Social Validation of Goals, Procedures, and Effects in Public Health

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By relying solely on tests of statistical significance as the measure of success for interventions in public health, and in community-based participatory research, we can miss important social dimensions of the project. These dimensions include how our interventions might affect the lives of participants (social validity) and the lives of people more broadly (clinical or public health significance). Social validation procedures were originally developed to assess the acceptability of procedures and effects of behavioral interventions among clients and consumers. This article describes the methods used to obtain social validity data for goals, procedures, and effects of interventions in health settings. The challenges in using these procedures are also discussed, and suggestions are offered for future research and practice in this area.

Keywords: *health promotion; social validity; evaluation; CBPR*

INTRODUCTION

Increasingly, public health practitioners and researchers are urged to involve the community in all phases of their work. By engaging community members in significant ways to assess, plan, implement, and evaluate intervention programs we learned that it results in higher quality and better outcomes Likewise, by involving community members in all phases of research studies, we expect that the specific goals, and the methods used to attain those goals, will be appropriate and the results will be valued by the community. Although relatively new in public health, community and behavioral psychologists have a rich literature on, and history of, this concept which is called *social validation* (Baer, Wolf, & Risley, 1987; Wolf, 1978). In essence, social validation is a process whereby consumers in the community are engaged to provide information about the social acceptability of goals, procedures, and outcomes (or effects) (Kazdin, 1977). In reality, social validity is most often operationalized as consumer satisfaction to validate procedures and less often to validate the significance of the goals themselves or the importance of achieved outcomes (Fawcett, 1991). Presumably, interventions that are socially valid and have positive behavioral outcomes are more likely to be disseminated and adopted (Winnett, Moore, & Anderson, 1991). Thus, social validity is related to dissemination of innovations (Rogers, 1983) and appropriate community techniques (Fawcett, Seekins, Whang, Muiu, & Suarez de Balcazar, 1984).

The development of citizen and community participatory approaches in the 1970s and 1980s complement

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the work of social validation. *Community participation* is broadly defined as the process of involving people in the institutions or decisions that affect their lives (Checkoway, 1989), and *citizen participation* is the mobilization of citizens for undertaking activities to improve the conditions in the community (Florin & Wandersman, 1990). In these approaches, evaluators and researchers were most often interested in who participated and why, how community organizations (such as neighborhood associations) were transformed by such participation, and finally, whether quality of life was improved for those participants. The problems that arose with encouraging inclusion and participation are that such practices are often used inconsistently and are authoritarian in origin, which limits the voice and involvement of participants (Tritter & McAllum, 2006).

Empowerment is a related process that refers to a community's capacity to identify problems and solutions or to achieve equity (Cottrell, 1983; Rappaport, 1984). The accepted, broad public health definition of empowerment is the "process by which individuals, communities and organizations gain mastery over their lives in the context of changing their social and political environments to improve equity and the quality of life" (Minkler & Wallerstein, 2005, p. 34). Empowerment can be used at the individual, organizational, or community level; it involves both the process of change and its outcomes (e.g., increasing community participation, achieving goals, and attracting resources) (Zimmerman, 2000; Zimmerman & Rappaport, 1988). Empowerment challenges power through community organizing and advocacy and expands power by strengthening community networks

and organizations (Minkler & Wallerstein, 2005).

A key question that faces community practitioners is "whether attempts to enhance a sense of empowerment create an *illusion* of power without affecting the actual *distribution* of power" (Riger, 1993, p. 282). For example, people who participate in community organizations often feel more empowered than nonparticipants, but participation may not result in more influence or control (Chavis & Wandersman, 1990; Zimmerman, Israel, Schultz, & Checkoway, 1992). Perhaps, interventions and organizations aiming to empower do not consider the larger sociopolitical forces that community members find difficult to change (Riger, 1993).

By the 1990s, the public health field began to embrace the concept of empowerment and participatory approaches and to form community coalitions and community academic partnerships for research and practice, especially in the areas of HIV and alcohol, tobacco, and other drug abuse prevention (Israel, Checkoway, Schultz, & Zimmerman, 1994; LaBonte, 1994; Zimmerman & Rappaport, 1988). Community-based participatory research (CBPR) soon emerged as a partnership approach that "*equitably* involves community members, organizational representatives and researchers in all phases of the research process" (Israel et al., 2003, p. 54). The community partners help researchers understand the social and cultural dynamics of the community in relation to a given community issue, and the researchers provide community members with methods and tools to analyze these issues of concern and make informed decisions on actions to improve the health and well-being of community

members (Hatch, Moss, Saran, Presley-Cantrell, & Mallory, 1993). Although CBPR researchers expect that collaborating with community members will result in relationships that surmount power differentials, CBPR, like other participatory approaches, never results in a perfect sharing of power. The agendas of researchers and community members may sometimes be shared and at other times conflicting, especially if resources and knowledge are not shared or if career advancement is pursued at the expense of the community (Wallerstein & Duran, 2003, p. 33). Most research efforts undergo cycles of questioning by community members that result in more or less buy-in and participation; if ignored, community members may express concerns in private (or in another language) and feign a willingness to participate (Wallerstein & Duran, 2003, p. 39). CBPR must be a committed, long-term process that includes partnership maintenance; community assessment and problem definition; development of research methods, data collection, analysis, and interpretation; determination of action and policy implications; dissemination of results; taking action; specification of lessons learned; and establishment of mechanisms for sustainability (Israel et al., 2003, p. 57).

Public health is beginning to appreciate multidisciplinary approaches that utilize a wide array of theories, methods, and tools. In doing so, practitioners can benefit from a rich tradition of participatory and inclusive approaches. Relying on any one approach may be problematic, except for answering the questions for which that approach may be best suited. With a very strong reliance on epidemiology, public health could miss other approaches to evaluation and research that might help enrich our understanding

of the data. For example, we might better understand how other approaches to framing the world (Smith & Pell, 2003), changing behavior (Baer & Schwartz, 1991), and choosing goals (among competing alternatives in communities and in public health) would better contribute to valued outcomes (Spoth & Greenberg, 2005).

Furthermore, by relying solely on tests of statistical significance as measures of success for interventions in public health and in CBPR, we can miss the important social dimensions of the project. These dimensions include how our interventions might impact the lives of participants (social validity) and the lives of people more broadly (clinical or public health significance). Social validation procedures were originally developed to assess the acceptability of procedures and effects of behavioral interventions among clients and consumers. This article describes methods used to obtain social validity data for goals, procedures, and effects of interventions in health settings. We also discuss the challenges in using these procedures and suggest future research and practice in this area.

What Is Social Validity?

Social validation is a process of quantifying the value of the research findings that grew out of clinical psychology (Kazdin, 1977), behavioral psychology (Wolf, 1978), and community development (Fawcett, 1991). Four kinds of validity are usually discussed in the peer-reviewed literature. They include statistical conclusion validity, internal validity, construct validity, and external validity (Cook, Campbell, & Peracchio, 1990). These four generally relate to statistical significance and our ability

to characterize findings and (hopefully) make good decisions about whether those findings might be replicable in our situation. Clinical and social significance are particularly important but very different from statistical significance. Clinical significance refers to whether recipients of the intervention actually improve enough to be satisfied with the improvement (Kazdin, 1977). Social significance lies where data and community context meet. Do others, those people who know the people receiving interventions, value the improvements in their lives? This question is at the heart of consumer feedback and acceptability.

A variety of approaches and definitions of social validity have developed over the past 30 years. Some controversy exists about who first codified the concept, but most agree that Montrose Wolf did a presentation about it during the Association for Behavior Analysis Conference in 1976. Following that presentation, Alan Kazdin (1977) published an article describing clinical and social validity for treatment programs involving behavior change. Montrose Wolf followed up with an article that detailed procedures for assessing the social significance of outcomes relating to treatment in group homes of adjudicated youth (1978). Wolf described ratings of consumer value, its importance and utility of treatment interventions as something we should be measuring and reporting. He further described the significance of goals, the social appropriateness of procedures, and the social importance of effects as three elements of social validity. Others have described similar concepts such as treatment acceptability (Elliott, 1988), adoption of procedures as a measure of social validity (Stoltz, 1981), and

continued treatment involvement as a measure of the worth of the program (Kennedy, 2002).

With all this history of researchers and program developers using these procedures and concepts to improve their initiatives through consumer involvement, there might be something that is useful for a broader public health audience. Like these other disciplines, public health is concerned with systems change in community and with the behavior change of individuals leading to valued broader public health outcomes (e.g., creating contexts in which people can be healthy). The following sections describe some procedures relevant for the social validation of public health initiatives, some equally relevant evaluation questions, the relevance of this effort for improving core human values, and conclude with some ideas for future work in this area.

Social Validation of Goals, Procedures, Effects

Social Validation of Goals

The social validation of goals involves little more than working with community representatives to identify relevant goals, and then involving the larger membership of the community in prioritizing or validating those goals. In the broader history of behavioral interventions, this meant the involvement of clients in the development of those behavioral and clinical interventions. For public health interventions, it will similarly involve the broader consumers, although the consumers of primary and secondary prevention efforts will more likely be the community as a whole.

Relevant evaluation questions might include

- Are we targeting a concern that is shared by the likely participants?
- Does the community in which we work value our goals as important to them?

Although we are not limited to these two questions, they do get at the heart of social validation of goals.

Procedures for socially validating goals can be quite varied, with focus groups and town hall meetings being the most qualitative and fluid ways of assessing goals. If one were being more systematic, however, one could first identify community members as judges (or experts) to help select and assess significance of goals. Second, we could identify the qualitative or evaluative dimensions on which assessments of significance of goals will be judged (often rated as the importance of those goals). This could be done with Likert scales (e.g., 1 to 5 rating scales of importance). Finally, if the ratings or other indicators of importance are not sufficiently high, then we could change the goals, rating scale or instructions, and/or educate community members about the importance of the goals.

Social Validation of Procedures

The social validation of procedures involves rating the implementation of our programs or interventions. Obtaining feedback on the implementation of community interventions can be as straightforward as getting feedback on goals.

The relevant evaluation questions might include the following?

- Do participants feel like they are making progress?
- Are no, or few, negative side effects reported by participants?

- Do participants report that they like involvement with the program?
- Do participants recommend it to others?
- Do those people around the participants (e.g., family and friends) report that participants are making progress and satisfied with their involvement?
- Do participants feel that they are included in the development and implementation process? Do they feel that they have a voice in program improvement?

Although not an exhaustive list of evaluation questions, this list can serve as a guide for how one might integrate this activity into an evaluation plan.

Procedures for socially validating the means might be something that we want to do more systematically than obtaining feedback on goals. However, if we continually pay attention to the broad theme (i.e., always being on the lookout for additional feedback that might improve implementation), then we might find many ways to improve our programs. If we were systematic in our evaluation efforts, we could start by identifying community members to serve as judges or experts. We could then identify the qualitative or evaluative dimensions on which assessments of acceptability of intervention procedures will be rated, often using Likert scale rating procedures as above. Then, we would identify other information that would suggest the value or appropriateness procedures for our priority audience of participants and potential participants. Finally, if ratings/indicators of appropriateness of procedures are not sufficiently high, we could change the procedures (by incorporating their feedback and suggestions),

change the rating scale or instructions (if we think that we were not clear earlier), and/or educate constituents about the acceptability of the intervention with other populations in an effort to help them see the bigger picture—if that is relevant.

The social validity of the means of accomplishing your goals depends on a variety of factors. These include, but are not limited to, the significance of the goals, the appropriateness of the intervention, and the observed effects and their perceived importance by key community members and participants.

Social Validation of Effects

The social validation of effects includes similar procedures as above but really focuses on the outcomes or impacts of our programs and interventions.

The evaluation questions that might be relevant here include:

- Are the outcomes felt by the broader community?
- Does the broader community value these outcomes as something that should be extended to others?
- Do health experts (e.g., health department representatives, researchers, government officials) value the outcomes and believe that they were indeed caused (or facilitated) by the interventions we developed?

Like before, these questions are not meant to be an exhaustive list but are meant as a guide for developing your own evaluative questions and criteria.

Procedures for socially validating the effects of our project might include some things that are similar

to what were stated above. First, we would identify community members as consumer judges (i.e., "experts") to help us assess the importance of effects observed through our evaluation. Second, we would identify qualitative or evaluative dimensions on which assessments of importance of effects will be judged. This would involve summarizing the data from our evaluation to make the results comprehensible and usable by community members. Graphs often communicate better than raw statistics and tables, especially if accompanied by text that helps the raters understand what they are viewing. This might take some trial and error through focus groups and presentations, but it is important to get it right. Finally, if the ratings or other indicators of importance of the effects are not high enough, then we might want to change the procedures involved in our interventions so that we get better outcomes that are valued by the community (and health expert) raters, change the rating scales or instructions, and/or educate the raters further about the importance of the effects.

Evidence for the social validity of effects includes a wide variety of responses from the raters. High ratings by community members and health experts, as measured through surveys (e.g., overall satisfaction, willingness to recommend to others), are definitely important. Recommending involvement in the intervention to others as something worthy is valuable evidence. Others might feel that they have social validation of effects when community members pay for the intervention by donating their time, materials, or leveraging financial resources within the community. Another piece of evidence might include the widespread adoption by consumers, or

continued use of the intervention by participants.

Value of the Procedures of Social Validity for Public Health

Incorporation of these procedures into public health practice is important for several reasons, including:

- The value of consumer involvement in developing community health interventions may be recognized, which is already established in the CBPR tradition;
- The broader social significance of our efforts may be realized, which will help to give them more legitimacy in the public policy sectors;
- Greater or enhanced procedural considerations and the involvement of broader audiences in development and implementation of important programs may occur;
- Procedures for obtaining social validation from participants and outside health experts may be improved (e.g., Are you satisfied that these community change data, taken as a whole, resulted in the outcomes as measured by health improvement rates? Will these outcome data likely result in significant health benefits for this population?)
- Finally, social validation of procedures could lead to improvements in how we summarize data from health experts so that those summaries are more easily consumable by priority audiences.

Conclusions and Implications for Future Work

A variety of unresolved issues exist in social validation, including questions that represent a variety of

issues with which we struggle as a society. For example, who are appropriate "experts" to judge the significance of the goals, procedures, and effects? This is no small question, but they might at least include the community members and participants. How can the experiential knowledge of grassroots leaders be valued along with that of health experts in making judgments about value? How can our understanding of the research process and outcomes be enhanced by the integration of data from quantitative and qualitative methods? How can data on the social acceptability of the implementation of procedures be used to increase the likelihood of accomplishing work that actually results in the increased appropriateness of new procedures? Will more socially valid procedures and goals result in more socially acceptable (and enhanced) effects? We leave it to you to help us answer these questions, and raise new ones implied by this important set of procedures.

In closing, we expect that being more systematic about the social validation of goals, means, and effects might lead to the following impacts: (a) create new roles for community members and client populations to develop and implement effective public health programs, (b) positively affect issues of health disparities and the elimination of adverse health outcomes resulting from generations of exclusion, (c) develop a better understanding and appreciation of grassroots wisdom as an important starting point in program development, and (d) build new capacities and competencies among our priority audiences and the general population. All these would be welcome improvements resulting from any effort to be more inclusive.

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