Mediator), and Behavioral Intentions to Implement Consultant Suggestions (Dependent Variable)

<table>
<thead>
<tr>
<th>Path</th>
<th>DV for each equation</th>
<th>Predictor(s) entered</th>
<th>β</th>
<th>SEB</th>
<th>$R^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>TSES</td>
<td>ARM</td>
<td>.13</td>
<td>.22</td>
<td>.02</td>
</tr>
<tr>
<td>b</td>
<td>BIS</td>
<td>TSES</td>
<td>.50*</td>
<td>.19</td>
<td>.25</td>
</tr>
<tr>
<td>c</td>
<td>BIS</td>
<td>ARM</td>
<td>.18</td>
<td>.22</td>
<td>.03</td>
</tr>
<tr>
<td>$c'$</td>
<td>BIS</td>
<td>ARM TSES</td>
<td>.12</td>
<td>.20</td>
<td>.26</td>
</tr>
</tbody>
</table>

Note. ARM = Agnew Relationship Measure. TSES = Teacher Sense of Efficacy Scale. BIS = Behavioral Intentions Scale.

*p < .05
Table 7.

Pearson Product-Moment Correlations for Working Alliance, Years of Head Start Teaching Experience, the Interaction Working Alliance and Years Teaching at Head Start, and Behavioral Intentions to Implement Consultants’ Suggestions

<table>
<thead>
<tr>
<th></th>
<th>YRS</th>
<th>ARMxYRS</th>
<th>BIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARM</td>
<td>.01</td>
<td>-.04</td>
<td>.18</td>
</tr>
<tr>
<td>YRS</td>
<td></td>
<td>.73**</td>
<td>-.59**</td>
</tr>
<tr>
<td>ARMxYRS</td>
<td></td>
<td></td>
<td>-.53*</td>
</tr>
</tbody>
</table>

*Note. ARM = Agnew Relationship Measure. YRS = Years Teaching at Head Start. ARMxYRS = Interaction of working alliance and years of experience. BIS = Behavioral Intentions.

*p < .05, 2-tailed

**p < .01, 2-tailed
Table 8.

Tests for Moderation: Multiple Regressions Statistics for Working Alliance, Years of Head Start Teaching Experience, and the Interaction of Working Alliance and Years Teaching at Head Start on Behavioral Intentions to Implement Consultant Suggestions

<table>
<thead>
<tr>
<th>Path</th>
<th>Predictor(s) entered</th>
<th>$\beta$</th>
<th>SEB</th>
<th>$R^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>ARM</td>
<td>.18</td>
<td>.22</td>
<td>.03</td>
</tr>
<tr>
<td>b</td>
<td>YRS</td>
<td>-.59</td>
<td>.18</td>
<td>.35**</td>
</tr>
<tr>
<td>c</td>
<td>ARMxYRS</td>
<td>-.20</td>
<td>.34</td>
<td>.40</td>
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</tbody>
</table>

*Note. ARM = Agnew Relationship Measure. YRS = Years Teaching at Head Start. Dependent Variable for all equations = Behavioral Intentions Scale.*

**$p < .01**
Table 9.

Pearson Product-Moment Correlations for Working Alliance, Teachers’ Educational Level, Interaction of Working Alliance and Educational Level, and Teachers’ Behavioral Intentions to Implement Consultants’ Suggestions

<table>
<thead>
<tr>
<th></th>
<th>ED</th>
<th>ARMxED</th>
<th>BIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARM</td>
<td>-.22</td>
<td>.46*</td>
<td>.18</td>
</tr>
<tr>
<td>ED</td>
<td>-.01</td>
<td>.49*</td>
<td></td>
</tr>
<tr>
<td>ARMxED</td>
<td></td>
<td>.13</td>
<td></td>
</tr>
</tbody>
</table>

*Note. ARM = Agnew Relationship Measure, ED = Teachers’ Educational Level. ARMxED = Interaction of working alliance and teachers’ educational level. BIS = Behavioral Intentions.

*p < .05, 2-tailed

**p < .01, 2-tailed
Table 10.

Tests for Moderation: Multiple Regressions Statistics for Working Alliance, Teachers’ Educational Level, and the Interaction of Working Alliance and Teachers’ Educational Level on Behavioral Intentions to Implement Consultant Suggestions

<table>
<thead>
<tr>
<th>Path</th>
<th>Predictor(s) entered</th>
<th>$\beta$</th>
<th>SEB</th>
<th>$R^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>ARM</td>
<td>.18</td>
<td>.22</td>
<td>.03</td>
</tr>
<tr>
<td>b</td>
<td>ED</td>
<td>.49</td>
<td>.20</td>
<td>.24*</td>
</tr>
<tr>
<td>c</td>
<td>ARMxED</td>
<td>-.02</td>
<td>.27</td>
<td>.32</td>
</tr>
</tbody>
</table>

*Note. ARM = Agnew Relationship Measure. ED = Teachers’ Educational Level. Dependent Variable for all equations = Behavioral Intentions Scale.

*p < .05
Table 11.

Pearson Product-Moment Correlations for Years of Head Start Teaching Experience, Teacher Efficacy, and Behavioral Intentions Measures

<table>
<thead>
<tr>
<th></th>
<th>YRS</th>
<th>BIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>TSES</td>
<td>-.38</td>
<td>.50*</td>
</tr>
<tr>
<td>YRS</td>
<td></td>
<td>-.59**</td>
</tr>
</tbody>
</table>

*Note. TSES = Teacher Sense of Efficacy Scale. BIS = Behavioral Intentions Scale. YRS = Years Teaching at Head Start.

*p < .05, 2-tailed

**p < .01, 2-tailed
Table 12.

Tests for Mediation: Multiple Regressions Statistics for Years of Head Start Teaching Experience (Independent Variable), Teacher Efficacy (Mediator), and Behavioral Intentions to Implement Consultant Suggestions (Dependent Variable)

<table>
<thead>
<tr>
<th>Path</th>
<th>DV for each equation</th>
<th>Predictor(s) entered</th>
<th>β</th>
<th>SEB</th>
<th>R²</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>TSES</td>
<td>YRS</td>
<td>-.38</td>
<td>.21</td>
<td>.15+</td>
</tr>
<tr>
<td>b</td>
<td>BIS</td>
<td>TSES</td>
<td>.50</td>
<td>.19</td>
<td>.25*</td>
</tr>
<tr>
<td>c</td>
<td>BIS</td>
<td>YRSS</td>
<td>-.59</td>
<td>.18</td>
<td>.35**</td>
</tr>
<tr>
<td>c'</td>
<td>BIS</td>
<td>YRS TSES</td>
<td>.32</td>
<td>.19</td>
<td>.43</td>
</tr>
</tbody>
</table>

Note. TSES = Teacher Sense of Efficacy Scale. YRS = Years Teaching at Head Start. BIS = Behavioral Intentions Scale.

+p < .10
* p < .05
** p < .01
Figure 1. Mediation Model

Teacher Efficacy

Working Alliance

Intention to Implement Suggestions

$a$

$b$

$c$

$c'$

65
Figure 2. Moderation Model
Appendix A
Exploring the Mental Health Consultation Experiences of Head Start Teachers

INFORMED CONSENT FOR TEACHERS

The purpose of this study is to explore teachers’ experience with the mental health consultation process. Specifically, this study seeks to examine the interactions between teachers’ and graduate student consultants, identify the value that teachers’ placed on the information that was provided during the consultations, and gain evaluative feedback on various aspects of the consultation process.

Your role in this study would be to complete the survey that addresses your perceptions of the consultation process, your sense of professional efficacy, evaluation of current consultation procedures, and suggestions for service improvement. The measures will take about 30 minutes to complete.

The benefit of participating is that this information may be helpful in identifying primary focuses of brief consultation processes. In addition, feedback may inform improvements in the mental health consultation processes provided by Miami University and the Center for School-Based Mental Health Programs. There are no risks to you of participating.

All of the information gathered during the study will be kept private and confidential. All surveys will be identified by numerical code. Your name will not be attached to your responses on the survey.

Your participation in this study is voluntary. There will be no penalty to you if you decide not to participate in this research. You can withdraw from this study at any time without penalty or consequence.

This study has been reviewed by the Office for the Advancement of Research and Scholarship at Miami University. If you have any questions about your rights as a research participant, you may contact the Office for the Advancement of Research and Scholarship at (513) 529-3734 or humansubjects@muohio.edu.

If you have any questions or need additional information about this study, please contact the graduate student researcher, Kathy Conaway, at (513) 529-4247 or conawaka@muohio.edu or the faculty supervisors, Dr. Patricia Kerig, Associate Professor of Psychology at Miami University, at (513) 529-6227 or kerigpk@muohio.edu or Dr. Jennifer Green, Visiting Assistant Professor at Miami University, at (513) 529-2448 or greenjh@muohio.edu.

☐ Yes. I agree to participate in the research study Exploring the Mental Health Consultation Experiences of Head Start Teachers.

☐ No. I do not choose to participate in this study.

By signing your name below, you are indicating that you understand your participation is voluntary, that your responses will be kept confidential, and that you are at least 18 years of age.

Signature: ___________________________________________ Date: ______________

Name (printed): ___________________________________________

Please sign one copy of this form and keep a copy for your records.
Appendix B
Exploring the Mental Health Consultation Experiences of Head Start Teachers
DEBRIEFING FORM

Many studies focus on the importance of collaboration in the consultation process and the benefits of teacher efficacy on classroom practices. Development of open, respectful, and collaborative relationships between Head Start teachers and the mental health consultants can help to facilitate teachers’ growth in the areas of knowledge, skills, and confidence (Caplan & Caplan, 1993). In other words, collaboration has the potential to increase teachers’ professional efficacy. Teachers’ efficacy has been linked to numerous positive teacher behaviors such as more effective use of classroom management techniques (Woolfolk, Rosoff, & Hoy, 1990), and increased openness to implementation of new or alternative classroom practices (Guskey, 1988). The implications of the above findings are that consultant-teacher collaboration can lead to higher levels of teacher efficacy, which will lead to greater teacher-receptivity to mental health consultations in general, resulting in increased openness to consultants’ suggestions, e.g. ways of incorporating preventative prosocial classroom management techniques into current practices.

The results of this study will be useful in determining if increased collaboration within the consultation process, mediated by the teacher’s sense of efficacy, will increase the likelihood that they will implement the consultant’s suggestions. In addition, the responses to this survey will allow the Center for School Based Mental Health Programs to further evaluate the processes used for delivering the mental health consultations.

Literature currently available that examines similar questions or topics:


If you would more information about the purposes of the study, or if you simply have any questions or concerns, please do not hesitate to contact the researcher:

Graduate Student
Researcher: Kathryn Conaway Phone: (513)529-4247 E-mail: conawaka@muohio.edu
Faculty Supervisor: Dr. Patricia Kerig Phone: (513)529-6227 Email: kerigpk@muohio.edu
Faculty Supervisor: Dr. Jennifer Green Phone: (513)529-2448 Email: greenjh@muohio.edu
In an effort to provide the most appropriate and supportive consultation services for your classroom, we would like to offer you the opportunity to share with us the goals that you have in mind for your classroom this year and also the strengths and challenges that you encounter. We will use this information as we are planning for the mental health consultation for your classroom.

Goals:


Strengths:
Challenges:


Additional Comments:


Thank you for taking the time to help us enhance our consultation services.
Appendix D
Butler County Head Start Classroom Observation/Consultation Form
Center for School-Based Health Programs
Department of Psychology
Miami University

School: _____________________ Class __________ Circle: AM PM FD INCL TIPP

Head Teacher: ____________________________ Assistant ____________________________
Observer: ____________________________________________________________________

Date: ________________ Time Period: ___________ # of children present _____ enrolled _____
Activities observed/context of observation:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Rating scales
NA= Not applicable (no opportunity for observation)
1= opportunity for improvement
2= strength or positive example observed in this area
3= outstanding practice in this area/strength observed consistently or pervasively

Physical Structure
_____ 1. Classroom is neat, clean, organized, secure/safe.
_____ 2. Classroom space and equipment is used effectively.
_____ 3. Classroom provides low stimulation areas away from traffic.
_____ 4. Classroom provides areas for small group activity/instruction.
_____ 5. Classroom provides stimulating and engaging environment.
_____ 6. Classroom provides warm and comfortable atmosphere.
_____ 7. Student work is displayed.
_____ 8. Teachers use visual strategies to support classroom rules, behavior systems.

Comments: ____________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
Behavioral Management

1. Rules are posted/illustrated prominently.
   A. Stated/ Illustrated positively.
   B. Understood by group.
   C. Referred to consistently.
   D. Limited in number.
   E. Behavior specific.
   F. Enforced consistently.

2. The schedule is followed consistently.

   A. Upon arrival and dismissal.
   B. To and from lunch.
   C. Between activities within the classroom.
   D. Teacher promotes transition effectively.

4. Evidence of prosocial behavior management.

5. Evidence of proactive teacher initiated positive behavior.

6. Continuous supervision of students.

Comments:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Teacher Skills

1. Teacher utilize the following strategies:
   A. Cueing/ Prompting (prepares children for upcoming transition)
   B. Proximity control (one-on-one teaching moments)
   C. Redirection (redirects child’s focus if stressed or upset)
   D. Modeling (demonstrates through personal example)
   E. Shaping (teaches/reinforces developmental steps of a behavior)
   F. Limit setting (clear communication & enforcement of rules)
   G. Selective attention (focuses on positives rather than negatives)
H. Generally positive environment
   1. Verbal encouragement ("you can do it," "keep trying" etc…)
   2. Non-verbal encouragement (winks, smiles, thumbs-up…)
I. Praise (behavior specific)
   J. Appropriate voice tone and body language
   K. Techniques for soothing a child
   L. Reflecting listening (restate child’s words to check understanding)
   M. Use of choice

2. Teacher models/teaches problem solving
   A. Helps the child to define the problem
   B. Helps the child to generate solutions
   C. Helps the child to consider consequences of each

3. All teachers work collaboratively

Comments:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Academic Structure and Instructional Techniques

1. Lessons are prepared and materials are ready. (Lesson plan & presentation)
2. Work time is intentional/ productive
3. Variety of instructional resources/ methods utilized.
4. Lessons are interesting and motivating.
5. Lessons are presented clearly.
6. Teacher checks for understanding. (Ask questions, listens to response)

Comments:__________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

I found the following activities/ characteristics to have a positive effect upon the classroom environment:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
<table>
<thead>
<tr>
<th>Date of Observation</th>
<th>Child’s First and Last Initial</th>
<th>Observed Behaviors</th>
<th>Possible Environmental Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Teacher Identified Goals
Mrs. Brown identified the following goals for her morning classroom:
- Children will follow the daily routine and structure of classroom
- Children will interactive in positive manner without hurting one another
- Children will learn some pre-academic skills (colors)

Observed Strengths of Teacher & Classroom
Mrs. Brown and Mrs. _____ set up their classroom and interact with the children in a number of ways that support the children’s social emotional development.

Physical Structure
- Classroom is neat, clean, organized, secure/safe
- Student work is displayed
- Teachers use visual strategies to support classroom rules. The rules were displayed with pictures on a bright colored bulletin board.
- Classroom provides a warm comfortable atmosphere. Teachers have done a nice job decorating the room with rugs, pillows and pictures.

Behavior Management
- Rules are clearly posted and indicate positive behaviors
- Rules are implemented consistently across children
- Teacher uses creative and effective strategies around transitions such as proving ample warnings visually and verbally.

Teacher Skills
- Teachers use verbal and non-verbal encouragement with the children
- Teachers assist children with self-regulation by reflecting feelings and offering choices for self-regulation techniques
- Teacher uses scaffolding and encouragement to promote problem solving

**Academic Structure & Instructional Techniques**
- Lessons are presented clearly
- Teacher checks for understanding
- Lessons are interesting and motivating for students

**Teacher Identified Classroom Challenges**
Mrs. Brown identified the following challenges in her classroom:
- Children don’t like to clean up toys
- Children sometimes don’t want to come in for recess
- It is difficult for some children to participate during group activities

**Recommendations & Potential Classroom Modifications to Address Challenges**
Teachers may find that consultation with the psychologist may be helpful in implementing some of these recommendations/modifications.
- Use of a posted daily routine/schedule
- Provide exaggerated positive praise for children cleaning up toys
- Adults can model clean-up
- Use a clean-up song to transition to clean-up time
- Lessons on identifying feelings and appropriate behaviors when angry
- Designate a “cool down” spot in the classroom for children to go to when they are angry
- Remove toys that are frequently the source of conflict from the room

**Children Recommended for Further Assessment**
See attached form.

Thank you for the opportunity to observe and be a part of your Head Start classroom. I enjoyed meeting Mrs. Brown and . I particularly enjoyed watching both teachers interact with the children around ….. Their dedication and care for the children in the classroom is evident.

______________________________  Date

*Miami University Head Start Consultant*

______________________________  Date

*Miami University Faculty Member*
In collaboration with _____________ (the classroom teacher), the following children have been identified as displaying behaviors that may require individualized interventions, such as increased use of positive behavior supports and/or further assessment.

Classroom teachers are the experts on the consistent behaviors displayed by individual children. The mental health observation provides only a snapshot of children’s behavior.

<table>
<thead>
<tr>
<th>Date of Observation</th>
<th>Child’s First and Last Initial</th>
<th>Observed Behaviors</th>
<th>Possible Environmental Adjustments</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Observation</td>
<td>Child's First and Last Initial</td>
<td>Observed Behaviors</td>
<td>Possible Environmental Adjustments</td>
<td>Next Steps</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------------------------</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Appendix G

HEAD START TEACHER SURVEY

Please answer the following questions about yourself. Fill in the circles completely using a number 2 pencil or black pen.

Head Start Site ____________________________ Class __________

1. What is your current job title?
   - Lead Teacher
   - Assistant Teacher
   - Other (specify) ____________________________

2. What type of program do you currently work in (fill in all that apply):
   - Typical half-day
   - Typical full-day
   - TIPP half-day
   - TIPP full-day
   - Inclusion classroom half-day
   - Inclusion classroom full-day
   - Title One Classroom
   - Other (specify) ____________________________

3. How long have you been in your current position? ________

4. How many years have you been teaching Head Start (as either lead or assistant)? ________

5. In total, how many years have you been teaching (include all grades & preschool)? ________

6. What is the highest level of education that you have obtained?
   - High School Diploma/GED
   - Child Development Associate Certificate (CDA)
   - 2 Year College Degree
   - 4 Year College Degree
   - Master’s Degree
   - Doctoral Degree
7. What is your gender?
   □ Male
   □ Female

8. How would you describe your race/ethnicity? (check all that apply)
   □ African American
   □ Asian/Pacific Islander
   □ Caucasian/White
   □ Hispanic/Latino
   □ Native American
   □ Other (please specify) ____________________

9. Did you receive a mental health consultation in the spring of 2006?
   Yes ☐ No ☐
Appendix H

Directions: This section will ask you about aspects of your interactions with the mental health consultant that provided your mental health consultation in the fall of 2005. Please indicate your opinion about each of the questions below. Your answers are confidential.

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Disagree</th>
<th>Moderately Disagree</th>
<th>Slightly Disagree</th>
<th>Neutral</th>
<th>Slightly Agree</th>
<th>Moderately Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel friendly towards my consultant.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>2. I have confidence in my consultant and his/her techniques.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>3. I feel critical or disappointed in my consultant.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>4. My consultant's professional skills are impressive.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>5. My consultant tries to influence me in ways that are not beneficial to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>6. My consultant finds it hard to understand me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>7. My consultant is warm and friendly with me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>8. My consultant does not give me the guidance I would like.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>9. My consultant is supportive.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>10. My consultant follows his/her own plans, ignoring my views of how to proceed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>11. My consultant is confident in him/herself and his/her techniques.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>12. My consultant seems bored or impatient with me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>13. My consultant and I agree about how to work together.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>14. My consultant and I have difficulty working jointly as a partnership.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>
Appendix I

Teacher’s Belief

Directions: This section is designed to help us gain a better understanding of the kinds of things that create difficulties for teachers in their school activities. Please indicate your opinion about each of the statements below. Your answers are confidential.

<table>
<thead>
<tr>
<th>How much can you do?</th>
<th>Nothing</th>
<th>Very Little</th>
<th>Some Influence</th>
<th>Quite A Bit</th>
<th>A Great Deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How much can you do to control disruptive behavior in the classroom?</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. How much can you do to motivate students who show low interest in schoolwork?</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. How much can you do to get students to believe they can do well in schoolwork?</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. How much can you do to help your students’ value learning?</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. To what extent can you craft good questions for your students?</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>6. How much can you do to get children to follow classroom rules?</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
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</tr>
<tr>
<td>7. How much can you do to calm a student who is disruptive or noisy?</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
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</tr>
<tr>
<td>8. How well can you establish a classroom management system with each group of students?</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>9. How much can you use a variety of assessment strategies?</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>10. To what extent can you provide an alternative explanation or example when students are confused?</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. How much can you assist families in helping their children do well in school?</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. How well can you implement alternative strategies in your classroom?</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix J

Directions: This section is about the suggestions that the consultant made during the mental health consultation. Please rate your opinion to following statements. Please note that many of the questions appear similar, however the end-points for the responses are different.

1. I intend to implement the consultant’s suggestions in my classroom within the next three months.
   Extremely Unlikely 1 2 3 4 5 6 7 Extremely Likely

2. I expect to implement the consultant’s suggestions in my classroom within the next three months.
   Definitely False 1 2 3 4 5 6 7 Definitely True

3. I plan to implement the consultant’s suggestions in my classroom within the next three months.
   Strongly Disagree 1 2 3 4 5 6 7 Strongly Agree