



improving on-task behavior, reducing disruptive behavior,



previous literature, it was expected that the daily report card would be significantly more acceptable than all other treatments (Curtis et al., 2006; Pisecco et al., 2001; Power et al., 1995) and that positive treatments (which includes promising treatments) would be significantly more acceptable than the negative treatment (e.g., time out). It was also hypothesized that stimulant medication would be rated no higher than a negative psychosocial treatment (time-out). Among promising treatments, it was suspected that both social skills and peer tutoring would have significantly higher ratings of acceptability than the self-reinforcement strategy as these interventions provide benefit for the entire class while concurrently addressing functional deficits of children with ADHD. The secondary analyses answer the research question: What teacher factors (e.g., age of teacher, number of students taught with ADHD, teacher self-efficacy, grade taught by teacher, teachers' highest obtained education level) predict treatment acceptability when promising treatments are included?

## Method

### Participants

Participants were 156 teachers (general and special education) of grades Pre-K through 6, from 11 elementary schools in Southeastern Ohio (see Table 1 for characteristics). Students eligible for free and reduced-price lunches at these schools ranged from 35 to 99% with a mean of 59% (U.S. Department of Education, 2005). The overall response rate across schools was 74%.

### Measures

#### Demographics Questionnaire

Participants provided information about age, ethnicity, gender, highest level of education, current grade level being taught, years of teaching experience, and classification (regular or special education).

#### Intervention Rating Profile-10 (IRP-10)

The IRP-10 (Power et al., 1995) was selected so that the results could be directly compared to previous work. The IRP-10 assesses teachers' acceptability of individual treatments. Items are rated on a 6-point scale that ranges from 1 ("Strongly Disagree") to 6 ("Strongly Agree"). Ratings for each item are summed to yield a total score reflecting a single dimension of acceptability. Higher

scores indicate higher acceptability of that treatment. IRP-10 items require that teachers indicate the extent to which they find the treatment acceptable, reasonable, fair, beneficial, and effective; the extent to which they are concerned about negative side effects; and the extent to which teachers would recommend the treatment to other teachers. The IRP-10 has excellent reliability with alpha coefficients ranging from .95 to .97 (Power et al., 1995) and the IRP-15 (the measure from which the IRP-10 was derived) has effectively discriminated between a variety of interventions showing good validity (Martens, Witt, Elliott, & Darveaux, 1985). The IRP-10 was used to evaluate the acceptability of each of the six treatments in this study. Total scores on this scale range from 10 to 60. In the current sample, internal reliability estimates across the six treatments were excellent, ranging from .94 to .97.

## Procedure

Procedures were approved by the University's Institutional Review Board prior to the start of recruitment. For 8 of the 11 schools, surveys were administered in a group format during the first half hour of a teacher in-service training held on different days at different schools (6 schools in

treatment. Given their positive nature, all promising treatments were rated significantly higher than the evidence-based reductive treatment (i.e., time-out). Lastly, it was believed that stimulant medication would be rated no higher than the reductive psychosocial treatment (time-

MacKenzie et al. 2004, future research should attempt to

particularly when the treatment includes reductive components.

### Teacher Factors

Results showed that only years of experience was a significant predictor, such that more experienced teachers are predictive of a greater preference for time-out over peer tutoring. Although speculative, it is possible that more experienced teachers are either more comfortable with reductive interventions or have more evidence for their effectiveness than less experienced teachers. Clearly, replication of this finding is warranted before such conclusions are drawn. As mentioned earlier, future research should attempt to clarify why peer tutoring may be less desirable to some teachers and how consultants may overcome this challenge in consultation.

### Limitations

First, this study is limited by its use of an analog design to depict a child with combined type ADHD. Thus, the results may not generalize to actual teachers' treatment preferences and decisions in their classrooms. However, because this study sought to examine teacher's acceptability of treatments not previously studied (i.e., promising treatments), it was important to maintain the use of vignettes in the interest of high internal validity and consistency with previous studies. Second, the majority of recruitment occurred during teacher in-services that did not require teacher attendance. It is possible that teachers not in attendance would have produced a different profile of acceptability ratings. However, the respectable response rate (74%) provides greater confidence that the results represent the majority of teacher perceptions. Third, it may be considered a limitation that teachers were asked to rate interventions in isolation, rather than combining interventions (Power et al 1995



## Appendix: Treatment Descriptions for Evidence-Based and Promising Treatments

### The Daily Report Card (DRC)

The teacher identifies 2–4 specific behaviors that John needs to improve (e.g., work completion, raises hand to

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