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Behavior Speak: Does Use of Behavior Jargon Affect Teacher Acceptability of Positive Behavior Interventions?

Katie Shemanski

Philadelphia College of Osteopathic Medicine, kathleensh@pcom.edu

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Philadelphia College of Osteopathic Medicine
Department of Psychology

BEHAVIOR SPEAK: DOES USE OF BEHAVIOR JARGON AFFECT TEACHER
ACCEPTABILITY OF POSITIVE BEHAVIOR INTERVENTIONS?

By Katie Shemanski

Submitted in Partial Fulfillment of the Requirements for the Degree of
Doctor of Psychology

May 2016



DISSERTATION APPROVAL

This is to certify that the thesis presented to us by Katie Shemanski on the 8th day of April, 2016, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

Committee Members' Signatures:

Jessica Glass Kendorski, PhD, NCSP, BCBA-D, Chairperson

Virginia Burks Salzer, PhD

Frank DeMatteo, EdD, NCSP

Robert A DiTomasso, PhD, ABPP, Chair, Department of Psychology

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So what's next, you ask? That's to be determined . . .

Abstract

The purpose of the present study was to examine acceptability and usage among elementary school (kindergarten through sixth grade) teachers of a positive behavioral intervention described in jargon terms and in nonjargon terms during the process of behavioral consultation, as measured by the Usage Rating Profile – Intervention Revised (URP–IR). Specifically, the study evaluated whether elementary school teachers' acceptability and usage ratings differed on a positive behavioral intervention described in jargon versus nonjargon terms. In addition, this study assessed whether differences in acceptability and usage existed when considering type of classroom (i.e., general education, special education, or specialized [e.g., art, gym, music] education). One hundred one elementary school teachers participated in the study. Results indicated that there was no statistically significant difference between acceptability and usage of a positive behavioral intervention when described in either jargon or nonjargon terms. Furthermore, there was no statistically significant difference when examining the type of classroom and acceptability and usage of the positive behavioral intervention when described in jargon or nonjargon terminology. These findings are congruent with previous research that found no difference in acceptability between jargon and nonjargon descriptions. The results have important implications for interaction with teachers and the use of jargon during the process of behavioral consultation.

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Chapter 1

Introduction

School psychologists and behavior analysts (also known as consultants) are being asked more frequently to assist teachers in developing individual behavioral interventions for the classroom setting through consultation services. Often, effective consultation in the school is beneficial to both teachers and consultants as it can assist in preventing problem behaviors, intervening in currently identified problems, or addressing problems after they occur (Gravois, 2012). If consultation is effective and individual behavior interventions are implemented, school psychologists may experience a decrease in referrals for special education evaluations, and teachers will have improved classroom management skills (Dufrene et al., 2012). Therefore, it is important for consultants to understand what elements influence acceptability of behavioral interventions among teachers.

Several factors have been shown to influence the acceptability of behavioral interventions in the school setting. Boone Von Brock and Elliott (1987) and Kazdin (1981) found that providing teachers with information on the effectiveness of the intervention influenced acceptability ratings. In addition, Witt, Martens, and Elliott (1984) discovered that interventions that required more time and involvement to implement were less acceptable to teachers. It has also been concluded that positive or reinforcing interventions received more acceptable ratings than negative or nonreinforcing interventions (Elliott, Witt, Galvin, & Peterson, 1984; Kutsick, Gutkin, & Witt, 1991), and those interventions producing negative side effects were also rated as undesirable (Kazdin, 1981). Furthermore, interventions, in general, that address behavior

problems that are considered severe are rated as more acceptable (Martens, Witt, Elliott, & Darveaux, 1985; Witt, Moe, Gutkin, & Andrews, 1984).

Statement of the problem.

The type of language used when describing behavioral interventions to teachers should be of particular interest to consultants. Specifically, should consultants be using jargon or nonjargon language when describing behavioral interventions to teachers during consultation? Concern for the type of language used during consultation was first noted in 1981, when Kazdin and Cole examined whether behavioral modification procedures and the use of jargon in describing behavioral methods affected evaluation of presented treatments. This research revealed that behavioral modification procedures were evaluated more negatively, whereas phrasing treatments using jargon resulted in more positive evaluations. Witt, Moe, et al. (1984) also examined type of language used in describing classroom interventions. The authors noted that acceptability ratings for three types of descriptions (pragmatic, humanistic, behavior) did not significantly differ. This finding was supported by Rhoades and Kratochwill (1992), whose research revealed that consultant language (jargon versus nonjargon) did not cause acceptability ratings to differ significantly. However, more recent research (Hyatt & Tingstrom, 1993) noted that jargon descriptions were associated with higher intervention acceptability ratings under certain conditions.

Because it has been shown that acceptability of an intervention is important for ensuring high levels of integrity (Reimers, Wacker, & Koepl, 1997) and acceptability of an intervention may or may not be influenced by the language used in the description (Kazdin, 1981; Rhoades & Kratochwill, 1992; Witt, Moe, et al. 1984), the type of

language used when describing a behavioral intervention is a topic that requires significant attention by consultants and further research. Furthermore, it is beneficial to consultants to know what type of language (jargon versus nonjargon) teachers prefer when behavioral interventions are described. Freeman, Simonsen, Briere, and MacSuga-Gage (2014) found that a significant gap existed between requirements for teacher training and effective classroom management. Similarly, Oliver and Reschly (2010) found, after reviewing course syllabi from 26 institutions of higher learning, that only 27% of university special education programs had an entire course devoted to classroom management. This lack of training in classroom management limits exposure to behavioral terminology and may affect acceptability of behavioral interventions described in jargon language.

Consultation, development, and implementation of behavioral interventions can be a lengthy process. Consultants and teachers should therefore strive to develop an intervention that is most likely to be implemented and effective from the initiation of consultation. Therefore, it is important for consultants to know if the type of language used to describe behavioral interventions affects acceptability. This information would guide consultants in presenting information regarding behavioral interventions to teachers.

Purpose of the study.

The purpose of the present study was to examine acceptability and usage of a positive behavioral intervention described in jargon terms and in nonjargon terms during the process of behavioral consultation, using the Usage Rating Profile – Intervention Revised (URP–IR; Briesch, Chafouleas, Rak Neugebauer, & Riley-Tillman, 2013).

Specifically, the study evaluated whether elementary school teachers' acceptability and usage ratings differed on positive behavioral interventions described in jargon or nonjargon. In addition, this study examined whether differences in acceptability and usage exist when considering type of classroom (i.e., general education, special education, or specialized [e.g., art, gym, music] education).

In particular, this research intended to provide insight into what type of language should be used by consultants when describing and developing positive behavioral interventions with teachers. This information would assist consultants in ensuring that teachers understand and accept positive behavioral interventions as they are described, increasing intervention usage (Allinder & Oats, 1997; Reimers et al. 1997).

Given the importance of knowing what type of language (jargon or nonjargon) to use with teachers when discussing and describing positive behavioral interventions, the following research questions were addressed by this study:

Does the type of language used (jargon or nonjargon) by consultants when discussing and describing positive behavioral interventions significantly affect total acceptability and usage ratings on the URP-IR? It was hypothesized that the type of language (jargon versus nonjargon) used by consultants to describe positive behavioral interventions would not significantly affect total acceptability and usage ratings on the URP-IR.

Does the type of classroom (general education, special education, or specialized education) significantly affect total acceptability and usage ratings on the URP-IR for positive behavioral interventions described in jargon and nonjargon language? It was hypothesized that there would be no statistically significant difference between the type

of classroom taught (i.e., general education, special education, or specialized education) and total acceptability and usage ratings on the URP–IR for a positive behavioral intervention described in jargon and nonjargon language.

Definition of Terms

For the purpose of this study, the following definition of terms is offered:

Acceptability: "...judgments about the treatment procedures by nonprofessionals, lay persons, clients, and other potential consumers of treatment...whether treatment is appropriate for the problem, whether the treatment is fair, reasonable, and intrusive, and whether treatment meets with conventional notions about what treatments should be" (Kazdin, 1980a, p. 259)

Behavioral consultation: a combination of strategies and principles of applied behavior analysis with a problem-solving approach (Bergan, 1977)

Consultant: "...a specialist [who] works cooperatively with a staff member to improve the learning and adjustment of a student (client) or group of students" (Erchul & Martens, 2012, p. 13)

Consultee: person "responsible for providing some form of psychological assistance to another (the client)" (Medway, 1979, p. 276)

External validity: "the extent to which findings in one study can be applied to another situation" (Gall, Gall, & Borg, 2007)

Internal validity: "changes observed in the dependent variable are due to the effect of the independent variable, not to some other unintended variables" (Mertens, 2015)

Jargon: the use of social language closely tied to an individual's professional role that does not necessarily promote mutual comprehension of behavior, such as *conditioning*,

shaping, self-awareness, reflective thinking (Hyatt & Tingstrom, 1993; Knotek, Kaniuka, & Ellingsen, 2008)

Nonjargon: using conversational, nontechnical, straightforward words (Hyatt, Tingstrom, & Edwards, 1991)

Positive behavioral interventions: approaches designed to increase behaviors that are contrary to the problem behavior (Witt, Elliott, & Martens, 1984; Witt, Martens, & Elliott, 1984).

Chapter 2

Review of the Literature

Consultation began in the 1950s, when community mental health was developed as an alternative to the traditional verbal psychotherapy. It was proposed that if the mental health care field continued to use the illness model of mental disorder, there would be a shortage of trained individuals to provide traditional verbal psychotherapy (Albee, 1968; Miller, 1969). In an effort to resolve this dilemma, Miller (1969) proposed training nonpsychologists in the skills necessary for providing mental health services. For example, Miller believed that not every psychological problem required formal treatment from a psychologist. Instead, he suggested that any educated individual could deliver psychological principles and techniques if guided properly, hence the development of consultation for mental health service delivery.

Before Albee (1968) and Miller (1969) offered their insight into effective mental health service delivery given the shortage of personnel, Caplan (1963) was the first to develop a systematic process of consultation. Caplan, a psychiatrist, suggested that consultants talk with consultees to improve knowledge or understanding, self-confidence, and/or objectivity. When a consultant lacked skill, Caplan recommended using didactic instruction in addition to direct methods such as modeling, role-playing, and reinforcing consultee skill development. Caplan's views were grounded in psychoanalytic theory; however, he understood the importance of teaching skills with methods more direct than didactic instruction.

Although Caplan (1963) stressed the importance of more direct instruction during consultation, Bergan's (1977) model of behavioral consultation was developed as an

indirect method of service delivery and has served as a foundation for the development of behavioral consultation (Kratochwill, Sladeczek, & Plunge, 1995). Even though Bergan's behavioral consultation model was developed from behavioral theory, he indicated that the consultant should not have direct contact with the client (child) during consultation. Rather, he proposed that the consultee should be taught the skills necessary to interact with the client outside of the naturalistic setting.

Over the years, advances in behavioral consultation have occurred in various areas, with the intention of making the process more effective. These areas include the description of consultation, standardization, training of consultants and consultees, increased research, focus on integrity, improvement in research design, and evaluation of outcomes. In reviewing the literature published between 1972 and 1977 (Medway, 1979) and 1985 and 1995 (Sheridan, Welch, & Orme, 1996), school consultation was found to be at least partially effective in 76% to 75% of studies, with behavioral consultation being the most effective. At the time, these results appeared to support consultation as a means to modify the behavior of consultees and clients.

In 1985, Medway and Updyke reviewed 54 consultation outcome studies. Their meta-analysis indicated that consultation had a positive impact on consultees and clients ($d = .71$). Furthermore, in a meta-analysis of consultation outcomes completed by Busse, Kratochwill, and Elliott (1995), results indicated that a majority of the consultation cases reviewed had positive outcomes ($d = .95$). In addition, Sheridan et al. (1996) noted that studies that utilized behavioral consultation had more positive results than other models (e.g., mental health, etc.). The authors speculated that these results may have been due to the structured nature of behavioral consultation and lack of a clear framework in other

models. Therefore, a review of consultation outcomes suggests mostly positive results and changes in consultee and client behavior (Busse et al., 1995; Medway, 1979; Medway & Updyke, 1985; Sheridan et al., 1996).

Various definitions of consultation have been provided over the years as the concept evolved. In 1979 Medway defined consultation as a process of “collaborative problem-solving between a mental health specialist (the consultant) and one or more persons (the consultees) who are responsible for providing some form of psychological assistance to another (the client)” (p. 276). In 2002, Zins and Erchul defined consultation as “a method of providing preventively oriented psychological and educational services in which consultants and consultees form cooperative partnerships and engage in a reciprocal, systematic problem-solving process guided by behavioral principles. The goal is to enhance and empower consultee systems, thereby promoting clients’ well-being and performance” (p. 626). In 2011, Erchul indicated that the characteristics of school consultation include (a) indirect form of service delivery, (b) delivery of services through the consultee, (c) reciprocal problem-solving process between the consultant and consultee, (d) remediation and prevention as goals, and (e) shared relationship between the consultant and consultee with equal status, voluntary participation, and confidentiality. An ecological approach to problem solving is often used based on the impact of the setting on the consultation.

Consultation can therefore be described as an indirect service delivery model that relies on a problem-solving process to develop services to be provided to the client. Additional aspects of consultation include development of a collaborative relationship between the consultant and consultee, improving consultee skill to promote appropriate

response to future, similar difficulties, and providing strategies to address problematic situations (Kratochwill, Altschaeffl, & Bice-Urbach, 2008). The three main individuals involved in the consultation process are the consultant (school psychologist or behavior analyst), consultee (teacher), and client (student) (Hughes, Kolbert, & Crothers, 2008).

Types of consultation.

There are several models of consultation noted throughout the literature. The most frequently cited are mental health consultation, consultee-centered consultation, behavioral consultation, and conjoint behavioral consultation. All models share common goals of preventing and remediating client outcomes and improving consultee functioning in order to enhance the consultee's skill set when preventing and responding to future, similar problems (Gutkin & Curtis, 2009).

Mental health consultation. Because consultation was developed from the illness model of treating mental health disorders (Miller 1969), one of the earliest forms of consultation was labeled as such: mental health consultation. Caplan (1963) described mental health consultation as part of a community program that strived to promote mental health and the prevention, treatment, and rehabilitation of mental disorders. Mental health consultation was designed to train nonpsychologists in the skills necessary to promote mental health, which was Miller's suggestion. Mental health consultation was intended for a small number of consultants to reach numerous individuals in communities through a large number of consultees. In order for this process to be successful, the time a consultant spent with a consultee was intended to be brief. In addition, the information acquired by consultees in this short amount of time must be maximally carried over to their work with clients. Given the nature of mental health consultation, this model is said

to have been foundational to school psychology research and practice (Caplan, Caplan, & Erchul, 1995), despite the lack of strong empirical support (Erchul & Young, 2008).

Although the mental health consultation model is designed to provide services to many clients, it was not meant to be used in isolation. Caplan (1963) noted that other techniques, such as psychoeducation, training of caregivers, and planning and coordinating with other agencies, should be included as part of comprehensive mental health service delivery. Furthermore, Caplan indicated four fundamental types of mental health consultation, described below.

Client-centered case consultation. According to Caplan (1963), Client-centered case consultation focuses primarily on the problems faced by the consultee when working on specific cases. The goal of this type of consultation is to help the consultee find the most effective treatment for the client. Secondary to finding the most effective treatment is educating the consultee and increasing knowledge so that the consultee may be more equipped to manage particular clients.

Program-centered administrative consultation. With program-centered administrative consultation, the consultant is called upon by the consultee or a group of consultees to provide guidance regarding problems with the administration of programs for the prevention, treatment, or rehabilitation of mental health disorders (Caplan, 1963). Of primary focus for the consultant are assessment of the program or policy that prompted consultation and the recommendation of a plan for resolution. Similar to client-centered case consultation, a secondary goal is to educate the consultee(s) on how to better handle future, similar situations. Consultants in this type of mental health consultation are often asked to provide the analysis of the program in a written report

with short- and long-term recommendations and actively assist in problem resolution (Caplan, 1963).

Consultee-centered case consultation. Caplan (1963) explained that during consultee-centered case consultation, the consultant is focused on identifying the barriers that may be interfering with the consultee's ability to deal with the client's presenting problems. There is little or no direct assessment of the client (Sandoval, 2008). Caplan identified four difficulties that may potentially interfere with a consultee's helping ability: lack of understanding of psychological factors in the case, lack of skill or resources to deal with the presenting problems, lack of professional objectivity in handling the case, and lack of confidence and self-esteem. Caplan advises that each of these factors be explored and remediated once identified.

Consultee-centered administrative consultation. Similar to program-centered administrative consultation, consultee-centered administrative consultation aims to help consultees develop the skills to solve problems in planning and maintenance of programs in order to prevent and manage mental health disorders (Caplan, 1963). In addition, Caplan explained that consultee-centered administrative consultation is often conducted over a lengthy period, with regularly scheduled meetings to discuss problems at the moment or ongoing administrative difficulties.

Consultee-centered consultation. A consultee-centered approach to consultation has developed over the past 15 years and was one of the first approaches developed when working with adults, who have a significant influence on children's development (Sandoval, 2008). This approach focused on making consultation with teachers and administrators in schools more feasible and collaborative. Knotek et al. (2008) described

several key features of consultee-centered consultation, including the importance of an equal consultant-consultee relationship, and knowledge and formulation of the problem as the goal of problem solving, and with the process of problem solving evolving over time. By focusing on such key features, consultee-centered consultation could be viewed as a way to provide professional development to ensure consultee growth (Newman, Ingraham, & Shriberg, 2014).

When consultee-centered consultation is initiated, consultants strive to assist in developing solutions or change rather than imposing predetermined views or perceptions on to the consultee. Consultants provide the expertise and experience of the problem-solving process and respect and value the knowledge that consultees contribute to the consultative process (Gravois, 2012; Newman et al., 2014; Sandoval, 2008). This typically results in increased willingness of consultees to implement new strategies and interventions. Even though the relationship and communication between the consultant and consultee is crucial for success, it is important to realize that this relationship is not therapeutic. The goal of consultee-centered consultation is to improve the consultee's job performance and skill with various presenting problems (Gravois, 2012; Newman et al., 2014). Given this goal, consultee-centered consultation does not follow prescribed steps or stages, and has an open agenda for how problems will be solved (Sandoval, 2008).

In schools, consultee-centered consultation has been shown to fit within the response to intervention model (Erchul, 2011; Gutkin & Curtis, 2009). According to Powers, Hagans, and Busse (2008), consultants work with teachers at Tier 1 to observe instruction, collect and analyze data, and examine progress monitoring data. For Tier 2, consultants work as members of problem-solving teams in which interventions are

designed and implemented, in addition to conducting ongoing data collection and analysis (Erchul, 2011; Powers et al., 2008). Lastly, Powers et al. describe Tier 3 as encompassing special education services; however, due to the emphasis in education on inclusion of special education students, teachers continue to require guidance on how to support these students in the classroom. Therefore, consultee-centered consultation is utilized frequently in the school setting.

Behavioral consultation. Many types of behavioral consultation are available but usually when behavioral consultation is referenced, it refers to Bergan's (1977) model. Bergan's model of behavioral consultation combines strategies and principles of applied behavior analysis with a problem-solving approach. The model set forth by Bergan utilizes structured stages; however, the order of the stages is not inflexible (Hughes et al., 2008). Bergan identified seven key assumptions of behavioral consultation. These assumptions include the consultee as an active participant throughout consultation, promoting the development of problem-solving skills by having the consultant work with the client, offering a means through which the consultant can link knowledge with consultees, attempting to connect decision making to empirical evidence by using such strategies as direct observations of client behavior and research regarding changing behavior, and defining problems presented in consultation as being unusual for the client. Therefore, diagnoses are typically not used, emphasizing the role of environmental factors in maintaining and changing behavior and centering its evaluation on goal attainment and plan effectiveness (Bergan, 1977).

Bergan (1977) also developed a four-stage problem-solving process, which consists of three separate interviews with objectives that the consultant is expected to

address. The first stage, problem identification, consists of identifying the problem to be solved through consultation (Bergan, 1977) and assists the consultant in understanding the student's difficulty in an effort to help the teacher (Hughes et al., 2008). Problem identification has been described as the most important stage in behavior consultation (Kratochwill et al., 2008). Baseline data are collected and analyzed during the second stage, problem analysis. The baseline data are examined to determine whether they are adequate and a problem exists, goals for change are established based on the data collected (Bergan, 1977), further analysis of the environmental conditions surrounding the problem is completed, the intervention plan is designed, data collection procedures are reviewed, and the next interview is scheduled (Kratochwill et al., 2008). During plan implementation, the third stage of the problem-solving process, the consultant and consultee exchange information through brief contacts. The consultant is responsible for determining whether the consultee has the skills to implement the intervention as designed, monitoring data collection, and determining the need for modification to the intervention, if necessary (Bergan, 1977). The last stage of problem solving is problem/plan evaluation and occurs after the intervention has been in place for sufficient time to produce a change. During the problem/plan evaluation interview, the consultant and consultee determine whether the intervention goals were met; assess plan effectiveness; consider continuation, modification or termination of the intervention; and decide whether to terminate consultation or schedule additional meetings to repeat the problem-solving process (Bergan, 1977; Kratochwill et al., 2008).

Despite Bergan's (1977) structured model of behavioral consultation, Erchul and Schulte (2009) noted weaknesses. Specifically, behavioral consultation has been reported

to be underutilized in schools due to the false assumptions of how and why teachers may change their behavior. In addition, behavior consultation has been criticized for being too client-centered, which may affect consultee professional development. Also, a lack of emphasis on treatment integrity and overreliance on consultee self-reports regarding assessment and intervention have been noted.

A study completed by Dufrene et al. (2012) examined the effects of direct behavioral consultation on Head Start teachers' use of praise and effective instruction delivery (EID) without providing feedback on the teacher's performance. The study also measured teacher maintenance of the intervention when direct behavioral consultation was removed and at 1-month follow-up. Four Head Start teachers participated in one-on-one training sessions in which consultants provided verbal instruction and direct training in praise and EID. Direct training consisted of consultants communicating with teachers via a one-way radio to assist in prompting the teacher to correctly use praise and EID. In order to assess maintenance, the researchers sat in the classroom and observed classroom activities. While these observations were occurring, the researchers did not provide any feedback or prompting. Not providing feedback or prompting evaluated whether the teacher was accurately implementing praise and EID. One month after the maintenance phase, the researchers observed in the classrooms again. No praise or feedback was given during the 1-month observations.

Results of this study indicated that training that occurred outside of the classroom setting did not result in significant improvement in teacher use of praise. Despite this finding, when direct training was provided within the classroom setting, rates of praise and use of EID increased. Given these results, direct behavioral consultation was

determined to be useful for Head Start teachers who lack classroom management skills and need consultation (Dufrene et al., 2012). This research supported that of Hiralall and Martens (1998), which found that a sequence of strategies developed during behavioral consultation became part of teachers' daily routine and ultimately increased appropriate behavior in a preschool classroom. However, half of the teachers had a decrease in praise use at 1-month follow-up. In another study completed by Reinke, Lewis-Palmer, and Merrell (2008), Classroom Check-up (a multicomponent consultation program) was implemented in an attempt to increase teacher use of praise and other effective behavior management strategies. During consultation, praise increased, but at 1-month follow-up, use of praise decreased for two of the three teachers who participated. It is important to note that training took place outside of the classroom setting for both the Hiralall and Martens (1998) and Reinke et al. (2008) studies. Despite the decrease in praise use after consultation was discontinued in these two studies, Bowles and Nelson (1976) discovered that using one-way radio training in the classroom resulted in increased teacher praise, which continued during a 1-month follow-up. Therefore, Dufrene et al. (2012) confirmed the findings of Bowles and Nelson (1976) that behavioral consultation is a useful, effective way to address problematic behavior.

Conjoint behavioral consultation. Consultation services that involve both parents and teachers in the development and implementation of interventions is called conjoint behavioral consultation. Specifically, conjoint behavioral consultation focuses on the relationship between home and school environments and how one affects the other (Auster, Feeney-Kettler, & Kratochwill, 2006). In addition, conjoint behavioral consultation attempts to encourage generalization of outcomes while expanding

intervention effects across the home and school settings (Kratochwill et al., 2008). Therefore, both parent and teacher involvement is essential for effective intervention. Although conjoint behavioral consultation originated to address problems in the home and school settings, it has shown utility when a problem is occurring in only one setting. Regardless of where the problem occurs, both settings interact and influence a child's functioning, making both parents and teachers an important part of the consultation process (Auster et al., 2006).

According to Auster et al. (2006), there are four main goals of conjoint behavioral consultation: (a) sharing responsibility for problem solution among all parties involved, (b) working to improve communication between parents, teachers, and students, (c) gathering comprehensive information regarding the identified problem, and (d) improving skills of all parties involved. Furthermore, there are four stages of conjoint behavioral consultation, which are similar to the stages of behavioral consultation. The stages in conjoint behavioral consultation are conjoint problem identification, conjoint problem analysis, conjoint treatment implementation, and conjoint treatment evaluation. Therefore, conjoint behavioral consultation can be used to address a variety of problems in the home and school settings (Auster et al., 2006) while striving to facilitate generalization of behavior (Kratochwill, Sladeczek, et al., 1995).

Factors affecting consultation.

When examining teacher use of school-based consultation services provided by a consultant, a number of barriers for success have been identified (Kratochwill & Van Someren, 1995). Because behavioral consultation is the model most often used (Medway & Updyke, 1985; Sheridan et al., 1996) and strives to increase teacher knowledge and

problem-solving skill set through services being delivered by a consultant (Gonzalez, Nelson, Gutkin, & Shwery, 2004), it is important to understand what factors may affect successful use of behavioral consultation. Kratochwill and Van Someren identified some barriers to effective consultation as lack of standardization of consultation, lack of specific training of consultants, little or no consultee (teacher) training, the consultant/consultee relationship, problems surrounding target behavior identification, intervention acceptability, and use of jargon when describing interventions.

Standardization of consultation. When engaging in behavioral consultation, a prescribed set of problem-solving steps is followed (Bergan, 1977). If such steps are not followed, it is possible that consultation will be ineffective, and a poorly developed intervention plan will be implemented. Therefore, integrity in implementation of the problem-solving process along with the developed intervention may prevent successful consultation. By standardizing consultation, it allows consultants to elicit responses from consultees and document such responses appropriately. In addition, standardized consultation assists in ensuring that the proper problem was identified for treatment (Bergan & Tombari, 1975). More specifically, Bergan and Tombari found that consultants were successful in identifying client problem behaviors when they demonstrated adequate problem identification skills through coding of verbal interactions.

Although standardization of consultation may help consultants properly identify problematic behaviors, it has its limitations. By standardizing consultation, consultant verbal flexibility may be limited. Consultants may become so concerned with adhering to the standardized format that important cues from the consultee are ignored or follow-

up questions are avoided. Furthermore, standardized formats of consultation may be more easily used with some problems than others (e.g., classroom management strategy versus multiple behavior problems within one child). Given these limitations, standardization of consultation may make the process more expensive and time consuming (Kratochwill & Van Someren, 1995).

Training of consultants. In order to be an effective consultant, proper training is required. Most consultants, particularly school psychologists, obtain some training in behavioral consultation through coursework; however, an accompanying practicum is usually absent (Kratochwill & Van Someren, 1995). There may be practical experience embedded within a consultation class, but this most likely focuses on the consultation process rather than the practical skills needed to conduct consultation with actual consultees. Because most consultation training takes place through coursework, one of the major barriers of effective behavioral consultation is a lack of applied training in the specific components of behavioral consultation (Kratochwill & Van Someren, 1995).

It would seem logical that training consultants in applied behavioral consultation skills would increase the implementation of effective treatments; however, such training is not without limitations. Specifically, identifying the precise skills to teach, such as the types of questions to ask (Bergan, 1977; Erchul & Young, 2008; Kratochwill & Van Someren, 1995) and how to be an active listener (Erchul & Young, 2008), is difficult. Furthermore, assessing student progress when utilizing a competency-based approach to consultation is problematic. Because characteristics of both the client and consultee can affect the consultation relationship, variability in training procedures is present. In addition, training in the university setting is often under analog conditions, which does

not guarantee that the consultation skills taught will be applied in practice. One way to ensure generalization to applied settings, as proposed by Kratochwill and Van Someren (1995), is to provide supervision to consultants in practice. Although training of consultants is deemed to be problematic, training should ultimately focus on developing the skills needed to ensure effective implementation of interventions (Gravois, 2012).

Kratochwill, Sheridan, Rotto, and Salmon (1991) examined whether a consultation training package increased behavioral consultation skills in master's level graduate students serving as consultants. The consultants were given a guide to behavioral consultation and a videotape that modeled the entire behavioral consultation process. After review of this material, the consultants were required to conduct practice interviews with graduate students. Feedback was given by a supervisor regarding performance during the practice interviews. Prior to implementation of the training package, baseline data were collected; consultants only met, on average, 41% of interview objectives. After the training package was completed, consultants met, on average, 87% of the interview objectives.

A second experiment was completed by Kratochwill et al. (1991) and examined whether an interactive approach to consultation training increased interview objectives met. Consultants (master's level school psychology students) participated in training phases that included verbalization skills in behavioral consultation, interpersonal-relationship factors, population and systems consideration, and peer supervision. At baseline, the consultants met 78% of the interview objectives; however, after participating in the interactive consultation training, consultants met 99% of the interview objectives, again indicating an increase in skill level after training. Overall, between the

two experiments, the authors found that consultant ability to meet consultation interview objectives increased after training. Thus, the results support specific consultation training to ensure competency in the consultation process. These findings were later confirmed by Kratochwill, Elliott, and Busse (1995), who also noted increases in objectives met after training and with supervision. Similarly, Sterling-Terner, Watson, and Moore (2002) found that when consultants received direct training in consultation, treatment integrity increased, which led to positive changes in behavior. In addition, the authors explained that when indirect methods of consultation training (e.g., didactic instruction) were used, consultants were unable to implement interventions correctly (less than 50% treatment integrity). These findings support the need for direct, practical training in consultation methods.

In order to obtain a better understanding of the availability of consultation training, Hellcamp, Zins, Ferguson, and Hodge (1998) surveyed faculty in clinical, counseling, school, and industrial/organizational graduate programs. The authors sought to gain insight into faculty attitudes and beliefs about the quality and trends in graduate training of consultation. Results indicated that 44.9% of the survey respondents reported no required consultation courses in their respective programs, and 62% reported no consultation practicum requirement. Despite the lack of formalized coursework or practicum experience in consultation, school psychology programs reportedly required more consultation courses and practicum experience than the other programs (clinical, counseling, and industrial/organizational). Only 40.5% of survey respondents indicated that their program was in the process of planning courses in consultation. Hellcamp et al. (1998) explained that providing professional development to faculty to improve

knowledge and confidence in consultation may be one way to enhance the quality of consultation training. At the time of the study, few opportunities for graduate students to become trained in consultation and as consultants were provided, resulting in a barrier to effective consultation services in the school setting.

In 2010, Hazel, Laviolette, and Lineman examined consultation course syllabi from 25 APA-approved school psychology doctoral program and found that 68% offered one course dedicated solely to consultation. Of the consultation syllabi reviewed, most indicated that the primary goal of the course was to provide students with background on theories and models of consultation and the research available regarding consultation practice. Assignments required in consultation courses included consultation case reports, literature reviews, and examinations. Lacking in the syllabi were supervision for consultation cases, promoting prevention, risk reduction, early intervention, diversity and cultural issues, and legal and ethical considerations. Although the of findings Hazel et al. (2010) were an improvement over those in the study conducted by Hellcamp et al. (1998), gaps still exist within consultation training. Hazel and coworkers suggested improved preinternship consultation preparation, cultural awareness, and prioritization of consultation services as ways to provide more comprehensive training in consultation.

McGarry Klose, Plotts, and Lasser (2012) attempted to evaluate consultant training by examining school psychology student skills during a consultation field-based practicum experience that occurred along with a didactic course. School psychology students were required to initiate a formal consultation relationship and meet with the teacher they were working with at least once a week; however, they could meet more frequently if necessary. The authors collected data over a 4-year period, which consisted

of the school psychology students and school-based teachers completing questionnaires regarding the consultation experience at the end of each academic semester. The questionnaire was used to evaluate the effectiveness of the school psychology student's training in consultation, along with the student's perception of the consultation process. Results showed that despite training on system entry concerns, there was limited confidence in the school psychology students' ability to generalize skills to the real-world setting. McGarry Klose and coworkers suggested that school psychology training programs focus more on system entry, possibly through prepracticum visits to various school systems. Furthermore, the study found that the school psychology students often struggled to share the problem-solving process and needed more balanced collaboration. Also, the school psychology student's knowledge of instructional practices was less than expected or needed during consultation. Such findings indicate that school psychology graduate students may require more formalized training in instructional strategies. Based on the results of McGarry Klose et al., there continues to be a discrepancy between teacher expectations of consultant training and the content of graduate level school psychology consultation classes.

Computer simulation was utilized by Newell (2012) to assess consultation competence of three school psychology graduate students. Each student was the consultant for three cases with consultees (teachers and students) that were computer-generated avatars. The students were permitted to use any consultation model they desired and had freedom in the type of questions asked, data collected, and procedures used throughout consultation. In order to engage in consultation with the consultees, the students typed questions in a chat dialogue box, and the consultee responded to the

questions within a 24-hour period with a preprogrammed response. The students were allowed to ask as many questions as they wished and request any data they wanted. After all questions were asked and the necessary data were obtained, each school psychology student developed an intervention and evaluation plan for the identified problem. This process was completed for each of the three cases, and at the conclusion of a case, each consultant was interviewed face-to-face regarding the case.

Newell (2012) found that none of the three consultants attempted to establish rapport with the consultee, ask the consultee what goals he/she had for the consultation process, confirm the problem behavior, or be sensitive to multicultural issues. Despite these weaknesses, the study showed that the consultants demonstrated strong ability to utilize a behavioral approach to problem identification, problem analysis, and plan implementation. These results were somewhat expected because behavioral consultation is one of the most frequently used models of consultation (Medway & Updyke, 1985; Sheridan et al., 1996) and given the artificial nature of the computer simulation. Even with this limitation, Newell's findings are clearly indicative of the need for more in-depth training for graduate level school psychology students in consultation methodology and multicultural competencies. Once again, as evidenced previously (Hazel et al., 2010; Hellcamp et al., 1998; McGarry Klose et al., 2012), Newell found a gap between consultant training and what is required in actual consultation practice.

Based on the literature on consultant training, it is evident that more structured, specific training is needed in order for consultants to become competent in the consultation process. Although attempts have been made to formalize consultation training (Kratochwill et al., 1991; McGarry Klose et al., 2012; Newell, 2012), gaps

continue to exist between training and what is required in practice. Therefore, school psychology and applied behavior analysis graduate programs should place emphasis on ensuring appropriate consultation training for school psychologists.

Consultee training. Because teachers are most often the consultees consultants work with, it is important that consultants understand what, if any, training consultees have had in consultation (Coddling, Hagermoser Sanetti, & DiGennaro Reed, 2008). It is also important that consultees be familiar with assessment and intervention; however, this is not always the case (Kratochwill & Van Someren, 1995). Consultants can provide information to teachers regarding the consultation process through professional development (Coddling et al., 2008) and in-service training (Kratochwill & Van Someren, 1995). Such in-service training can consist of providing information on the consultation process and more specific strategies, such as classroom management skills and positive reinforcement. By providing such information to teachers, they may be more comfortable and willing to seek consultation services (Kratochwill & Van Someren, 1995).

Examination of teacher preparation to manage behavior problems began in 1982, when Nicholson and Lasley examined whether curricular changes were made in Ohio's colleges and universities in response to new teacher training standards, including managing behavior problems. The authors distributed a questionnaire to faculty asking whether certain concepts were emphasized and important to the teaching of behavior management and how the college or university responded to the changing teacher preparation standards. Almost half of the respondents indicated that courses were added in response to the changes in the teacher preparation standards. More specifically,

approximately 25% of the colleges and universities that responded indicated that new courses were added to address behavior management issues, with almost 50% indicating that such courses already existed but modifications were made to improve content.

In addition, Freeman et al. (2014) examined the number of states with policies requiring preservice teachers to receive instruction in classroom management and the extent to which teacher preparation programs provide such instruction. Overall, they found that many preservice teachers were not prepared upon graduation to effectively manage misbehavior. Most states have a requirement that teacher preparation programs include instruction on classroom management; however, few programs offer evidence-based instruction in classroom management unless they are National Council for Accreditation of Teacher Education accredited. Freeman et al. reported acceptable percentages of teacher preparation programs that offered a course specifically related to classroom management (74%) or the nonacademic needs of students (77%), which is an improvement from Nicholson and Lasley's (1982) study.

Nicholson and Lasley interviewed 113 teachers about their perceptions of adequate preparation to deal with classroom management problems (1982) and found that most teachers were satisfied with the training received in behavior management and believe they were appropriately trained to deal with classroom management problems. Therefore, colleges and universities identified behavior management training as an important component of teacher preparation programs over 30 years ago.

Based on Nicholson and Lasley's (1982) findings, Burden (1983) made several suggestions for course content to address behavior management during teacher training programs. One suggestion was to provide a course on behavior management when

students were not responsible for classroom management. This approach is important in enabling students to explore discipline procedures rather than focusing on controlling behavior. In addition, during the student teaching experience, students could be provided with a forum to express concerns and present problematic behavior for guidance. Burden noted that preservice teacher training in behavior management techniques and approaches may increase confidence in addressing problematic behavior.

Despite Nicholson's and Lasley's (1982) findings and Burden's (1983) suggestions for course content, several studies have indicated a lack of thorough training in behavior management techniques. O'Neill and Stephenson (2011) found that, although some undergraduate programs provided mandatory coursework in behavior management, most training was embedded in other classes with only a few hours of instruction provided. Also, O'Neill and Stephenson (2012a) reported that undergraduate education students received some mandatory training in behavior management; however, most of this training was again embedded in other coursework rather than provided in an separate class. In a 1-year follow-up that examined perceptions of preparedness now that they were teachers, O'Neill and Stephenson (2013) found that subjects perceived themselves as *only somewhat* prepared to manage disruptive and noncompliant behavior. Teachers rated themselves as *less than somewhat* prepared to manage student disorganization and *not at all* prepared to manage aggressive, antisocial, and destructive behaviors. These results indicate that, despite having received some mandatory training in behavior management, teachers believed they were unprepared to handle problematic behavior once in the classroom setting and that preservice coursework did not prepare

them well. Thus, it appears that coursework in behavior management does not generalize to the classroom setting.

In an attempt to determine the effectiveness of training on general learning principles and behavioral interventions, Tingstrom (1989) examined pretraining and posttraining acceptability ratings. Participants were given four case descriptions and asked to rate the acceptability of each intervention on the Treatment Evaluation Inventory (TEI; Kazdin, 1980a) prior to receiving any training. Participants then received 5 hours of lecture spread across four classes. The lecture material began with content on general learning principles, then covered the specific interventions targeted for the study. Two weeks after the pretest, the participants rated the acceptability of the four interventions again on the TEI. The participants rated all four interventions as more acceptable posttraining (Tingstrom, 1989). These findings are significant, as they support the need for additional information and training on interventions in order to enhance acceptability. Tingstrom indicated that, based on these results, information and training should be provided in teacher education programs and in-service sessions to increase teachers' understanding and acceptance of behavioral principles and interventions.

Because previous research has indicated a lack of sufficient teacher training in behavior management techniques, Brophy (1988) set forth several guidelines for effective teacher training in problematic behavior. Most importantly, Brophy stressed imposing structure, not only for the students, but for teachers as well. Structure makes the classroom routine and school day predictable and simplified, thereby reducing the need for students to ask for directions and potentially act out in order to get the teacher's attention. However, Brophy noted that should a teacher need to implement a behavior

management strategy, it is important to know what technique to implement, when to implement the technique, and why that particular technique is appropriate for the situation. The author suggested that the most effective way to teach these concepts is through modeling, scaffolding, and fading in a classroom setting with an expert teacher. Such practical training, according to Brophy, should be incorporated with didactic instruction, field experiences, and case literature and simulation exercises. A combination of such teaching strategies would be considered an integrative, comprehensive approach to teacher training in behavior management techniques (Brophy, 1988). This was later confirmed by McEwan Landau (2001) in her paper that stressed the importance of a standalone, required course on behavior management in teacher preparation programs.

A study was conducted by Merrett and Wheldall (1993) in which teachers were interviewed regarding their views and opinions on their initial training in behavior management, including practical experience. Of the 176 teachers interviewed, 72% reported that they were dissatisfied with the preparation they were given in the area of behavior management. In addition, 82% indicated that they had learned behavior management skills on the job rather than during initial teaching training. Furthermore, 70% were dissatisfied with course content that addressed meeting the needs of struggling students and problematic behaviors. Merrett and Wheldall's results, although obtained through interviews with teachers, contradict those of Nicholson and Lasley (1982), who found that teachers were satisfied with preservice training in behavior management strategies.

Similar to Nicholson and Lasley's (1982) findings, O'Neill and Stephenson (2012b) found that completion of a mandatory behavior management course was associated with high perceptions of teacher preparedness to manage problematic behaviors. Those who had not completed a course on behavior management rated themselves as somewhat unprepared to manage misbehavior. Therefore, O'Neill and Stephenson concluded that independent coursework on behavior management increases teacher knowledge about and confidence in managing misbehavior in the classroom.

Bromfield (2006) provided questionnaires to students who were completing school experience requirements for an education degree. The questionnaires examined what behaviors the students' thought would be most difficult to handle and were completed again half way through the school placement to determine whether views had changed. Prior to beginning their field placements, students identified out of control behavior and violent and threatening behavior as the most concerning. Results of the questionnaire completed half way through the field placement indicated significantly different concerns. Behavioral concerns included work refusal, talking when the teacher was talking, inappropriate noise (e.g., talking over the teacher, talking to one another), defiance of teacher instruction, and out of seat behavior. Overall, the students indicated that they were not prepared to manage such behaviors, and handling disruptive behavior was a major concern. These findings confirm those of Merrett and Wheldall (1993), who found that a large majority of teachers perceived their coursework as lacking focus on managing difficult behaviors.

When Begeny and Martens (2006) investigated the amount of coursework and practicum training in behavioral instruction received by elementary, secondary, and

special education master's students, participants indicated some training on only approximately 57% of the survey items. Specific training in behavioral interventions did not differ significantly by college or university attended; however, special education programs had significantly more training and coursework in strategies than elementary or secondary programs. Begeny and Martens therefore encouraged consultants to examine the training teachers have in behavioral interventions before suggesting an intervention for implementation.

Even though Begeny and Martens (2006) reported that special education programs provided significantly more training and coursework in behavior management strategies, Oliver and Reschley's (2010) results differed. The authors surveyed 26 institutes of higher education in a Midwestern state. Specifically, course syllabi from special education programs were examined to determine whether content regarding behavior management was included. Oliver and Reschley found that only 25% of special education programs had a course devoted entirely to behavior management. The remaining programs had behavior management content throughout various courses. Given the lack of comprehensive behavior management training in the syllabi reviewed, Oliver and Reschley concluded that special education teachers may not be adequately trained to address behavioral needs; however, such results should be interpreted with caution, as the study examined syllabi from institutions in one state only.

To further investigate Begeny and Martens' (2006) study results, Alvarez (2007) examined whether teacher training affected responses to classroom aggression. Participants were given four hypothetical vignettes of student aggression and were asked to respond on measures of attributions, affective reactions and interventions. Alvarez

found that participants with some training in behavior management indicated they would implement more positive interventions, whereas teachers with no training were more likely to refer the problematic student to outside personnel for management. Because the results indicated that the teachers' response to aggressive behavior was impacted by prior training in behavior management, Alvarez suggests that advanced training in behavior management techniques be provided to teachers. Merrett and Wheldall (1993) also reported the need for more in-depth training in behavior management techniques.

Attempting to train teachers during consultation is not without its flaws. Providing teachers with information regarding the consultation process and classroom management skills does not ensure that it will be generalized to the classroom setting (Kratochwill & Van Someren, 1995). In addition, consultation is usually viewed as a cost-effective way to provide psychological services in education settings (Bergan, 1977). However, training teachers increases costs and time, especially when done so as to support generalization and maintenance (Kratochwill & Van Someren, 1995).

Consultant/consultee relationship. It has been speculated that the relationship between consultant and consultee is important in treatment effectiveness. Several variables have been identified that are known to influence the effectiveness of consultation. Such variables include the physical presence of the consultant, physical location of the consultant and contact with the consultee, and consultant demonstration of concern for the consultee and client. Furthermore, consultants who have had more experience in the classroom and can identify with the consultee have been perceived as more effective and ultimately receive more cooperation from consultees (Kratochwill & Van Someren, 1995).

Despite the identification of several consultant/consultee relationship issues in the literature, there is little to no published research on such issues in behavioral consultation. Therefore, it cannot be determined whether such factors influence the effectiveness of behavioral consultation in applied settings. Further research in this area is needed to ascertain whether the nature of the consultant/consultee relationship is of importance in behavioral consultation (Kratochwill & Van Someren, 1995).

Identifying target behaviors. During problem identification, the consultee is encouraged by the consultant to identify the problematic behaviors that prompted consultation. Problem identification is the first and possibly the most important step in consultation. If the proper selection of target behaviors does not occur, the client will not receive adequate intervention. It is important that consultants and consultees strive to identify target behaviors that represent the reason consultation was requested. It is not uncommon for problem identification to focus on behaviors that present a mild level of disruption or reduce the aversiveness to the teacher; however, behaviors that are dangerous to the client or others, maximize natural reinforcers available in the environment, and are positive and need to be strengthened should be identified for intervention (Kratochwill & Van Someren, 1995).

It may be important for consultants and consultees to focus more on interventions that address the conditions that surround the problematic behavior rather than the problematic behavior itself. An additional strategy for identifying problematic behaviors that may be useful is alternative assessment formats. Typically, the target behavior for intervention is identified through a problem identification interview, with a few direct observations possibly taking place. By adding additional assessments, such as rating

scales, checklists, and self-monitoring tools, identification of target behaviors may be more precise (Kratochwill & Van Someren, 1995).

Intervention acceptability. Kazdin provided one of the first definitions of acceptability:

...judgments about the treatment procedures by nonprofessionals, lay persons, clients, and other potential consumers of treatment...whether treatment is appropriate for the problem, whether the treatment is fair, reasonable, and intrusive, and whether treatment meets with conventional notions about what treatments should be (1980a, p. 259).

This concept began to be questioned when the use of aversive techniques became popular (Kratochwill & Van Someren, 1995). Ensuring intervention acceptability is important, as those strategies that are deemed appropriate by the consultee and client may result in a higher probability of implementation, leading to positive outcomes. Furthermore, intervention acceptability must be addressed through the consultation process, as it is possible that ethical and legal concerns may arise. Consultants and consultees should avoid choosing interventions that are discriminatory, biased, and potentially harmful to the client. In order to ensure intervention acceptability, consultants should be prepared to present numerous treatment options to the consultee (Kratochwill & Van Someren, 1995). Although intervention acceptability appears to be important, research in this area is limited and mostly dated.

In a study conducted by Kazdin (1981), the extent to which acceptability ratings were influenced by the effects treatments had on child behavior was examined. The first experiment completed by Kazdin investigated whether acceptability of a treatment was

altered by the treatment's therapeutic effects. Undergraduate students in an introduction to psychology class participated by listening to one of two descriptions of children who were presenting with behavioral problems warranting treatment. After hearing one of the two descriptions of the child, participants then listened to four different treatments that were applied to the case (reinforcement, time out from reinforcement, positive practice, and medication). Included in each treatment description was information regarding treatment efficacy. Treatments were described to have either strong or weak therapeutic effects.

A second experiment was completed that investigated whether adverse or undesirable side effects impacted treatment acceptability. Undergraduate students from an introduction to psychology class participated. The same cases and treatment descriptions were used as in the first experiment; however, information regarding side effects was included. Side effects were described as either strong (continued over the course of treatment and resulted in new problem behaviors) or weak (appeared early in treatment and disappeared) (Kazdin, 1981).

Both experiments found that the most acceptable treatment was reinforcement followed by positive practice, time out, and medication. In addition, efficacy of treatment was found to be unrelated to treatment acceptability in the first experiment, and adverse side effects associated with the intervention affected acceptability ratings in the second experiment. More specifically, descriptions of stronger side effects resulted in greater decreases in acceptability than weak side effects (Kazdin, 1981).

Such findings differed somewhat from Boone Von Brock and Elliott's (1987) study, specifically in regards to treatment effectiveness. Teacher participants were given

a short paragraph describing a problem behavior and an additional paragraph describing an intervention used to address the problem behavior. Teachers were either given no information regarding the effectiveness of the intervention, information on consumer satisfaction with the intervention, or research-based outcome information. The teachers read all information and then used the Behavior Intervention Rating Scale (BIRS; Boone Von Brock & Elliot, 1987) to rate acceptability and effectiveness of the intervention. Boone Von Brock and Elliott found that intervention effectiveness information influenced acceptability ratings when problem severity was taken into consideration. In addition, teachers who rated interventions as less acceptable also rated them as less effective. Although Kazdin's (1981) initial findings set the framework for treatment acceptability, it is clear that several factors may influence the potential acceptability of any given intervention.

Elliott et al. (1984) first examined the acceptability of positive interventions and then studied the acceptability of negative or reductive interventions. When studying the acceptability of positive interventions, teacher participants were given a case study to read that described a positive intervention for one of three problematic behaviors. They were then asked to complete the Intervention Rating Profile (IRP) (Witt & Martens, 1983). Results revealed that acceptability varied for the three problematic behaviors, with no significant difference when examining the severity of the behavior problem. During the second study, teacher participants were given a case study to read that described one of three negative interventions to address one of three problematic behaviors. The participants were asked to read the case description and complete the IRP. Again, similar to the first study, teachers' ratings of acceptability of the three

negative interventions varied for the three behavior problems. The authors examined whether positive or negative interventions were rated as more acceptable in general. The results confirmed the authors' original hypothesis that positive interventions would be rated as significantly more acceptable than negative interventions. This study also confirmed previous research that indicates positive interventions are rated as more acceptable than reductive interventions (Kazdin, 1980a, 1981; Witt & Martens, 1983).

Similar research was completed by Witt and Robbins (1985), in which the acceptability of interventions designed to decrease the rate of inappropriate responding was evaluated. In their first investigation, six interventions were examined (differential reinforcement of other behaviors, differential reinforcement of low rates of responding, reprimands, seclusion time-out, staying after school, and corporal punishment). One-page case descriptions were provided containing information about a fifth grade boy and one of three problematic behaviors and a description of one of six interventions for the identified problematic behavior. Each participant was given one case description and a copy of the IRP to complete. Results indicated that differential reinforcement of other behavior was significantly more acceptable than time-out, differential reinforcement of low rates of responding, staying after school, and reprimands. Furthermore, corporal punishment was significantly less acceptable than any of the other interventions. These results are similar to those found by Kazdin (1980a, 1980b), in which exclusion time-out was less acceptable than other forms of intervention, and positive reinforcement of incompatible behavior was rated as more acceptable than punishment procedures. In addition, Waas and Anderson (1991) found that removing a problematic child to a specialized classroom was rated as less acceptable than other positive interventions.

For the second study, teachers were given a case description that described a child with one of two problematic behaviors; however, all cases consisted of staying in at recess as the intervention. One intervention required the teacher to monitor the student's behavior during recess, whereas the second vignette required the child to report to the office during recess to be supervised by the principal. Again, all participants were asked to read the vignette and respond on the IRP. Results revealed that the teacher-supervised intervention was rated as significantly more acceptable than the principal-supervised intervention. In addition, behavior severity affected acceptability, with interventions applied to more serious behaviors being rated as more acceptable (Witt & Robbins, 1985), which confirms previous research (Martens et al., 1985). Although Witt and Robbins (1985) utilized analog research for their investigation, it is clear from their findings that treatment acceptability is a potential factor in situations when interventions are unsuccessful.

Hall and Didier (1987) examined whether acceptability ratings varied when interventions were described from a pragmatic, humanistic, or behavioral approach. Seventy-three teachers were asked to rate the descriptions of the three interventions on the IRP-15. Results indicated that acceptability ratings significantly differed for all three interventions. The humanistic approach to intervention was rated as most acceptable, with pragmatic being the least acceptable.

For consultants, it is also important to know whether the means by which interventions are developed affects acceptability. For example, do consultees prefer interventions that are developed in collaboration with a consultant, by themselves, or by the consultant alone? Kutsick et al. (1991) examined these factors, along with whether

the type of intervention (positive versus negative) and the seriousness of the problem (mild versus severe) affected treatment acceptability.

Participants in the Kutsick et al. (1991) study were elementary school teachers who were asked to read a written case description and complete the Intervention-Process Rating Scale (IPRS; as cited in Kutsick et al., 1991). The IPRS is designed to measure perceptions of treatment acceptability. Outlined in the case descriptions was a problematic behavior faced by a teacher, an intervention chosen by the teacher to address the problematic behavior, and a description of how the intervention was developed. The authors examined acceptability with respect to how the intervention was developed, the problem behavior severity, and the intervention type. According to Kutsick et al., the most important finding was that interventions developed in collaboration with a consultant were rated as significantly more acceptable than those developed by the teacher or consultant alone. Of interest is that the authors discovered that negative interventions were more acceptable when developed collaboratively and were as acceptable as positive interventions developed collaboratively. This contradicts previous research that found negative interventions to be less acceptable to teachers (Elliott, 1988; Kazdin, 1980b; Reimers et al., 1987; Witt & Martens, 1983). Although this finding is somewhat surprising, teachers preferred positive rather than negative interventions overall, which confirms previous research (Elliott et al., 1984; Kazdin, 1980a, 1980b, 1981; Witt & Martens, 1983). Lastly, Kutsick et al. did not find a significant difference between treatment acceptability when mild versus severe problems were examined, consistent with previous investigations completed by Elliott et al. (1984), but contradicting that found by Martens et al. (1985).

When examining outcomes related to intervention acceptability, Allinder and Oats (1997) investigated whether teachers who found curriculum-based measurement (CBM) more acceptable, implemented them with more fidelity and saw greater student improvements in math. For this study, 22 elementary school special education teachers used CBM math probes with two students each over a 4-month period. Each teacher formulated an end of the year goal (grade level) for each student. Twice a week, the teacher asked the student to complete a CBM that represented the appropriate grade level. After four CBMs, the teacher specified a performance goal (e.g., 45 digits per minute) on the predetermined grade level. CBMs were then administered at the teacher's discretion, with progress monitored on a graph. The CBM Acceptability Scale (CBM-AS; as cited in Allinder & Oats, 1997) was completed by each teacher at the end of the study.

Results indicated that those teachers who rated CBM as highly acceptable on the CBM-AS implemented at least some components with greater fidelity. In addition, teachers who rated CBM as more acceptable asked their students to complete the CBM more frequently and set more earnest goals for their students. Most importantly, Allinder and Oats (1997) discovered that teachers who found CBM more acceptable and implemented them with greater fidelity saw significant improvement in math scores on the CBM. Although Allinder and Oats were examining acceptability and outcomes as they relate to academics and not behavior, these results are telling. Given these findings, consultants should strive to obtain high levels of intervention acceptability and fidelity with consultees.

When Cross Calvert and Johnston (1990) reviewed treatment acceptability research, it was determined that positive reinforcement, positive practice, differential

reinforcement, and response cost were rated as acceptable, whereas corporal punishment and shock were rated as least acceptable. In addition, Reimers et al. (1987) reviewed treatment acceptability research to conceptualize the factors that influence acceptability. Factors identified by the authors included severity of the problem behavior, time needed to implement the intervention, and type of intervention (e.g., positive versus negative). Reimers et al. found that, generally, the more severe the problem, the higher the acceptability ratings for the indicated treatment. Furthermore, interventions were rated as more acceptable by teachers when strategies required less time to implement and when interventions were positive in nature (as compared to those that were negative or reductive), which confirms previous findings by Witt, Martens, et al. (1984). Although not one of the original factors identified by Reimers et al., the researchers found that most literature indicates that treatments that are viewed as effective are also deemed to be more acceptable.

Use of jargon. It is clear that there are numerous factors that may influence behavioral consultation and intervention acceptability. Although limited research has been completed that clearly identifies the influences on behavioral consultation and intervention acceptability, even less attention has been given to the type of language used when consultants describe interventions to consultees.

This issue was first identified in 1977, when Woolfolk, Woolfolk, and Wilson presented two groups of participants (undergraduate and graduate students) with either a videotape of a teacher using reinforcement labeled behavior modification or reinforcement labeled humanistic education. The authors defined behavior modification as techniques based largely on the work of B. F. Skinner, such as shaping. For

humanistic education, Woolfolk et al. explained that humanistic interventions integrate affective with cognitive learning while recognizing the importance of feelings and thinking in the overall development of the individual (1977).

After watching the videos, participants were asked to complete a two-part evaluation questionnaire on perceptions of the teacher, intervention, and student and semantic differential questions. Results indicated that the humanistic education label produced higher teacher efficacy ratings than the behavior modification label. Furthermore, both samples rated the personal qualities of the teacher in the video as more favorable in the humanistic education example. Based on these findings, Woolfolk et al. (1977) concluded that when discussing and applying behavior modification principles, terminology should be presented in less complicated language to ensure acceptance and understanding.

In a similar study completed by Woolfolk and Woolfolk (1979), typical behavioral modification procedures described using language portraying growth were rated as more favorable than when using behavioral terminology. Participants (undergraduate and graduate students) were randomly assigned to one of four conditions: humanistic education, behavior modification, behavior modification presented with evidence of efficacy, and behavior modification presented with information that highlighted conditioning as applied to humans. After watching a video of a teacher employing a behavior modification technique, participants were asked to complete the same ratings as in the Woolfolk et al. (1977) study. Given the results of these two studies, the tendency to rate techniques labeled behavior modification more negatively

may be attributed to the language of behavior modification, rather than to the actual procedures utilized.

In 1981, Kazdin and Cole again examined whether the label behavior modification resulted in negative evaluations of treatment. The authors conducted three experiments with the first requiring undergraduate education students to rate three descriptions of an intervention on the Teacher-Classroom Evaluation Scale (as used in Kazdin & Cole, 1981) and the Semantic Differential Scale (Osgood, Suci, & Tannenbaum, 1957). The interventions were described in terms that were behavioral (emphasized control and manipulation of behavior), humanistic (emphasized development and expression of feelings), or neutral terms (learning, development, guidance, etc.). Results indicated that the participants rated the intervention described in behavioral terms more negatively than the interventions described in humanistic or neutral terms (Kazdin & Cole, 1981).

Kazdin and Cole's (1981) second experiment investigated whether presenting treatments in jargon terms or ordinary language resulted in differing acceptability ratings. Participants were 118 students in introductory psychology courses. They were presented with two basic descriptions of an intervention. One was labeled behavior modification, and terminology such as shaping and reinforcement was used. The other was labeled developmental education and used more general terms (e.g., individual and group activities, engaging in discussion). Half of the participants received the behavioral modification description; the other half received the developmental education description. The descriptions contained one of two levels of jargon. Half of the participants received a description that utilized jargon and explained work with laboratory animals. Examples

of terms used in the jargon description included positive reinforcement, token reinforcement, extinction, chains of responding, and shaping. The nonjargon description used terminology that was ordinary and simple. Participants heard descriptions of the interventions and were asked to rate the interventions on the Treatment Evaluation Inventory and the Semantic Differential (Kazdin & Cole, 1981).

Results suggested that the behavioral teaching method was consistently rated more negatively, regardless of how it was presented (jargon versus nonjargon terminology). This suggests that presenting behavioral techniques in nonjargon terminology may not result in more acceptable ratings of the approach (Kazdin & Cole, 1981).

In their third experiment, Kazdin and Cole (1981) examined whether manipulating the label (behavioral modification or no label) and jargon use altered acceptability of the intervention. Participants were 121 undergraduate students in introductory psychology courses who, as in the second study, listened to descriptions of one of four teaching methods. The participants then completed the Treatment Evaluation Inventory and the Semantic Differential. The behavior modification method was presented in one of four ways: with the label, without the label, in jargon terms, or in ordinary language. Results indicated that, overall, interventions described in jargon terms were rated as more acceptable than those described in ordinary terms. Therefore, when comparing these results with those of the second experiment, jargon may or may not affect the evaluation and acceptability of behavior modification procedures.

In a follow-up to Kazdin and Cole's (1981) original work examining the use of jargon when describing interventions, Witt, Moe, et al. (1984) examined whether teacher

judgments relating to acceptability of an intervention differed depending on the way in which the intervention was described (behavioral, pragmatic, or humanistic jargon) and the rationale provided for the intervention. Participants were 112 elementary school teachers. One-page written case descriptions were developed, with the first part containing information on a child with one of two behavior problems (mild or severe). The second portion of the case description explained an intervention to be applied to the problematic behavior (e.g., staying in at recess). The language and technical terms used to describe the intervention varied. The behavioral description utilized terms that emphasized staying in at recess and contingent use of punishment to control the child's behavior. The humanistic description emphasized staying in at recess as a way to help the child understand and express his/her feelings. For the pragmatic description, staying in at recess was used as a logical consequence for the problem behavior described. The participants were given one case description, then asked to complete the IRP-20.

Witt, Moe, et al. (1984) found that, in general, intervention descriptions were evaluated more positively when the problematic behavior was considered severe. When examining the type of language used, pragmatic descriptions were rated as more acceptable than humanistic or behavioral descriptions. These findings are similar to those of Kazdin and Cole (1981) and support the need for ongoing research in this area.

When Hyatt et al. (1991) examined the effects of technical language on intervention acceptance, the authors hypothesized that a preference for nontechnical language among experienced teachers would be found, but undergraduate students would rate interventions described in jargon terms as more acceptable. Participants were asked to read one of two case descriptions of a child displaying a problematic behavior and an

intervention to be implemented by the teacher. One case description outlined the intervention using jargon; the other case description did not. After reading the case description, participants rated the intervention using the Treatment Evaluation Inventory (TEI; Kazdin, 1980a). Results indicated that teachers rated the jargon description of the intervention as more acceptable than the nonjargon explanation, whereas there was no difference in students' acceptability ratings. Statistical analysis also found no statistically significant difference between the ratings of upperclassmen and underclassmen. These findings contradict earlier studies (Witt, Moe, et al., 1984; Woolfolk et al., 1977; Woolfolk & Woolfolk, 1979) in which jargon descriptions were rated less favorably. However, in Kazdin and Cole's (1981) third experiment, interventions described in jargon terms were rated as more acceptable than those described in ordinary terms. Such conflicting findings support the need for ongoing research to determine the type of language preferred by teachers when describing a behavioral intervention.

In an attempt to clarify these conflicting results previously presented, Rhoades and Kratochwill (1992) again examined teacher acceptability of behavior interventions presented in jargon terminology. The authors also investigated whether the level of consultee involvement (with or without teacher involvement) in intervention development affected acceptability levels. Participants were 60 regular education teachers who were assigned to one of four conditions: technical language with teacher involvement, technical language without teacher involvement, nontechnical language with teacher involvement, or nontechnical language without teacher involvement. After being assigned to a condition, participants viewed a video of a teacher engaging in consultation with a psychologist. After viewing the video, the participants completed the

Intervention Rating Profile–15 (IRP–15) to assess acceptability. Rhoades and Kratochwill found that the highest acceptability ratings were given to the vignette in which teacher involvement was low and jargon was used by the psychologist. Rated as least acceptable was the vignette with low teacher involvement and nontechnical language used by the psychologist. After examining these findings, the authors concluded that participant ratings on the IRP–15 did not indicate differences in acceptability levels of technical versus nontechnical language. The authors explained the variability in their findings by weaknesses in the IRP–15 and the possibility that this measure may not accurately assess the acceptability of consultee involvement in consultation. These findings by Rhoades and Kratochwill further confirm the variability in outcomes when attempting to determine the type of language preferred by teachers when describing behavioral interventions.

Because prior research in the area of jargon acceptability has utilized both written case descriptions and videotaped consultation sessions, Hyatt and Tingstrom (1993) studied whether intervention presentation (written versus videotaped), use of a reinforcement-based or punishment-based intervention, or use of jargon affected teacher acceptability of interventions. Ninety-four teachers were randomly assigned to conditions. Approximately half of the teachers viewed videotapes of a school psychologist describing two interventions to a teacher: differential reinforcement of incompatible behavior (reinforcement-based) and time-out (punishment-based). The remaining participants read written descriptions of the same interventions. Half of the teachers who viewed the videotapes and half who read written descriptions did so using jargon or nonjargon terminology. After viewing a video or reading a case description, the

teachers completed the TEI. Hyatt and Tingstrom found that ratings on the TEI were significantly higher for differential reinforcement of incompatible behavior (DRI) than for time-out intervention. However, the effects of jargon differed, depending on the type of intervention presented. The jargon description of time-out was rated significantly higher, whereas the jargon description of DRI was not rated as significantly different from the nonjargon description. When examining written versus videotaped presentations, written descriptions of time-out that included jargon were rated higher than the videotaped version. The description of DRI using jargon did not differ significantly between written and videotaped presentations. The results of this study are, again, conflicting and indicate that jargon descriptions may be more acceptable under certain conditions, which is similar to previous research (Hyatt et al., 1991; Kazdin & Cole, 1981; Rhoades & Kratochwill, 1992). Hyatt and Tingstrom (1993) further noted that, based on their findings, teachers generally provide higher acceptability ratings for reinforcement-based interventions than punishment-based interventions, regardless of the type of language used, as indicated by others (Elliott et al., 1984; Kazdin, 1980a, 1981; Witt & Martens, 1983).

A different approach to assessing jargon usage during consultation was taken by Knotek (2003). Knotek set out to qualitatively examine how jargon and slang affected the problem identification stage of student study teams. During student study team meetings at two elementary schools, consultative interactions were recorded and transcriptions were developed. Results revealed that when jargon and slang were used during student study team meetings, participants did not reflect upon their language. In addition, the use of jargon and slang were associated with a lack of clarification among

the student study team participants. Knotek further indicated that when professional jargon was utilized, the student study team's conceptualization of the problem was unclear and disjointed, often with assumptions being made about the problem.

To summarize the effects of jargon usage on intervention acceptability, several studies have shown that the label a treatment is given and the way in which it is described affect acceptability (Kazdin & Cole, 1981; Witt, Moe, et al., 1984; Woolfolk & Woolfolk, 1979; Woolfolk et al., 1977). Some research found that teachers rated jargon descriptions of an intervention as more acceptable than a nonjargon explanation (Hyatt et al., 1991; Kazdin & Cole, 1981). Rhoades and Kratochwill (1992) discovered conflicting outcomes when attempting to determine the type of language preferred by teachers when describing behavioral interventions. They concluded that there were no differences in acceptability levels of technical versus nontechnical language, despite high acceptability ratings given to a vignette in which teacher involvement was low and jargon was used by the psychologist. In Hyatt and Tingstrom's (1993) investigation, acceptability of the use of jargon depended on the type of intervention presented. In addition, Knotek's (2003) qualitative analysis of jargon and slang usage during student study team meetings revealed that problems were described in an ambiguous and unclear manner resulted in a lack of clarification and conceptualization of the problem. Given these results, it is clear that the research on the use of jargon during consultation is conflicting. Consultants should ensure that consultees understand interventions as presented in an attempt to increase integrity and effectiveness. Research has shown that improving a consultee's understanding of an intervention can improve acceptability of that intervention, resulting in higher compliance (Reimers et al., 1987). Eckert, Russo, and Hier (2008) present best

practices as avoiding jargon and technical language; however, additional research is needed to determine whether consultants should use jargon or nontechnical language when describing behavioral interventions to teachers. The present study investigated this issue.

Measuring acceptability.

Several measures of intervention acceptability have been noted in the literature. Finn and Sladeczek (2001) completed a review of nine treatment acceptability measures. Specifically, they examined each instrument's purpose, psychometric properties, scoring procedures and interpretation, and use in practice. Finn and Sladeczek found it important to examine intervention acceptability measures because when interventions are thought to be effective, initial opinions about treatment acceptability will be higher (Witt & Elliott, 1985). Furthermore, Reimers et al. (1987) indicated that if an intervention is not understood, treatment integrity and effectiveness will decrease. Therefore, understanding acceptability and ways in which to measure this factor are important for school consultants to consider.

Treatment evaluation inventory (TEI). Early reviews of treatment acceptability (Cross Calvert & Johnston, 1990; Kazdin, 1980a) have indicated that the Treatment Evaluation Inventory (TEI) and the Intervention Rating Profile–20 (IRP–20; Witt & Martens, 1983) were the most commonly used acceptability measures. The TEI was the first acceptability measure developed (Miltenberger, 1990) and originated from experiments designed to examine the acceptability of behavioral interventions for children with deviant behavior (Kazdin, 1980a). Originally, when Kazdin first developed the TEI, it contained 15 questions that were related to the acceptability and fairness of

treatment, potential side effects of the treatment, perceived effectiveness of the treatment, and appropriateness for use with children. Responses on the TEI were rated on a 7-point Likert scale with descriptive points assigned to each question. Total scores were obtained by summing all of the items with a higher score indicating greater treatment acceptability. Studies examining the reliability of the TEI indicate good internal consistency (.89 and .97; Finn & Sladeczek, 2001; Kelley, Heffer, Gresham, & Elliott, 1989; Spirrison, Noland, & Savoie, 1992).

Factor analysis has been the statistical analysis of choice when attempting to validate the TEI. Kazdin's (1980a) original study of 60 college students, which resulted in the creation of the 15-item TEI, noted that all questions loaded onto one factor: acceptability. A follow-up study by Kazdin (1980b), which utilized college students, reported a similar factor structure. However, when Kelley et al. (1989) examined the factor structure of the TEI with mothers of young children, two factors were discovered: acceptability, which accounted for 42% of the variance, and ethical issues/discomfort, which accounted for 19% of the variance. Kelley et al. studied a second validation sample of 264 college students and found similar results. Two factors were uncovered: acceptability (accounting for 42% of the variance) and ethical issues (accounting for 15% of the variance). In addition, Spirrison et al. (1992) examined responses from 164 college students who were asked to evaluate the acceptability of six interventions. These results also indicated a two-factor structure of the TEI. The first structure, effectiveness, accounted for 70% of the variance; the second factor, ethical/moral evaluation, accounted for 7% of the variance. Both Kelley et al. and Spirrison et al. propose that the

discrepancies between Kazdin's early research and their findings may be due to differences in sample sizes, demographic characteristics, and the proposed interventions.

Although some of the research regarding the factor structure of the TEI is conflicting, the TEI continues to be considered the most commonly used measure of treatment acceptability (Cross Calvert & Johnston, 1990; Miltenberger, 1990). However, the TEI has its weaknesses. The TEI was originally developed using college students; thus, it is unclear whether it is suitable to use with other populations, such as parents (Cross Calvert & Johnston, 1990; Kelley et al., 1989). Furthermore, some (Kelly et al., 1989) have indicated that the wording on the TEI is too difficult to understand for parents of low socioeconomic status, who lack advanced literacy skills. In addition, Elliott (1988) noted that the TEI is a poor measure to assess acceptability of interventions for elementary school children because of its sentence structure complexity. Despite the criticisms of the TEI, attempts have been made to modify it for use with children, parents, and grandparents (Kazdin, French, & Sherick, 1981; Miltenberger, Parrish, Rickert, & Kohr, 1989).

Intervention Rating Profile–20 (IRP–20). The IRP–20 was Witt and Martens' (1983) attempt to expand Kazdin's (1980a) early findings on treatment acceptability in the classroom. However, Witt and Martens attempted to bring more awareness to the characteristics of an intervention that teachers perceived as acceptable and develop a reliable tool for assessing such variables that influence teachers' judgments on treatment acceptability. The IRP–20 is a 20-item questionnaire that uses a 6-point scale (1, *strongly disagree*; 6, *strongly agree*). The items are summed to obtain an overall acceptability score, with higher scores indicating greater acceptability. Reliability of the IRP–20 has

been shown to be high, with values of .89 (Witt & Martens, 1983) and .85 (Meller, Martens, & Hurwitz, 1990).

Similar to the TEI, attempts to validate the IRP–20 have focused on factor analyses completed with teachers. Witt and Martens (1983) found that a principal component analysis of teacher responses on the IRP–20 indicated a general acceptability factor that accounted for 41% of the variance. Secondary factors discovered included the amount of risk for the target child, the amount of time teachers needed to dedicate to the intervention, whether the intervention would affect other children, and the skill level needed by teachers to implement the intervention. Meller et al. (1990) later found similar results of a five-factor structure of the IRP–20.

The IRP–20 has been used mainly with school personnel, such as teachers in training, student teachers, and regular and special education teachers (Witt, Elliott, et al., 1984; Witt & Martens, 1983; Witt, Martens, et al., 1984). These authors have noted that the IRP–20 is successful in differentiating between the acceptability of behavioral interventions in the school setting. Furthermore, the IRP–20 has been deemed an appropriate tool for researchers to utilize when examining the factors that may influence acceptability of behavioral interventions in the school setting. However, the IRP–20 lacks the utility of assisting practitioners in identifying specific information regarding why or how to make an intervention more acceptable (Martens et al., 1985; Rhoades & Kratochwill, 1992).

Abbreviated Acceptability Rating Profile (AARP). The AARP is an 8-item questionnaire that was developed from existing treatment acceptability tools, such as the TEI and IRP–20. Given the length of the TEI and IRP–20, the AARP was designed with

simpler language and to take less time to complete (Tarnowski & Simonian, 1992). The authors found that it took mothers of children being treated at pediatric outpatient clinics 10 minutes to complete the AARP, which is approximately half the time required to complete other treatment acceptability scales. In the same study, Tarnowski and Simonian (1992) discovered that items on the AARP were presented at a beginning fifth grade reading level, whereas other treatment acceptability measures were written at an eighth grade reading level.

Psychometric properties of the AARP have been shown to be acceptable (Tarnowski & Simonian, 1992). Split-half and Cronbach's α coefficients were .95 and .97, respectively, when 60 mothers were asked to rate the acceptability of five interventions used to treat childhood depression. In addition, a cross-validation sample of 80 mothers was asked to rate the same interventions on the AARP. Similar split-half and α coefficients were discovered: .97 and .98, respectively. Factor analyses indicated one factor: general acceptability. Given these findings and the nature of the validation research (analog studies), the AARP would be best suited for research purposes. More support is needed to determine the appropriateness of the AARP for naturalistic settings such as schools (Tarnowski & Simonian, 1992).

Behavior Intervention Rating Scale (BIRS). Boone Von Brock and Elliott (1987) developed the BIRS as a revision and extension of previous treatment acceptability measures. The BIRS consists of 24 items rated on a 6-point Likert scale. Items are summed to obtain an overall treatment acceptability score, with higher scores indicating greater treatment acceptability. A study completed and reported in two different articles (Boone Von Brock & Elliott, 1987; Elliott & Von Brock Treuting, 1991)

asked 216 teachers to rate three interventions for a child with behavior problems on the BIRS. An α coefficient of .97 indicates acceptable internal consistency (Elliott & Von Brock Treuting, 1991).

In addition, Elliott and Von Brock Treuting (1991) found a three-factor structure for the BIRS through factor analysis: acceptability, effectiveness, and time of effectiveness. The acceptability factor accounted for 63% of the variance and was concluded to be the primary factor of the scale. Furthermore, according to Boone Von Brock and Elliott (1987), the BIRS was able to discriminate between interventions, specifically between time out and response cost or token economy systems.

Usage Rating Profile for Intervention (URP-I). In an attempt to provide a more comprehensive tool to assess intervention usage, Chafouleas, Riley-Tillman, Briesch, and Chanese (2008) developed the IRP-20. Their intent was to develop a self-report tool that would potentially have five factors to assess influences on intervention usage: acceptability, integrity, feasibility, effectiveness, and understanding. In the pilot study, participants (196 members from the National Association of School Psychologists) responded to 39 statements by indicating their level of agreement or disagreement with each. Throughout the development of the URP-I, the IRP-20 (Martens et al., 1985) was considered a model. Initial items on the URP-I came from the IRP-20, and new items that were hypothesized to load on to the additional constructs were added (Chafouleas et al., 2008).

In order to conduct a factor analysis, 196 URP-Is were completed from a sample of 1,000 members of the National Association of School Psychologists. The respondents were asked to complete the URP-I with regard to use of daily behavior report cards

(DBRCs). A brief description of the DBRC for use when intervening with various school-based behavioral problems was provided. Respondents were asked to complete the URP–I while referencing the description of the DBRC (Chafouleas et al., 2008).

Results of the pilot study indicated that Factor I, acceptability, accounted for 33% of the variance, with Factor II, understanding, accounted for 8% of the variance, Factor III, feasibility, accounted for 5% of the variance, and Factor IV, integrity accounted for 4% of the variance. The fifth factor, effectiveness, was removed from the URP–I because only two of the 39 items had a significant pattern coefficient. Therefore, the URP–I became a 26-item instrument. When examining levels of reliability, acceptability and understanding had high reliability ($\alpha = .88$ and $.92$, respectively); however, understanding was renamed knowledge, as it was discovered that many of the items of this construct measured level of knowledge and skill the rater perceives he/she has in using the rating scale. Feasibility had an internal consistency estimate of $.89$, whereas integrity had a reliability of $.86$. Therefore, all four factors had high levels of reliability (Chafouleas et al., 2008).

Although the pilot study to develop the URP–I was successful in developing a tool that assessed the multiple facets of intervention usage, this research did not support previous outcomes that indicated effectiveness was a separate construct (Elliott & Von Brock Treuting, 1991). On the URP–I, items measuring effectiveness were included with the acceptability factor. Furthermore, Chafouleas et al. (2008) reported that further research was needed to determine if results would generalize across different types of interventions or uses.

In 2009, Chafouleas, Briesch, Riley-Tillman, and McCoach reexamined the factor structure of the URP–I. Undergraduate and graduate students were recruited from courses focusing on education. In total, 254 students participated in the study. First, they were asked to read a vignette that described a self-management intervention with a hypothetical student. They were then required to complete the URP–I while referencing the vignette. Results revealed four factors with high reliability: acceptability ($\alpha = .96$; 30% of variance), understanding ($\alpha = .90$), feasibility ($\alpha = .85$), and systems support ($\alpha = .84$). Although previous research on the URP–I also found four factors with high reliability (Chafouleas et al., 2008), the four factors were named differently and found to assess different constructs. Therefore, ongoing research is required to confirm the factors uncovered by Chafouleas et al. (2009).

In an attempt to improve the URP–I, Briesch et al. (2013) developed the Usage Rating Profile – Intervention Revised (URP–IR). The goal of the URP–IR was the same as that of the URP–I: assess the factors that influence the likelihood of intervention usage. The goal was to expand and strengthen the existing subscales and incorporate additional items that examined environmental levels of influence. In order to develop the URP–IR, the original 35 items from the URP–I were retained and new items were generated to strengthen the reliability of the systems support factor. Furthermore, the authors aimed to improve the wording of the items and ultimately agreed on 60 items to study.

To assess the newly developed URP–IR, 1,005 elementary school teachers were recruited through a survey procurement company. The URP–IR was administered via phone by the company in an attempt to increase response rate. Participants were

randomly read one of five vignettes that described a classroom teacher who was experiencing high levels of disruptive behavior and wanted to implement a class-wide intervention. Each vignette was a different intervention, and participants were asked to rate their level of agreement with the 60 URP-IR items (Briesch et al., 2013).

Examination of the factor analysis found acceptable levels of internal consistency for five of the six subscales ($\alpha > .70$). The systems support factor had lower reliability ($\alpha = .67$), but the authors attributed this to the small number of items that loaded onto this factor. In addition to the acceptable internal consistency, the factors were found to be weakly correlated with one another. By having factors that are weakly correlated, the validity of the scale is increased because such findings indicate each factor is distinct. Overall, Briesch et al. (2013) concluded that the acceptability and feasibility factors were improved. On the URP-IR, both factors contain fewer items; however, acceptability was deemed to be the strongest factor, with most of its items carried over from the original URP-I.

When Briesch et al. (2013) began development of the URP-IR, one of the main goals was to improve the system support factor. This concept was broadened to include practical and philosophical aspects of intervention support. As a result of this study, two factors became apparent: system climate and system support, which consisted only of newly developed items. Unexpectedly, the authors found family-school collaboration to be a distinct factor. Initially, the items that ultimately developed into the family-school collaboration factor were meant to strengthen the system support factor. Due to the strong reliability of the family-school collaboration factor ($\alpha = .79$), it was deemed to be a construct for inclusion in the URP-IR (Briesch et al., 2013).

The authors noted several limitations in their validation of the URP–IR. Wording of items, response bias, or social desirability may have influenced responses because participants were read vignettes and questions from the URP–IR. In addition, although participants could ask for the vignettes to be repeated, they did not have access to the vignettes for reference when answering the questions on the URP–IR. Therefore, the oral administration may have influenced responses. Briesch et al. (2013) reported that research was being completed to determine the utility of the URP–IR in assessing the usability of academic interventions; however, this research had yet to be completed for examination and inclusion in the present study.

Based on the literature reviewed, it is evident that behavioral consultation has much utility in the school setting. Specifically, it can decrease referrals for special education evaluations and teachers will have improved classroom management skills (Dufrene et al., 2012). Despite its benefits, there are many factors that may influence effectiveness of behavioral consultation and acceptability of interventions developed. Of particular importance to consultants should be the type of language used (jargon versus nonjargon) when describing interventions to teachers. The research in this area is conflicting and indicates certain circumstances in which jargon is more acceptable than nonjargon descriptions and vice versa (Hyatt et al., 1991; Hyatt & Tingstrom, 1993; Kazdin & Cole, 1981; Knotek, 2003; Witt, Moe, et al., 1984; Woolfolk & Woolfolk, 1979; Woolfolk et al., 1977).

The present study therefore examined teacher acceptability and usage of a positive behavioral intervention described in jargon terms and in nonjargon terms when using the Usage Rating Profile – Intervention Revised (URP–IR). There is limited

published research on the URP–IR, and the URP–IR has yet to be used in research that specifically examines teacher acceptability and usage of behavioral interventions.

Because the strongest factor of the URP–IR is acceptability, which also contains the most items, using this factor to determine acceptability of behavioral interventions would be appropriate. Therefore, this study utilized the URP–IR to determine teacher preference for interventions described in jargon and nonjargon terms.

More specifically, the study evaluated whether total acceptability and usage ratings differed when considering type of classroom (i.e., general education, special education, or specialized education). Examination of these factors will provide consultants with information on how to approach behavioral consultation with teachers, particularly what type of language (jargon versus nonjargon) to use when describing behavioral interventions, and help to clarify previous conflicting findings.

Chapter 3

Method

Participants in this study (kindergarten through sixth grade teachers) read a brief background description of a student displaying a problematic behavior in the classroom setting. Upon completion of reading the background description of the student and corresponding problematic behavior, participants were required to read one of two positive behavioral interventions to address the problematic behavior. Some participants were presented with a positive behavioral intervention described in nonjargon terms, and others were provided a description in jargon terms. Participants were then required to rate the acceptability and usage of the intervention read on the Usage Rating Profile – Intervention Revised (URP–IR).

The online survey was anonymous and designed using SurveyMonkey. SurveyMonkey's capacity to track Internet addresses was disabled, so there was no way of tracking the individuals accessing the survey. Furthermore, no identifying information was collected as part of the survey.

Participants.

This study utilized 101 employed teachers (K-6) of both genders. To be included in the study, participants were required to be an employed kindergarten through sixth grade (K-6) teacher in a school setting. This included general education and special education teachers, as well as those who taught specialized classes (e.g., art, gym, music, etc.). Participants who were employed in a school setting but were not K-6 teachers, such as individuals speech therapists, occupational therapists, physical therapists, hearing

therapists, vision therapists, orientation and mobility specialists, and administrators, were excluded.

Recruitment. Participants were recruited from school districts that had employee e-mail addresses publicly available on the district website. Approximately 5,000 K-6 teachers from across the United States were sent recruitment e-mails (Appendix A).

Sample size, power, and precision.

The goal for this study was to obtain between 100 and 150 participants. One hundred one elementary school (K-6) teachers ultimately participated. In previously conducted research on this topic, samples sizes ranged from 43 participants to 151 participants (Hyatt & Tingstrom, 1993; Hyatt, Tingstrom, & Edwards, 1991; Kazdin & Cole, 1981; Rhoades & Kratochwill, 1992; Witt, Moe, et al., 1984; Woolfolk & Woolfolk, 1979; Woolfolk, et al., 1997). Therefore, the aforementioned goal for participants in this study was deemed appropriate.

Measures and materials.

Two vignettes of a positive behavioral intervention, one described in nonjargon terms and one described in jargon terms, were used for the study. The vignettes were modified from Hall and Didier's (1987) vignettes to make them appropriate for the current investigation. In addition, a brief explanation of the student and a presenting problematic behavior was provided, which was also modified from Hall and Didier's original research. Hall and Didier gave permission for use and modification of their original vignettes as well as the brief description of the student and corresponding problematic behavior.

The Usage Rating Profile – Intervention Revised (URP–IR) was used to measure intervention acceptability and usage. The URP–IR assesses the factors that influence the likelihood of intervention usage. The final version of the URP–IR consists of 29 items rated on a 6-point Likert scale ranging from 1, *strongly disagree*, to 6, *strongly agree*, and six factors: acceptability, understanding, family- school collaboration, feasibility, system climate, and system support. The highest possible score on the URP–IR is 164, and the lowest possible score is 39, with higher scores indicating increased acceptability and potential usage (Briesch et al., 2013).

Research design

The current study was quantitative in nature. Demographic information was collected, and the URP–IR was used to obtain acceptability and usage ratings of a positive behavioral intervention described in one of two ways: jargon terms or nonjargon terms.

Dependent variable. Acceptability and usage of a positive behavioral intervention, as measured by the URP–IR was the dependent variable.

Independent variables. The independent variables were type of language used (jargon or nonjargon) and type of classroom (general education, special education, or specialized education).

Procedure

Participants whose last name started with A through M were instructed to click on the first Survey Monkey link provided in the e-mail. Participants whose the last name started with N through Z were instructed to click on the second Survey Monkey link to complete the study. After clicking the link for the study, SurveyMonkey’s privacy policy

was provided to inform participants about respondent anonymity. After completing the questions on demographics (Appendix B), participants were directed to the study content. Participants were instructed to read the vignettes (Appendix C) and answer the corresponding questions on the URP-IR (Appendix D) as they related to the vignette, which required approximately 15 to 20 minutes.

Upon completion of the URP-IR, participants were thanked for their participation in the study.

The URP-IR was scored according to Appendix E; however, participants did not have access to the scores corresponding to answers on the URP-IR.

The SurveyMonkey privacy policy was also available to all participants at any time, had questions regarding privacy arisen.

Chapter 4

Results

Table 1 provides the participants' demographics of the; Table 2 provides teaching characteristics.

Table 1

Demographic Characteristics of Participants

Variable	<i>N</i>	%
Terminology		
Jargon	43	42.6
Nonjargon	58	57.4
Age		
20 to 25	2	2.0
26 to 30	8	7.9
31 to 35	18	17.8
36 to 40	19	18.8
41 to 45	12	11.9
46 to 50	13	12.9
51 to 55	12	11.9
56 to 60	14	13.9
61 to 65	1	1.0

Variable	<i>N</i>	%
>65	2	2.0
Gender		
Male	15	14.9
Female	86	85.1
Race/Ethnicity		
White	98	97.0
Puerto Rican	1	1.0
Spanish Origin	1	1.0
Hispanic	1	1.0
State		
Pennsylvania	99	98.0
Alaska	2	2.0

Examination of the demographic characteristics of the participants indicates that most participants (36.6%) were between the ages of 31 and 40. Participants were mostly female (85.1%) and White (97%). Lastly, almost all of the participants came from Pennsylvania (98%), despite e-mails being sent to teachers throughout the country.

Table 2

Teaching Characteristics of Participants

Variable	<i>N</i>	%
Educational attainment		
Bachelor's	18	17.8
Master's	78	77.2
Educational specialist	2	2.0
Doctorate	3	3.0
Grade taught		
Kindergarten	19	18.8
First	11	10.9
Second	8	7.9
Third	12	11.9
Fourth	13	12.9
Fifth	28	27.7
Sixth	10	9.9
Type of Class Taught		
General education	72	71.3
Special education	10	9.9
Specialized education	19	18.8

Variable	<i>N</i>	%
Years Taught		
0 to 5	10	9.9
6 to 10	24	23.8
11 to 15	25	24.8
16 to 20	16	15.8
21 to 25	9	8.9
26 to 30	12	11.9
➤ 30	5	5.0
Type of District		
Rural	49	48.5
Suburban	33	32.7
Urban	19	18.8
Behavior analysis course		
Yes	41	40.6
No	60	59.4

When examining the demographic characteristics of the respondents, most (77.2%) had earned a master's degree, and taught fifth grade (27.7%) or kindergarten (18.8%). General education teachers comprised the majority of participants (71.3%). The majority of participants (48.6) had been teaching for more than 6 years. The type of

district taught in was mostly rural (48.5%), and 59.4% of participants had never taken a class in behavior analysis.

A one-way analysis of variance (ANOVA) was conducted to determine whether the type of language (jargon versus nonjargon) used by consultants affected total acceptability and usage ratings on the URP-IR. The results revealed that there was not a significant difference between the type of language used (jargon versus nonjargon) and total acceptability and usage ratings on the URP-IR, $F(1, 99) = .05, p = .823$. Therefore, the use of jargon or nonjargon terminology did not affect acceptance by elementary school (K-6) teachers of a positive behavioral intervention, as described by a consultant. The results of this analysis are presented in Table 3. The means and standard deviations by types of terminology are presented in Table 4. In addition, for the acceptability and usage ratings on the URP-IR, the variances were equal for the positive behavioral intervention described in jargon and nonjargon language, $F(1, 99) = .123, p = .727$. The mean acceptability and usage rating for each group was also almost exactly the same (jargon, $M = 136.12$; nonjargon, $M = 136.79$).

Table 3

Analysis of Variance for Jargon Versus Nonjargon Vignette

Source	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P</i>
Between groups	11.31	1	11.31	.050	.823
Within groups	22,209.94	99	224.34		
Total	22,221.25	100			

Table 4

Means and Standard Deviations for Total Score on the URP–IR by Vignette

Vignette	<i>N</i>	<i>M</i>	<i>SD</i>	<i>SE</i>	95% Confidence Interval for Mean	
					Lower	Upper
Jargon	43	136.12	14.75	2.25	131.58	140.66
Nonjargon	58	136.79	15.14	1.99	132.81	140.78
Total	101	136.51	14.91	1.48	133.56	139.45

A two-way analysis of variance (ANOVA) was utilized to determine whether the type of classroom affected total acceptability and usage ratings on the URP–IR for a positive behavioral intervention described in jargon and nonjargon language. The results of this analysis are presented in Table 5.

Table 5

Two-Way Analysis of Variance Between Subjects for Jargon Versus Nonjargon Vignette and Type of Classroom

Source	SS	df	MS	F	p
Vignette	129.14	1	129.14	.56	.46
Class	118.02	2	59.01	.26	.78
Vignette x class	205.53	2	102.76	.45	.64
Class within-group error	21,926.26	95	230.80		
Total	1,904,215.00	101			

Results indicated that there was not a significant main effect for the vignette. The jargon ($M = 136.12$) vignette was not rated as significantly different from the nonjargon ($M = 136.79$) vignette, $F(1, 95) = .560, p = .456$. Furthermore, there was no main effect for type of classroom. Specialized ($M = 138.00$) classroom teachers did not provide a significantly higher rating than general education ($M = 136.32$) or special education ($M = 135.00$) teachers, $F(2, 95) = .256, p = .775$. Lastly, there was no significant vignette by class interaction, $F(2, 95) = .445, p = .642$. Overall, these results suggest that total acceptability and usage of a positive behavioral intervention on the URP-IR did not significantly differ based on type of language used (jargon versus nonjargon) or on the type of classroom. The means and standard deviations are presented in Table 6.

Table 6

Means and Standard Deviations for Total Score on the URP-IR by Vignette and Type of Classroom

Vignette	Type of Class	<i>N</i>	<i>M</i>	<i>SD</i>
Jargon	General education	31	136.77	14.06
	Special education	2	130.50	2.12
	Specialized education	10	135.20	18.62
	Total	43	136.12	14.75
Nonjargon	General education	41	135.98	13.83
	Special education	8	136.13	22.17
	Specialized education	9	141.11	14.92
	Total	58	136.79	15.14
Total	General education	72	136.32	13.84
	Special education	10	135.00	19.71
	Specialized education	19	138.00	16.78
	Total	101	136.51	14.10

Chapter 5

Discussion

The results indicated that elementary school (K-6) teachers did not have different levels of acceptability and usage for a positive behavioral intervention described in jargon or nonjargon terms by a consultant when rated on the URP-IR, which supports the first research hypothesis. Acceptability and usage will be the same, regardless of the type of language used (jargon or nonjargon) when describing a positive behavioral intervention. This is congruent with previous research (Kazdin & Cole, 1981; Knotek, 2003; Rhoades & Kratochwill, 1992; Witt, Moe, et al., 1984; Woolfolk, et al., 1977; Woolfolk & Woolfolk, 1979).

When examining whether general education, special education, and specialized teachers differed in acceptability and usage of a positive behavioral intervention described in jargon or nonjargon terminology when rated on the URP-IR, no difference was found among the three groups. Therefore, given these findings, consultants can use jargon or nonjargon terminology when describing positive behavioral interventions without acceptability and usage being affected, regardless of type of classroom.

Significance of the findings.

The results of this research assist in clarifying previous conflicting findings on this topic (Hyatt et al., 1991; Hyatt & Tingstrom's, 1993; Kazdin & Cole, 1981; Knotek, 2003; Witt, Moe, et al., 1984; Woolfolk & Woolfolk, 1979; Woolfolk et al., 1977).

Because this is the first research of its kind to be conducted in over 20 years, the results provide relevant insight whether teachers prefer jargon or nonjargon when a consultant is describing a positive behavioral intervention.

Previous research on the topic of type of language to use in behavioral consultation when describing a positive behavioral intervention has yielded conflicting results (Hyatt et al., 1991; Hyatt & Tingstrom's, 1993; Kazdin & Cole, 1981; Knotek, 2003; Witt, Moe, et al., 1984; Woolfolk & Woolfolk, 1979; Woolfolk et al., 1977). The current research identified no significant difference between elementary school (K-6) teachers' ratings on overall acceptability and usage of a positive behavioral intervention described in jargon or nonjargon terminology. These findings impact the behavioral consultation literature by clarifying the previously conducted conflicting results.

Theoretical implications.

This study was designed with Bergen's (1977) model of behavioral consultation in mind. Although Bergen does not offer an opinion on or support for the type of language to be used during behavioral consultation, specifically when presenting behavioral interventions to teachers, the findings of the present study have significant theoretical implications.

The results contribute to the theoretical foundation of behavioral consultation by providing support for the lack of preference in type of language used (jargon versus nonjargon) when measuring overall acceptability and usage of a positive behavioral intervention described by a consultant. There is no current theory that suggests the usage of jargon versus nonjargon when consultants are describing positive behavioral interventions to teachers. Therefore, the present research can serve as the underpinning for a theory on this topic.

Practical implications.

Because the results showed no significant difference between teachers' preference for jargon versus nonjargon descriptions when measuring overall acceptability and usage, this allows consultants to apply their discretion in the type of language used. Also, because there was no significant difference in language preference and type of classroom when measuring overall acceptability and usage, consultants only need to briefly consider this when deciding on the type of language to use during behavioral consultation; however, it is advisable to assess in some manner the acceptability and potential usage of a positive behavioral intervention after presentation. This could be done with a formal measure, such as the URP-IR (Briesch, et al., 2013), or through more informal means, such as asking teachers whether they agree with the intervention and would be willing to use and implement it as presented.

The findings of the present study also have practical implications for school psychology and applied behavior analysis graduate training problems. Courses that contain content related to behavioral consultation or applied behavior analysis can present these results as a foundation for relationship/rapport building with consultees, particularly teachers. Given the results of this research and the its impact and implications, the following recommendations are made:

- School psychology and applied behavior analysis graduate programs should continue to teach the terminology for the scientific foundations and principles of the respective field.
- Because acceptability and usage ratings did not differ based on type of language used, consultants should avoid use of jargon during behavioral

consultation, particularly when describing positive behavior interventions, to ensure understanding.

- Consultants should informally or formally assess acceptability and usage of positive behavioral interventions as part of the behavioral consultation process.

Limitations.

For purposes of this study, internal validity is defined as “changes observed in the dependent variable are due to the effect of the independent variable, not to some other unintended variables” (Mertens, 2015). External validity is defined as “the extent to which findings in one study can be applied to another situation” (Gall et al., 2007).

Threats to internal validity.

Overall acceptability and usage of a positive behavioral intervention described in jargon or nonjargon terminology, as rated on the URP–IR, could have been influenced by three main factors affecting internal validity: Measurement tool utilized, analog nature of the investigation, and lack of randomization of participants.

The dependent variable of overall acceptability and usage could have been influenced by the measurement tool (URP–IR) utilized in this study. Although the URP–IR has been shown, through factor analysis, to have weakly correlated factors and acceptable levels of internal consistency on five of the six subscales (Briesch et al., 2013), the present study is the first to utilize the URP–IR to measure overall teacher acceptability and usage of a positive behavioral intervention when described in jargon versus nonjargon terminology. Thus, there is no foundational research for comparison purposes and no way of knowing whether the URP–IR was a valid and reliable tool for

measuring overall acceptability and usage of a positive behavioral intervention.

However, the results of this study confirm those of some previous research (Kazdin & Cole, 1981; Knotek, 2003; Rhoades & Kratochwill, 1992; Witt, Moe, et al., 1984; Woolfolk, et al., 1977; Woolfolk & Woolfolk, 1979).

Furthermore, the present research was analog in nature, completed as an online survey through SurveyMonkey. There is no way of knowing whether participants thoroughly read the vignettes and URP–IR questions. If participants rushed through the vignettes and questions, accuracy in responding would be comprised. Furthermore, characteristics of the teachers who chose to participate may have impacted the results of this study. The teachers who participated in the present study may be more willing to engage in behavioral consultation, which ultimately could influence their preference, or lack thereof, for a positive behavioral intervention described in jargon versus nonjargon terminology. Without interpersonal interaction with the participants in the study, there is no way of determining whether specific characteristics may have affected ratings on the URP–IR.

Lastly, the participants in this study were not randomized when assigned to the jargon or nonjargon terminology intervention description groups. Participants were assigned to either group based on the first letter of their last name. This approach to assigning participants to groups can and did result in an uneven number of participants in each group. Although the participants did not know which vignette they would be presented with upon beginning the survey, complete randomization of groups would have ensured lack of bias in group assignment.

Threats to external validity.

When considering threats to external validity, three primary concerns arose during this research: sample size, lack of participant demographic diversity, and analog nature of the investigation.

Although the sample size of the current study (101 participants) was within the range of previous research conducted on this topic (Hyatt & Tingstrom, 1993; Hyatt, Tingstrom, & Edwards, 1991; Kazdin & Cole, 1981; Rhoades & Kratochwill, 1992; Witt, Moe, et al., 1984; Woolfolk & Woolfolk, 1979; Woolfolk, et al., 1997), it is quite small when considering the number of teachers (approximately 3.1 million) in the United States (National Center for Education Statistics, 2011). Therefore, the sample may not be truly representative of the teacher population as a whole, and generalizability may be limited.

The second threat to external validity is the lack of demographic diversity of the sample used for this study. Respondents in the current study were almost all from Pennsylvania (98.0%), despite recruitment e-mails being sent to teachers in throughout the country. In addition, most of the participants in this study were White (97.0%), female (85.1%), and taught general education classes (71.3%). This limits the ability to generalize the current findings to other demographic categories.

Lastly, in addition to possibly affecting the interval validity of the study, the analog nature of this research may affect external validity. Using a survey to collect the data was the most feasible approach, but also probably the least realistic. Without the interpersonal interaction that takes place in actual behavioral consultation practice in schools, it is difficult to control for other variables that may interfere with and affect measured outcomes, such as consultant likeability.

Given the identified threats to internal and external validity, the research should be interpreted while taking into consideration these points. Future research should strive to control for these threats to internal and external validity, which would improve the reliability and generalizability of the results.

Suggestions for future research.

There are several options for expanding on the current research. It will be important for researchers to continue exploring teacher preference for positive behavioral interventions described in jargon or nonjargon terminology, as the current study is the only examination of the topic in over 20 years. Replication of this research and expansion to examine additional factors that may influence teacher preference for jargon versus nonjargon in descriptions of positive behavioral interventions should be considered.

Specifically, additional research should emphasize randomization of participants into groups. This will ensure equal group size for more reliable statistical analysis. Furthermore, the present study only included 10 special education teachers. Recruitment of a larger sample size of special education teachers may assist in determining further whether a preference differential for jargon versus nonjargon terminology exists among the type of classroom. Also, although e-mails requesting participation were sent to teachers throughout the United States, almost all responses came from Pennsylvania. Obtaining a more geographically diverse population may provide insight into whether preferences differ by the area of the United States in which the teacher is practicing. If a more diverse population is obtained, researchers could then examine the ratings on the URP–IR in more detail. For example, individual scores on each of the factors of the

URP–IR in addition to the total score could be investigated to determine whether preferences differ on each factor. Demographic information (e.g., age, gender, education, grade taught, years taught, state teaching in, type of district teaching in, whether a behavior analysis class was taken, and race/ethnicity) could be analyzed to determine whether specific preferences for jargon versus nonjargon terminology emerge. Due to the lack of diversity in this study, this analysis could not be conducted.

In an attempt to expand on the current study and previous research conducted on acceptance of positive behavioral interventions, assessment of likeability and willingness to collaborate with a consultant could be explored. More specifically, jargon and nonjargon vignettes of a positive behavioral intervention could be developed and consultants portraying certain characteristics (e.g., directive approach to consultation or a collaborative approach) could meet with teachers to deliver the vignettes. The teacher would then rate the likeability of and willingness to collaborate with the consultant, using measures that assess these factors. Teachers would also rate their preference for the positive behavioral intervention described in jargon or nonjargon terminology depending on the group to which they were assigned (directive or collaborative approach). Research that focuses on likeability and willingness to collaborate with a consultant would assist in further determining whether the type of language used affects acceptability of a positive behavioral intervention or whether other factors may also influence teacher preference for how a positive behavioral intervention is described to them.

To expand further on likeability and willingness to collaborate with a consultant, intervention implementation and intervention integrity could also be examined. It would

be interesting to explore whether intervention implementation and/or integrity is affected depending on the type of language used or likeability ratings.

Future research using in vivo experiences would have greater external validity and would generalize to a variety of settings. Research investigating acceptability of positive behavioral interventions when using jargon versus nonjargon terminology (Hyatt & Tingstrom, 1993; Hyatt, Tingstrom, & Edwards, 1991; Kazdin & Cole, 1981; Rhoades & Kratochwill, 1992; Witt, Moe, et al., 1984; Woolfolk & Woolfolk, 1979; Woolfolk, et al., 1997), including the present research, is analog in nature and thus limited in generalizability.

Lastly, researchers may wish to examine the medical literature related to this topic and explore whether medical jargon affects patient perception (e.g., likeability) of physicians or adherence to treatment. A brief review of the medical literature indicates that medical students often underestimate patients' understanding of medical terminology and that training on patient knowledge of medical jargon should be incorporated into the curriculum (LeBlanc et al., 2014). Examination of the medical literature related to jargon usage could bridge the gap between school-based behavioral consultation and the communication approach used in the medical field.

It is clear that additional and ongoing research that examines teacher preferences in behavioral consultation is needed in order for consultants to fully understand how to approach and develop the consultative relationship. The opportunities for expansion of the current research are considerable and necessary in order for consultants to fully understand the role jargon or nonjargon terminology plays in behavioral consultation practices.

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Appendix A

E-mail Distributed to Potential Participants

Subject: Research Participation Request

Dear Educator:

My name is Katie Shemanski and I am a doctoral candidate in the School Psychology Psy.D. program at Philadelphia College of Osteopathic Medicine (PCOM) in Philadelphia, PA. Because you are a K-6 teacher I am inviting you to participate in this research study, which will assist me in partially fulfilling the requirements for the degree of Doctor of Psychology (Psy.D.) at PCOM under the advisement of Dr. Jessica Kendorski, Ph.D, NCSP, BCBA-D. If you are not a K-6 teacher and you received this e-mail in error, please disregard.

This research will require you to read a short vignette regarding a problematic student and intervention then complete a survey regarding the intervention. Reading the short vignette and completing the survey will take approximately 15-20 minutes. There is no compensation for your participation nor is there any known risk.

Your participation in this research is completely voluntary and you may discontinue participation at any time. All your responses will be kept confidential. No personally identifiable information will be associated with your responses to any reports of these data. The PCOM Institutional Review Board has approved this research.

Please click the appropriate link below to access the survey. By clicking the appropriate link below, you are providing consent to participate in this research.

Should you have any questions, please feel free to contact me at
kathleensh@pcom.edu or Dr. Jessica Kendorski (dissertation chair) at
jessicagl@pcom.edu.

Thank you in advance for taking the time to assist me with this research.

Last name A-M [click \(link here\)](#).

Last name N-Z [click \(link here\)](#).

Sincerely,

Katie Shemanski

Doctoral Candidate

Philadelphia College of Osteopathic Medicine

kathleensh@pcom.edu

Appendix B

Demographic Questionnaire

Age:

- 20-25
- 26-30
- 31-35
- 36-40
- 41-45
- 46-50
- 51-55
- 56-60
- 61-65
- >65

Education (Highest degree earned):

- Bachelor's Degree
- Master's Degree
- Educational Specialist (Ed.S.) Degree
- Doctorate Degree
- Other (Please specify) _____

Gender:

- Male
- Female

Grade Taught (Check all that apply):

- K
- 1
- 2
- 3
- 4
- 5
- 6

Type of Class Taught:

- General Education
- Special Education
- Specialized (e.g., gym, art, music, etc.)

Years Taught:

- 0-5 6-10
- 11-15 16-20
- 21-25 26-30
- 30+

State Teaching In:Type of District:

- Rural
- Urban
- Suburban

Have you ever taken a course in behavior analysis?

- Yes
- No

Race:

- American Indian or Alaska Native
- Asian Indian
- Black or African American
- Chicano
- Chinese
- Cuban
- Filipino
- Guamanian or Chamorro
- Hispanic
- Japanese
- Korean
- Latino
- Mexican
- Mexican American
- Native Hawaiian
- Other Asian
- Other Pacific Islander
- Puerto Rican
- Samoan
- Spanish Origin
- White

Appendix C

Directions and Vignettes

Please read the following description of a student displaying problematic behavior in the classroom setting and corresponding intervention to address the problematic behavior.

Upon conclusion of reading the description, please complete the provided questions.

Nonjargon Vignette and Intervention

Background:

Michael is an 8-year-old 3rd grade general education student. Michael has been observed to get out of his seat at inappropriate times (i.e., teacher directed instruction, whole group seat work, independent seat work). Michael is out of his seat so frequently that he misses a significant amount of teacher instruction and disrupts his classmates' learning.

Intervention:

One way to change Michael's habit of getting out of his seat at unwanted times is to replace the unwanted behavior with a more desirable behavior. This procedure is designed to develop positive and appropriate behaviors. It works by rewarding desirable behaviors. A description of how to replace unwanted behavior with a more desirable behavior for Michael is the following:

In order to change Michael's habit of getting out of his seat at unwanted times, the plan is to teach him to sit correctly by using rewards. Michael will be rewarded for sitting correctly. If he sits correctly in his chair for the entire class period he'll be rewarded. It has been determined that reading is rewarding for Michael so he'll be allowed 5 minutes of free reading time at the end of the class period. In essence, the plan is to reward

Michael when he sits correctly. As a final result Michael will be more likely to remain seated in his chair.

Jargon Vignette and Intervention

Background:

Michael is an 8-year-old 3rd grade general education student. Michael has been observed to get out of his seat at inappropriate times (i.e., teacher directed instruction, whole group seat work, independent seat work). Michael is out of his seat so frequently that he misses a significant amount of teacher instruction and disrupts his classmates' learning.

Intervention:

One way to modify Michael's inappropriate out of seat behavior is to use reinforcement of incompatible behavior (DRI). This procedure is designed to develop compliant and cooperative behaviors. It works by reinforcing desirable behaviors that are incompatible with the undesired behavior. A description of reinforcement of incompatible behavior developed for Michael is the following:

In order to control Michael's inappropriate out of seat behavior, the plan is to operantly condition an incompatible appropriate behavior by implementing a reinforcement-based intervention. Michael will be reinforced for the occurrence of appropriate sitting behavior. If Michael has engaged in appropriate sitting behavior for the entire class period, he will be given an activity reinforcer. It has been determined that reading is a reinforcer for Michael so he'll be allowed 5 minutes of free reading time at the end of the class period. In essence, the intervention will provide Michael the opportunity to receive

reinforcement contingent upon occurrence of the desired sitting behavior. As a final result Michael's appropriate sitting behavior will be increased.

Appendix D

Usage Rating Profile – Intervention Revised (URP–IR)

Directions: Consider the described intervention when answering the following statements. Circle the number that best reflects your agreement with the statement, using the scale provided below.

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1. This intervention is an effective choice for addressing a variety of problems.	1	2	3	4	5	6
2. I would need additional resources to carry out this intervention.	1	2	3	4	5	6
3. I would be able to allocate my time to implement this intervention.	1	2	3	4	5	6
4. I understand how to use this intervention.	1	2	3	4	5	6
5. A positive home-school relationship is needed to implement this intervention.	1	2	3	4	5	6
6. I am knowledgeable about the intervention procedures.	1	2	3	4	5	6
7. The intervention is a fair way to handle the child's behavior problem.	1	2	3	4	5	6
8. The total time required to implement the intervention procedures would be manageable.	1	2	3	4	5	6
9. I would not be interested in implementing this intervention.	1	2	3	4	5	6
10. My administrator would be supportive of my use of this intervention.	1	2	3	4	5	6
11. I would have positive attitudes about implementing this intervention.	1	2	3	4	5	6

12. This intervention is a good way to handle the child's behavior problem.	1	2	3	4	5	6
13. Preparation of materials needed for this intervention would be minimal.	1	2	3	4	5	6
14. Use of this intervention would be consistent with the mission of my school.	1	2	3	4	5	6
15. Parental collaboration is required in order to use this intervention.	1	2	3	4	5	6
16. Implementation of this intervention is well matched to what is expected in my job.	1	2	3	4	5	6
17. Material resources needed for this intervention are reasonable.	1	2	3	4	5	6
18. I would implement this intervention with a good deal of enthusiasm.	1	2	3	4	5	6
19. This intervention is too complex to carry out accurately.	1	2	3	4	5	6
20. These intervention procedures are consistent with the way things are done in my system.	1	2	3	4	5	6
21. This intervention would not be disruptive to other students.	1	2	3	4	5	6
22. I would be committed to carrying out this intervention.	1	2	3	4	5	6
23. The intervention procedures easily fit in with my current practices.	1	2	3	4	5	6
24. I would need consultative support to implement this intervention.	1	2	3	4	5	6
25. I understand the procedures of this intervention.	1	2	3	4	5	6
26. My work environment is conducive to implementation of an intervention like this one.	1	2	3	4	5	6

27. The amount of time required for record keeping would be reasonable.	1	2	3	4	5	6
28. Regular home-school communication is needed to implement intervention procedures.	1	2	3	4	5	6
29. I would require additional professional development in order to implement this intervention.	1	2	3	4	5	6

Appendix E

URP-IR Scoring

Factor I: Acceptability

Items – 1, 7, 9*, 11, 12, 18, 21, 22, 23

Factor II: Understanding

Items – 4, 6, 25

Factor III: Home School Collaboration

Items – 5, 15, 28

Factor IV: Feasibility

Items – 3, 8, 13, 17, 19*, 27

Factor V: System Climate

Items – 10, 14, 16, 20, 26

Factor VI: System Support

Items – 2, 24, 29

*Reverse code these items when scoring