SOCIAL VALIDATION IN SPECIAL EDUCATION

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Abstract

Social validation refers to the evaluation of intervention procedures by those who receive, and implement these interventions whether they are fair, reasonable and appropriate. In the present paper, social validation literature is evaluated in the context of four areas: (a) problem behaviors, (b) instructional procedures, (c) social skills interventions, and (d) language interventions. A brief description of evaluation methods of treatment acceptability is also provided. Finally, suggestions for future research are offered.

Key Words: Social validation, special education, problem behaviors, language interventions.

Researchers, practitioners and family members frequently participate in the decision-making and evaluation process related to intervention programs. Traditionally, researchers and practitioners have evaluated intervention programs in terms of their outcomes (Von Brock & Elliott, 1987). They were primarily interested in assessing whether intervention programs produced strong and reliable effects on behaviour. However, these evaluations did not necessarily afford insights about the preferences of consumers. This is important because effectiveness is not the only criterion for choosing an intervention program.

Over the past two decades, increasing attention has been directed toward social validation research (Elliott, Witt, Galvin, & Peterson, 1984; Kazdin, 1980a, 1980b, 1981; Reimers, Wacker, & Cooper, 1991; Witt, Moe, Gutkin, & Andrews, 1984). "The use of evaluative feedback from consumers to guide program planning and evaluation is often referred to as assessment of social validation" (Schwartz & Baer, 1991). According to Elliott (1988), the conceptual foundation for social validation research originated from Wolf's (1978) early efforts related to treatment* acceptability. Wolf suggested that programs need to be treatment acceptability on three levels: The social significance of goals, the social appropriateness of procedures, and the social importance of outcomes. Treatment acceptability, the second level, refers to "the judgments by lay persons, clients and others of whether treatment procedures are appropriate, fair, and reasonable for the problem or client" (Kazdin, 1981, p. 493).

Researchers have identified a number of reasons for evaluating the acceptability of interventions. Several researchers noted that effectiveness might be related to an intervention's acceptability (Kazdin, 1980a; Reimers, Wacker, & Koeppl, 1987; Wolf, 1978). For example, Kazdin stated that if treatments are judged to be effective, they are more likely to be initiated. Obviously, if the treatment is not initiated, there is a small likelihood that desired behaviour change would occur (Witt & Elliott, 1985). Furthermore, treatments may be poorly implemented which might lead to outcomes that are less satisfactory than the potential of that particular treatment.

A second reason to evaluate social validation pertains to ethical issues (Kazdin, 1980a, 1981). Social validation is one means of evaluating whether the treatment procedures violate an individual's rights. One
example of such infringement includes the use of aversive techniques (e.g., shock and isolation) to suppress problem behaviours. The issue here is whether teachers, parents, and other consumers would accept particular treatments or interventions from an ethical point of view (Budd & Baer, 1976).

Finally, evaluation of social validation may help identify variables that affect consumers' perceptions of a particular treatment. Once the variables affecting preferences are identified, it might be feasible to educate consumers in order to expand their understanding of specific treatments (Reimers,

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Wacker, Derby & Cooper, 1995). Furthermore, identifying problematic variables might provide hints about which treatment components will result in compliance and maintenance of treatment implementations (Reimers et al., 1987). This information can be beneficial in terms of recommending treatments that are more likely to be initiated and maintained. In addition, this information can guide researchers and direct-care providers as they make necessary modifications to these treatments to increase their acceptability.

A number of studies have been conducted to assess social validation. However, social validation research has been mainly evaluated in the context of problem behaviors (Elliott et al., 1984; Kazdin, 1980a, 1980b, 1981; Reimers et al., 1991; Witt, Moe, et al., 1984) A few studies have been conducted to assess acceptability in other areas (i.e., Billingsley & Kelley, 1994; Odom, McConnell, & Chandler, 1993; Whinnery, Fuchs, & Fuchs, 1991) with the exception of consumer satisfaction measures associated with any particular study. The focus of this section is to review literature with respect to methods used to assess acceptability and factors that affect acceptability of interventions in the area of problem behaviors, instructional procedures, social skill interventions and language interventions. The present review is devoted mostly to literature on problem behaviors; because, the majority of studies pertinent to treatment acceptability have focused on it.

Acceptability of Interventions for Behaviour Problems

Methods Used to Assess Acceptability for Behaviour Problems

When assessment of acceptability is an issue, it is necessary to use instruments that accurately measure consumers' perceptions with respect to treatments. Kazdin (1980a) was the first to develop a measure to assess social validation (Miltenberger, 1990). His instrument, Treatment Evaluation Inventory (TEI), included 15 items that were rated using a 7-point Likert scale. The TEI was designed to assess factors such as the acceptability of treatments, the appropriateness of the procedures for children with problem behaviours, the level of cruelty or fairness of treatment, and how much the consumer liked the procedures (Kazdin, 1980a, 1980b). Another measure that has commonly been cited in the literature was developed by Witt and Martens (1983). The Intervention Rating Profile (IRP) contains 20 items with a 6-point Likert scale designed to assess the acceptability of school-based interventions for problem behaviours.

The TEI and the IRP have been used with some modifications. They have been adapted for the different purposes pertinent to the field of social validation (Miltenberger, 1990). For example, the Behaviour Intervention Rating Scale (BIRS) (Von Brock & Elliot, 1987), a modified version of the IRP, includes nine additional items to determine the relation between effectiveness and acceptability. Similarly, the Treatment Acceptability Rating Profile (TARF) (Reimers & Wacker, 1988) is a modified version of the TEI. This version allows researchers to examine other factors that may affect acceptability such as problem severity and compliance.

Social validation studies have employed two primary methods to evaluate acceptability, analogue and clinical (Miltenberger, 1990). In analogue methodology, subjects are given a written case description of a child exhibiting problem behaviour and a description of an intervention procedure that addresses that problem behaviour. After the consumers read the description of the problem and the intervention, they complete a questionnaire to evaluate the treatment procedures (e.g., TEI and IRP). Often consumers rate several treatments that apply to the same problem or they evaluate treatments that apply to a number of different problems.

In contrast, actual cases are used in clinical methodology (Miltenberger, 1990). Researchers ask consumers to employ a treatment procedure for a clinical problem (e.g., tantrum) and then evaluate this specific treatment procedure at different times during the intervention process. Miltenberger believes that because consumers are actually experiencing the treatment, clinical methodologies provide more valid information than analogue evaluations to identify those variables influencing acceptability of and compliance with treatments.

Variables Influencing Acceptability

A number of variables that influence consumers' ratings of acceptability have been identified in the literature. In particular, variables such as the severity of the problem behaviour, the type of treatment approach, the effectiveness of treatment, and time required to implement a treatment have received a great deal of attention (Clavert & Johnston, 1990; Elliott et al., 1984; Hasting, Boulton, Monzani & Tombs, 2004; Reimers et al., 1991; Witt, Moe, et al., 1984;). A discussion of these four variables that might affect acceptability follows.

Severity of the Problem: Researchers assumed that the way consumers view a problem (e.g., severe or mild) might influence their rating of treatments (Storey & Horner, 1991). Kazdin (1980a) conducted an analogue study to investigate the relationship between problem severity and acceptability of several treatments. In this study, audio taped case descriptions of a child with severe or a mild problem behaviour and interventions for these problems were presented to 88 undergraduates. After listening to the case descriptions, the participants rated each of the treatments using the TEI. In addition, the subjects evaluated these treatments on the Semantic Differential (SD), a list of bipolar adjectives that describes the qualities of a treatment. The results of this study showed that the acceptability of treatments varied and all treatments were found more acceptable when applied to more severe behaviour problems.

Since Kazdin (1980a) used undergraduate students as subjects in his studies, some have expressed concerns about the ecological validity and generality of his findings (Elliott, 1988). As Elliott pointed out, subsequent studies have not substantiated Kazdin's findings. These studies looked at the variables influencing acceptability by regular and special education teachers (Elliott et al., 1984; Martens et al., 1985; Witt, Moe, et al., 1984). For example, Witt, Moe et al. provided written case descriptions of a child with mild or severe problem behaviours, and the interventions that applied to those behaviours, to classroom teachers with varying experience. They categorized the intervention procedures as behavioural, pragmatic, or humanistic. Results from the 112 teachers who rated the interventions on the IRP (Witt & Martens, 1983) indicated that there were differential effects for the treatment approach and teacher experience, and that all interventions were rated more acceptable when the child had severe problems.

These findings make sense in light of how much a problem matters to teachers. Teachers might not be as concerned about the type of treatment if a child is experiencing severe problems. In other words, they might be willing to try different types of treatment if they believe they will be helpful for a child with extremely challenging problem behaviours.

Types of Treatment Approach: The treatment procedures used to intervene with problem behaviours are typically described as either positive (e.g., praise, token economy, and differential reinforcement) or reductive (e.g., timeout, response cost, and electric shock). Positive treatment procedures have been found more acceptable than reductive treatment procedures with undergraduate students (Kazdin, 1980a, 1980b, 1981), pre-service student teachers (Witt, Elliott, et al., 1984), and regular and special education teachers (Elliott et al., 1984).

In an investigation with teachers, Elliott et al. (1984) assessed the acceptability of positive and reductive behavioural treatments for behaviours such as day dreaming, using obscene language, and destroying property. In this analogue study, positive interventions consisted of praise, home-based reinforcement and token economy. Reductive interventions consisted of ignoring, response-cost, and seclusionary time-out. Using the IRP, the researchers found that, for these behaviours, positive treatments were rated more acceptable than reductive treatments by general and special education teachers.

Findings of later studies have strengthened the ecological validity of these results. For example, Reimers et al. (1991) replicated these findings with 20 parents who were seeking services for their children who demonstrated problem behaviours. Using the TEI, parents rated three alternative treatments (i.e., positive reinforcement, time-out, and medication) that applied to two different problem behaviours (i.e., noncompliance and aggressive behaviour). The results of ratings indicated that positive reinforcement was the most acceptable while medication was the least acceptable treatment.

In a more recent study, Cowan and Sheridan (2003) investigated acceptability ratings that were derived from field-based consultation cases. Participants' included 67 parents, 67 teachers, and 67 children with an age range 5 to 15 years old. Results indicated that all of the participants rated behaviour interventions including (i.e., home notes, self-monitoring, training/ skills enhancement, reductive

consequence) inventions as very acceptable. For parents, interventions involving reductive components were found more acceptable than those compromised of both positive and reductive components. Furthermore for parents as a group, there was not a significant relationship between intervention complexity and treatment acceptability ratings. For teachers as a group there was a significant relationship between complexity of intervention and treatment acceptability ratings. However, the pattern was the opposite of what was predicted. Instead of reflecting the pattern that as complexity increases acceptability ratings decrease, data indicated that as intervention complexity increased so did treatment acceptability ratings.

It appears that positive treatments (e.g., treatments using praise, differential reinforcement, or token economies) are more acceptable than reductive treatments (e.g. response cost, time out or loss of privileges) regardless of consumer focus (e.g., teacher and parents). From an ethical standpoint, these results are promising as reductive procedures are typically more intrusive and aversive.

Effectiveness of Treatments: Given the fact that both social validation and effectiveness are critical evaluation criteria, it is important to examine the relationship between these two factors (Elliott, 1988). Several researchers have investigated this relationship (Kazdin, 1981; Reimers & Wacker, 1988; Reimers, Wacker, Cooper, & DeRaad, 1992; Von Brock & Elliott, 1987). Kazdin (1981) recruited 112 undergraduates to investigate the relationship between effectiveness, potential side effects and acceptability. After listening to case descriptions of behaviour problems (e.g., aggressive and hyperactive behaviour) and interventions addressing these problem behaviours (e.g., reinforcement of incompatible behaviour, positive practice, timeout, and medication), undergraduates rated their acceptability on the TEI and the SD. In the case description, the participants were given information about potential side effects and effectiveness information (strong vs. weak effect) about the interventions. Although the reported side effects of a treatment negatively influenced acceptability, the reported effectiveness information (strong vs. weak) did not influence the ratings.

In contrast, effectiveness of an intervention has been reported as an important factor in teachers' rating of acceptability. In a study by Von Brock and Elliott (1987), 216 teachers rated three interventions applied to a mild or severe problem. In their analogue study, the intervention descriptions included one of three types of effectiveness information (e.g., no effectiveness information, teacher-satisfaction effectiveness information or research-based effectiveness information). Findings demonstrated that research based effectiveness had an impact on the acceptability of that treatment when the treatment applied to a mild problem. The reason for this discrepancy between college students and teachers might be due to fact that teachers are potential consumers who are involved with the decision-making process related to implementing interventions (Miltenberger, 1990).

Results of more recent studies examining the influence of effectiveness on social validation also have conflicted with Kazdin's findings. These studies used the clinical methodology (Reimers & Wacker, 1988; Reimers et al., 1992). For example, in a study by Reimers and Wacker (1988), treatment specific to their child's problem was recommended to 20 parents of children with severe problem behaviours. The parents rated the treatments before and after they had an opportunity to try the recommended treatment for a month. The results showed effectiveness was correlated with acceptability ratings.

It appears that the findings of studies examining the relationship between effectiveness and acceptability have been mixed. However, these results make sense given the fact that there is a potential problem in analogue studies in which social validation is assessed before the intervention is implemented and before outcomes are observed (e.g., Kazdin, 1981). Hence, if a social validation is affected by outcomes (e.g., effectiveness), then assessing acceptability prior to implementation might not provide accurate information (Reimers et al., 1987). Also consumers varied in studies that produced different findings (e.g., undergraduate students vs. teacher/parent).

Time Involvement: Time required to implement an intervention was another critical factor that influenced general and special education teachers' ratings of acceptability (Elliott, et al., 1984; Witt, Martens & Elliott, 1984) and pre-service and student teachers' ratings (Witt, Elliott, et al., 1984; Witt & Marten, 1983). These studies indicated that teachers prefer treatments which do not require extensive time to implement.

A study conducted by Witt, Martens, et al. (1984), illustrates how the relationship between time and acceptability can be assessed. These researchers used an analogue method in which the description of treatments included an estimate of time required to implement the treatments. One hundred and eighty

teachers rated the treatments on the IRP. The results revealed that, all other factors being equal, teachers rated treatments requiring less time as more acceptable.

The complexity of the intervention: The complexity of the intervention has also been identified as factor potentially affecting social validation ratings. In general, the interventions procedures that are more complex (i.e., more steps and more procedures) were viewed as less acceptable than they did for the less complex procedures (Eckert & Hintze, 2000; Elliot, 1988; Remiers et al., 1987*).* In a recent study by Cowan and Sheridan (2004), these findings were replicated for teacher participants while social validation ratings did not vary as a function of intervention complexity for parent participants.

Acceptability of Interventions for Instructional Procedures

To date, few researchers have investigated the acceptability of interventions in the context of instructional procedures (Billingsley & Kelley, 1994; Johnson, McDonnell, Holzworth, & Hunter, 2004; Allinder, & Oats, 1997; Whinnery et al., 1991). Researchers have used survey methods, which differ from other research (e.g., acceptability of interventions for problem behaviour) in several ways. In previous research, acceptability of a small number of interventions was examined (Kazdin, 1980a, 1980b; Witt, Elliott, et al., 1984; Witt & Marten, 1983). However, using survey methodology, many individual components of several intervention packets were evaluated. Furthermore, treatment packages included only interventions that were highly recommended or frequently disseminated. Finally, instead of using a few hypothetical case descriptions (i.e., analogue studies), participants were usually asked to rate intervention on the basis of their own classrooms.

For example, Billingsley and Kelley (1994) developed a 51-item questionnaire to obtain information on recommended and widely disseminated instructional procedures for students with severe disabilities. Fifty-one instructional methods were grouped into seven sections including setting events, delivery systems, naturalistic strategies, antecedent conditions, transfer of stimulus control, consequent events, and generalization and maintenance. Fifty-one special educators including professors, teachers, and administrators were asked to complete the two-part questionnaire. First, they were asked to indicate whether each method was sound and then they were asked to indicate whether each was appropriate to use in their classroom and other settings within their school. The findings of this survey indicated that instructional procedures were largely applicable in both classroom settings and in other general education environments. The most frequent reason for a rating of an inappropriate judgment was due to the level of effort, personnel requirement, or time.

Similarly, Whinnery et al. (1991) developed a questionnaire using a 5-point Likert scale to determine factors influencing intervention acceptability of 114 general, special and remedial education teachers. Intervention strategies in the survey were grouped under three categories: mainstreaming practices, academic instruction, and social interventions. Results of the study were consistent with the findings of previous studies for challenging behaviours. Effectiveness and time required were important factors that influenced acceptability.

Acceptability of Social Skill Interventions

To date, only one study was located examining acceptability of social-skills interventions (Odom et al., 1993). The study was designed to assess preschool teachers' judgments of the acceptability and feasibility of social-skills interventions. The method used to assess acceptability was similar to the acceptability studies for instructional procedures. The researchers developed a 36-item questionnaire that utilized a 5-point Likert scale. Each item corresponded to one intervention procedure. Interventions were grouped under three main categories: child-specific, peer-mediated, and environmental-arrangement approaches. In addition, open-ended questions were included in the questionnaire. Results of this study demonstrated that interventions in all three categories were found acceptable by preschool teachers. The peer-mediated strategies were rated as most acceptable, followed by the child-specific and environmental approaches. Barriers to the implementation of these interventions included time, resources, and access to children without disabilities.

Acceptability of Language Interventions

In the area of language, mainly consumer satisfaction measures research is available (Alpert & Kaiser, 1992; Hemmeter & Kaiser, 1994; Hester, Kaiser, Alpert, & Whiteman, 1995; Kaiser & Hester, 1994). Consumer satisfaction measures are associated only with intervention programs that have just been

completed by the respondents (Calvert & Johnston, 1990). Thus, little comparative information is obtained about consumers' preferences for different interventions or about variables influencing acceptability when several effective approaches are available. Researchers focusing on problem behaviour identified several factors related to differences among (a) alternative interventions, (b) consumers, and (c) problem behaviours that influenced acceptability of interventions (Reimers et al., 1987). These factors include type of treatments (e.g., positive and reductive treatments), intervention agents (e.g., parents, teachers, and staff), and level of problem behaviour (e.g., severe and mild problems). Similar factors also might affect the acceptability of language interventions. Each of these factors and its relationship to acceptability is considered below in the context of language programs.

First, previous acceptability research has revealed that differences among the alternative intervention programs have contributed to consumers' preferences of interventions for behaviour problems. In general, positive behavioural intervention programs (e.g., reinforcement procedures) are more acceptable than reductive behavioural intervention programs (e.g., time out, spanking, and electrical shock) (Kazdin, 1980a, 1980b, 1981; Reimers et al., 1991).

In the context of language intervention, treatment acceptability might also differ depending on what approach is used. Intervention programs for children with disabilities to promote language acquisition might be divided broadly into two different groups, therapeutic and naturalistic approaches. Early researchers and clinicians used a therapeutic approach in which an adult worked with a child for a few minutes per day in an isolated context to teach language skills. This approach often did not result in acceptable generalization from training settings to natural settings (Halle, 1982; Oliver & Halle, 1982; Rule, Losardo, Dinnebeil, Kaiser, & Rowland, 1998). As inclusive practices have become more prevalent, there has been a gradual shift from a therapeutic to a naturalistic approach. Milieu teaching, derived from the naturalistic model, is characterized by the use of typically occurring events, activities, and consequences as contexts in which to teach specific language skills (Rule et al., 1998).

It might be hypothesized that consumers would find the naturalistic approach to be more practical and functional because naturally occurring language opportunities are used for teaching. Results of satisfaction measures have revealed such findings: mothers liked milieu teaching techniques because these techniques could be used in everyday situations (Alpert & Kaiser, 1992; Hemmeter & Kaiser, 1994; Hester et al., 1995; Kaiser & Hester, 1994).

Another reason that the naturalistic approach might be preferred is that inclusive practices are encouraged in the federal law and have began to be used in educational settings. Naturalistic language interventions are consistent with the philosophy of inclusion (Rule, Lasardo, Dinnebeil, Kalser, Rowland., 1998) as students with special needs do not need to be removed from general education classrooms to receive language training.

Social validation of these approaches may also depend on consumers' familiarity with them. For instance, teachers who have received training on intervention programs would have a better understanding of how to implement them, which might result in higher acceptability. Similarly, approaches with which teachers have worked or observed in their current educational settings (i.e., inclusive vs. pull out) might influence their acceptability ratings depending on their positive or negative experience with these approaches.

Second, social validation of interventions might also depend on who provides training to students with language difficulties. When the training is provided in the child's classroom, teachers might vary in their ratings depending on whether they believe that they themselves or therapists will implement the intervention. Some teachers might want assistance from a therapist because they believe they lack the expertise or that such help might save them a lot of time. Others teachers might prefer to implement interventions by themselves, because they like to have control of their own classroom. For such teachers, the therapist's presence in the classroom may make them feel uncomfortable.

Finally, previous research in the context of interventions with problem behaviours revealed that if the behaviour problems were severe, all of the intervention approaches were more acceptable than when they were applied to mild problem behaviours (Elliott et al., 1984; Kazdin, 1980a; Martens, Witt, Elliott, & Darveaux, 1985; Witt, Moe, et al., 1984). Likewise, teachers might rate language programs differently depending on the severity of the language problem. They may prefer the therapeutic approach to the naturalistic approach when a child has severe language impairment for two reasons. First, naturalistic interventions require some level of adaptation in the classroom. When a child has severe language impairment, more time and effort might be required of the teacher to make the necessary

adaptations and accommodations. Second, teachers might believe that children with severe language difficulties require intensive instruction such as that provided by a therapeutic approach.

To date, only one study located investigating affect of these variables on teachers' acceptability (Turan, Ostrosky, Halle, & DeStefano, 2004). These authors used structured analogue situations to examine factors that might influence teachers' preferences and opinions about language interventions. These factors included respondent groups (preschool vs. elementary school teachers), type of treatment approach (naturalistic vs. therapeutic), person delivering the intervention (classroom teacher vs. speech and language pathologist [SLP]), and severity of language delay (mild vs. severe). Sixty-six teachers (28 elementary and 38 preschool teachers) participated in this survey study. Results showed that preschool teachers found naturalistic approaches slightly more acceptable than the therapeutic approach, whereas elementary school teachers viewed the therapeutic approach as somewhat more acceptable than naturalistic approaches. Teachers rated three intervention approaches differently when they were applied to children with mild versus severe language delays. This study summarizes information on factors that might influence parents' and teachers' social validation ratings.

Conclusions and Future Research

Analysis of variables influencing acceptability has afforded a number of insights into clinical issues related to social validation. First, positive treatment approaches might be the first treatment option for any given problem behavior, because these treatments consistently received the highest rates. Second, if problem behavior is severe, any given treatment will be attempted (Kazdin 1980a). In such cases, recommending positive treatments would be more reasonable as they require unaversive procedures (Reimers et al., 1987). Third, given the fact that effectiveness might influence the initiation and maintenance of a treatment, the conditions that contribute to the success of a treatment should be assured and the consumers should be educated on the use of treatments.

Existing literature has enhanced our knowledge of acceptability regarding methods, and factors that affect social validation. However, there are several areas that warrant future research. First, the majority of studies used the analogue methodology in which the relationship between acceptability and only those variables of interest has been examined. Qualitative research might contribute to an identification of those salient factors that are not addressed in analogue studies. Second, findings from the majority of research are based on self-reports of consumers. An acceptable treatment does not always guarantee that it will be actually initiated in real life situations. It would be useful to investigate the relationship between rated acceptability of a treatment and compliance (Reimers & Wacker, 1988). Third, most of the social validation research has been conducted with Caucasian clients. Very few investigations of treatment acceptability concerning the effects of ethnic and socioeconomic variables have been documented (Tarnowski, Simonian, Park & Bekeny, 1992). The United State is a diverse country made up of people from various ethnic and socioeconomic backgrounds. In order to ensure the most appropriate matches between treatment and clients, further research concerning these variables would be valuable. Finally, it is important to keep in mind that behavioral interventions represent only one of many interventions in the repertoire of special and general education. It is clear that evaluating acceptability is critical in terms of practical and ethical reasons. Future researchers should evaluate acceptability of interventions in other areas (e.g., language, social and academic skill interventions).

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