1-1-2000

The Effects of Diagnostic Status, Assessment Information, and Intervention Type on Teachers' Acceptability of Treatment Recommendations

Rebecca Hassell Fogarty
Eastern Illinois University

This research is a product of the graduate program in School Psychology at Eastern Illinois University. Find out more about the program.

Recommended Citation
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The Effects of Diagnostic Status, Assessment Information, and Intervention

Type On Teachers' Acceptability of Treatment Recommendations

(Title)

BY

Rebecca Hassell Fogarty

THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

Specialist in School Psychology

IN THE GRADUATE SCHOOL, EASTERN ILLINOIS UNIVERSITY

CHARLESTON, ILLINOIS

2000

YEAR

I HEREBY RECOMMEND THAT THIS THESIS BE ACCEPTED AS FULFILLING THIS PART OF THE GRADUATE DEGREE CITED ABOVE
Acknowledgment

This study would not have been possible without the guidance, assistance and support of Dr. Kevin Jones, Dr. Michael Havey and Dr. Gary Canivez.

Dr. Kevin Jones assisted me throughout my thesis, from the initial stages of deciding on a definite research direction to the finishing touches on the discussion section.

Dr. Havey and Dr. Canivez helped to guide my research, offered many suggestions and assisted greatly with the statistical portion of the thesis.
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The Effects of Diagnostic Status, Assessment Information, and Intervention Type On Teachers' Acceptability of Treatment Recommendations

Rebecca Hassell Fogarty

Eastern Illinois University
Abstract

This study explored the effects of diagnostic status, assessment information and intervention type on teachers' acceptability of treatment recommendations in an analog procedure. Teachers from both a suburban and a rural school district read one of eight vignettes that varied diagnostic status (ADHD vs. no diagnosis), assessment information (traditional vs. functional), and intervention type (behavioral vs. pharmacological). Teachers' ratings of treatment acceptability were examined as a function of diagnostic status, assessment information and intervention type. Results indicated a significant main effect for assessment information, with the traditional method rated as more acceptable than the functional method, and a significant main effect for intervention type, with the behavioral method rated more acceptable than the pharmacological method. A significant interaction was also found between diagnostic status and intervention type, with the behavioral intervention being more accepted than the pharmacological when the students had not been given a classification.
The Effects of Diagnostic Status, Assessment Information, and Intervention Type

On Teachers' Acceptability of Treatment Recommendations

The number of students exhibiting behavioral or learning disabilities is greater than ever before. Given that these numbers are large and continue to grow, it is vital for teachers to understand the full spectrum of student problems and learn effective ways to help them. Although special education laws have been in place for more than two decades, students who experience difficulties in school are still often placed in separate rooms that are not seen by mainstream students. With recent movements, such as the Regular Education Initiative (Kubicek, 1993), there is increasing pressure to serve at-risk and disabled students in mainstream classrooms. Due to the overwhelming number of students who need assistance, providing services outside the classroom has become nearly impossible; nor is it clear whether this is in the best interest of these students. As a result, it has become vital to educate teachers on new, easy and effective intervention techniques that work with these students.

As school psychologists enter the classroom and consult with teachers about various student problems, it is important for them to know how suggestions for various interventions will be perceived. A large part of how teachers perceive interventions depends on whether or not the student has been diagnosed with a certain disorder. Teachers are generally less willing to accept and/or implement interventions for students who exhibit disruptive behaviors, but have not officially been diagnosed with a disorder because they often feel the behaviors are within the control of the student (Cornett-Ruiz & Hendricks, 1993). Teachers may attribute the exhibited behaviors to lack of discipline at home, the student’s unwillingness to learn, and/or the student defying authority. On the
other hand, if the student exhibits the same disruptive behaviors and also has been diagnosed, (e.g. Attention Deficit Hyperactivity Disorder), the teacher may be more accepting of the intervention because they feel the behaviors are beyond the control of the student (Cornett-Ruiz & Hendricks, 1993). There are, of course, exceptions to this general rule; however, it leads to the question of whether or not diagnostic status influences teachers’ willingness to accept and implement interventions. Identifying what affects teacher treatment acceptability is important for anyone working in the special education field. Many times half the battle is determining what intervention teachers are willing to implement. If it can be determined what effective interventions are acceptable when the student has been diagnosed and what interventions are acceptable when there has not been a diagnosis, school psychologists may have a better understanding when working with classroom teachers. It should be noted however, that there continues to be another problem and that is the lack of acceptance by teachers of effective interventions and the resulting lack of implementation.

The Influence of Diagnoses on Teacher Perceptions

Diagnostic status (specifically Attention-Deficit Hyperactivity Disorder) has become the focus of much recent research. The idea of labeling bias refers to “the expectations that an individual might have of others given a particular label” (Fairbanks & Stinnett, 1997, p. 329). This factor can greatly affect how teachers perceive students and their behaviors, as well as influence the type of intervention they are willing to implement.

Epstein, Matson, Repp, and Helsel (1986) examined the effects of teacher status (regular education versus special education) and student level (learning disabled or mentally impaired) on the acceptability of treatment alternatives. The authors found
varying levels of acceptability in regard to the treatment alternatives. The teachers rated the treatment options from most to least acceptable in the following order: special education classes, counseling, affective education, behavior modification, and medication. No differences were found in the ratings between regular and special education teachers or for children labeled learning disabled or mentally impaired. The problem with this particular study however, was that the labels used (Learning Disabled and Mental Retardation) may not have presented enough variance to affect teacher’s true attributions (Epstein et al., 1986). In other words, the two conditions that were presented to the teachers may have been too similar. Perhaps the difference between a learning disability and mental retardation is not as salient as the difference between a student with slight behavior problems and a severely mentally retarded individual. As a result, the teachers rated the various interventions in the same manner regardless of what label was presented.

Fairbanks and Stinnett (1997) studied the effects of diagnostic labels (LD, BD and ADD), professional group membership (teachers, school psychologists and school social workers), and intervention type (verbal praise and token economy vs. time-out from reinforcement program and verbal praise) on treatment acceptability. This study found that the interaction of professional group membership and type of intervention had an effect on the treatment acceptability. Specifically, teachers rated the negative intervention as more acceptable than the school psychologists or school social workers. Diagnostic labels were not found to have an effect on the way the subjects rated the treatment options. These findings were consistent with those of Epstein et al. (1986). Fairbanks & Stinnett (1997) stated that the label effects might not have been as salient as if the judgments would have been made in real-life.
Cornett-Ruiz and Hendricks (1993) assessed the effects of diagnostic labels and ADHD behaviors on teacher and peer first-impressions ratings. This study presented a 4.5-minute video in which a child displayed stereotypical ADHD behavior or normal behavior and was either given no label or labeled ADHD. The study found that actual behaviors had more influence on the peer and teachers’ first impression ratings than the labels.

Previous studies that assessed diagnostic labels found there to be no effect on teachers' acceptability of treatments. Some of these studies, however, did not present labels that offered enough variance from one another in order to assess true acceptability. In addition to diagnostic status, the amount or type of assessment information may be important in predicting acceptability.

Teacher Perceptions of Traditional versus Functional Behavioral Assessment

Assessment (traditional vs. functional) is an issue that has recently surfaced in treatment acceptability studies. Traditional assessment, which primarily consists of identifying the “form” of behavior (topography, rate, duration, or intensity), has been most commonly used. In using traditional assessment, a school psychologist administers a battery of standardized tests to the student, teacher and/or parents. In addition to assessing the student’s abilities in this manner, the psychologist may also include a naturalistic observation of the student in the classroom (Eckert, Hintze & Shapiro, 1997). This provides the examiner with a sample of the student’s behavior and a set of scores that can be compared to national norms. The results indicate how the individual student functions compared to peers of the same age.
Functional assessment, on the other hand, is primarily interested in the "function" of behavior. This is addressed by conducting interviews, direct classroom observation of problem behaviors and environmental variables, and manipulating the environmental events to examine the functional relationship between the problem behavior and environmental events (DuPaul, Eckert, & McGoey, 1997). DuPaul and Ervin (1996) reviewed the literature and identified four functions of ADHD-related behavior: avoid or escape tasks; gain adult or peer attention; gain access to an object or activity; or sensory stimulation. The authors suggested that when functional assessment is used, more effective treatments are generally developed. This is due to the fact that individual differences, which can affect behavior, are taken into account (DuPaul & Ervin, 1996). Rather than assume that similar behaviors serve the same function for all individuals, alternative hypotheses are generated and tested and treatment recommendations are specifically tailored to a particular student. For example, one student may engage in off-task behavior in order to escape doing schoolwork while another student may engage in the same behavior in order to gain peer attention.

Using functional assessment to develop effective intervention programs has been the topic of many recent studies. Few studies, however, have assessed the effects of assessment information on teacher acceptability of reinforcement-based interventions. Some recent studies, however, have proposed that teachers may actually consider assessment information when making treatment decisions. Alderman and Nix (1997) provided one group of teachers with explanations for a hypothetical problem behavior such as "(the child) feels some need to control" (p. 91), while another group received no
explanation. The teachers who were provided an explanation endorsed the reinforcement-based strategy more than the punishment-based intervention.

Aldrich and Martens (1993) used written vignettes to compare the effects of two types of assessment information on several teacher variables, including acceptability. The teachers were provided percentages of the student’s on-task behavior. One group of participants was given a written description of a comprehensive behavioral problem analysis, including antecedents and consequences (e.g., teacher or peer attention) surrounding that behavior. The second group of subjects was given information regarding instructional variables, such as modeling of appropriate responses. The results suggested that problem attribution, but not acceptability ratings, was sensitive to the assessment information.

These studies are important because intervention selection is always within the context of prior knowledge about the problem behavior. The current acceptability literature suggests that we know a great deal about teachers’ preferences, but more attention to the natural conditions surrounding the referral problem is needed. The effect of assessment information is an area that, if given more attention, could increase our basic understanding of teacher attitudes toward recommended interventions. Recent advances in behavioral assessment have indicated a need for more thorough analyses of intervention recommendations as well. There is growing evidence, for example, that reinforcement-based treatments may be more effective if the reinforcers employed are based on a prior functional assessment (Broussard & Northup, 1997; Lewis & Sugai, 1996; Umbreit, 1995). If peers positively reinforce a child's disruptive behavior, a treatment that includes
peer attention contingent on appropriate academic behavior may be more successful than providing teacher attention or a tangible reward.

Previous studies that have examined assessment techniques have found assessment information to have an effect on problem attribution, but not treatment acceptability ratings. Eckert et al. (1997) investigated school psychologists' acceptability of behavioral and traditional assessment procedures for externalizing problem behaviors. The authors found behavioral assessment procedures (observation of behaviors and standardized behavior rating scales) to be more acceptable than traditional assessment procedures (administering a battery of tests which included a measure of perceptual functioning, thematic techniques and projective drawings) across a variety of acceptability questions. Although behavioral assessment was rated as more acceptable overall, portions of traditional assessment were rated as acceptable in the evaluation process. One of the limitations of these studies thus far, is that no one has compared the acceptability of traditional assessment to functional assessment. However, it should be noted that Eckert et al. (1997) began addressing that question, given that their definition of behavioral assessment contained some of the same components as that of functional assessment. In addition to the type of assessment and diagnostic status, one final area that may be important in predicting acceptability is the type of intervention.

Teacher Perceptions of Different Treatments

Several recent studies have looked at the various types of interventions used in treating ADHD children. Two of the most commonly discussed are behavioral interventions and medication. Medication has been used as a form of treatment for children with ADHD for over the past four decades, however, there has been a fourfold
increase in the prescribing of Ritalin in the last decade alone (Livingston, 1997). Stimulant medication is believed to improve ADHD children's ability to concentrate in class, sit in their seats and therefore, increase their ability to learn. Barkley (1977) found that medication decreases ADHD children's inattentiveness, impulsiveness, and rebelliousness; however, it has not been shown to increase the learning capacity. Swanson et al. (1993) also found stimulants had an effect on attention, concentration and motivation, but there was no clear effect on academic performance or learning. Kasten, Coury, and Heron (1992) examined the effects of methylphenidate on children with ADHD. Overall, the study found stimulant medication to improve concentration, decrease impulsiveness, improve classroom performance, improve child-parent and child-teacher interaction, decrease unnecessary gross and minor motor movements and decrease noncompliance. Medication has also been associated with negative side effects such as decreasing appetite, difficulty in sleeping at night, stomachaches, headaches, irritability and in a few situations the onset of Tourette's Syndrome. The improvements in long-term memory, ability to retain learned information or improve social skills have not been established (Kasten et al., 1992).

Using medication as a form of treatment for children has been debated for quite some time. More recently however, emotions have heightened with the increase in prescribing drugs for children diagnosed with ADHD. This could be due to the fact that there has been an increased likelihood that ADHD is being poorly diagnosed and overly diagnosed. The U.S. Drug Enforcement Agency (1996) has recorded a fourfold increase in the consumption of methylphenidate (Ritalin) between 1989-1994, with the authors noting that "ninety percent of the total amount of this drug consumed each year is by
citizens who are not old enough to legally drink or smoke" (Livingston, 1997 p. 5). With
the increase in the diagnosis of ADHD and the overwhelming number of prescriptions for
Ritalin, some teachers, school psychologists and a percentage of the public believe that
children are being medicated without consideration of other treatments. As one child
psychiatrist stated, “Ritalin is nothing more than a street drug being administered to cover
the fact that we don’t know what is going on with these children” (Livingston, 1997, p.5).
On the other side, there are teachers and members of the public who feel that medication is
acceptable for treating ADHD. Of concern however, is their lack of knowledge of the
drug. Teachers have stated that they do not feel they have adequate training in the area of
medication, yet often respond that they have recommended to parents to see a physician
regarding their child’s inattentive or hyperactive behavior (Kasten et al., 1992). Given
that a large number of children are on medication at any given time, especially those
students with ADHD, it is important for school psychologists to be aware of how teachers
perceive this treatment.

Behavioral techniques include a variety of intervention types, such as
reinforcement, punishment, token economy, or time-out. These techniques can be used to
help a teacher with a wide range of student problems (e.g., a student who cannot sit still in
his/her chair or a student who has social/emotional problems). Witt, Martens, and Elliott
(1984) examined the effects of teacher time involvement (low, moderate and high),
behavior problem severity (daydreaming, using obscene language and destruction of
others’ property) and intervention type (positive vs. reductive), on acceptability of
behavioral interventions. This study found that the less time consuming the intervention,
the more acceptable it was to the teachers. The type of intervention (praise, home-based
reinforcement and token economy vs. ignoring, response cost and seclusion) was not found to have an effect on the acceptability of the intervention (Witt, Martens, & Elliott, 1984). These findings were contrary to those of Fairbanks and Stinnett (1997). As stated earlier, Fairbanks and Stinnett found that intervention type had an effect on treatment acceptability.

Powers et al. (1995) investigated the acceptability of behavioral and pharmacological interventions for children with Attention-Deficit Hyperactivity Disorder among elementary and middle school teachers. The behavioral interventions consisted of two parts: daily report (positive consequences administered at home or in school when goal is achieved) and response cost (misbehavior results in loss of reward or privilege). The acceptability ratings were examined as a function of knowledge of ADHD and level of teaching experience. The results indicated that the teachers rated daily report significantly more acceptable than response cost or stimulant medication. These findings are similar to earlier studies in that teachers generally are more accepting of positive interventions than of negative ones. Medication was viewed as more acceptable when used in combination with behavioral interventions rather than by itself. Knowledge of ADHD and years of teaching experience were not found to have an effect on acceptability ratings (Powers et al., 1995).

Purpose of the Present Study

The purpose of the current study was to replicate the findings of Powers et al. (1995), while manipulating the diagnostic classification status and introducing a third variable, the type of assessment information provided. Past research has attempted to link teacher acceptability to important variables such as diagnostic status, assessment
information and treatment modality. The effect of diagnostic status has been inconclusive (Fairbanks & Stinnett, 1997). To some extent, the literature suggests assessment information may be an important variable (e.g., it provides information regarding the student's ability level in addition to environmental variables) (Alderman & Nix, 1997), although a direct comparison of traditional versus functional assessment has not been conducted. Finally, it appears that teachers generally favor positive reinforcement procedures over punishment or medication (e.g., teachers rate verbal praise as more favorable than time-out or the prescribing of Ritalin) (Powers et al., 1995).

The present literature may be limited, however, because each of these variables have been presented in isolation. In actual ("natural") cases these variables are presented in some combination. Therefore, the purpose of this study is to answer the following question: What are the main and interaction effects of diagnostic status, assessment information, and intervention modality on teachers' acceptance of treatment?

Method

Participants

A total of 173 educators participated in the following procedures. Completed demographic data indicated this group was primarily composed of regular education teachers (n=139) and special education teachers (n=34) from two school districts. One school district was situated in a middle class, suburban community, located approximately 30 miles west of Chicago, while the other district was situated in a small, rural community located approximately 265 miles south of Chicago. The sample consisted of 92 elementary teachers (from five schools) and 81 middle school teachers (from three schools). Within this group, 150 teachers were female and 23 were male, while the mean
number of years experience was 17.5. Approximately 12% of the teachers from the suburban district participated and approximately 50% of the teachers from the rural school district participated. The participating school districts were divided into 16 elementary schools (kindergarten through grade 5) and 4 middle schools (grades 6 through 8). In the elementary schools, teachers generally worked with the same group of students for a majority of the day, while middle school teachers worked in a departmentalized system and taught about 6 classes per day. Class size typically ranged from 20 to 35 students.

Instrument

The Intervention Rating Profile Scale is a 10-item treatment acceptability scale, which is a shortened version of the original Intervention Rating Profile-15 (Martens, Witt, Elliott, Darveaux, 1985). The original scale was designed to reflect a single dimension of treatment acceptability, the degree to which interventions were judged as suitable for use in the regular classroom. Witt and Martens (1983) found the internal consistency of the IRP-15 to be .98. Martens et al. (1985) found the IRP-15 was able to differentiate between two interventions (teacher implemented response cost and sending the child to the office) in terms of the degree to which they were acceptable to teachers.

The IRPS-10 was created by Powers et al. (1995). Five items from the original IRP-15 were eliminated (e.g. “I would be willing to use this intervention in the classroom”) because they were not appropriate when the teachers were asked to rate the acceptability of medication (Powers et al., 1995). Responses are coded on a 6-point Likert Scale, ranging from 1 (strongly disagree) to 6 (strongly agree). Powers et al. (1995) found the internal consistency of the IRPS-10 to range from .95 to .97 across several experimental conditions. The authors also found the scale to differentiate between
differential reinforcement, response cost and methylphenidate treatments (Powers et al., 1995).

**Experimental Conditions**

All teachers were asked to complete a packet that contained a consent form, case description, IRPS, and debriefing form. An identical consent form (see Appendix A), IRPS (see Appendix B), and debriefing form (see Appendix C) were included in all packets.

Written case descriptions were used to manipulate all possible combinations of the three primary independent variables (a) diagnostic status (ADHD vs. No Diagnosis), (b) assessment information (Traditional vs. Functional) and (c) treatment modality (Medication vs. Behavioral) (see Appendices D - K).

Each written vignette included the same problem description, adapted from Fairbanks & Stinnett (1997):

Gary is an eight-year-old child in the beginning of third grade who is exhibiting serious behavior problems in the classroom. He has difficulty attending to classroom instruction, completing assignments, and following directions. Gary often gets out of his seat and disturbs other children.

**Diagnostic status.** In half the vignettes, the problem description included a diagnosis of Attention-Deficit/Hyperactivity Disorder (e.g., Appendix E), while the other half included no diagnosis (e.g., Appendix J).

**Assessment information.** In half the vignettes, the assessment summary included traditional assessment information (e.g., Appendix E), including estimates of intellectual, achievement and social/emotional functioning translated into percentile ranks. These scores were intended to reflect a typical ADHD profile, with moderate reading delays and
elevated teacher ratings of core hyperactivity items. Direct observation corroborated high levels of off-task behavior.

The other half of the vignettes included functional assessment information (e.g., Appendix J), including descriptive observation data suggesting that off-task behaviors were more likely to occur during the independent seatwork, and that peer attention was the most likely behavioral function.

**Intervention type.** In half the vignettes, the primary intervention was 15mg of Ritalin twice daily (e.g., Appendix E), with monitoring of progress and potential side effects. This medication regimen was “linked” to assessment to the extent that Ritalin has been shown to effectively reduce the core features of ADHD (Barkley, 1977; Kasten et al., 1992; Swanson et al., 1993). This condition also featured mild instructional modifications, such as individualized instruction, because medication is rarely used in isolation (Powers et al., 1995).

In the other half of the vignettes, the same mild instructional modifications were featured, as well as a differential reinforcement program linked to the functional assessment (e.g., Appendix J). Specifically, independent seatwork was the target setting, with access to peer attention contingent on improved classroom behavior and work completion. An extinction component included seating the child away from high-responding peers and teaching the class to ignore misbehavior.

**Procedures**

Principals at selected schools were contacted and permission to conduct the research was obtained. Distribution of the surveys was primarily conducted by administering the packets during a regularly scheduled faculty meeting. Prior to the
administration of the questionnaires, the teachers were given the following introduction to the project either verbally or in a text format (see Appendix L). These instructions were given by this researcher in a group format or by having the participants read them individually:

My name is Rebecca Hassell and I am researching various ways to help students who have learning and emotional problems. Today, I will be asking each of you to provide me with important information about classroom interventions. Please read the informed consent page of your packet. If you agree to participate, please read the case description carefully. Then, rate the intervention recommendations using the attached rating form and complete the demographic questionnaire. After everyone is done, I will read to you a summary of my research questions. It is important that you do not discuss the study during the administration.

Teachers were given the choice not to participate and they were assured that their responses would be kept anonymous. Teachers were given a packet including the demographic sheet, followed by one of the vignettes and acceptability measure. The eight vignettes were randomly distributed to the participating teachers. Following the completion of the questionnaire the teachers were given a debriefing statement.

Analysis

This study was a between subjects, completely randomized design. A 2 (diagnostic status) X 2 (assessment information) X 2 (intervention type) analysis of variance was conducted to test the effects of the independent variables (diagnostic label x assessment information x intervention type) on the dependent measure (acceptability rating on the IRPS-10). $R^2$ was used to estimate effect size for all effects (Cohen, 1965).
Results

A total of 173 teachers returned usable IRPS-10 rating scales and demographic information. The number of participants rating each vignette ranged from 20 (Vignette 1) to 24 (Vignette 8). The IRPS-10 scores were calculated for each of the eight vignettes, with a score of 60 being the highest possible.

To assess whether diagnostic status, the manner in which the assessment information was collected, and the specific intervention type had an effect on teacher acceptability, a three-way analysis of variance was completed (see Table 1). Assessment information (traditional vs. functional) had a significant main effect on teacher acceptability, $F(1, 173) = 6.75, p < .05, R^2 = .03$. The traditional method of assessment ($M = 42.88$) was more acceptable than the functional method ($M = 38.48$). Intervention type (pharmaceutical vs. behavioral) also had a significant main effect on teacher acceptability, $F(1, 173) = 8.08, p < .01, R^2 = .04$. A significant two-way interaction was found between diagnostic status and intervention type, $F(1, 173) = 10.02, p < .01, R^2 = .05$. Participants rated the two interventions differently depending on the assigned diagnostic status. Figure 1 shows that behavioral intervention ($M = 45.02$) was more acceptable than medication ($M = 35.14$) when there was no diagnosis, yet there appears to be no difference between either treatment type (behavioral ($M = 40.86$) and medication ($M = 41.40$)) when a diagnosis was provided. No other interactions or main effects were found to be significant.

Discussion

The goal of this study was to assess the effects of diagnostic status, assessment information and intervention type on teacher acceptability. Assessment information,
whether the information collected on the student was conducted in a traditional or functional manner, also was found to have a significant effect on how teachers responded on the rating scale. The traditional method (administering a battery of standardized tests) was rated more favorably by classroom teachers than the functional method (observing behaviors and the conditions which maintain behaviors). It was also found that the interaction between the diagnostic status and intervention type significantly affected teachers' acceptability ratings. Teachers rated the behavioral intervention as being more acceptable when the scenario did not identify the student with a label.

While statistically significant, the effect sizes for the main effect of assessment, intervention type and the interaction between diagnostic status and treatment type (.0345, .0413 and .0512, respectively) were low. Thus, the reliability of these findings is suspect. Even if replicated in future work, the practical utility of these effects are questionable.

The results produced by this study contribute support that diagnostic status, assessment information and intervention type are related to teachers' acceptability of treatment interventions. Diagnostic status alone did not have a significant effect on teachers' acceptability ratings, supporting previous studies (Cornett-Ruiz & Hendricks, 1993; Epstein et al., 1986; Fairbanks & Stinnett, 1997). Although diagnostic status was not found to be significant on its own, it was found to have an interaction with the intervention type. When the student had not been given a diagnosis, participants were more accepting of the behavioral intervention than medication. On the other hand, when the student had been diagnosed with ADHD, participants did not indicate a difference in treatment acceptance between either treatment type.
Assessment information was found to have a significant effect on teachers’ ratings of treatment acceptability, with the traditional method rated slightly more acceptable than the functional method. Eckert et al. (1997) previously found that behavioral assessment was more acceptable than traditional assessment, and the current study appears to contradict these findings. At closer inspection, however, important differences emerge between the Eckert et al. study and the current one. The primary difference is that Eckert et al. assessed school psychologists’ ratings of acceptability, while the current study assessed teachers’ intervention acceptability. Another important difference is that Eckert’s traditional versus behavioral assessment conditions focused more on contrasting high-inference versus low-inference measures of behavior. For example, Eckert et al. included thematic techniques and projective drawings in the traditional assessment condition, while their behavioral assessment condition included (among some functional assessment components) norm-referenced behavior ratings scales. To a large extent, the current study attempted to divide this condition into measures of “form” versus measures of “function”. The traditional assessment condition included a variety of clearly defined child behaviors from laboratory measures, informant ratings and direct observations, without reference to environmental context. The functional assessment condition included a single measure of off-task behavior across a variety of clearly defined environmental contexts. Together, these results and Eckert et al.’s findings suggest that among the various components of a behavioral assessment, educators may prefer child-centered strategies versus strategies that focus on the instructional environment.

Intervention type was found to have a significant effect on teachers’ acceptability, with behavioral interventions being more acceptable than pharmaceutical interventions
when the student was not given a diagnostic label. This finding was inconsistent with Powers et al. (1995), who found that teachers rated positive behavioral interventions higher than either negative behavioral interventions or stimulant medication when the student had been diagnosed with ADHD.

A discussion of these findings is not complete without consideration of several limitations of this study. Although this study examined three independent variables, the complexity of the research question went well beyond those variables. In the future, there should be consideration of additional variables that may have impacted the current findings (i.e., level of teacher education, number of years teaching experience, sex of the participants and type of teacher (regular versus special education)).

A second limitation was the Intervention Rating Profile Scale used to record the participants’ responses. Teachers were asked 10 questions regarding their likelihood of using an intervention. This simply measured teachers’ self-report rather than directly observing the implementation.

A third limitation of the present study was its analogue format. Participants were given a limited amount of information about a hypothetical problem behavior and intervention, on which they based their acceptability ratings. Future studies should investigate acceptability ratings of teachers during actual implementation of interventions.

The fourth limitation of the study was the administration of only one vignette to each participant. In addition to providing limited information about the problem behavior and intervention, the rating of only one vignette did not provide the participants with a means for comparison. It is unclear whether the acceptability ratings would have differed if each of the eight vignettes had been administered to each participant. On the other
hand, because only one vignette was presented, the interference that may have occurred due to receiving multiple vignettes was eliminated.

The fifth limitation of the study was the small effect sizes that were obtained for each of the three significant findings. Although the variables were found to be significant, small effect sizes diminish the practical utility of the findings and the likelihood that other researchers will replicate the findings of the current study.

The final possible limitation of the study was the false dichotomy regarding the traditional versus functional assessment. One purpose of traditional assessment is to gather information necessary for classification and differential diagnosis. Functional assessment, on the other hand, is designed to gather necessary information to develop specific treatments for individual behaviors. Therefore, presenting the two assessment approaches as complementary, rather than exclusionary, may be more consistent with best practices. In reality, traditional and functional assessments are typically combined to appropriately diagnose and treat individual students.

Despite the small effect sizes, the results of the current study are promising and indicate a need for additional research. Future studies should use the same methodology so that other potential variables can be directly compared to those in the current study. It would be important to look further at the interaction between diagnostic status and intervention type. As in previous studies, diagnostic status in isolation was not found to have an effect on acceptability ratings, however, when combined with intervention type it was found to have an effect. It is important for future studies to replicate these exact variables in order to verify that diagnostic status is significant when paired with intervention type. Looking at different diagnostic labels would also be important to
determine if teachers' acceptability was based solely on the issue of ADHD or if other types of behaviors would yield similar results. Of particular interest would be to provide case descriptions that depicted students with internalizing disorders (depression, withdrawal, etc.) and determine whether identifying those behaviors with a label had an impact on teachers' ratings. Having teachers rate different intervention types (e.g., behavioral, counseling, consultation) would also provide valuable information to individuals who work with teachers about what they can expect when presenting teachers with intervention alternatives.

Additional research should be conducted on the comparison of traditional and functional assessment. Clear definitions of both traditional and functional assessment should be provided in the study, in addition to other assessment types that are examined. This will provide for direct comparisons between the current study and those in the future, as well as creating a new path for additional studies in this area.

Ultimately, future studies should include the actual use of the intervention as the dependent variable, rather than self-report. This would eliminate researchers having to depend on the participant's self-report and would instead provide information on how and what they actually implement. Direct measures of treatment integrity would be the most valid indicator of teacher acceptability.
References


### Table 1

**Analysis of Variance Summary Table for Teacher Acceptability**

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>R²</th>
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<td>1</td>
<td>36.48</td>
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<td>0.00170</td>
</tr>
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<td>Assessment</td>
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<td>1</td>
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<td>0.03448</td>
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<td>Intervention Type</td>
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<td>8.08**</td>
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<td>0.00033</td>
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<td>Assessment X Intervention</td>
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<td>1095.93</td>
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<td>0.05118</td>
</tr>
<tr>
<td>Diag. X Interven. X Assess.</td>
<td>0.22</td>
<td>1</td>
<td>0.22</td>
<td>0.002</td>
<td>0.00001</td>
</tr>
<tr>
<td>Error (Within)</td>
<td>18054.63</td>
<td>165</td>
<td>109.42</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>21414.82</td>
<td>172</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* Diag. = Diagnostic Status; Interven. = Intervention Type; Assess. = Assessment Information; * p < .05; ** p < .01
Figure 1

Interaction Between Diagnostic Status and Treatment Type

Figure 1. Average teacher acceptability ratings for behavioral and pharmaceutical interventions, when a diagnostic label is given and when no diagnostic label is given.
Appendix A
Informed Consent
Teacher Informed Consent to Participate in
Eastern Illinois University Research Project

Project Title: Treatment Acceptability

Investigator: Rebecca Hassell

You are being asked to help the research team discover ways to help students with learning and emotional problems. This project will attempt to identify what types of assessment information and treatments teachers prefer.

PROCEDURES: If you participate in this study, you will be asked to read a vignette that describes a hypothetical classroom behavior problem and a suggested treatment strategy. You will then be asked to complete a rating form, some demographic information, and two questions that assess your opinions of the treatment.

POTENTIAL RISK OR DISCOMFORT: There is no potential risk involved in participation in this project.

BENEFITS: All ratings will be combined to determine relationships between types of interventions and teacher perceptions. Findings may help the research team determine how school-based consultants can work collaboratively with classroom teachers in solving common discipline problems.

RIGHT TO REFUSE PARTICIPATION: You do not have to take part in this study. You may return a blank form if you do not wish to participate.

RIGHT TO INQUIRE: If you have any questions about this study, you may write to the supervisor of this project, Kevin M. Jones, Department of Psychology, Eastern Illinois University, Charleston, IL 61920 or call him at (217) 581-2128.

RESEARCH STANDARDS: This page will be detached from your ratings and the research team will not be able to link your name with any of the completed rating forms.

INFORMED CONSENT STATEMENT:

I have read this form and the possible risks and benefits have been adequately described to me. I agree to participate in this study.

Participant's Signature _______________________ Date ________________
Appendix B
Intervention Rating Profile Scale (IRPS) and Demographic Information
INTERVENTION RATING PROFILE SCALE (IRPS)

Rate each of the items 1 to 6, 1=strongly disagree, 2= disagree, 3=slightly disagree, 4=slightly agree, 5=agree, 6=strongly agree.

This would be an acceptable intervention for the child's problem behavior.
1 2 3 4 5 6
This intervention should prove effective in changing the child’s problem behavior.
1 2 3 4 5 6
The child’s behavior problem is severe enough to warrant use of this intervention.
1 2 3 4 5 6
Most teachers would find this intervention suitable for the behavior problem described.
1 2 3 4 5 6
This intervention would not result in negative side effects for the child.
1 2 3 4 5 6
This intervention would be appropriate for a variety of children.
1 2 3 4 5 6
The intervention was a fair way to handle the child’s problem behavior.
1 2 3 4 5 6
This intervention is reasonable for the behavior problem described.
1 2 3 4 5 6
This intervention was a good way to handle the child’s behavior problem.
1 2 3 4 5 6
Overall, this intervention would be beneficial for the child.
1 2 3 4 5 6

TEACHER BACKGROUND INFORMATION FORM

Directions: Please provide the following information. Your responses will be anonymous. Please do not put your name on this sheet.

Sex: Male _______ Female _______

Highest Degree Earned: __________________________

Number of years employed as a teacher: _________

Grade level currently teaching: ___________

Regular Ed. _______ Special Ed. ________ Other (please specify) ________________
Appendix C
Debriefing
Debriefing Statement

Thank you for participating in this study. The purpose of this research is to identify the kind of assessment information and treatments teachers find most acceptable for use with their students. Each of you rated an intervention that included different information and we will be comparing your ratings to determine which type of treatments were rated the highest. This information is important to any professional who works with teachers to design special programs for children with learning or behavior problems. If you have any questions regarding the study, please feel free to contact me, Becky Hassell, at (630) 293-7482. If you would like a copy of the final results please provide the necessary information in the spaces below.

Request for Results

NAME: ____________________________________________

ADDRESS: ____________________________________________

________________________________________________________

TELEPHONE
NUMBER: ____________________________________________
Appendix D
Vignette V1ATR
Problem

Gary is an eight-year-old child in the beginning of third grade who is exhibiting serious behavior problems in the classroom. He has difficulty attending to classroom instruction, completing assignments, and following directions. Gary often gets out of his seat and disturbs other children. Gary has been diagnosed with Attention Deficit Hyperactivity Disorder.

Assessment

**Wechsler Intelligence Scale for Children –III (WISC-III)**

Verbal IQ 61st percentile Average Range
(Gary's performance exceeded 61% of his peers, which is considered within the Average Range)

Performance IQ 34th percentile Average Range
Full Scale IQ 47th percentile Average Range

**Kaufman Test of Education Achievement (KTEA)**

Reading Composite 19th percentile Below Average Range
Mathematics Composite 45th percentile Average Range

**Conners' Teacher Rating Scale (ACTRS)**

Gary obtained a mean hyperactivity index score of 22 (98th percentile) on the ACTRS. A cut-off score of 20 is considered clinically significant.

Naturalistic Observation

"A 30 minute observation during multiple settings indicated that Gary was off-task (including talking, out of seat, disturbing others) during 50% of the intervals."

Treatment Recommendations

At a conference involving Gary’s parents, teachers, school psychologist, social worker and pediatrician, the following recommendations are made:

1. Gary will receive individualized instruction and close teacher supervision during unstructured time and independent work. When possible, Gary will be seated away from peers who are likely to attend to his disruptions.

2. The teacher will review a new rule in the class: “Ignore Misbehavior.” The steps in ignoring misbehavior are to look away, look at the teacher or do your work.

A STARZ program will be attempted to improve Gary’s self-control and increase his motivation. During each independent work exercise, Gary will draw a star in his pocket memo if he does not disturb others and completes his work. At the end of the day, Gary and his teacher will privately chart the number of stars. If he exceeds the goal for that day, Gary will be allowed to spend time with his favorite classmate.

The team will meet again in one month to review progress.
Appendix E
Vignette V2ATR
Case Description

Problem

Gary is an eight-year-old child in the beginning of third grade who is exhibiting serious behavior problems in the classroom. He has difficulty attending to classroom instruction, completing assignments, and following directions. Gary often gets out of his seat and disturbs other children. Gary has been diagnosed with Attention Deficit Hyperactivity Disorder.

Assessment

Wechsler Intelligence Scale for Children –III (WISC-III)
Verbal IQ 61st percentile Average Range
(Gary’s performance exceeded 61% of his peers, which is considered within the Average Range)
Performance IQ 34th percentile Average Range
Full Scale IQ 47th percentile Average Range

Kaufman Test of Education Achievement (KTEA)
Reading Composite 19th percentile Below Average Range
Mathematics Composite 45th percentile Average Range

Conners’ Teacher Rating Scale (ACTRS)
Gary obtained a mean hyperactivity index score of 22 (98th percentile) on the ACTRS. A cut-off score of 20 is considered clinically significant.

Naturalistic Observation

“A 30 minute observation during multiple settings indicated that Gary was off-task (including talking, out of seat, disturbing others) during 50% of the intervals.”

Treatment Recommendations

At a conference involving Gary’s parents, teachers, school psychologist, social worker and pediatrician, the following recommendations are made:

1. Gary will receive individualized instruction and close teacher supervision during unstructured time and independent work.

2. Gary will receive 15 mg of methylphenidate (Ritalin) twice daily. Monitoring of progress and possible side effects will be conducted weekly.

The team will meet again in one month to review progress.
Appendix F
Vignette V3AFR
Problem

Gary is an eight-year-old child in the beginning of third grade who is exhibiting serious behavior problems in the classroom. He has difficulty attending to classroom instruction, completing assignments, and following directions. Gary often gets out of his seat and disturbs other children. Gary has been diagnosed with Attention Deficit Hyperactivity Disorder.

Assessment

At the request of the teacher, the school psychologist conducted a functional assessment of Gary’s off-task behavior. A series of observations revealed the following:

Off task - “A 30 minute observation during multiple settings indicated that Gary was off-task (including talking, out of seat, disturbing others) during 50% of the intervals.”

Gary was observed to be off-task more during independent seatwork (65%) versus teacher-directed activities (10%). While off-task during independent seatwork, Gary was usually out of his seat, talking or digging through his desk. Gary’s classmates often teased, laughed or made remarks to him while he was off-task.

In order to assess the influence of peer attention, Gary was observed for three periods, sometimes seated away from peers and sometimes seated in his regular desk. The following levels of off-task behavior were observed:

<table>
<thead>
<tr>
<th>Setting</th>
<th>With Peers</th>
<th>Alone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading</td>
<td>55%</td>
<td>10%</td>
</tr>
<tr>
<td>Math</td>
<td>65%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Treatment Recommendations

At a conference involving Gary’s parents, teachers, school psychologist, social worker and pediatrician, the following recommendations are made:

1. Gary will receive individualized instruction and close teacher supervision during unstructured time and independent work. When possible, Gary will be seated away from peers who are likely to attend to his disruptions.

2. The teacher will review a new rule in the class: “Ignore Misbehavior.” The steps in ignoring misbehavior are to look away, look at the teacher or do your work.

3. A STARZ program will be attempted to improve Gary’s self-control and increase his motivation. During each independent work exercise, Gary will draw a star in his pocket memo if he does not disturb others and completes his work. At the end of the day, Gary and his teacher will privately chart the number of stars. If he exceeds the goal for that day, Gary will be allowed to spend time with his favorite classmate.

The team will meet again in one month to review progress.
Appendix G
V4AFM
Case Description

Problem

Gary is an eight-year-old child in the beginning of third grade who is exhibiting serious behavior problems in the classroom. He has difficulty attending to classroom instruction, completing assignments, and following directions. Gary often gets out of his seat and disturbs other children. Gary has been diagnosed with Attention Deficit Hyperactivity Disorder.

Assessment

At the request of the teacher, the school psychologist conducted a functional assessment of Gary’s off-task behavior. A series of observations revealed the following:

Off task - “A 30 minute observation during multiple settings indicated that Gary was off-task (including talking, out of seat, disturbing others) during 50% of the intervals.”

Gary was observed to be off-task more during independent seatwork (65%) versus teacher-directed activities (10%). While off-task during independent seatwork, Gary was usually out of his seat, talking or digging through his desk. Gary’s classmates often teased, laughed or made remarks to him while he was off-task.

In order to assess the influence of peer attention, Gary was observed for three periods, sometimes seated away from peers and sometimes seated in his regular desk. The following levels of off-task behavior were observed:

<table>
<thead>
<tr>
<th>Setting</th>
<th>With Peers</th>
<th>Alone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading</td>
<td>55%</td>
<td>10%</td>
</tr>
<tr>
<td>Math</td>
<td>65%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Treatment Recommendations

At a conference involving Gary’s parents, teachers, school psychologist, social worker and pediatrician, the following recommendations are made:

1. Gary will receive individualized instruction and close teacher supervision during unstructured time and independent work.

2. Gary will receive 15 mg of methylphenidate (Ritalin) twice daily. Monitoring of progress and possible side effects will be conducted weekly.

The team will meet again in one month to review progress.
Appendix H
V5NTR
Case Description

Problem

Gary is an eight-year-old child in the beginning of third grade who is exhibiting serious behavior problems in the classroom. He has difficulty attending to classroom instruction, completing assignments, and following directions. Gary often gets out of his seat and disturbs other children.

Assessment

Wechsler Intelligence Scale for Children –III (WISC-III)
Verbal IQ 61st percentile Average Range
(Gary's performance exceeded 61% of his peers, which is considered within the Average Range)
Performance IQ 34th percentile Average Range
Full Scale IQ 47th percentile Average Range

Kaufman Test of Education Achievement (KTEA)
Reading Composite 19th percentile Below Average Range
Mathematics Composite 45th percentile Average Range

Conners' Teacher Rating Scale (ACTRS)
Gary obtained a mean hyperactivity index score of 22 (98th percentile) on the ACTRS. A cut-off score of 20 is considered clinically significant.

Naturalistic Observation

"A 30 minute observation during multiple settings indicated that Gary was off-task (including talking, out of seat, disturbing others) during 50% of the intervals."

Treatment Recommendations

At a conference involving Gary’s parents, teachers, school psychologist, social worker and pediatrician, the following recommendations are made:

1. Gary will receive individualized instruction and close teacher supervision during unstructured time and independent work. When possible, Gary will be seated away from peers who are likely to attend to his disruptions.

2. The teacher will review a new rule in the class: “Ignore Misbehavior.” The steps in ignoring misbehavior are to look away, look at the teacher or do your work.

3. A STARZ program will be attempted to improve Gary’s self-control and increase his motivation. During each independent work exercise, Gary will draw a star in his pocket memo if he does not disturb others and completes his work. At the end of the day, Gary and his teacher will privately chart the number of stars. If he exceeds the goal for that day, Gary will be allowed to spend time with his favorite classmate.

The team will meet again in one month to review progress.
Appendix I
Vignette V6NTM
Case Description

**Problem**

Gary is an eight-year-old child in the beginning of third grade who is exhibiting serious behavior problems in the classroom. He has difficulty attending to classroom instruction, completing assignments, and following directions. Gary often gets out of his seat and disturbs other children.

**Assessment**

**Wechsler Intelligence Scale for Children -III (WISC-III)**

<table>
<thead>
<tr>
<th>IQ Type</th>
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<td>Verbal IQ</td>
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<td>Full Scale IQ</td>
<td>47th</td>
<td>Average</td>
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(Gary’s performance exceeded 61% of his peers, which is considered within the Average Range)

**Kaufman Test of Education Achievement (KTEA)**

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<thead>
<tr>
<th>Composite</th>
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</thead>
<tbody>
<tr>
<td>Reading Composite</td>
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<tr>
<td>Mathematics Composite</td>
<td>45th</td>
<td>Average</td>
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</table>

**Conners’ Teacher Rating Scale (ACTRS)**

Gary obtained a mean hyperactivity index score of 22 (98th percentile) on the ACTRS. A cut-off score of 20 is considered clinically significant.

**Naturalistic Observation**

“A 30 minute observation during multiple settings indicated that Gary was off-task (including talking, out of seat, disturbing others) during 50% of the intervals.”

**Treatment Recommendations**

At a conference involving Gary’s parents, teachers, school psychologist, social worker and pediatrician, the following recommendations are made:

1. Gary will receive individualized instruction and close teacher supervision during unstructured time and independent work.

2. Gary will receive 15 mg of methylphenidate (Ritalin) twice daily. Monitoring of progress and possible side effects will be conducted weekly.

The team will meet again in one month to review progress.
Appendix J
Vignette V7NFR
Case Description

**Problem**

Gary is an eight-year-old child in the beginning of third grade who is exhibiting serious behavior problems in the classroom. He has difficulty attending to classroom instruction, completing assignments, and following directions. Gary often gets out of his seat and disturbs other children.

**Assessment**

At the request of the teacher, the school psychologist conducted a functional assessment of Gary’s off-task behavior. A series of observations revealed the following:

**Off task** - “A 30 minute observation during multiple settings indicated that Gary was off-task (including talking, out of seat, disturbing others) during 50% of the intervals.”

Gary was observed to be off-task more during independent seatwork (65%) versus teacher-directed activities (10%). While off-task during independent seatwork, Gary was usually out of his seat, talking or digging through his desk. Gary’s classmates often teased, laughed or made remarks to him while he was off-task.

In order to assess the influence of peer attention, Gary was observed for three periods, sometimes seated away from peers and sometimes seated in his regular desk. The following levels of off-task behavior were observed:

<table>
<thead>
<tr>
<th>Setting</th>
<th>With Peers</th>
<th>Alone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading</td>
<td>55%</td>
<td>10%</td>
</tr>
<tr>
<td>Math</td>
<td>65%</td>
<td>15%</td>
</tr>
</tbody>
</table>

**Treatment Recommendations**

At a conference involving Gary’s parents, teachers, school psychologist, social worker and pediatrician, the following recommendations are made:

1. Gary will receive individualized instruction and close teacher supervision during unstructured time and independent work. When possible, Gary will be seated away from peers who are likely to attend to his disruptions.

2. The teacher will review a new rule in the class: “Ignore Misbehavior.” The steps in ignoring misbehavior are to look away, look at the teacher or do your work.

A STARZ program will be attempted to improve Gary’s self-control and increase his motivation. During each independent work exercise, Gary will draw a star in his pocket memo if he does not disturb others and completes his work. At the end of the day, Gary and his teacher will privately chart the number of stars. If he exceeds the goal for that day, Gary will be allowed to spend time with his favorite classmate.

The team will meet again in one month to review progress.
Appendix K
V8NFM
Case Description

Problems

Gary is an eight-year-old child in the beginning of third grade who is exhibiting serious behavior problems in the classroom. He has difficulty attending to classroom instruction, completing assignments, and following directions. Gary often gets out of his seat and disturbs other children.

Assessment

At the request of the teacher, the school psychologist conducted a functional assessment of Gary’s off-task behavior. A series of observations revealed the following:

Off-task - “A 30 minute observation during multiple settings indicated that Gary was off-task (including talking, out of seat, disturbing others) during 50% of the intervals.”

Gary was observed to be off-task more during independent seatwork (65%) versus teacher-directed activities (10%). While off-task during independent seatwork, Gary was usually out of his seat, talking or digging through his desk. Gary’s classmates often teased, laughed or made remarks to him while he was off-task.

In order to assess the influence of peer attention, Gary was observed for three periods, sometimes seated away from peers and sometimes seated in his regular desk. The following levels of off-task behavior were observed:

<table>
<thead>
<tr>
<th>Setting</th>
<th>With Peers (%)</th>
<th>Alone (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading</td>
<td>55</td>
<td>10</td>
</tr>
<tr>
<td>Math</td>
<td>65</td>
<td>15</td>
</tr>
</tbody>
</table>

Treatment Recommendations

At a conference involving Gary’s parents, teachers, school psychologist, social worker and pediatrician, the following recommendations are made:

1. Gary will receive individualized instruction and close teacher supervision during unstructured time and independent work.

2. Gary will receive 15 mg of methylphenidate (Ritalin) twice daily. Monitoring of progress and possible side effects will be conducted weekly.

The team will meet again in one month to review progress.
Appendix L
Introductory Statement
Introductory Statement

My name is Rebecca Hassell and I am researching various ways to help students who have learning and emotional problems. I am asking each of you to provide me with important information about classroom interventions. Please read the informed consent page of your packet. If you agree to participate, please read the case description carefully. Then, rate the intervention recommendations using the attached rating form and complete the demographic questionnaire. After everyone is done, I will read to you a summary of my research questions. It is important that you do not discuss the study during the administration.