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Development of an instrument for diagnosing significant limitations in adaptive behavior in early childhood

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ABSTRACT

Although adaptive behavior became a diagnostic criterion in the 5th edition of the American Association on Intellectual and Developmental Disabilities, AAIDD (Heber, 1959, 1961), there are no measures with adequate psychometric properties for diagnosing significant limitations in adaptive behavior according to the current conception of the construct. This fact has led to an excessive reliance on intellectual functioning measures. The goal of the present paper consists of presenting the development of the AAIDD's forthcoming Diagnostic Adaptive Behavior Scale (DABS) in Spain, and, specifically, it will be focused on one of its three forms: DABS Form 4–8 years old. The sample consisted of 388 people, aged 4–8 years old, with and without intellectual disabilities. The functioning of an initial pool of 168 items was analyzed under the assumptions of Item Response Theory models (IRT) with the aim to select those items around the cut-off point for determining significant limitations in adaptive behavior. A set of 72 items was selected (96 items were removed due to misfit, unsatisfying response category functioning, or low precision of measurement). The final version seems to be essentially unidimensional, shows good fit to the model, and represents an accurate precision of measurement around the cutoff point for diagnosing significant limitations in conceptual, social or practical skills.

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1. Introduction

The diagnosis and classification of intellectual disability (ID) are main topics of interest to all those who try to understand this phenomenon and want to get a little closer to the complex intervention in this field. In educational and clinical settings, the diagnostic assessment of people with ID has always been a problematic issue for teachers and psychologists (Smith, 2005). In most cases, this fact leads to an excessive reliance on standardized intelligence measures (Greenspan, 1997, 2012) in order to make eligibility decisions. In fact, the measurement of intellectual functioning has sometimes played an exclusive role in the assessment of ID, reinforcing the mistaken belief of 'incurability' (Schalock, 1999). Consequently, the familiar categories of profound, severe, moderate, and mild intellectual disabilities have become 'watertight compartments' (Navas, Verdugo, & Gómez, 2008) or a way to understand and react to the reality of having this condition (Florian & McLaughlin, 2008).

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Intellectual functioning assessment does not by itself capture the nature of disability. Significant limitations in adaptive behavior, since their inclusion in the American Association on Mental Deficiency (AMMD) definition of intellectual disability (Heber, 1959, 1961) constitutes, along with significant limitations in intellectual functioning, and an age of onset before 18, a necessary (although not sufficient) criterion for a diagnosis of ID. These criteria are also included in major international classification systems (Lecavalier, Tassé, & Lévesque, 2002).

The inclusion of adaptive behavior as one of the main diagnostic criteria emphasized that intellectual disability involves deficits in intellectual functioning but also limitations in our ability to respond to environmental requirements. However, the operational definition of adaptive behavior has been debated for decades and has given rise to controversy regarding its assessment.

In order to provide an answer for this lack of agreement, some authors like Greenspan (Greenspan & Driscoll, 1997; Greenspan, Switzky, & Granfield, 1996; Greenspan, 1997, 2006, 2012) or Schalock (1999) started to define a theoretical framework of personal competence; consequently, establishing a strong parallel between intelligence and adaptive behavior domains, and specifying three types of skills that could define both constructs: conceptual, social and practical skills.

Although this model still presents too many questions that have to be resolved (Tassé et al., *in press-a*), it encouraged the development of factor analysis studies on the structure of adaptive behavior (Harrison & Oakland, 2003; Mathias & Nettelbeck, 1992; McGrew & Bruininks, 1990; Widaman & McGrew, 1996). As a result of this multidimensional approach to the conceptualization of adaptive behavior, it is defined in 2002 American Association on Mental Retardation (AAMR, formerly AAMD) Manual (Luckasson et al., 2002) as the “collection of conceptual, social and practical skills that have been learned and are performed by people in their everyday lives” (Luckasson et al., 2002, p. 17). Likewise, significant limitations in adaptive behavior are defined as “a performance that is approximately two standard deviations below the mean of either (a) one of the following three types of adaptive skills: conceptual, social or practical or (b) an overall score on a standardized measure of adaptive behavior” (Luckasson et al., 2002, p. 17). This definition has been reaffirmed in the current definition of ID proposed by the American Association on Intellectual and Developmental Disabilities (AAIDD, formerly, AAMR) (Schalock et al., 2010, p. 15; Verdugo & Schalock, 2010).

The agreement reached in defining the construct was also reflected in the establishment of a number of key issues that should be taken into account in its assessment (Harrison & Boney, 2002; Harrison & Raineri, 2008; Luckasson et al., 2002; Schalock et al., 2010; Schalock, 1999; Tassé et al., *in press-a*; Tassé, 2009; Wehmeyer et al., 2008): (a) adaptive behavior assessment should emphasize daily performance instead of maximum performance or thinking processes; (b) the assessment of adaptive behavior should take into account the opportunities that people with ID have to participate in community life according to their age; (c) as important as having opportunities is the cultural environment or context in which behavior takes place; therefore, the assessment should consider culturally relevant expectations, factors, and aspects related to the situational specificity in behavior assessment.

Specifically related to diagnosis function, the current manuals of ID (Luckasson et al., 2002; Schalock et al., 2010), as well as the forthcoming revision of the DSM (American Psychiatric Association, 2011), address the use of standardized measures with current norms that should be developed on a representative sample of the general population, thereby establishing the presence/absence of significant limitations in adaptive behavior (i.e., approximately two standard deviations below the mean). However, and despite the growing importance of norm-referenced adaptive behavior measures in the assessment of intellectual disability (Harrison & Boney, 2002; Harrison & Raineri, 2008; Luckasson et al., 2002; Schalock et al., 2010), there are no standardized measures in accordance with its current definition or that are exclusively focused on diagnosis. Up to this point, approximately 200 adaptive behavior scales exist (Schalock, 1999), but there are only four adaptive behavior scales that have strong evidences of reliability and validity, and that have been standardized on the general population (Schalock et al., 2010; Tassé et al., *in press-a*): (a) the Vineland Adaptive Behavior Scales (VABS) – second edition (Sparrow, Cicchetti, & Balla, 2005); (b) the Adaptive Behavior Assessment System-II (ABAS-II) (Harrison & Oakland, 2003); (c) the Scales of Independent Behavior-Revised (SIB-R) (Bruininks, Woodcock, Weatherman, & Hill, 1996); and (d) the Adaptive Behavior Scale-School Version (ABS-S: 2) (Lambert, Nihira, & Leland, 1993).

Concerned about this situation, the AAIDD began in 2006 a project focused on developing an assessment tool whose aim was to provide accurate diagnostic information around the cut-off point within an individual is deemed to have significant limitations in adaptive behavior. The forthcoming Diagnostic Adaptive Behavior Scale (DABS) (Tassé et al., *in press-b*) is focused on identifying significant limitations in adaptive behavior for a diagnosis of ID, assessing those domains of adaptive behavior (i.e., practical, conceptual, and social skills) that have resulted from factor analysis work, and including relevant items related to the concepts of gullibility, vulnerability, and social cognition, which are critical to identify mild intellectual disabilities (Greenspan, Loughlin, & Black, 2001; Greenspan, 2006, 2012). Item Response Theory (IRT) has been used in its development to reliably measure individual levels of performance across the continuum of adaptive skills. Also, due to adaptive behavior increases in complexity with age and then plateaus (Luckasson et al., 2002; Schalock et al., 2010), items are being calibrated, according to IRT models, for the following age groups: DABS Form 4–8 years old; DABS Form 9–15 years old; and DABS Form 16–21 years old.

The DABS aims to become a measure exclusively focused on diagnosis that could help clinicians to assess a full range of adaptive behavior skills. An instrument with such characteristics would be very helpful in Spain, where there are no measures focused on diagnosis. In fact, the Inventory for Client and Agency Planning, ICAP (Bruininks, Hill, Weatherman, & Woodcock, 1986) is the only measure that clinicians currently have in order to assess adaptive behavior, and their aim is not diagnosis, but rather services planning and program evaluation.

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