

Development of a Modified Treatment Evaluation Inventory

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Kazdin's (1980a) Treatment Evaluation Inventory (TEI) is the major instrument used to assess parents' acceptance of procedures for behavior problem children. The length of the TEI, however, as well as problems with its scaling and wording limits its value as a clinical research instrument. In the present study, three experiments were conducted to develop a modified TEI. In Experiment 1, 153 parents completed the TEI to evaluate a behavioral treatment for noncompliant and oppositional children. A factor analysis of the data was used to obtain a reliable factor structure for the TEI and to construct a 9-item TEI-Short Form (TEI-SF) with a 5-point scale, consistent anchors on the scale, and simplified text and instructions. Experiment 2 evaluated the psychometric characteristics of the TEI and the TEI-SF. These data indicated the TEI-SF is a sound alternative to the original TEI. Experiment 3 compared the readability and completion time of the two instruments.

KEY WORDS: Treatment Evaluation Inventory (TEI); oppositional children; TEI—Short Form.

INTRODUCTION

The social validity of behavioral interventions has become an important area of research and clinical concern. Although social validation may

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be accomplished in a variety of ways, assessing clients' acceptance of treatment procedures is a burgeoning area of research. This focus on treatment acceptability is particularly evident in the area of child behavior therapy. Researchers have obtained opinions from parents, teachers, institutional staff members, and children regarding their acceptance of a large variety of behavioral interventions applied to children in several different settings.

Several rationales exist for assessing clients' acceptance of behavioral interventions. First, legal and ethical concerns suggest that children be provided with treatments that are considered humane and appropriate from a societal perspective (Kazdin, 1980a). Second, if treatment consumers judge a specific intervention as unacceptable it is unlikely the treatment would be employed with integrity or at all (Witt, Martens, & Elliott, 1984). Third, in situations where several interventions are effective for treating a given problem, treatment choice should be influenced by variables other than efficacy, including client preferences. In fact, the dictates of good clinical practice would suggest that therapists assess clients' judgments of specific interventions prior to treatment implementation (Heffer & Kelley, 1987). In this way, the likelihood that clients are offered treatments they judge as acceptable, ethical, and without significant negative side effects can be enhanced (Witt *et al.*, 1984).

Treatment acceptability frequently is measured by requiring consumers or potential treatment consumers to evaluate the degree to which they believe a specific intervention is fair, reasonable, and appropriate given the problem(s) to which it is applied (Kazdin, French, & Sherick, 1981). The Treatment Evaluation Inventory (TEI; Kazdin, 1980a, 1981, 1984) has been the most widely used instrument to evaluate parents' acceptance of interventions for children, although Witt and his associates have developed two reliable rating scales, the Intervention Rating Profile and the Children's Intervention Rating Profile, for evaluating school-based interventions (Witt & Elliott, 1985; Witt & Martens, 1983). A common research paradigm in the treatment acceptability literature has involved presentation of a description of a behavior problem child and several different procedures for remediating the child's problem. Respondents then evaluate each treatment using the TEI.

Although the TEI has been shown to discriminate between alternative treatments (Cross-Calvert & McMahon, 1987; Dorsett, Matlock, & Hobbs, 1986; Kazdin, 1986; Pickering & Morgan, 1985; Singh & Katz, 1985), the utility of the instrument is limited in several ways. First, several of the 15 items appear redundant, particularly in light of the very high factor loadings obtained by Kazdin; thus, the measure is unnecessarily lengthy. As discussed elsewhere (Norton, Austen, Allen, & Hilton, 1983), a simplified, shortened measure may be more acceptable to raters. A second limiting factor is the readability of the instrument. For example, many of our low-income

subjects did not know the meaning of or could not read words such as “ambivalent,” “institutionalized,” and “humanely” (Heffer & Kelley, 1987). Furthermore, scrutiny of previous research using the TEI (Cavell, Frentz, & Kelley, 1986a,b; Frentz & Kelley, 1986; Heffer & Kelley, 1987) indicated that respondents often did not use the full range of responses available (7-point Likert scale) but, instead, used primarily the three anchored response choices (1, 4, and 7).

Although Kazdin’s (1980a) use of factor analysis to refine the TEI reflects an empirical approach to test construction, his sample sizes may be considered too small to satisfy statistical requirements. Whereas some authors have suggested sampling 10 subjects per item to establish a reliable factor structure for an instrument (e.g., Harman, 1976), Kazdin (1980a) factor analyzed data from separate samples of 60, 88, and 144 subjects. Thus, in all but the latter case, Kazdin’s samples were well below the number of subjects suggested to justify confidence in a reliable factor structure for the TEI.

The purpose of the present study was to develop a shortened and simplified version of the TEI. It was assumed that a simplified form of the TEI would enhance client cooperation and increase the acceptability of the instrument to less educated clients.

To accomplish our goal, factor analyses were conducted on the TEI in its present form using a sufficiently large sample. These data were used to determine which items to retain in a short form of the TEI. Next, the internal consistency and factor structure of the TEI and the TEI—Short Form (TEI-SF) were compared. Finally, the ability of the TEI-SF to discriminate among three treatments was investigated to test the validity of the TEI-SF.

EXPERIMENT 1

In Experiment 1 parents completed the TEI to evaluate a behavioral treatment for oppositional children. A factor analysis of the TEI guided item selection for the TEI-SF.

Method

Subjects

Mothers ($n = 153$) with children between 2 and 12 years of age were recruited from parent workshops, shopping centers, the YMCA, and waiting rooms of pediatricians. Demographic data indicated that the sample was heterogeneous with regard to recruitment setting, age, race, education, and family income. For example, 41% of the subjects were black or hispanic and

59% were white. Income levels of the subjects spanned from 20% earning less than \$20,000 to 8% earning more than \$50,000; the modal income (27%) was \$20,000–\$30,000.

Materials

Case Description. Subjects were presented with one of three case descriptions of an 8-year-old male, who displayed noncompliant and oppositional behavior toward his parents and aggression toward his younger sister. On a continuum of problem severity, each case description represented either a relatively mild, a moderate, or a severe level of problem behavior. The problems described in each case were typical of those reported by parents referred for parent training.

Treatment Method. Subjects were presented with a response cost procedure that might be used to correct the child's behavior problem. In this treatment, a privilege was withdrawn whenever the boy disobeyed or fought with his sister. Privileges included things the boy enjoyed, such as watching TV, going to a friend's house, eating a dessert or snack, or playing a game.

Dependent Measure

Treatment Evaluation Inventory (TEI). The TEI was used to assess parents' acceptance of the response cost procedure. TEI items are designed to evaluate the acceptability, appropriateness, and predicted effectiveness of a given treatment. TEI item selection was based on factor analysis replicated across separate samples (Kazdin, 1980a). All 15 items were reported to load highly on one principal factor before and after varimax rotation (range, .61 to .95). The median interitem correlation for this factor was .67.

Procedure

Mothers who agreed to participate completed a packet of materials that included a consent form, a demographic questionnaire, a case description, and a treatment description followed by the TEI. Subjects were asked to complete the materials in the order presented. An experimenter was available to answer questions regarding instructions or vocabulary of the TEI.

Results

The 15 TEI items were subjected to a principal-components analysis as the initial method of factor extraction. Using an eigenvalue one criterion, two factors were extracted and rotated orthogonally to a varimax criterion.

Table I. Varimax-Rotated Factor Matrix of TEI Responses from Experiment 1

TEI item	Factor 1	Factor 2	Communality estimate
1. Acceptability	<u>.83</u>	.23	.74
2. Willing to use	<u>.82</u>	.17	.70
3. Suitable	.48	.47	.45
4. Consent	.28	<u>.58</u>	.41
5. Cruel/unfair	.44	.62	.57
6. No choice	.30	<u>.59</u>	.43
7. Common sense	.69	.34	.59
8. Humane	.71	.26	.56
9. Risks	.55	.53	.59
10. Like	<u>.82</u>	.29	.76
11. Effective	<u>.85</u>	.17	.75
12. Improvement	<u>.78</u>	.23	.66
13. Side effects	.57	.57	.66
14. Discomfort	.12	<u>.72</u>	.53
15. Reaction	<u>.81</u>	.23	.70
Eigenvalue	6.30	2.85	
Percentage variance explained	42	19	
Cumulative percentage variance	42	61	

The rotated factor matrix presented in Table I shows two distinct factors contrary to Kazdin's (1980) initial report. Factor 1 (Acceptability) accounted for 42% of the variance and Factor 2 (Ethical Issues/Discomfort) accounted for 19% of the variance.

To guide item selection for an abbreviated, simplified TEI, the content of six items with the highest factor loadings on Factor 1 (Acceptability) and three items with the highest factor loadings on Factor 2 (Ethical Issues/Discomfort) were incorporated into a nine-item TEI-Short Form (TEI-SF). TEI items with dual loadings of .30 or greater on both factors were eliminated. The criteria used to select TEI-SF items were correlations above .78 for the Acceptability factor and .58 for the Ethical Issues/Discomfort factor. As shown in Table I, factor loadings for retained items were considerably higher than those for deleted items. The TEI-SF was constructed with a 5-point scale, consistent anchors on the scale, and a simplified text. The TEI-SF is displayed in Fig. 1.

EXPERIMENT 2

In Experiment 2, the factor structure, internal consistency, and ability to differentiate alternative treatments were evaluated for the TEI and the TEI-SF.

TREATMENT EVALUATION INVENTORY SHORT FORM (TEI-SF)

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

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

Fig. 1. The Treatment Evaluation Inventory-Short Form. Items are scored using a 5-point scale, with 1 equaling strongly disagree and 5 equaling strongly agree on items 1 to 5 and 7 to 9. Item 6 is reverse scored. TEI-SF scores can range from 9 to 45, with higher scores representing greater acceptance of a given treatment. Based on Kazdin and co-workers' (1981) formula for the TEI, a "moderate" acceptability rating on the TEI-SF would result from a midpoint score of 3 on each item. A total TEI-SF score of moderate acceptability for the nine items would be 27.

Method

Subjects

The subjects were 264 undergraduate students enrolled in an introductory psychology course at a large state university in south-central Louisiana.

Materials

Case Description. Subjects were presented with the case description used in Experiment 1 that represented a moderate level of problem severity.

Treatment Methods. Subjects were randomly provided with one of three methods for remediating the child's behavior problems. The three methods evaluated were response cost (see Experiment 1), time-out, and positive reinforcement. Time-out involved placing the boy in a boring room for 10 min when he misbehaved. Positive reinforcement involved the mother praising and rewarding her son when he behaved appropriately.

Dependent Measures

TEI and TEI–Short Form. Each subject evaluated a single treatment using the TEI and the TEI-SF.

Procedure

Subjects were given a packet containing a consent form, demographic questionnaire, case description, and one treatment description, followed by both the TEI and the TEI-SF. The order of the two acceptability instruments was randomized across subjects. Subjects were instructed to complete the instruments based on their opinions about the treatment suggested to correct the boy's problems.

Results

The TEI and TEI-SF were subjected to principal-components analyses using an eigenvalue one criterion and rotated orthogonally to a varimax criterion. The rotated factor matrices for the TEI and TEI-SF are shown in Tables II and III, respectively.

As shown in Table II, TEI items load on two factors, with Factor 1 (Acceptability) accounting for 42% of the variance and Factor 2 (Ethical Issues/Discomfort) accounting for 15% of the variance. The factor matrix showed clear simple structure except for item 3 (consent) which dual-loaded across the two factors.

Coefficients of congruence (vector comparisons) were calculated for each factor across the two factor matrices for the TEI (Experiment 1 and Experiment 2) to estimate the generalizability of the factor structures. For Factor 1 (Acceptability) the coefficient of congruence was .95, and for Factor 2 the congruence coefficient was .87. It should be noted that coefficients

Table II. Varimax-Rotated Factor Matrix of TEI Responses from Experiment 2

TEI item	Factor 1	Factor 2	Communality estimate
1. Acceptable	<u>.87</u>	.08	.76
2. Willing to use	<u>.87</u>	.11	.76
3. Suitable	<u>.45</u>	.24	.26
4. Consent	.16	<u>.60</u>	.39
5. Cruel/unfair	.08	<u>.68</u>	.47
6. No choice	.14	<u>.52</u>	.29
7. Common sense	<u>.65</u>	.21	.47
8. Humane	.27	<u>.69</u>	.56
9. Risks	.24	<u>.66</u>	.50
10. Like	<u>.87</u>	.23	.81
11. Effective	<u>.88</u>	.07	.77
12. Improvement	<u>.80</u>	.12	.66
13. Side effects	.34	.64	.52
14. Discomfort	-.21	<u>.57</u>	.37
15. Reaction	<u>.88</u>	.22	.82
Eigenvalue	6.30	2.25	
Percentage variance explained	42	15	
Cumulative percentage variance	42	57	

of congruence using orthogonal components (vectors) as in the present study represent correlation coefficients between extracted factor scores (Gorsuch, 1983). These vector correlations suggest that the factor patterns are similar across parent and student raters.

As shown in Table III, TEI-SF items loaded on two factors, with Factor 1 (Acceptability) accounting for 57% of the variance and Factor 2 (Discomfort) accounting for 12% of the variance. The Acceptability factor extracted from the TEI-SF accounted for slightly more variance than did the TEI Acceptability factor, although this is likely due to the reduced number of items on the TEI-SF. Only one item ("I believe the child will experience discomfort during treatment") loaded exclusively on the TEI-SF Discomfort factor.

Coefficient alpha estimates of internal consistency for the TEI and TEI-SF indicated that both measures were internally consistent. Coefficient alpha was .89 for the TEI and .85 for the TEI-SF. Thus, shortening and simplifying the TEI did not result in a substantial reduction in scale reliability.

Two separate fixed-effects one-way ANOVAs were completed to assess the degree to which each measure (TEI and TEI-SF) discriminated among the three treatments. A significant treatment effect as measured by the TEI [$F(2, 261) = 16.36$, $p < .001$] and the TEI-SF [$F(2, 261) = 20.80$, $p < .001$] was observed. Scheffe's multiple-comparison procedure showed that response

Table III. Varimax-Rotated Factor Matrix of TEI-SF Responses from Experiment 2

TEI-SF item	Factor 1	Factor 2	Communality estimate
1. Acceptable	<u>.93</u>	-.05	.86
2. Willing to use	<u>.91</u>	-.09	.83
3. Consent	<u>.49</u>	.47	.46
4. Like	<u>.93</u>	-.02	.87
5. Effective	<u>.85</u>	-.23	.77
6. Discomfort	<u>.23</u>	<u>.82</u>	.73
7. Improvement	<u>.62</u>	-.31	.48
8. No choice	<u>.57</u>	.23	.38
9. Reaction	<u>.93</u>	-.03	.86
Eigenvalue	5.13	1.08	
Percentage variance explained	57	12	
Cumulative percentage variance	57	69	

cost (TEI $M = 69.30$, TEI-SF $M = 29.80$) and positive reinforcement (TEI $M = 69.40$ and TEI-SF $M = 29.30$) were rated as more acceptable than time-out (TEI $M = 57.90$, TEI-SF $M = 24.10$) at the .01 level of significance.

EXPERIMENT 3

Experiment 3 was designed to assess whether the TEI-SF is in fact less time-consuming to complete and easier to read than the TEI.

Subjects

The subjects were 25 mothers of children between 2 and 12 years of age. Demographic characteristics were similar to those of the Experiment 1 subjects; the subjects were heterogeneous with regard to race, education, and income.

Procedures

Completion Time

The procedures and materials used to assess completion time of the two measures were identical to those employed in Experiment 2 with the exception that subjects indicated when they began and finished completing each

instrument. Subjects evaluated a single treatment using both the TEI and the TEI-SF presented in a random order across subjects. The amount of time for completion of each instrument was recorded by a research assistant unfamiliar with the purpose of the study.

Reading Difficulty

Reading level of the TEI and the TEI-SF items was assessed using the Harris-Jacobson Wide Range Readability Formula (Harris & Sipay, 1975). As noted by Prout and Chizik (1988) the formula is the most current formula of its type. To assess the reading difficulty of the TEI and the TEI-SF, each item was considered a passage (Prout & Chizik, 1988).

On the average, subjects completed the TEI in 3 min, 30 sec and the TEI-SF in 2 min, 10 sec. One subject, whose data were excluded from the study, failed to comprehend the TEI items and, therefore, did not complete the instrument. She did, however, complete the TEI-SF. When asked which of the two instruments they preferred, 71% of the subjects reported liking the TEI-SF best.

Using the Harris-Jacobson Formula, the overall reading level was 5.1 for the TEI and 4.2 for the TEI-SF. Thus, the TEI-SF was approximately 1 year lower in reading difficulty than the TEI.

DISCUSSION

The purpose of this set of experiments was to develop a modified TEI to increase its utility for research and clinical applications. The findings indicated that the TEI-SF is an internally consistent and valid instrument for assessing the acceptability of behavioral treatments for children. The TEI-SF is more readable, quicker to complete, and better liked by a sample of mothers than the TEI. Analyses of the TEI-SF demonstrated that it differentiated among alternative treatments, thus supporting its construct validity.

In spite of Kazdin's (1980a,b, 1981) claim that the TEI is a single-factor instrument, the results indicated that TEI items load on *two* factors that account for a substantial percentage of variance. Specifically, the results from Experiments 1 and 2 suggest that the TEI is composed of a primary factor, which measures general acceptance, and a secondary, seemingly more specific factor, which assesses perceived side effects. Pinpointing why our research findings differed from those obtained by Kazdin is difficult because his factor analysis data on the TEI have not been published. The conflicting results may be due to idiosyncratic differences in the samples such as sample size or demographic characteristics. For example, TEI item factor loadings

differed slightly in our research, depending on the respondents (parents vs. undergraduates).

The finding that acceptability may be a multifactor concept has been obtained elsewhere in the literature. For example, factor analytic studies on the 20-item IRP, a scale developed to assess teachers' perceptions of the acceptability of classroom interventions (Witt & Elliott, 1985), indicated that the items loaded into one primary factor and four secondary factors. According to the authors, the primary factor assessed general acceptability and the secondary factors represented specific teacher concerns such as amount of risk to the student and amount of time required to implement the intervention. The authors later refined the IRP (Witt & Martens, 1983) to reduce the number of factors to one.

Based on factor analysis of TEI data from a sufficiently large sample of parents, we developed a shortened and simplified instrument, the TEI-SF. TEI-SF items loaded on two factors, as did the TEI in our study. Our development of a two-factor scale mirrored with the factor structure of the TEI was based on the assumption that treatment acceptability may or may not be a unitary construct. Our research suggested that treatment acceptability involves judgments about treatment appropriateness, as well as ethical considerations. Researchers who view acceptability as a unitary construct might have preferred our developing the TEI-SF based solely on the primary factor of the TEI. However, the decision to construct the TEI-SF in a parallel manner to the TEI was viewed as an empirical rather than intuitive approach to test construction of a replacement instrument. Future research is needed to assess whether treatment acceptability is most appropriately considered a single or multifactor construct.

The TEI-SF required more than 1 min less to complete than the TEI and the respondents generally preferred the short instrument. Some readers may question whether this time savings is clinically significant. Although definitive statements regarding the relative advantages of the TEI-SF over the original TEI cannot be made, we believe that the time savings is likely to increase client cooperation and instrument utility in clinical settings. Respondents usually are asked to complete the instrument several times, evaluating a different intervention each time. Thus, actual use of the instrument would produce time savings much greater than a minute. In our research the instrument might save up to 7 min, which is a sizable amount for most individuals completing the instrument while awaiting appointments with small children. We also believe that the time savings differential probably would increase as clients complete the measure several times in a single setting because the TEI-SF, as opposed to the TEI, uses the same response anchors for all items. However, the relative advantages of TEI-SF over the TEI were not firmly established by a preliminary study of this sort.

In sum, the TEI-SF appears to be a psychometrically sound, yet abbreviated, alternative to the TEI. Additional research is needed to establish further the psychometric properties of the TEI-SF and to assess its usefulness with poorly educated and/or clinical samples. For example, future studies are needed that examine the factor structure of the TEI and TEI-SF and relative utility of the two instruments in clinical settings. Although the TEI-SF shows promise, whether the instrument will prove to be significantly more useful, convenient, and socially valid than the original TEI must be addressed in future studies.

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