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## The Effects of Teacher Attitudes Toward Prereferral Interventions as a Function of Consulting Source

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THE EFFECTS OF TEACHER ATTITUDES TOWARD PREREFERRAL  
INTERVENTIONS AS A FUNCTION OF CONSULTING SOURCE

A Field Project  
Presented to the  
Department of Psychology  
and the  
Faculty of the Graduate College University  
of Nebraska at Omaha

In Partial Fulfillment  
of the Requirements for the Degree  
Specialist in Education  
in School Psychology  
University of Nebraska at Omaha

by  
Denise Barsdorf Greenberg

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FIELD PROJECT ACCEPTANCE

Accepted for the faculty of the Graduate College,  
University of Nebraska at Omaha, in partial fulfillment  
of the requirements for the degree Specialist in  
Education in School Psychology, University of Nebraska at  
Omaha.

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## The Effects of Teacher Attitudes Toward Prereferral Interventions as a Function of Consulting Source

In recent years the topic of prereferral activities has received increasing attention in the field of education. The move toward prereferral interventions stems from dissatisfaction with the current system of referring a student for special education services (Graden, Casey & Christenson, 1985; Curtis, Zins, & Graden, 1987). In this system a child is referred for evaluation by the classroom teacher if the teacher feels the child is having academic or behavioral difficulties. Research by Christenson, Ysseldyke, & Algozzine (1982) has shown that numerous variables influence a teacher as to whether to refer a student for a special education assessment. These researchers reported that nationally between 4% and 6% of the schoolage population are referred each year for evaluation. There are usually attempts by the teacher to initiate some form of intervention prior to a formal referral, however it appears that there is a great deal of variability in attempted prereferral interventions. These interventions are typically not well documented, do not have a specific time period, and seem to lack in accountability (Ysseldyke, Pianta, Christenson, Wang, & Algozzine, 1983).

Once a student is referred for evaluation, the likelihood of the student being tested and placed in a special education program is high. In a national study it was found that 92% of the students referred for evaluation were tested and of those tested 73% were placed in special education programs (Algozzine, Christenson, & Ysseldyke, 1982). These referral issues become even more complex when one considers that assessment strategies are often inadequate and lack a consistent framework for diagnostic decision-making (Ysseldyke, Thurlow, Graden, Wesson, Algozzine, & Deno, 1983; Ysseldyke, Algozzine, Richey, & Graden, 1982). The large number of students identified as educationally disabled has led to a concern about the overidentification of special education students coupled with declining financial resources (Algozzine & Korinek, 1985; Gerber, 1984; Zins, Graden, & Ponti, 1989). Will (1986) believes that many slow learners are misclassified as needing special education services because of the lack financial incentives to serve these students in the regular education program.

There are other problems involving the traditional method of the referral system. First, assessments are usually descriptive rather than prescriptive. Descriptive assessments are not instructionally relevant and therefore not helpful to teachers (Thurlow &

Ysseldyke, 1982). When a student does not qualify for special education services descriptive assessments do not give teachers suggestions for alternative classroom interventions (Graden, Casey, & Christenson, 1985). Second, several weeks usually pass between the initiation of the referral and the completion of the assessment. During those weeks little if any interventions take place. Third, the focus of the current system is the identification and placement of students in a special education program. This takes away from effective intervention services for those students experiencing difficulties in the regular education classroom (Curtis, Zins, & Graden, 1987). Finally, there is concern about the large amount of time and money which is spent on determining who is "special" and who is "regular" (Stainback & Stainback, 1984).

Pre-evaluation or prereferral systems of intervention have been developed as an attempt to remedy the problems of the current system. "Prereferral intervention refers to the systematic provisions and documentation of interventions within the regular classroom setting prior to referral for special education evaluation and decision-making" (Curtis, Zins, & Graden, 1987). Curtis, Zins, & Graden (1987) identify four ways in which prereferral interventions have the potential to improve service delivery and benefit students. First,

the needs of the student is given immediate attention. Under this system there is no need to wait for a formal assessment before developing a plan to help the student. Second, assessments change their focus from identification for special education placement to intervention activities. Third, the prereferral system requires systematic documentation and evaluation of the interventions attempted. This "should enhance the likelihood of meaningful changes resulting for the students served". And fourth, prereferral interventions have the ability to reduce the number of students who are inappropriately placed in special education programs, therefore increasing the availability of special education services to those students for whom special education programs are imperative. The goal of prereferral interventions is not to prevent formal assessment or delay the provision of special education services, but to add a step where students are afforded the opportunity to receive help while still in the regular classroom.

Several models of prereferral intervention have been developed over the last few years. Some models, such as Teacher Assistance Teams (Chalfant, Pysh, & Moultrie, 1979) suggest a system where regular education teachers work together to develop strategies for assisting students with learning and behavior problems. Other

models suggest a system where special education support staff work with teachers to assist students with learning and behavior problems (Graden, Casey, & Christenson, 1985; Curtis, Zins, & Graden, 1987; Zins, Graden, & Ponti, 1989). Both of these systems are based on a "systems/ecological" model of consultation. Curtis and Meyers (1985) have defined consultation as

a collaborative problem solving process in which two or more persons [consultant(s) and consultee(s)] engage in efforts to benefit one or more persons [client(s)] for whom they bear some level of responsibility, within a context of reciprocal interactions. (p.80).

School based consultation (SBC) as defined by Zins & Ponti (1990), is a "method of providing preventively oriented psychological and educational services in which a consultant and consultee(s) form a collaborative partnership in a systems context and engage in a reciprocal and systematic problem solving process to empower consultee systems; thereby enhancing students well being and performance" (p. 674). There are certain assumptions that are inherent in these definitions of consultation. First, and perhaps the most important assumption, is that a collaborative and voluntary relationship exist between the consultant and the consultee for the purpose of engaging in problem solving for the benefit of the student. Underlying this assumption is a sense of trust and the belief that both

parties value each others skills and knowledge, and that the consultee has the right to accept or reject strategies suggested. A second assumption of this model is that services are indirect. Thus the teacher (consultee) works with the consultant(s) in problem solving to help a student (client). A third assumption is that consultation focuses on work-related issues (Gutkin & Curtis, 1982; Graden, Casey, & Christenson, 1985; Curtis, Zins, & Graden, 1987; Gutkin & Curtis, 1990). The fourth assumption is that certain skills are essential in order for the model to work. Curtis and Meyers (1984) describe these skills as 1) interpersonal skills, 2) problem solving skills, 3) content expertise and 4) an understanding of systems theory. Research on the consultation model has shown it to be "desired by teachers and administrators, effective in improving teachers' skills and attitudes in dealing with diverse groups of students and to reduce referral rates over time" (Graden, Casey, & Bonstrom, 1985). As mentioned previously, there are different models of prereferral activities. Of these models, the Teacher Assistance Team proposed by Chalfant, Pysh, and Moultrie, (1979) and school based consultation by a school psychologist will be discussed. While each of the approaches for prereferral activities have been reported to be effective, the differential effectiveness of any one

approached has not been proven (Curtis, Zins, & Graden, 1987). Carter & Sugai (1989) recently surveyed state directors of special educations throughout the United States about the use of prereferral interventions. They found that while most states required some form of prereferral intervention, there is little empirical evidence to indicate that these interventions are effective in keeping students in the least restrictive environment.

Teacher Assistance Teams (TAT) is a collegial consultation model based on four assumptions 1) "regular education teachers have the skills and knowledge to help many students with learning and behavior problems; 2) teachers can resolve more problems working together than alone; 3) regular education should make every effort to resolve problems at the building level before referring a child to special education and labeling him as handicapped; and 4) teachers learn best by doing; the best way to increase their skills is by helping them solve immediate problems in their classroom" (Chalfant, & Pysch, 1981).

The first step in the process is the teacher's referral to the TAT. The referral describes 1) what skill or behavior the teacher wants the student to have, 2) what the students strengths and weaknesses are, 3) previous attempts at helping the student cope with the



problem, and 4) any background information. The team coordinator reviews the referral and sends the referral to the team. The team draws a diagram, which is a visual-conceptual look at the problem that shows the relationship between problem areas. The basic purpose of the diagram is to visually represent the teacher's perceptions of the problem, which can be adapted as the team and the teacher feel necessary. After the team reviews the referral the team coordinator may work with the teacher to clarify concerns or to obtain additional information. A member of the team may also visit the classroom to observe the student. The next step is the problem solving meeting at which the following takes place: 1) a consensus is reached on the nature of the child's problem, 2) objectives are negotiated, 3) brainstorming of problem solutions take place, 4) the teacher either selects suggestions for trial or sends the team back to the drawing board, 5) the team refines their suggestions, decides how the intervention will be measured, and assigns responsibility for carrying out the intervention, and 6) a follow up plan for continued support or further evaluations established. This meeting usually lasts about 30 minutes (Chalfant & Pysh, 1981; Chalfant, 1987). Chalfant and Pysh (1981) gathered data from fifteen schools in Arizona, Nebraska, and Illinois during the second year of the TAT program. They report

that of the 200 students staffed, the team helped teachers resolve the problems of 133 (67%) of all students who were referred. This included 103 (89%) of the 116 non-disabled students and 30 (100%) of the disabled students that were mainstreamed into regular education programs. There were 67 students whose problems the team could not resolve, 54 of those were referred for special education assessments and were found to be eligible for services. There were no false referrals to special education. The team was not able to solve the problems of 13 (7%) of the students referred (Chalfant & Pysh, 1981). Where the TAT model uses a team made up of primarily regular education teachers, the prereferral intervention model (Curtis, Zins, & Graden, 1987; Zins, Graden, & Ponti, 1989; Zins & Ponti, 1990) utilizes the services of special education support staff. The initial step in this procedure is when the teacher or parent observes a problem, either academic or behavioral, and brings it to the attention of the special educational support staff. Any member or members of the special education support staff may serve as the consultant in this model. If it is the teacher who observes the problem, the teacher must notify the parent/guardian of the child prior to a referral for assistance. It is highly recommended that parents be involved as much as possible in prereferral interventions. The next step is

problem-solving with the special education support staff. Here the problem is operationally defined, and analyzed. Problem analysis may include the collection of data and classroom observations. Once the problem has been analyzed an intervention plan is developed and implemented within the regular classroom. A specific amount of time is allotted for the intervention and data is collected on its effectiveness. The effectiveness of the intervention is then evaluated according to previously set criteria. If the intervention is effective the progress of the student is monitored and the intervention is modified as needed. If the intervention is not effective a referral for further assessment is made.

One of the benefits for the psychologist of using any of the prereferral models is that it allows them to expand their role from psychometrician to consultant. This has the potential to be more rewarding to the psychologist because it allows more use of their professional's expertise. This system allows for more students to benefit from the psychologist's expanded services, since less time is spent in formal testing activities.

In order for a prereferral system to be successful, it must be carefully implemented in the school and the school system. As in any new approach, if the school

administration, teachers, and support staff are not involved with how the program will be implemented, there is less chance that they will be committed to the program (Phillips & McCoullough, 1990). Since regular education teachers may be required to alter their curriculum or teaching strategies to meet the needs of certain students, it is crucial to have their support.

While the literature speaks to the benefits of prereferral activities, Carter and Sugai's (1989) research questions the effectiveness of current models. In reviewing the literature, Zins and Ponti (1990) refer to three factors that influence the success of the prereferral consultation process. The first factor is acceptability which refers to the social validity of a proposed intervention. Specifically, it refers to consultee's acceptance of the consultant's proposed intervention plan as appropriate, fair and reasonable (Witt & Martens, 1988; Zins and Ponti, 1990). Kazdin (1980) defines acceptability as the judgements of consumers regarding the fairness of a treatment plan in relation to a given problem, reasonable or intrusive in its application, and consistent with conventional notions of what treatment should be. Adherence, the second factor, involves both the willingness of the consultee to fully implement the intervention plan, and the willingness of the client (in this case, the student) to

engage in the planned behavior changes (Zins & Ponti, 1990). The third factor, treatment integrity refers to the extent to which the consultee implements the intervention plan as designed (Gresham, 1989; Zins & Ponti, 1990). According to Zins and Ponti (1990), these factors are interrelated and that the elements that are most directly linked with the effectiveness of interventions are adherence and integrity. In short, if a consultee believes a treatment plan is fair (acceptance) and is motivated to implement it there is strong likelihood that the consultee will follow the planned intervention (treatment integrity).

While these factors have been described in the literature, empirical research in this area has been limited. Empirical evidence supporting the acceptability, adherence and integrity factors, unfortunately only exists for the first factor. These studies on the acceptability factor have shown that interventions which are complicated, time consuming and require material and equipment which are not easily procurable in the school setting are perceived by teachers as intrusive and lacking feasibility (Phillips, & McCullough, 1990; Witt, Martens, & Elliott, 1984; Witt & Martens, 1988). All evidence that willingness to adhere and actually adhering to a prescribed plan is more effective than deviating has been simply considered a

professional truism (Zins, note 1).

### Statement of Problem

As noted above, a consultee's motivation to adhere to a prescribed intervention plan has been shown to be affected by components of the plan. No research to date has addressed the effect of who recommends the intervention. The proponents of the TAT model (Chalfant & Pysh, 1981) would assert that fellow teachers are more effective in getting their peers to utilize a pre-referral plan than if that same plan was developed by professionals such as school psychologists. This effect is usually attributed to the general understanding that teachers view fellow teachers as more credible sources of pre-referral interventions.

It has been well documented in the social psychology literature on attitude and behavior change that the more credible the communicator of a message the more likely the audience will adopt the communicator's position (e.g., Hovland, Janis, & Kelley, 1953; McGuire, 1968). Teachers may therefore form different beliefs about the pre-referral interventions as a function of who made the recommendation. Thus, the primary purpose of this study is to ascertain if intervention plans are influenced to a different extent when the source is a TAT or a team of professionals outside the teaching ranks.

### Statement of Hypotheses

Since there is no data to support the notion that fellow teachers are seen as more credible than professional school psychologists with respect to pre-referral interventions, this study simply seeks to determine if such differences exist. Consequently, no directional hypothesis is offered as to whether the TAT or the school based consultation model is going to result in teachers having more favorable beliefs.

Furthermore, this study explores the main and interaction effects of these two consultant sources and teacher background information. Specifically, the study investigates belief differences between more/less experienced teachers, and primary (K-3)/intermediate (4-6) grade teachers. Again, because of the exploratory nature of this study no directional hypotheses are offered.

While it may be advantageous to know if these differences do exist, it is also important to understand why teachers accept or reject one consultant group over the other. This study attempts to gather some preliminary information through the use of open ended questions asking teachers why they hold their specific beliefs.

## Method

### Subjects

All of the 143 regular education elementary teachers from a single school district served as the target sample. 65 surveys were returned, which constituted a return rate of 45%. Since there were only six male respondents, these were dropped from further analysis. Thus, the sample included 59 female teachers.

Most all the teachers in the sample said that their school requires prereferral interventions (98%) and that 97% of the teachers used prereferral interventions. This indicates that the current sample were knowledgeable about this type of program in the special education field. The sample was weighted in the direction of the primary (K-3) school grades (57%). The remaining 43% of the teachers taught grades 4-6. Teaching experience ranged from 1 year to 34 years with the sample averaging 12.8 years (SD=6.3). Most of the teachers (76%) worked in a school setting where their fellow teachers recommended the interventions. Only 2% indicated that school psychologists made the recommendations, while 20% said that both groups performed this consulting activity.

### Design and Independent Variables

The primary experimental manipulation is the source of the prereferral intervention plan. Half of the target population received plans attributed to a Teacher



Assistance Team. The other half received the same scenarios except that the intervention plan was attributed to school psychologists. Uneven cell sizes emerged. Thirty-four teachers receiving interventions attributed to teacher assistant teams returned the survey, while 25 teachers in the school psychologist condition returned the survey.

### Vignettes

Since the key independent variable is source of the pre-referral intervention, it was necessary to create scenarios or vignettes that presented a situation in which teacher beliefs could be influenced. It was important not to select a child's problem that was too insurmountable, or an intervention that most teachers would readily accept or reject, regardless of its recommending source. Indeed, such cases would result in no differences between the two groups of consultants.

A small pilot study was instituted to determine the most appropriate intervention to use given a specific problem. A small group of special education consultants (n=5) were asked to review three cases each with four alternative interventions. The consultants all had a Master's degree in Special Education and more than four years of teaching experience. Three of the consultants returned the pilot study questionnaire. The interventions in the

pilot study were taken from the following books and professional manuals: Kaufman Assessment Battery for Children Interpretive Manual (Kaufman & Kaufman, 1983); Behavioral Intervention Manual (McCarney, Provin, & Jackson, 1985); The Learning Disability Intervention Manual (McCarney & Wending, 1987); and Teaching Strategies for Children in Conflict Curriculum, Methods and Materials (Swanson & Reinhart, 1979). The interventions that produced the greatest amount of variability in opinions and/or had the most neutral belief were selected. The vignettes were shown to the consultants without attribution to a particular consultant group (teacher/ psychologist) (see Appendix A).

#### Procedure

The target population was mailed a packet including a letter asking them to participate in the study, 2-3 one page case study vignettes, and a short questionnaire to be completed on each case and a background questionnaire (see Appendices B and C). They were instructed to return their questionnaires to a designated envelope in the Principal's office. Two follow -up mailings were sent requesting teachers to return the questionnaire, with a second copy of the questionnaire included in the last mailing (see Appendix D).

Each vignette used the same consultant group.

Multiple vignettes per subject were used to prevent any effects being attributed to the specifics of that case. Same case group were used to prevent subjects from ascertaining the experimental manipulation, which would be easily identifiable.

Subjects were be asked to read the first vignette and answer some questions about it. They then proceeded to read the second vignette and answer the same set of questions. The same procedure was to be used for the third vignette. The last questionnaire completed was a background sheet which gathered information about the subjects teaching experience, gender, teaching grade, and perceptions of the consulting source (teacher/psychologist).

#### Dependent Variables

Subjects evaluated each vignette using the Teacher Evaluation Inventory Short Form (TEI-SF) developed by Kratochwill, Elliott & Rotto, (1990) (see Appendix E). This nine item questionnaire taps at the teacher's belief system concerning acceptability and adherence of the treatment. Each subject rated the credibility of both school psychologists and teachers as consultants for recommending prereferral interventions. Ratings ranged from 1= "not at all credible" to 5= "extremely credible".

For each vignette subjects had the opportunity to explain why they hold their beliefs.

## Results

### Data Analysis

The nine primary dependent variables collected in the study were analyzed in a repeated measures analysis of variance program (SAS Institute, 1985). In all analyses the repeated measure was the vignette. Between group effects were conducted on Consulting Source alone, Consulting Source and Teacher Experience, and Consulting Source and Grade taught. Statistical tables for these analyses are located in Appendices F, G, and H, respectively.

### Consulting Source Effects

For each the nine dependent variables assessing teachers' perceptions of the prereferral interventions showed that the source did not have any effect on their attitudes. As shown in Table 1 the means are almost identical.

At the end of the questionnaire packet teachers were asked to rate the credibility of both teachers and school psychologists as consultants for recommending prereferral interventions. Analysis of these data using a matched t-test indicated that teachers ( $M=4.07$ ,  $SD=0.93$ ) were perceived as having significantly more credibility than school psychologists ( $M=3.22$ ,  $SD=0.97$ ;  $t(54)=4.75$ ,  $p<.001$ ).

Table 1  
 Mean Ratings for Dependent Variables  
 by Consulting Source

Dependent Variable	Fellow Teachers	School Psychologist
1. Acceptable Way	2.67	2.92
2. Willing to Use	2.88	3.08
3. No Child Consent Needed	3.19	3.28
4. Like Procedures	2.71	2.77
5. Effective	2.68	2.59
6. Child Discomfort	2.78	2.71
7. Permanent Improvement	2.46	2.45
8. Cannot Choose Treatment	2.98	3.22
9. Positive Reaction	2.72	2.65

Asking teachers a straight-forward question " Which do you think is more effective as a source of prereferral intervention recommendations?", 75% indicated "fellow teachers", 17% checked "school psychologists" and 3% indicated "both".

Taken together these results suggest that teachers have a more favorable attitude toward their colleagues providing the consultation service, but that this bias does not affect their attitudes towards the interventions that are recommended by school psychologists. Teachers apparently can separate the consulting source from the quality of the intervention itself.

#### Vignette Effects

Table 2 shows that for some the dependent measures vignettes presented to subjects were viewed differently. These data could be viewed as a method effect and has little relevance to this study. On the other hand, these results lend credence to the above interpretation that teachers were indeed differentiating between the credibility of the consulting source and the content of the intervention.

Table 2  
 Mean Ratings for Dependent Variables  
 by Vignette

Dependent Variable	Vignette		
	Sara	Brad	Shawna
1. Acceptable Way	2.62	2.75	2.96
2. Willing to Use	2.89	2.88	3.15
3. No Child Consent Needed	3.10	3.18	3.42
4. Like Procedures	2.63	2.60	2.98
5. Effective	2.49	2.25	2.91
6. Child Discomfort	3.32a	2.61b	2.31b
7. Permanent Improvement	2.37	2.47	2.53
8. Cannot Choose Treatment	2.84a	3.02ab	3.40b
9. Positive Reaction	2.57	2.60	2.89

Note: Means not sharing the same subscript are significantly different from each other according to Duncan Multiple Range Tests ( $\alpha=.05$ ).

### Teaching Experience Effects

The sample was divided into two groups of teaching experience: those with 10 or fewer years (n=24) and those with 11 or more years (n=35). ANOVAs revealed that teaching experience had no significant effect on attitudes towards the interventions, nor did it produce any significant interaction effects with the consulting source (see Appendix G). Means for teaching experience groups are presented in Table 3.

Table 3  
Mean Ratings for Dependent Variables  
by Teaching Experience

Dependent Variable	10 yrs. or less	11 yrs. or more
1. Acceptable Way	2.80	2.76
2. Willing to Use	2.88	3.08
3. No Child Consent Needed	3.24	3.22
4. Like Procedures	2.78	2.70
5. Effective	2.56	2.70
6. Child Discomfort	2.69	2.79
7. Permanent Improvement	2.41	2.49
8. Cannot Choose Treatment	3.16	3.04
9. Positive Reaction	2.70	2.67



### Teaching Grade Effects

Results shown in Appendix H and Table 4 show that the grade teachers were assigned did not significantly affect intervention perceptions, nor did they produce any meaningful interactions. Where interactions emerged they were associated with the vignette and are thus considered method bound.

Table 4  
Mean Ratings for Dependent Variables  
by Teaching Grade

Dependent Variable	K - 3	4 - 6
1. Acceptable Way	2.83	2.66
2. Willing to Use	3.00	2.89
3. No Child Consent Needed	3.40	2.99
4. Like Procedures	2.72	2.71
5. Effective	2.67	2.57
6. Child Discomfort	2.71	2.86
7. Permanent Improvement	2.53	2.36
8. Cannot Choose Treatment	3.24	2.85
9. Positive Reaction	2.71	2.62

### Consulting Preference Explanations

Teachers were given the opportunity to respond to an open-ended question as to their reasons why they find either teachers or school psychologists more effective as consultants for prereferral interventions. Of the 58

comments received, 39 (67%) reported that the lack of classroom experience hinders school psychologists from being able to develop realistic interventions, teachers have the opportunity to observe the students more, and fellow teachers better understand the problem. The remaining comments were spread to a variety of comment themes, none of which yielded many responses. A complete account of comment themes can be found in Appendix I.

After teachers rated each intervention they were asked to give reasons as to why they felt the treatment was effective or ineffective. These data did not produce any insights into the consulting source credibility. The majority of comments dealt specifically with the intervention and did not attribute the effectiveness to the consulting source. Most of the comments were critical of the intervention, regardless to whom it was attributed. Appendix J summarizes these comment themes by experimental condition.

## Discussion

The results of this study indicate that teachers' attitudes towards a suggested intervention are not affected by a consulting source. The acceptance of suggested interventions are based on the merits of the intervention rather than consulting source credibility. Teachers agreed that they would attempt suggested interventions regardless of the consulting source. However, when teachers were asked who they perceived as a more credible consulting source for developing prereferral interventions, they endorsed their fellow teachers over school psychologists. Thus, while teachers will agree to adhere to the interventions developed by either consulting source, they indicated a preference to working with their fellow teachers. Their preference of working with peers is consistent with the philosophy of the TAT model of prereferral interventions (Chalfont & Pysh, 1981).

This is further supported by research which indicates that teachers prefer the collaborative approach to problem solving over the expert consulting approach (Pryzwansky & White, 1983; Jason & Ferone, 1978). The reason for the preference of fellow teachers as consultants over school psychologists tended to focus on the respondents' beliefs that fellow teachers provide

more feasible and useful suggestions than psychologists. The responding teachers felt that the psychologists' lack of classroom experience affected their ability to provide realistic interventions that could be implemented in a large classroom.

Results of this study has wide ranging implications. First and foremost, research has shown that a consultee is less likely to adhere to an intervention plan if they do not find the plan acceptable (Zins & Ponti, 1990). Since the acceptability of a plan is based on how reasonable or intrusive it is in its application and its consistency with conventional notions of what treatment should be (Kazdin, 1980), it appears that there is a greater chance that a teacher who would attempt a prereferral intervention plan would be less likely to adhere to the plan if developed with a school psychologist, as school psychologists are perceived as providing suggestions which are unrealistic. If the treatment is not adhered to it loses its integrity and its effectiveness which could lead to frustration on the part of the teacher, student and consultant.

When an intervention plan is not attempted due to lack of respect for that intervention, then the school district loses financially in that the resources of the district (both the teacher and the consultant) are not being used to their fullest capacity. Developing and

implementing prereferral interventions take time and if the intervention is not attempted or the treatment loses its integrity, then the district has spent money on something for which it gets no return.

Another implication is one of professional image and role. The majority of the teachers' comments implied that they did not view the school psychologist as an appropriate consultant for prereferral intervention activities, however they did not question the need for the school psychologist in other roles. While psychologists are attempting to broaden their role in the schools in order to assist more students, teachers appear to have specific ideas as to what the role of the psychologist should or should not be. This could lead to a strain in relationships if the psychologists feel their skills are not being used to their fullest while teachers feel that psychologists are moving into an area in which they lack expertise.

There is a growing amount of literature which supports the effectiveness of prereferral interventions (Graden, Casey & Bonstrom, 1985; Curtis, Zins & Graden, 1987; Chalant & Pysh, 1981). Given the results of this study, it would be important to consider who would be the most appropriate consulting source in this process. While more indepth research is warranted, the results of this study suggest that teachers respond more positively

to preferral interventions when the consultant sources are fellow teachers. School psychologists and other non-teaching professionals may be perceived as more helpful if they serve as an additional support to the team of teachers who are involved in the consultation process.

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APPENDIX A  
PILOT STUDY QUESTIONNAIRE

## Vignette I

Sara, one of your third grade students, has difficulty learning to spell. You suspect that she has a problem with visual sequencing because she has trouble remembering the correct order of the letters in her spelling words. Before referring Sara for a special education evaluation you must attempt prereferral interventions. The following are possibilities.

Please evaluate each intervention (treatment) by completing the rating scale. Rate Treatment #1 first, then Treatment #2, and so on. Be sure to have a number in each space. There should be a total of 36 ratings.

1. Scramble Sara's spelling words and have her practice rewriting the spelling list using a model. When she is able to complete this task successfully, present the scrambled words to her and then have her rewrite the words without using the model.
2. Have Sara trace her spelling words from a model several times. Then have her look at the words before asking her to spell the words on a separate sheet of paper.
3. Go back to the second grade curriculum and have Sara learn the words she did not learn in second grade.
4. Teach Sara to look for specific letter sequences, such as *tion*. Have Sara first pronounce the sound these letters make (*shun*). Then put the letter sequence in the middle of a diagram. Have Sara look at her spelling list and write on the diagram all the words which contain the letter sequence you are teaching.

## Vignette 2

Brad, a student in your 4th grade class is struggling with math problems that require regrouping. The following prereferral interventions are possibilities.

Please evaluate each intervention (treatment) by completing the rating scale. Rate Treatment #1 first, then Treatment #2, and so on. Be sure to have a number in each space. There should be a total of 36 ratings.

1. Give Brad a simple addition problem which involves carrying. Have him solve the problem using the following steps:

- a. Add the 2 numbers in the ones column.

$$\begin{array}{r} 21 \\ +9 \\ \hline \end{array}$$

- b. Check to see if that number is more than 10. If it is, carry the ten over to the tens place.

$$\begin{array}{r} 1 \\ 21 \\ +9 \\ \hline 0 \end{array}$$

- c. Add the numbers in the tens column.

$$\begin{array}{r} 1 \\ 21 \quad 2 \text{ tens} + \text{ten} = 3 \text{ tens} \\ +9 \\ \hline 30 \end{array}$$

2. Teach Brad to visualize the steps involved in carrying.

- a. Have Brad look at a problem :

$$\begin{array}{r} \text{tens ones} \\ 2 \quad 1 \\ + \quad \underline{9} \end{array}$$

- b. Ask Brad to close his eyes and picture the steps needed to solve the problem.

3. Check to see if Brad has mastered the prerequisite skills for arithmetic problems. If not, teach him the skills he has not yet mastered.

4. Provide Brad with many concrete experiences to help him learn and remember regrouping skills. Use popsicle sticks, tongue depressors, paper clips, buttons, base ten blocks, etc. to form groupings to teach regrouping.

## Vignette 3

Shawna, one of your 6th grade students, has been diagnosed as having a mild attention deficit problem. Her parents do not want her to take medication since they are fearful of its side effects and their doctor agrees with them. You are concerned about Shawna's short attention span since it interferes with her ability to stay on task in the classroom. You would like to know if she is eligible for special education services. Before referring her for a special education evaluation you must attempt prereferral interventions. The following are possibilities.

Please evaluate each intervention (treatment) by completing the rating scale. Rate Treatment #1 first, then Treatment #2, and so on. Be sure to have a number in each box. There should be a total of 36 ratings.

1. When giving Shawna directions state only the essential information.
2. Interact frequently with Shawna in order to maintain her involvement in the classroom activities (e.g., ask Shawna questions, ask for her opinions on certain topics of discussion, maintain close physical proximity).
3. Have Shawna maintain a chart representing the amount of time spent on task and provide reinforcers for increasing appropriate behavior.
4. Provide Shawna with a predetermined signal when she begins to display off-task behavior.



APPENDIX B

TAT CONDITION VIGNETTES, QUESTIONNAIRE AND COVER LETTER

April 1, 1991

Dear Teacher:

Recently, the field of education has emphasized the use of interventions prior to referring a student for a special education evaluation. As a graduate student in school psychology at the University of Nebraska at Omaha, I am doing research on teacher attitudes towards "prereferral interventions."

Your school district has approved my requesting your participation in a research study. All that you need to do is: (1) read three cases each concerning a student problem with an associated intervention; and (2) complete a short questionnaire. This should take you less than 15 minutes.

Your responses will be completely anonymous. No individual responses will be reported. All data will be summarized in group form. A final report will be used to complete the graduate requirements for my Educational Specialist degree. I will provide your school district with a summary of the results.

I will greatly appreciate your completing the questionnaire and returning it to the envelope in your Principal's office by April 22, 1991.

Thank you in advance for your participation in this project.

Sincerely,

Denise B. Greenberg

Sara, one of your third grade students, has difficulty learning to spell. You suspect that she has a problem with visual sequencing because she has trouble remembering the correct order of the letters in her spelling words.

You would like to refer Sara for a special education evaluation to see if she qualifies for Resource Room assistance as a learning disabled student. Prior to a formal referral to the special education team, you are required to attempt prereferral interventions. You meet with your school's Teacher Assistance Team which is made up of four of your fellow regular education teachers. After 30 minutes of brainstorming possible treatments and evaluating the positive and negative aspects of those interventions, you decide to try the following: Scramble Sara's spelling words and have her practice rewriting the spelling list using a model. When she is able to complete this task successfully, present the scrambled words to her and have her rewrite them without using the model.

Please evaluate the treatment by completing the rating scale below. Then answer the questions at the bottom of the page.

Please complete the items listed below by placing a checkmark on the line next to each question that best indicates how you feel about the treatment. Please read the items very carefully because a checkmark accidentally placed on one space rather than another may not represent the meaning you intended.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I find this treatment to be an acceptable way of dealing with the child's problem behavior.	_____	_____	_____	_____	_____
2. I would be willing to use this procedure if I had to change the child's problem behavior.	_____	_____	_____	_____	_____
3. I believe that it would be acceptable to use this treatment without children's consent	_____	_____	_____	_____	_____
4. I like the procedures used in this treatment.	_____	_____	_____	_____	_____
5. I believe this treatment is likely to be effective.	_____	_____	_____	_____	_____
6. I believe the child will experience discomfort during the treatment.	_____	_____	_____	_____	_____
7. I believe this treatment is likely to result in permanent improvement.	_____	_____	_____	_____	_____
8. I believe it would be acceptable to use this treatment with individuals who cannot choose treatments for themselves.	_____	_____	_____	_____	_____
9. Overall, I have a positive reaction to this treatment.	_____	_____	_____	_____	_____

Why do you think this was an effective or ineffective prereferral treatment? \_\_\_\_\_

\_\_\_\_\_

Brad, one of your fourth grade students, is struggling with math problems that require regrouping. You question whether he has a learning disability in math and would like to refer him for a special education evaluation. Prior to a formal referral to the special education team you are required to meet with your school's Teacher Assistance Team. The team is composed of four of your fellow regular education teachers who spend about 30 minutes brainstorming possible prereferral interventions with you. After evaluating the positive and negative aspects of the suggested treatments, you decide to try the following:

Teach Brad to visualize the steps involved in carrying.

- a. Have Brad look at a problem:

$$\begin{array}{r} \text{tens ones} \\ 2 \quad 1 \\ + \quad \underline{9} \end{array}$$

- b. Ask Brad to close his eyes and picture the steps needed to solve the problem.

Please evaluate the treatment by completing the rating scale below. Then answer the question at the bottom of the page.

Please complete the items listed below by placing a checkmark on the line next to each question that best indicates how you feel about the treatment. Please read the items very carefully because a checkmark accidentally placed on one space rather than another may not represent the meaning you intended.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I find this treatment to be an acceptable way of dealing with the child's problem behavior.	_____	_____	_____	_____	_____
2. I would be willing to use this procedure if I had to change the child's problem behavior.	_____	_____	_____	_____	_____
3. I believe that it would be acceptable to use this treatment without children's consent.	_____	_____	_____	_____	_____
4. I like the procedures used in this treatment.	_____	_____	_____	_____	_____
5. I believe this treatment is likely to be effective.	_____	_____	_____	_____	_____
6. I believe the child will experience discomfort during the treatment.	_____	_____	_____	_____	_____
7. I believe this treatment is likely to result in permanent improvement.	_____	_____	_____	_____	_____
8. I believe it would be acceptable to use this treatment with individuals who cannot choose treatments for themselves.	_____	_____	_____	_____	_____
9. Overall, I have a positive reaction to this treatment.	_____	_____	_____	_____	_____

Why do you think this was an effective or ineffective prereferral treatment? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Shawna, one of your 6th grade students, has been diagnosed as having a mild attention deficit problem. Her parents do not want her to take medication since they are fearful of its side effects and their doctor agrees with them. You are concerned about Shawna's short attention span since it interferes with her ability to stay on task in the classroom. You believe she would benefit from the small group special education instruction which is provided in the resource room. An evaluation by the special education team is needed to determine if Shawna is eligible for resource room services. Prior to a formal referral for a special education evaluation you are required to meet with your school's Teacher Assistance Team. The team is composed of four of your fellow regular education teachers who spend 30 minutes brainstorming possible prereferral interventions with you. After evaluating the positive and negative aspects of the suggested treatments, you decide to try the following: When giving Shawna directions state only the essential information.

Please evaluate the treatment by completing the rating scale below. Then answer the question at the bottom of the page.

Please complete the items listed below by placing a checkmark on the line next to each question that best indicates how you feel about the treatment. Please read the items very carefully because a checkmark accidentally placed on one space rather than another may not represent the meaning you intended.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I find this treatment to be an acceptable way of dealing with the child's problem behavior.	_____	_____	_____	_____	_____
2. I would be willing to use this procedure if I had to change the child's problem behavior.	_____	_____	_____	_____	_____
3. I believe that it would be acceptable to use this treatment without children's consent	_____	_____	_____	_____	_____
4. I like the procedures used in this treatment.	_____	_____	_____	_____	_____
5. I believe this treatment is likely to be effective.	_____	_____	_____	_____	_____
6. I believe the child will experience discomfort during the treatment.	_____	_____	_____	_____	_____
7. I believe this treatment is likely to result in permanent improvement.	_____	_____	_____	_____	_____
8. I believe it would be acceptable to use this treatment with individuals who cannot choose treatments for themselves.	_____	_____	_____	_____	_____
9. Overall, I have a positive reaction to this treatment.	_____	_____	_____	_____	_____

Why do you think this was an effective or ineffective prereferral treatment? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## BACKGROUND INFORMATION

1. What is your gender?

Female  Male

2. How many years have you been a teacher (round to the nearest year)?

\_\_\_\_\_ years

3. What grade do you currently teach?

K - 3  4 - 6

4. Are you required to use prereferral interventions prior to a special education evaluation?

Yes  No

5. Have you ever used a prereferral intervention on a student?

Yes  No (skip to question # 7)

6. Who most often recommended the interventions?  
(CHECK ONLY ONE)

Fellow Teachers

School Psychologist

Both

Other (Specify) \_\_\_\_\_

6. Overall, how credible do you think your fellow teachers are as consultants for recommending effective prereferral interventions? (CIRCLE THE NUMBER THAT APPLIES)

1-----2-----3-----4-----5  
not at all credible extremely credible

7. Overall, how credible do you think school psychologists are as consultants for recommending effective prereferral interventions? (CIRCLE THE NUMBER THAT APPLIES)

1-----2-----3-----4-----5  
not at all credible extremely credible

8. Which do you think is more effective as a source of prereferral intervention recommendations?

Your fellow teachers  School Psychologists

9. Why? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

APPENDIX C

SCHOOL PSYCHOLOGIST VIGNETTES, QUESTIONNAIRE AND COVER LETTER

April 1, 1991

Dear Teacher:

Recently, the field of education has emphasized the use of interventions prior to referring a student for a special education evaluation. As a graduate student in school psychology at the University of Nebraska at Omaha, I am doing research on teacher attitudes towards "prereferral interventions."

Your school district has approved my requesting your participation in a research study. All that you need to do is: (1) read three cases each concerning a student problem with an associated intervention; and (2) complete a short questionnaire. This should take you less than 15 minutes.

Your responses will be completely anonymous. No individual responses will be reported. All data will be summarized in group form. A final report will be used to complete the graduate requirements for my Educational Specialist degree. I will provide your school district with a summary of the results.

I will greatly appreciate your completing the questionnaire and returning it to the envelope in your Principal's office by April 22, 1991.

Thank you in advance for your participation in this project.

Sincerely,

Denise B. Greenberg



Sad Spelling Sara

Sara, one of your third grade students, has difficulty learning to spell. You suspect that she has a problem with visual sequencing because she has trouble remembering the correct order of the letters in her spelling words.

You would like to refer Sara for a special education evaluation to see if she qualifies for Resource Room assistance as a learning disabled student. Prior to a formal referral to the special education team, you are required to attempt prereferral interventions. You meet with your school's psychologist. After 30 minutes of brainstorming possible treatments and evaluating the positive and negative aspects of those interventions, you decide to try the following: Scramble Sara's spelling words and have her practice rewriting the spelling list using a model. When she is able to complete this task successfully, present the scrambled words to her and then have her rewrite them without using the model.

Please evaluate the treatment by completing the rating scale below. Then answer the questions at the bottom of the page.

Please complete the items listed below by placing a checkmark on the line next to each question that best indicates how you feel about the treatment. Please read the items very carefully because a checkmark accidentally placed on one space rather than another may not represent the meaning you intended.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I find this treatment to be an acceptable way of dealing with the child's problem behavior.	_____	_____	_____	_____	_____
2. I would be willing to use this procedure if I had to change the child's problem behavior.	_____	_____	_____	_____	_____
3. I believe that it would be acceptable to use this treatment without children's consent	_____	_____	_____	_____	_____
4. I like the procedures used in this treatment	_____	_____	_____	_____	_____
5. I believe this treatment is likely to be effective.	_____	_____	_____	_____	_____
6. I believe the child will experience discomfort during the treatment.	_____	_____	_____	_____	_____
7. I believe this treatment is likely to result in permanent improvement.	_____	_____	_____	_____	_____
8. I believe it would be acceptable to use this treatment with individuals who cannot choose treatments for themselves.	_____	_____	_____	_____	_____
9. Overall, I have a positive reaction to this treatment.	_____	_____	_____	_____	_____

Why do you think this was an effective or ineffective prereferral treatment? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Brad, one of your fourth grade students, is struggling with math problems that require regrouping. You question whether he has a learning disability in math and would like to refer him for a special education evaluation. Prior to a formal referral to the special education team you are required to meet with your school's psychologist. After 30 minutes of brainstorming possible treatments and evaluating the positive and negative aspects of those interventions, you decide to try the following:

Teach Brad to visualize the steps involved in carrying.

- a. Have Brad look at a problem:

$$\begin{array}{r} \text{tens ones} \\ 2 \quad 1 \\ + \quad \underline{9} \end{array}$$

- b. Ask Brad to close his eyes and picture the steps needed to solve the problem.

Please evaluate the treatment by completing the rating scale below. Then answer the question at the bottom of the page.

Please complete the items listed below by placing a checkmark on the line next to each question that best indicates how you feel about the treatment. Please read the items very carefully because a checkmark accidentally placed on one space rather than another may not represent the meaning you intended.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I find this treatment to be an acceptable way of dealing with the child's problem behavior.	_____	_____	_____	_____	_____
2. I would be willing to use this procedure if I had to change the child's problem behavior.	_____	_____	_____	_____	_____
3. I believe that it would be acceptable to use this treatment without children's consent	_____	_____	_____	_____	_____
4. I like the procedures used in this treatment.	_____	_____	_____	_____	_____
5. I believe this treatment is likely to be effective.	_____	_____	_____	_____	_____
6. I believe the child will experience discomfort during the treatment.	_____	_____	_____	_____	_____
7. I believe this treatment is likely to result in permanent improvement.	_____	_____	_____	_____	_____
8. I believe it would be acceptable to use this treatment with individuals who cannot choose treatments for themselves.	_____	_____	_____	_____	_____
9. Overall, I have a positive reaction to this treatment.	_____	_____	_____	_____	_____

Why do you think this was an effective or ineffective prereferral treatment? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Shawna, one of your 6th grade students, has been diagnosed as having a mild attention deficit problem. Her parents do not want her to take medication since they are fearful of its side effects and their doctor agrees with them. You are concerned about Shawna's short attention span since it interferes with her ability to stay on task in the classroom. You believe she would benefit from the small group special education instruction which is provided in the resource room. An evaluation by the special education team is needed to determine if Shawna is eligible for resource room services. Prior to a formal referral for a special education evaluation you are required to meet with your school's psychologist. After 30 minutes brainstorming possible treatments and evaluating the positive and negative aspects of those interventions you decide to try the following: When giving Shawna directions state only the essential information.

Please evaluate the treatment by completing the rating scale below. Then answer the question at the bottom of the page.

Please complete the items listed below by placing a checkmark on the line next to each question that best indicates how you feel about the treatment. Please read the items very carefully because a checkmark accidentally placed on one space rather than another may not represent the meaning you intended.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I find this treatment to be an acceptable way of dealing with the child's problem behavior.	_____	_____	_____	_____	_____
2. I would be willing to use this procedure if I had to change the child's problem behavior.	_____	_____	_____	_____	_____
3. I believe that it would be acceptable to use this treatment without children's consent	_____	_____	_____	_____	_____
4. I like the procedures used in this treatment.	_____	_____	_____	_____	_____
5. I believe this treatment is likely to be effective.	_____	_____	_____	_____	_____
6. I believe the child will experience discomfort during the treatment.	_____	_____	_____	_____	_____
7. I believe this treatment is likely to result in permanent improvement.	_____	_____	_____	_____	_____
8. I believe it would be acceptable to use this treatment with individuals who cannot choose treatments for themselves.	_____	_____	_____	_____	_____
9. Overall, I have a positive reaction to this treatment.	_____	_____	_____	_____	_____

Why do you think this was an effective or ineffective prereferral treatment? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## BACKGROUND INFORMATION

1. What is your gender?

\_\_\_\_\_ Female \_\_\_\_\_ Male

2. How many years have you been a teacher (round to the nearest year)?

\_\_\_\_\_ years

3. What grade do you currently teach?

\_\_\_\_\_ K - 3 \_\_\_\_\_ 4 - 6

4. Are you required to use prereferral interventions prior to a special education evaluation?

\_\_\_\_\_ Yes \_\_\_\_\_ No

5. Have you ever used a prereferral intervention on a student?

\_\_\_\_\_ Yes \_\_\_\_\_ No (skip to question # 7)

6. Who most often recommended the interventions?  
(CHECK ONLY ONE)

\_\_\_\_\_ Fellow Teachers

\_\_\_\_\_ School Psychologist

\_\_\_\_\_ Both

\_\_\_\_\_ Other (Specify) \_\_\_\_\_

6. Overall, how credible do you think your fellow teachers are as consultants for recommending effective prereferral interventions? (CIRCLE THE NUMBER THAT APPLIES)

1-----2-----3-----4-----5  
not at all credible extremely credible

7. Overall, how credible do you think school psychologists are as consultants for recommending effective prereferral interventions? (CIRCLE THE NUMBER THAT APPLIES)

1-----2-----3-----4-----5  
not at all credible extremely credible

8. Which do you think is more effective as a source of prereferral intervention recommendations?

\_\_\_\_\_ Your fellow teachers \_\_\_\_\_ School Psychologists

9. Why? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

APPENDIX D  
TEACHER FOLLOW-UP LETTERS

April 19, 1991

Dear Teacher:

Several days ago you received a survey from me which asked for your input on prereferral interventions. In order for my study to be valid, I need a high response rate. If you have already completed the survey and returned it to the office, please accept my sincere thanks. If you have not completed it there is still time. A new envelope has been placed in the office and extra surveys are available in case you have misplaced yours. Please take a few minutes to complete the survey. Your input is important. Completed surveys need to be returned to the office no later than April 29th.

Once again, let me express my appreciation for your help.

Sincerely,

  
Denise B. Greenberg

May 15, 1991

It is hard to believe that the school year is almost over and summer will soon be upon us. Before the end of the year craziness totally overwhelms you, I must ask that those of you who have not already sent back this survey take a few minutes to complete this task.

As I mentioned in my previous requests, this research has been approved by your school district. I have been told that when the study is completed the results might be used by the administration for future planning. In order for the results to be representative of your feelings about prereferral interventions, a high response rate is needed. As of now, I have not received enough surveys to make this study representative.

I know this is a very busy time for you, but please pour yourself a cup of tea and take a few minutes to complete this survey. An envelope has been placed in the office for the completed surveys. All surveys should be submitted no later than May 24th. If you are among those who have already sent back your survey, take a break, have a cup of tea and please accept my sincere appreciation.

Thanks to all of you for your time and assistance. Wishing you a good summer.

Sincerely,

  
Denise B. Greenberg

APPENDIX E  
TREATMENT EVALUATION



Appendix B

Treatment Evaluation Inventory Short Form (TEI-SF)

Please complete the items listed below by placing a checkmark on the line next to each question that best indicates how you feel about the treatment. Please read the items very carefully because a checkmark accidentally placed on one space rather than another may not represent the meaning you intended.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I find this treatment to be an acceptable way of dealing with the child's problem behavior.	_____	_____	_____	_____	_____
2. I would be willing to use this procedure if I had to change the child's problem behavior.	_____	_____	_____	_____	_____
3. I believe that it would be acceptable to use this treatment without children's consent	_____	_____	_____	_____	_____
4. I like the procedures used in this treatment.	_____	_____	_____	_____	_____
5. I believe this treatment is likely to be effective.	_____	_____	_____	_____	_____
6. I believe the child will experience discomfort during the treatment.	_____	_____	_____	_____	_____
7. I believe this treatment is likely to result in permanent improvement.	_____	_____	_____	_____	_____
8. I believe it would be acceptable to use this treatment with individuals who cannot choose treatments for themselves.	_____	_____	_____	_____	_____
9. Overall, I have a positive reaction to this treatment.	_____	_____	_____	_____	_____

APPENDIX F  
CONSULTING SOURCE (2) X VIGNETTE (3)  
ANALYSIS OF VARIANCE TABLES

Analysis of Variance Table for  
the Dependent Variable:

Treatment is an Acceptable Way of Dealing with Problem

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	2.36	1	1.40	.24
Error	91.32	54		
Vignette (V)	3.18	2	1.50	.23
CS X V	0.12	2	0.06	.94
Error	112.03	106		

Willing to Use Procedure to Change Behavior

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	1.42	1	0.70	.41
Error	109.15	54		
Vignette (V)	2.37	2	1.29	.28
CS X V	1.05	2	0.57	.57
Error	96.60	105		

Acceptable to Use Without Child's Consent

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	0.41	1	0.16	.24
Error	133.28	53		
Vignette (V)	3.06	2	2.95	.06
CS X V	0.24	2	0.24	.79
Error	52.29	101		

## Like Procedures Used in Treatment

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	0.10	1	0.07	.80
Error	82.19	55		
Vignette (V)	4.99	2	2.40	.10
CS X V	0.11	2	0.05	.95
Error	112.08	108		

## Likely to be Effective

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	0.49	1	0.35	.56
Error	77.49	55		
Vignette (V)	5.99	2	3.41	.04
CS X V	1.30	2	0.74	.48
Error	94.81	108		

## Child Will Experience Discomfort During Treatment

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	0.06	1	0.03	.86
Error	98.29	55		
Vignette (V)	29.83	2	1.50	.23
CS X V	0.87	2	0.55	.58
Error	84.03	106		

## Will Result in Permanent Improvement

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	0.00	1	0.00	.97
Error	61.63	55		
Vignette (V)	0.76	2	0.66	.52
CS X V	0.88	2	0.08	.93
Error	61.43	107		

## Acceptable For Those Who Cannot Choose For Themselves

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	2.21	1	1.14	.29
Error	107.05	55		
Vignette (V)	11.41	2	8.06	.00
CS X V	0.65	2	0.46	.63
Error	74.28	105		

## Overall Positive Reaction to Treatment

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	0.39	1	0.18	.67
Error	90.77	55		
Vignette (V)	3.91	2	2.51	.09
CS X V	1.11	2	0.71	.49
Error	83.42	107		

APPENDIX G  
CONSULTING SOURCE (2) X TEACHING EXPERIENCE (2)  
X VIGNETTE (3)  
ANALYSIS OF VARIANCE TABLES

Analysis of Variance Table for  
the Dependent Variable:

Treatment is an Acceptable Way of Dealing with Problem

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	1.86	1	1.08	.30
Experience (E)	0.23	1	0.01	.91
CS X E	1.49	1	0.86	.36
Error	89.81	52		
Vignette (V)	3.20	2	1.53	.22
CS X V	0.27	2	0.13	.88
E X V	2.48	2	1.19	.31
CS X E X V	3.17	2	1.52	.22
Error	106.54	102		

Willing to Use Procedure to Change Behavior

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	0.65	1	0.33	.57
Experience (E)	0.14	1	0.07	.79
CS X E	6.15	1	3.11	.08
Error	102.82	52		
Vignette (V)	2.15	2	1.15	.32
CS X V	1.26	2	0.68	.51
E X V	0.58	2	0.31	.73
CS X E X V	1.62	2	0.87	.42
Error	94.38	101		

## Acceptable to Use Without Child's Consent

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	0.22	1	0.09	.77
Experience (E)	0.05	1	0.02	.89
CS X E	5.32	1	2.12	.15
Error	127.74	51		
Vignette (V)	3.02	2	2.87	.06
CS X V	0.31	2	0.30	.74
E X V	0.94	2	0.89	.41
CS X E X V	0.45	2	0.43	.65
Error	50.97	97		

## Like Procedures Used in Treatment

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	0.03	1	0.02	.90
Experience (E)	0.64	1	0.04	.84
CS X E	0.96	1	0.63	.43
Error	80.91	53		
Vignette (V)	5.36	2	2.61	.08
CS X V	0.14	2	0.07	.94
E X V	2.32	2	1.13	.33
CS X E X V	2.62	2	1.28	.28
Error	107.00	104		



## Likely to be Effective

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	0.44	1	0.31	.58
Experience (E)	0.97	1	0.69	.41
CS X E	1.77	1	1.26	.27
Error	74.63	53		
Vignette (V)	6.58	2	3.88	.02
CS X V	2.26	2	1.33	.27
E X V	4.09	2	2.41	.09
CS X E X V	2.38	2	1.40	.25
Error	88.17	104		

## Child Will Experience Discomfort During Treatment

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	0.00	1	0.00	.96
Experience (E)	0.18	1	0.10	.76
CS X E	1.88	1	1.04	.31
Error	95.97	53		
Vignette (V)	28.06	2	17.85	.00
CS X V	0.72	2	0.46	.63
E X V	2.41	2	1.53	.22
CS X E X V	1.69	2	1.08	.35
Error	80.20	102		

## Will Result in Permanent Improvement

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	0.00	1	0.00	.98
Experience (E)	0.26	1	0.22	.64
CS X E	0.00	1	0.00	.96
Error	61.53	53		
Vignette (V)	0.66	2	0.58	.56
CS X V	0.16	2	0.14	.87
E X V	0.47	2	0.41	.67
CS X E X V	2.33	2	2.04	.14
Error	58.70	103		

## Acceptable For Those Who Cannot Choose For Themselves

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	1.27	1	0.66	.42
Experience (E)	0.09	1	0.05	.83
CS X E	3.56	1	1.84	.18
Error	102.77	53		
Vignette (V)	10.83	2	7.61	.00
CS X V	0.92	2	0.65	.53
E X V	0.39	2	0.28	.76
CS X E X V	1.99	2	1.40	.25
Error	71.86	101		

## Overall Positive Reaction to Treatment

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	0.54	1	0.32	.57
Experience (E)	0.00	1	0.00	.96
CS X E	1.96	1	1.17	.29
Error	88.94	53		
Vignette (V)	3.82	2	2.43	.09
CS X V	1.29	2	0.83	.44
E X V	1.63	2	1.04	.36
CS X E X V	0.92	2	0.60	.55
Error	80.92	103		

APPENDIX H  
CONSULTING SOURCE (2) X GRADE TAUGHT (2) X VIGNETTE  
ANALYSIS OF VARIANCE TABLES

Analysis of Variance Table for  
the Dependent Variable:

Treatment is an Acceptable Way of Dealing with Problem

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	2.06	1	1.24	.27
Grade (G)	1.69	1	1.01	.32
CS X G	0.68	1	0.41	.53
Error	85.02	51		
Vignette (V)	2.82	2	1.33	.27
CS X V	0.17	2	0.08	.92
G X V	3.31	2	1.57	.21
CS X G X V	3.73	2	1.77	.18
Error	105.53	100		

Willing to Use Procedure to Change Behavior

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	1.04	1	0.50	.48
Grade (G)	0.94	1	0.45	.50
CS X G	0.14	1	0.07	.80
Error	105.52	51		
Vignette (V)	2.17	2	1.14	.32
CS X V	1.21	2	0.64	.53
G X V	1.50	2	0.79	.46
CS X G X V	1.41	2	0.74	.48
Error	93.78	99		

## Acceptable to Use Without Child's Consent

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	0.75	1	0.30	.58
Grade (G)	6.97	1	2.81	.10
CS X G	0.61	1	0.02	.88
Error	123.92	50		
Vignette (V)	2.97	2	2.73	.07
CS X V	0.21	2	0.20	.82
G X V	0.36	2	0.33	.72
CS X G X V	0.22	2	0.20	.82
Error	51.70	95		

## Like Procedures Used in Treatment

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	0.01	1	0.01	.94
Grade (G)	0.00	1	0.00	.96
CS X G	1.19	1	0.76	.39
Error	76.21	52		
Vignette (V)	4.66	2	2.30	.11
CS X V	0.24	2	0.12	.89
G X V	6.52	2	3.22	.04
CS X G X V	3.11	2	1.54	.22
Error	103.05	102		

## Likely to be Effective

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	0.47	1	0.32	.58
Grade (G)	0.21	1	0.15	.70
CS X G	0.15	1	0.10	.75
Error	76.50	52		
Vignette (V)	5.44	2	1.32	.04
CS X V	1.33	2	0.80	.45
G X V	4.21	2	2.53	.09
CS X G X V	4.39	2	2.63	.08
Error	84.93	102		

## Child Will Experience Discomfort During Treatment

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	0.00	1	0.00	.98
Grade (G)	1.22	1	0.72	.40
CS X G	0.01	1	0.01	.93
Error	87.65	52		
Vignette (V)	29.60	2	17.87	.00
CS X V	0.99	2	0.60	.55
G X V	0.39	2	0.24	.79
CS X G X V	0.26	2	0.16	.86
Error	82.84	100		

## Will Result in Permanent Improvement

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	0.02	1	0.02	.90
Grade (G)	0.72	1	0.64	.43
CS X E	2.01	1	1.79	.19
Error	58.61	52		
Vignette (V)	0.65	2	0.59	.55
CS X V	0.05	2	0.04	.96
G X V	0.93	2	0.85	.43
CS X G X V	4.95	2	4.53	.01
Error	55.16	101		

## Acceptable For Those Who Cannot Choose For Themselves

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	3.11	1	1.70	.20
Grade (G)	7.13	1	3.88	.05
CS X G	1.30	1	0.71	.40
Error	95.43	52		
Vignette (V)	10.81	2	7.57	.00
CS X V	0.56	2	0.39	.68
G X V	1.09	2	0.77	.47
CS X G X V	2.52	2	1.77	.18
Error	70.66	99		



## Overall Positive Reaction to Treatment

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>p</u>
Consulting Source (CS)	0.43	1	0.26	.61
Grade (G)	0.18	1	0.11	.74
CS X G	0.06	1	0.64	.43
Error	86.16	52		
Vignette (V)	3.36	2	2.20	.12
CS X V	1.06	2	0.70	.50
G X V	4.06	2	2.66	.07
CS X G X V	2.58	2	1.69	.19
Error	76.90	101		

## Appendix I

TEACHERS' RESPONSES TO BACKGROUND INFORMATION QUESTION:  
WHY DO YOU FIND THE SCHOOL PSYCHOLOGIST OR YOUR  
FELLOW TEACHERS MORE EFFECTIVE?

1. Psychologists are not teachers, they are too removed from the day-to-day classroom experience. Classroom experience allows teachers to know the kids and the dynamics of the classroom better. Thus teachers offer more realistic interventions to their fellow teachers.  
N=45
2. The credibility of the psychologist is dependent on the individual and their background.  
N=4
3. Depends on the situation.  
N=4
4. Both are effective as each offers a different perspective and a combination of ideas is effective.  
N=4
5. Psychologists too busy.  
N=3
6. Psychologists have the training to give recommendations to teachers.  
N=2
7. No opinion.  
N=2
8. Psychologists are more effective because classroom teachers are too prejudiced about students to be objective.  
N=1
9. The psychologist's time is more flexible than a classroom teacher's and therefore they are more likely to be able to assist with prereferral interventions.  
N=1
10. Psychologists look at students in clinical terms on a short term basis and only as requested.  
N=1

Appendix J  
RESPONSES REGARDING THE EFFECTIVENESS  
OF SUGGESTED PREREFERRAL INTERVENTIONS

VIGNETTE 1 (SAD SPELLING SARA)

1. The treatment is ineffective or wrong.  
TAT N=8                      School Psychologist N=5
2. The treatment will confuse or frustrate the child more.  
TAT N=11                      School Psychologist N=5
3. Alternative treatments offered.  
TAT N=2                      School Psychologist N=2
4. The treatment is or could be effective. It would be worth trying.  
TAT N=6                      School Psychologist N=8
5. Not sure if this is a good intervention or not. Would have to know more about the student.  
TAT N=0                      School Psychologist N=4
6. I do not know how scrambling the words will help.  
TAT N=0                      School Psychologist N=2
7. TAT teams offer more than one suggestion, I do not want my feeling for an incorrect treatment to reflect on the TAT process, so I refused to complete the vignette portions of the study.  
TAT N=2                      School Psychologist N=0
8. This is not necessarily the only cause of the problem.  
TAT N=0                      School Psychologist N=1

## VIGNETTE 2 (MATH BOTHERS BRAD)

1. Ineffective or wrong treatment.  
TAT N=4                      School Psychologist N=3
2. The student needs more concrete materials or  
manipulatives.  
TAT N= 12                      School Psychologist N=12
3. This is an effective treatment. It would be worth  
trying.  
TAT N=8                      School Psychologist N=6
4. The effectiveness depends on the individual student.  
TAT N=2                      School Psychologist N=0
5. I do not know if the treatment will work but it would be  
worth trying.  
TAT N=0                      School Psychologist N=2
6. Not enough information is given to make a decision.  
TAT N=0                      School Psychologist N=3

## VIGNETTE 3 (OFF TASK SHAWNA)

1. Ineffective treatment.  
TAT N=4                      School Psychologist N=4
2. Alternative interventions suggested.  
TAT N=10                      School Psychologist N=4
3. Effective treatment, a good start, would be worth trying.  
TAT N=7                      School Psychologist N=11
4. This intervention would be difficult to administer in a large classroom.  
TAT N=2                      School Psychologist N=0
5. Not enough information provided.  
TAT N=0                      School Psychologist N=2
6. The effectiveness depends on the individual student.  
TAT N=0                      School Psychologist N=1
7. We already do this with all children.  
TAT N=0                      School Psychologist N=2
8. This is only one of many ways to help.  
TAT N=1                      School Psychologist N=0