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# Treatment Acceptability by Label and Role

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Treatment Acceptability by Label and Role

\_\_\_\_\_  
(TITLE)

BY

Larry D. Fairbanks

**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

1995  
YEAR

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TABLE OF CONTENTS

|                           | <u>Page</u> |
|---------------------------|-------------|
| List of Tables.....       | ii          |
| Acknowledgements.....     | iii         |
| Abstract.....             | iv          |
| Introduction.....         | 1           |
| Review of Literature..... | 1           |
| Method.....               | 18          |
| Participants.....         | 18          |
| Instrumentation.....      | 18          |
| Procedure.....            | 19          |
| Results.....              | 20          |
| Discussion.....           | 23          |
| References.....           | 27          |
| Appendix A.....           | 32          |
| Appendix B.....           | 33          |
| Appendix C.....           | 34          |
| Appendix D.....           | 35          |
| Appendix E.....           | 37          |

LIST OF TABLES

| <u>Table</u> |  | <u>Page</u> |
|--------------|--|-------------|
| 1            | Means and standard deviations for the<br>IRP-15 by intervention, group, & label.....             | 20          |
| 2            | ANOVA by intervention, group, & label<br>on the IRP-15.....                                      | 21          |
| 3            | Student Newman-Keuls Multiple-Range<br>analysis for effects of group within<br>intervention..... | 22          |

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## ABSTRACT

This study examined differences in ratings of treatment acceptability among groups of individuals who are often involved in the recommendation, selection, implementation, and evaluation of behavioral interventions in the educational setting; teachers, school psychologists, and school social workers. An analogue-type study was conducted, utilizing a written case description of a 3rd grader exhibiting a problem behavior, a written case description of an intervention applied to that problem behavior, and a 15-item instrument utilized in rating treatment acceptability (IRP-15). Also varied in the study was a label (LD, BD, ADD) placed on the student in the vignette, and intervention type (positive or negative-based). There was a significant effect of professional group membership on ratings of treatment acceptability. There was an effect of intervention type on treatment acceptability, however, no label bias was noted. A group by intervention-type interaction was also noted. Implications of the present study, and future research directions are discussed.

## CHAPTER I

Introduction.

During the past two decades behavioral treatment procedures with applications in education have been thoroughly scrutinized. Initially the focus of this attention was on the effectiveness of new treatment procedures, and only recently have researchers become interested in the social perception or acceptability of the treatment approaches. Many variables related to treatment acceptability have been delineated, reliable and valid scales have been developed to rate treatment acceptability, and many different groups of individuals have been utilized as raters. As the body of research on the acceptability of behavioral interventions continues to grow, its value as an evaluative criterion becomes more pronounced.

Review of the literature.

Kazdin (1977) and Wolf (1978) reasoned that it is not enough for behavioral procedures to be effective; they must also be accepted by the individuals with whom they are being implemented. According to Kazdin (1980) acceptability refers to "judgments about the treatment procedures by nonprofessionals, lay persons, clients, and other potential consumers of treatments". Kazdin extended this definition by adding that a treatment is acceptable when it is appropriate to the problem, fair, reasonable,



nonintrusive, and meets with conventional notions about what treatment should be. Following this groundwork laid by Kazdin and Wolf, many issues related to treatment acceptability have garnered much consideration. Issues receiving substantial attention include the following; instruments used to assess treatment acceptability (Kazdin, 1980; Kelley, Heffer, Gresham, & Elliott, 1989; Reimers & Wacker, 1988; VonBrock & Elliott, 1987; Witt & Martens, 1983), variables related to acceptability (Elliott, 1988; Lennox & Miltenberger, 1990; Miltenberger, 1990; Reimers, Wacker, & Koepl, 1987), raters of acceptability (Elliott, Turco, & Gresham, 1987; Kazdin, 1980; Kazdin, French, & Sherick; Kutsick, Gutkin, & Witt, 1991; Miller & Kelley, 1992; Waas & Anderson, 1991), proposed models of acceptability (Elliott, 1988; Lennox & Miltenberger, 1990; Reimers et al. 1987; Witt & Elliott, 1985), and the relationship between effectiveness and acceptability (Kazdin, 1981; Reimers & Wacker, 1988; Tingstrom, McPhail & Bolton, 1988; VonBrock & Elliott, 1987).

The assessment of treatment acceptability is accomplished through the use of questionnaires or rating scales. Kazdin (1980) was the first to develop and validate an instrument for assessing treatment acceptability. Kazdin's Treatment Evaluation Inventory (TEI) is a 15-item questionnaire with items answered on a 7-point Likert scale. Kazdin's (1980) factor analysis of the TEI indicated

that it loaded highly on one factor, that being acceptability. Spirrison, Noland, and Savoie (1992) examined the factor structure of the TEI, and suggested that although the TEI is a reliable instrument, sensitive assessment of the treatment acceptability construct probably requires "multidimensional measurement". Kelley, Heffer, Gresham, and Elliott (1989) modified the TEI into a short form (TEI-SF), which consisted of only 9-items on a 5-point Likert scale. They noted that the length of the original TEI, as well as problems with its scaling and wording limits its value as a clinical research instrument. Kelley et al. (1989) concluded that the TEI-SF is "more readable, quicker to complete, and better liked by a sample of mothers than the TEI" (p.244). Spirrison and Noland (1991) investigated the nature of the lack of agreement between the TEI and the TEI-SF items. Their findings suggest that, relative to the original TEI, the nine-item scale tends to overestimate the acceptability of differential reinforcement of other behavior and underestimate the acceptability of overcorrection. With such findings, they suggest that one cannot assume that the short form yields data which are directly analogous to data of the full scale (Spirrison & Noland, 1991).

Another major instrument utilized in assessing treatment acceptability is the Intervention Rating Profile (IRP). Developed by Witt and Martens (1983), the IRP

consists of 20 items, each answered on a 6-point Likert scale. The results of a factor analysis showed the IRP to be composed of one primary factor, general acceptability, and four secondary factors; those being risk, time, effects on other children, and teacher skill (Witt & Martens, 1983). The alpha coefficient for the scale was .91, suggesting adequate reliability (Witt & Martens, 1983).

In 1985 Martens, Witt, Elliott, and Darveaux reported a short version of the IRP. This version (the IRP-15) was composed of just 15 items that loaded highly on one factor, that being general acceptability. Martens et al. (1985) showed the short form to be very reliable, with an alpha coefficient of .98.

Researchers using the IRP subsequent to 1985 have utilized the 15-item version (Miltenberger, 1990). While the TEI has been used to evaluate the acceptability of treatments for child problem behaviors in general, the IRP has been primarily used to evaluate school-based interventions (Miltenberger, 1990).

Other acceptability rating instruments have been developed, however most are based on the TEI or IRP. For example, Reimers and Wacker (1988) modified the TEI to produce the 15-item Treatment Acceptability Rating Form (TARF). VonBrock and Elliott (1987) added nine items to the IRP and labeled this scale the Behavior Intervention Rating Scale (BIRS). Most recently, Hunsley (1992) described the

development and psychometric properties of a new acceptability measure called the Treatment Acceptability Questionnaire (TAQ). Evidence of reliability and concurrent validity were reported, however further validation was suggested (Hunsley, 1992).

With reasonably valid and reliable assessment instruments available, a main objective of treatment acceptability research became determining variables related to acceptability. Reimers et al. (1987) discuss several factors related to acceptability including (a) problem severity, (b) time needed to implement, (c) type of treatment approach, (d) side effects, and (e) cost.

In terms of problem severity, most studies show that treatments are more acceptable for more severe problems (Kazdin, 1980; Frenz & Kelley, 1986; Miltenberger, 1990; Reimers, et al. 1987; Reimers, Wacker, & Cooper, 1991; Witt, Moe, Gutkin, & Andrews, 1984). Kazdin (1980), for example, presented case descriptions to college students, and found that all interventions were rated as more acceptable when the problem behavior was more severe (Reimers, et al. 1987).

Also providing support to this finding was Witt, Moe, Gutkin, and Andrews (1984). Witt et al. examined the extent to which various types of jargon used to describe treatments affected acceptability ratings when applied to both mild and severe problems. Using the IRP, they had 112 school teachers assess the acceptability of classroom

interventions. Besides showing a differential effect for jargon, results indicated that all interventions were rated as more acceptable when they were applied to a severe case. Similarly, Frenz and Kelley (1986) asked mothers to rate their perceptions of five different procedures applied to one of two written case descriptions of children experiencing behavior problems. Results indicated that parents rated all treatments as being more acceptable when applied to a severe behavior problem (Reimers et al. 1987).

Because teachers are often the personnel left to implement behavioral interventions, and because they already have many time constraints in the classroom, it is important to investigate the relationship between the time needed to implement an intervention and the acceptability of that intervention. Witt and Elliott (1982) have noted that teachers frequently complain that they do not have the time or resources to implement many behavioral interventions (Witt & Martens, 1983). With this in mind it is not surprising that research has well documented the fact that treatments requiring less time are more acceptable (Witt, Martens, & Elliott, 1984; Reimers et al. 1987; Miltenberger, 1990). Witt et al. (1984) presented 180 teachers with written case studies describing a child with a behavior problem and an intervention as applied to that problem. Using the IRP-20, they found that teachers' ratings of acceptability varied as a function of the time needed to

implement; as time involvement increased, acceptability decreased. However, when confronted with severe problems, the teachers seemed to increase their expectations about the complexity of a successful treatment and consequently the time involved to change the problem behavior (Witt et al. 1984). Elliott (1988) suggested that on the basis of this and other analogue studies, teachers appear to be time conscious, but not time obsessed, when selecting treatments. Reimers et al. (1987) suggest that when the costs (e.g. teacher's time) outweigh the benefits (e.g. eliminating the problem behavior), it is likely that the teacher will resort to other means to solve the problem.

When considering the relationship between treatment approach and acceptability, it has generally been reported that those interventions involving reinforcement procedures are more acceptable (Elliot, Witt, Galvin, & Peterson, 1984; Hall & Didier, 1987; Miltenberger, 1990; Reimers et al. 1987). For example, Elliott et al. (1984) asked experienced teachers to rate the acceptability for positive and reductive behavioral interventions. Using the IRP and a case study methodology, it was established that positive or reinforcing interventions received more acceptable ratings than negative or non-reinforcing interventions for the same target behavior.

Hall and Didier (1987) examined the relationship between treatment approach and acceptability by assessing

the acceptability ratings of three types of interventions (behavioral, pragmatic, and humanistic) applied to two types of behavior problems (acting out and passive resistance). Utilizing the IRP-15 they asked student teachers (N=73) to read a vignette of two behavior problems and then rate the acceptability of three different interventions as applied to those problems. The results indicated that the teachers regarded the humanistic approach as being most acceptable, with behavioral intervention being next, and the pragmatic approach as being least acceptable. These results applied to both the acting out and passive behavior problems.

Such results have generally been shown to be the case across problems and raters, in analogue and in clinical studies (Miltenberger, 1990; Reimers et al. 1987). Miltenberger (1990) states "that even when a problem severity by treatment interaction exists in a study such that restrictive approaches are more acceptable for severe problems, they are still less acceptable overall than positive approaches" (p. 31).

Research has also documented the fact that cost and side effects are related to treatment acceptability (Lennox & Miltenberger, 1990; Reimers, Wacker, & Koepl, 1987).

Reimers et al. (1987) propose that the cost of an intervention likely has an influence on ratings of acceptability when two or more treatment options exist which vary in cost. When considering side effects,

they suggest that the stronger the adverse side effects, the lower the ratings of acceptability.

Lennox and Miltenberger (1990) found that side effects may be predicted and assessed at different stages of the treatment process. They also suggest that by reviewing the past literature utilizing identical or similar interventions, possible side effects may be determined. Lennox and Miltenberger add that although cost effectiveness is not directed to clinical concerns for the individual, it cannot be neglected as an important treatment characteristic.

When considering who provides ratings of acceptability, there has been an evolution toward greater ecological validity as treatment acceptability research has developed (Miltenberger, 1990). Kazdin (1980) initially used college students as raters. Although Kazdin's early work was valuable in delineating some of the variables related to acceptability, subsequent researchers have focused more on potential or actual consumers of behavioral treatments.

For example, Elliott, Turco, and Gresham (1987), investigated acceptability ratings of three consumers of behavioral treatments; teachers, fifth-graders, and school psychologists. The acceptability of three types of group contingencies (dependent, independent, and interdependent) was evaluated, via the Children's Intervention Rating Profile (CIRP) and the adults version of



the Intervention Rating Profile (IRP). Other variables which were examined included treatment type, sex of the rater, and the severity of the hypothetical behavior problem. Incongruent with previous research, Elliott et al. (1987) found none of these variables to have a significant effect on the acceptability ratings. Also found was that fifth-graders rated all types of group contingencies mildly acceptable, while teachers and school psychologists rated the dependent form of the group contingency unacceptable, and the independent and interdependent forms acceptable.

Kutsick, Gutkin, and Witt (1991), also utilized teachers in assessing treatment acceptability. Kutsick et al. (1991) presented teachers with a case study and informed them that the recommended treatments for the presenting problem were developed in one of three ways: (a) by a teacher and a school psychologist collaboration with each other, (b) by a teacher alone, or (c) by school psychologist alone. Results indicated that teachers found interventions developed via the collaborative model to be more acceptable than those developed by either a teacher or a school psychologist working in isolation from each other.

Irvin and Lundervold (1988) assessed the acceptability, intrusiveness, restrictiveness, and efficacy of 18 decelerative interventions, with ratings from 58 special education teachers of students with severe handicaps. Results indicated that high and low mean ratings were found

across all raters for restrictiveness, intrusiveness, and acceptability. Ratings of efficacy, however, were generally neither high nor low across raters, and demonstrated lower variability across the 18 interventions, and lower reliability across raters than did ratings on the other three dimensions. Also found was that ratings of restrictiveness were negatively correlated with ratings of acceptability, ratings of intrusiveness and restrictiveness were positively correlated, and ratings of acceptability and efficacy were positively correlated (Irvin & Lundervold, 1988).

Miller and Kelley (1992) assessed mothers' and fathers' acceptability of six interventions frequently used to alter children's behavior problems. This was the first study to assess fathers' perceptions of behavioral interventions for children (Miller & Kelley, 1992). The six interventions (positive reinforcement, response cost, medication, room timeout, chair timeout, and spanking) were evaluated via the TEI. Also assessed was parents' perception of their own marital adjustment, measured by standardized checklists. They found that parents' acceptability ratings differed significantly across treatment conditions, depending on parent gender, child behavior problems, and marital adjustment. Treatment preference order was equivalent for all groups (Miller & Kelley, 1992).

Kazdin, French, and Sherick (1981) asked child

psychiatric inpatients, parents, and staff to evaluate the acceptability of alternative treatments for children. Clinical cases were described, and four interventions were suggested; positive reinforcement of incompatible behavior, positive practice, medication, and time out from reinforcement. Although children rated treatments as less acceptable than did parents, the relative standing of different treatments was identical for children, parents, and staff. Results indicate that disturbed children and their parents can readily distinguish the acceptability of alternative treatments (Kazdin et al. 1981).

A few researchers have proposed models from which to view the construct of acceptability (Reimers, Wacker, & Koepl, 1987; Witt & Elliott, 1985). Although no model fully characterizes the variables that potentially interact to influence the implementation of behavioral interventions, they have been useful in guiding research (Reimers, Wacker, & Koepl, 1987).

Witt & Elliott (1985), developed a working model of acceptability which stressed the interrelations of four elements; treatment acceptability, treatment use, treatment integrity, and treatment effectiveness. They hypothesized the relationship among these four elements as being sequential and reciprocal.

Reimers, Wacker, and Koepl (1987), attempted to expand Witt and Elliott's model. They incorporated a treatment

knowledge component into the decision making process. Reimers et al. (1987) assumed that a treatment must be well understood before acceptability can be assessed, and that once understood, a treatment may be viewed as either acceptable or unacceptable. This model proposes that poor understanding of the intervention leads to low compliance, which leads to low effectiveness. Once the intervention is understood, however, acceptability can be assessed as either high or low. Low acceptability brings about low compliance followed by low effectiveness, which leads to a modification of the treatment or the proposal of a new treatment. If the acceptability of the intervention is high, then high compliance is likely to follow. High compliance followed by high effectiveness is likely to lead to high maintenance, but if followed by low effectiveness will likely lead to low maintenance and a need to re-assess. Reimers et al. (1987) write that they "offer this model, not only as a way of conceptualizing previous research, but also as a stimulus to conduct future research" (p.226).

Although much research on behavioral procedures has shifted its focus from effectiveness to acceptability, it is important to keep in mind the relationship between the two factors. The two appear to be highly related, however differences are apparent. Von Brock and Elliott (1987), defined an effective treatment as "one that changes a problem behavior in the desired direction", and reiterated

Kazdin's (1980) definition of acceptability as "being defined in terms of subjective judgments of its appropriateness, fairness, reasonableness, and intrusiveness" (p.131). One would hypothesize that if a treatment is effective, that it would be viewed as acceptable. There is plenty of overlap between between the two constructs and findings from research studies are mixed regarding support for this hypothesis. Von Brock and Elliott (1987), reinforce the fact that not all effective treatments are totally acceptable (e.g., restraining an overly active school child), and that an acceptable treatment may be totally ineffective (e.g., suspension for truancy).

Kazdin (1981) researched the influence of treatment efficacy and adverse effects on TEI ratings of acceptability. The reported treatment efficacy information, which accompanied each vignette, was not shown to influence acceptability ratings, although the presence of undesired side effects did reduce acceptability ratings of all treatments. In contrast to Kazdin's findings, Tingstrom, McPhail, and Bolton (1988) found that reported effectiveness of a procedure did affect the acceptability ratings.

Tingstrom et al. (1988) assessed the acceptability of four school-based interventions as a function of the reported effectiveness of the procedure and the age of the

target child. Using the TEI, they had undergraduates rate one of four interventions (DRI, time out, corporal punishment or presence of parent observer), as applied to either an 8-year-old or a 13-year-old boy. Findings from this study suggest that higher acceptability ratings will be obtained if the adult who is responsible for the intervention has prior knowledge that the intervention has been effective in the past than if the intervention has not been effective.

Von Brock and Elliott (1987) designed a rating scale, the BIRS, and utilized it to differentiate between the constructs of effectiveness and acceptability and to investigate their relationship. They asked 216 teachers to rate one of three classroom interventions (token economy, response cost, or time-out), as applied to either a mild or severe behavior problem. Behavior problems were described in a vignette in which the effectiveness information accompanying each intervention varied. They found that an effectiveness by problem severity interaction existed, which increased acceptability ratings for a mild problem but not for a severe problem. In addition, when teachers rated interventions as less acceptable they also rated them as less effective (Von Brock & Elliott, 1987). These findings lend support to the hypothesis of a positive relationship posited by Tingstrom et al. (1988) but are incongruent with the conclusions of Kazdin's (1981)

investigation.

Elliott (1988) suggests that "after a treatment has been implemented, the ultimate criterion for evaluating it is effectiveness" (p. 72). He adds that "before selection and implementation of a treatment, however, acceptability is hypothesized to be an important evaluation criterion" (p. 72). Reimers, Wacker, and Koepl (1987) point out a potential problem with the nature of most acceptability research. In all analogue-type studies, treatment acceptability is assessed prior to the actual implementation or outcome of treatment. Therefore, if a treatment's acceptability depends primarily on the effectiveness, then assessing acceptability a priori may be irrelevant. In other words "it is possible that treatments which are viewed as unacceptable before treatment may be viewed as highly acceptable if the treatment is effective" (Reimers et al. 1987; p. 221).

## CHAPTER II

## Method

Participants

Thirty-one teachers, 33 school psychologists, and 33 school social workers participated in the study. Teachers were solicited from three schools in a small southwestern Illinois school district. School psychologists were recruited from four school districts in southwestern Illinois. School social workers were selected from the Illinois Association of School Social Workers state directory. Only those social workers residing in central to southwestern Illinois were chosen to participate.

Instrumentation

Subjects were presented with an examiner written case description of a 3rd grade student exhibiting behavior problems (i.e., talking excessively, out of seat, overly active, etc.). The student in the vignette was given one of three labels; LD, BD, or ADD. Also presented was one of two written descriptions of a behavioral intervention to be applied to the students behavior problems (a positive and a negative-based). A standardized instrument used in rating the acceptability of school-based behavioral interventions, the 15-item Intervention Rating Profile (IRP-15), was also presented to each subject.



### Procedure

A packet containing the following was sent to each participant; instructions for completing the enclosed materials, a vignette of a student exhibiting a behavior problem, a written description of an intervention to be applied to that problem behavior, and an IRP-15. Each participant was instructed to read the vignette, read the intervention description, then rate the acceptability of that intervention, utilizing the IRP-15. Subjects were also asked to rate their agreement or disagreement with the label applied to the child (using a 7-point Likert-Type scale). The return rate from participants was 65%. The vignette is in Appendix A. The behavior plans are in Appendices B and C. The IRP-15 is in Appendix D. Instructions and the cover letter are in appendix E.

## CHAPTER III

## Results:

The sample means and standard deviations were calculated for the IRP-15 by intervention, group, and label (see Table 1).

Table 1

Means and standard deviations for the IRP-15 by intervention, group, and label.

|                            | N  | M     | SD    |
|----------------------------|----|-------|-------|
| Positive Intervention      | 47 | 65.87 | 13.07 |
| Negative Intervention      | 50 | 52.94 | 15.87 |
| Teachers                   | 31 | 66.45 | 14.09 |
| School Psychologists       | 33 | 57.12 | 15.31 |
| School Social Workers      | 33 | 54.48 | 16.04 |
| Learning Disability        | 33 | 62.00 | 12.48 |
| Attention-Deficit Disorder | 33 | 58.76 | 17.61 |
| Behavior Disorder          | 31 | 56.71 | 17.15 |

Note. Acceptability ratings on the IRP-15 can range between 15 and 90. The higher the total rating, the more acceptable the treatment.

A three-way analysis of variance was calculated to test the effects of the independent variables (intervention x group x label) on the dependent measure (acceptability ratings on the IRP-15). The results of the three-way ANOVA indicated a statistically significant main effect for intervention,  $[F(1,97)=39.818, p<.05]$ , and a significant

main effect for group, [ $F(2,97)=8.851, p<.05$ ], and a significant interaction between intervention and group, [ $F(2,97)=3.387, p<.05$ ]. No other effects were significant. Table 2 summarizes the ANOVA, as well as the three-way interaction. The interaction between intervention and group was further analyzed by post-hoc contrasts (Student Newman-Keuls Multiple Range test, see Table 3).

Table 2

Analysis of Variance by Intervention, Group, and Label on the IRP-15.

| Source                          | SS        | df | MS       | F       | p    |
|---------------------------------|-----------|----|----------|---------|------|
| Intervention                    | 5295.608  | 1  | 5295.608 | 39.818* | .000 |
| Label                           | 178.908   | 2  | 89.454   | .673    | .514 |
| Group                           | 2354.384  | 2  | 1177.192 | 8.851*  | .000 |
| Intervention<br>x Label         | 272.406   | 2  | 136.203  | 1.024   | .365 |
| Intervention<br>x Group         | 900.909   | 2  | 450.454  | 3.387*  | .040 |
| Label<br>x Group                | 571.679   | 4  | 142.920  | 1.075   | .377 |
| Intervention x<br>Label x Group | 315.724   | 4  | 78.931   | .593    | .669 |
| Error                           | 8245.650  | 62 | 132.994  |         |      |
| Total                           | 17891.988 | 79 | 226.481  |         |      |

\*  $p<.05$

Results of the multiple-range test indicated that ratings of acceptability among the three groups did not vary significantly within the positive intervention. Significant differences among all three groups existed

within the negative intervention. The mean rating for teachers (64.00) was significantly higher than school psychologists (48.21), while school psychologists ratings were significantly higher than school social workers (41.75).

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Table 3

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Student Newman-Keuls Multiple-Range analysis  
for effects of group within intervention.

---

| Group means & mean differences<br>for positive intervention. |       |       | No.<br>steps | Critical M dif.<br>p. |      |
|--|-------|-------|--------------|-----------------------|------|
| T  | SP    | SW    |              | .05                   | .01  |
| 70.33  | 66.27 | 65.27 |              |                       |      |
| 1  | 4.06  | 5.06  | 3            | 6.80                  | 8.56 |
| 2  |       | 1.00  | 2            | 5.66                  | 7.5  |

---

| Group means & mean differences<br>for negative intervention. |         |         | No.<br>steps | Critical M dif.<br>p. |      |
|--|---------|---------|--------------|-----------------------|------|
| T  | SP      | SW      |              | .05                   | .01  |
| 64.00  | 48.21   | 41.75   |              |                       |      |
| 1  | 19.52** | 22.25** | 3            | 6.80                  | 8.56 |
| 2  |         | 6.46*   | 2            | 5.66                  | 7.52 |

\* p<.05  
\*\*p<.01

Note. T=teacher SP=school psychologist  
SW=school social worker

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## CHAPTER IV

## Discussion

The present study investigated ratings of treatment acceptability among three groups of individuals who often act as behavior change agents in the school setting; teachers, school psychologists, and school social workers. Also varied in the present study was the label placed on the child exhibiting the problem behavior (LD, BD, & ADD) and the type of intervention applied to the problem behavior (positive-based & negative-based).

Primary findings from the present investigation indicate that: (a) There is an effect of intervention type on ratings of treatment acceptability, (b) there is an effect of professional group membership on ratings of treatment acceptability, and (c) there is an interactive effect of intervention and group membership on treatment acceptability.

The finding that the positive intervention was rated as more acceptable than the negative intervention is a consistent finding in the literature on treatment acceptability (Miltenberger, 1990; Reimers et al., 1987; Witt & Elliott, 1985).

The significant effect of professional group membership on ratings of treatment acceptability indicated that teachers rated the negative-based intervention as more

acceptable than did school psychologists or school social workers. No significant differences were noted by group membership within the positive intervention.

The finding that teachers rated the negative-based intervention consistently higher than did school psychologists or school social workers might be explained by a couple of factors. One hypothesis is that, because teachers are the individuals who are exposed to the problem behavior on a daily basis, they may be more accepting of any behavioral intervention, which they view as potentially effective. They may have found the negative intervention more acceptable than the other professionals because teachers are likely to have already attempted a positive-based intervention first, with limited results.

No label bias on ratings of treatment acceptability was noted. This finding is consistent with those of Epstein et al. (1986). Epstein et al. (1986), utilized the labels of mental retardation and learning disabled, and reported no significant differences, among the two labels, in acceptability ratings to modify a classroom behavior. Based on these combined findings, label does not appear to be an important factor when considering treatment acceptability ratings.

The present study furthers the treatment acceptability research by making it more educationally relevant. Many times before a referral for behavioral concerns, a building

level team, consisting of teachers, principals, and other school personnel such as school psychologists and school social workers, collaborate on possible classroom interventions for the target behavior. Teacher's and school psychologists' acceptability ratings of behavioral interventions have been examined in past literature (Elliott et al., 1987; Miltenberger, 1990) however, school social workers have not been included until the present study. Having an understanding of differences in the ratings of treatment acceptability among these three groups, can be helpful for planning interventions. For example, if you, as a behavior change agent, are confident that a certain intervention is best suited for a problem behavior, yet expect a low rate of acceptability, from the individual(s) who will implement the intervention, (based on previous treatment acceptability research) you can be prepared to encounter the problem (Tingstrom, 1989). As Tingstrom (1989) suggests, consultants expecting a low rate of acceptability are faced with two primary alternatives. The intervention can be modified so the implementor finds it acceptable, or the implementors pre-existing level of acceptability of the intervention can be increased through education. Increasing acceptability ratings (see Sing & Katz, 1985; Tingstrom, 1989) increases the likelihood that a treatment will be implemented properly and followed more thoroughly (Kazdin, 1981; Witt & Elliott, 1985).

It has been well documented that a limitation of analogue studies is the lack of ecological validity (Tingstrom, 1989; Witt et al., 1984), this limitation also applies to the present study. Other limitations which merit mention include: (1) A limited regional sample, (2) results may be specific to the behavior(s) described or the specific intervention used, and (3) limited rater variables were noted (i.e., age, sex, years of experience, training in behavioral principles, etc.).

While research on treatment acceptability continues to accrue, several areas remained unexamined. For example, Reimers et al., (1987) suggest a cataloging of the frequency and acceptability of a wide range of behavioral interventions to increase the overall efficiency of the consultation process. This cataloging may also incorporate variables utilized in the present study. By cataloging differences in acceptability from a wide range of raters (teachers, school psychologists, school social workers, parents, principals, students, etc.), we can be prepared to encounter resistance in the behavioral consultation process.



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## Appendix A

BOB

Bob's teacher felt it necessary to call his parents for a conference toward the end of the first grading period of his 3rd grade. Even though he was thought of as a bright and intelligent child, Bob's academic performance varied markedly.

Bob's parents indicated that he rarely brought school work home, and that they didn't have time to check for errors or completion when he did bring work home. They report that Bob spends much of his time in front of the television, and his mom states that "this is the only time Bob sit's still". When not watching T.V. Bob is usually playing with his 12-year-old brother, or neighbor kids, most often wrestling or riding bikes.

Bob's teacher reports he rarely finishes his seatwork, even though he is encouraged often throughout the day. She indicates that he seems to listen, but never hear her instructions. His work which he takes home is hardly ever completed, and when it is, it's done sloppily and without much thought. Bob often talks without raising his hand, usually requesting repeated directions, or simply talking out loud to classmates. He interrupts the class often with this talking, being out of his seat, or playing in his desk which is kept vary unorganized and messy. His teacher reports that he has difficulty interacting with his peers, most likely because of his aggressive and disruptive behaviors. The behaviors of most concern to Bob's teacher are those which interrupt the entire class; being out of his seat and talking inappropriately during class.

Bob's classroom performance warranted a referral for special education, and he is currently receiving services with eligibility as (L.D., B.D., or A.D.D.).

**\*\* With the limited profile of Bob's performance given above, both academically and behaviorally, please rate the degree to which you agree or disagree with the "label" under which Bob was found eligible to receive special education services. (please circle the corresponding number)**

1 = strongly disagree    2 = disagree    3 = slightly disagree  
4 = slightly agree    5 = agree    6 = strongly agree

## Appendix B

## BEHAVIOR PROGRAM

Bob's teacher implemented a program consisting of exclusionary time-out and verbal praise. The focus of this intervention was to increase appropriate behaviors. Behaviors to be increased were "in seat", non-disruption during class, and appropriate talking in class.

Bob's behavior was recorded at 5 minute intervals. Each time Bob was out of his seat, disrupting the class, or talking inappropriately, he was removed from the activity/lesson and placed in a time-out area (a seat in the corner of the room, facing the wall). Bob would remain in this area until the end of the activity/lesson, then return to his desk. Each time Bob was in his seat, not disrupting the class, or talking appropriately he received verbal praise from his teacher (i.e., I like the way you're sitting in your seat, I like the way you raised your hand when you had a comment, etc.).

**\*\* Please rate the acceptability of this intervention, as it applies to "Bob", utilizing the IRP-15.**

## Appendix C

## BEHAVIOR PROGRAM

Bob's teacher implemented a program of positive reinforcement consisting of a token economy and verbal praise. The focus of this program was to increase appropriate behaviors. Behaviors to be increased were "in seat", non-disruption during class, and appropriate talking in class.

Bob's behavior was recorded at 5 minute intervals. If Bob was in his seat, not disrupting the class, and talking appropriately, his teacher would place a token in a small container on his desk. These token's could be exchanged weekly for privileges such as computer time, books, stickers, or free time. Bob's teacher would verbally praise him (i.e., I like the way you are sitting in your seat, I like the way you raised your hand when you had a comment, etc.) each time he received a token, or otherwise engaged in appropriate behavior.

**\*\* Please rate the acceptability of this intervention, as it applies to "Bob", utilizing the IRP-15.**



## Appendix D

**Intervention Rating Profile (IRP-15)**

The purpose of this questionnaire is to obtain information that will aid in the selection of classroom interventions. These interventions will be used by teachers of children with behavior problems. Please circle the number which best describes your agreement or disagreement with each statement.

1=strongly disagree      2=disagree      3= slightly disagree  
4=slightly agree      5=agree      6= strongly agree

- |  |   |   |   |   |   |   |
|--|---|---|---|---|---|---|
| 1. This would be an acceptable intervention for the child's problem behavior.  | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. Most professionals would find this intervention appropriate for behavior problems in addition to the one described. | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. This intervention should prove effective in changing the child's problem behavior.                                  | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. I would suggest the use of this intervention.   | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. The child's behavior problem is severe enough to warrant use of this intervention.                                  | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. Most professionals would find this intervention suitable for the behavior problem described.                        | 1 | 2 | 3 | 4 | 5 | 6 |
| 7. I would be willing to use or recommend the use of this intervention in the classroom setting.                       | 1 | 2 | 3 | 4 | 5 | 6 |
| 8. This intervention would <u>not</u> result in negative side-effects for the child.                                   | 1 | 2 | 3 | 4 | 5 | 6 |
| 9. This intervention would be appropriate for a variety of children.   | 1 | 2 | 3 | 4 | 5 | 6 |
| 10. This intervention is consistent with those I have used, or recommended using, in the home or classroom setting.    | 1 | 2 | 3 | 4 | 5 | 6 |

IRP-15 continued...

- |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|
| 11. The intervention was a fair way to handle the child's problem behavior.   | 1 | 2 | 3 | 4 | 5 | 6 |
| 12. This intervention is reasonable for for the behavior problem described.   | 1 | 2 | 3 | 4 | 5 | 6 |
| 13. I liked the procedures used in this intervention.                         | 1 | 2 | 3 | 4 | 5 | 6 |
| 14. This intervention was a good way to handle this child's behavior problem. | 1 | 2 | 3 | 4 | 5 | 6 |
| 15. Overall, this intervention would be beneficial for this child.            | 1 | 2 | 3 | 4 | 5 | 6 |

## Appendix E

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Dear Participants,

Thank you for taking the time to read and complete the enclosed forms. Many changes in state guidelines and procedures for implementing and evaluating behavioral programs in schools are currently underway. Anticipated among these changes are more strict guidelines concerning the use of both reinforcement (token economy, free time, etc.) and punishment techniques (detention, time-out, etc.). The purpose of this research is three-fold: (1) It will help me complete my thesis and fulfill a requirement for my specialist degree, (2) it may provide information that can be used as a guide in selecting and implementing effective classroom interventions, and (3) such information may help guide future revisions in state laws and social policy.

Completion of the enclosed forms should take no more than 10-15 minutes. Simply read the vignette labeled "Bob". and answer the question at the bottom of that page. Next, read the behavior program which "Bob's" teacher implemented. Finally, using the Intervention Rating Profile- 15 (IRP-15) rate your agreement or disagreement with each item, as it applies to the behavior program (intervention).

If you would like a summary of this study I can be reached, in late August, at the above address or phone number. Thanks again for your assistance.

Sincerely,

Larry D. Fairbanks  
Intern Psychologist