Best Practices in the Assessment of Adaptive Behavior

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OVERVIEW

Adaptive behavior assessment has been emphasized for many years in the definition, diagnosis, and classification of mental retardation. Chapters in previous editions of Best Practices in School Psychology have called for the application of the construct of adaptive behavior to assessment and intervention for all students with disabilities (Harrison & Robinson, 1995; Reschly, 1985, 1990). Every person must use daily adaptive skills to function effectively and independently. A person who has deficits in their adaptive skills can experience problems in meeting the varied demands of many environments and situations. Children who have major deficits in adaptive skills may have difficulties with important life activities, including interacting with peers, taking care of personal needs, learning new skills, and general functioning in the home, school, and community. Comprehensive assessment of children’s adaptive skills by school psychologists is important for identifying children’s strengths and needs and for focusing on important goals for intervention programs. The purpose of this chapter is to provide current information about adaptive behavior assessment, including perspectives, assessment methods, and research findings with practical implications for practice in school psychology. The chapter presents adaptive behavior assessment as an important component in data-based decision making for children with disabilities and other learning and behavior problems.

The following sections provide the foundation for using adaptive behavior assessment in decision-making; definition and characteristics of adaptive behavior, historical perspectives, current perspectives of diagnosis and classification systems, and adaptive behavior assessment linked to interventions of functional skills.

Definition and Characteristics

Adaptive behavior refers to everyday coping with environmental demands and includes the skills in daily living that people perform to care of themselves and relate to others (Grossman, 1983). The American Association on Mental Retardation (AAMR, 1992) emphasized that adaptive behavior includes an array of important competencies and identified 10 specific areas of adaptive skills: communication, self-care, social, community-use, self-direction, health and safety, functional academics, home living, leisure, and work. The AAMR focused on “adaptive skills,” rather than the more global “adaptive behavior.” According to the AAMR manual on definition and classification, adaptive skill limitations often coexist with strengths in other adaptive skills or other areas of personal competence, and the existence of these limitations and strengths in adaptive skills must be both documented within the context of community environments typical of the individual’s age peers and tied to the person’s individualized needs for support (AAMR, 1992, p. 39).

Adaptive skills have several general characteristics, as summarized by AAMR (1992) and Harrison...
Adaptive skills demonstrate situational specifics, or the ability of a person to match skills to the current environment and to change behavior to fit the specific demands of any situation. Thus, children's adaptive skills are influenced by the demands of specific situations and environments, including home, school, community, and workplace, and by the expectations of important people within the environments. Another concept is the developmental relevance of adaptive skills. Adaptive skills develop across the age range and are associated with both the growth in children's abilities and with the expanded and more complex demands of important environments. Adaptive skills of infancy, early childhood, elementary school years, adolescence, and adulthood are quite different and reflect the development and expectations of individuals in the different age ranges.

The AAMR emphasized that cultural, linguistic, communication, and behavioral factors are important components of a person's adaptive skills. An important assumption about adaptive skills is that with appropriate supports and interventions for a person's adaptive skill deficits, life functioning will generally improve. The general characteristics of adaptive skills listed above illustrate that data-based decision making for adaptive skills must take into account (a) the requirements in a person's specific environments; (b) the developmental expectations for the person's age group; (c) the person's culture and linguistic characteristics, communication skills, and problem behaviors; and (d) the supports and interventions that are needed to improve the person's functioning.

The concept of adaptive behavior has been incorporated into broader models of general competence or personal competence. The Greenspan model of competence has been the most widely utilized. According to one of the latest descriptions of the Greenspan model (Greenspan & Driscoll, 1997), general competence consists of the following:

1. Physical competence, including organ and motor competence
2. Affective competence, including temperament and character
3. Everyday competence, including social and practical intelligence
4. Academic competence, including conceptual intelligence and language

Adaptive skills are important components with everyday competence. The construct of conceptual intelligence, or the skills measured by traditional intelligence tests, is distinguished from everyday competence.

Historical Perspectives

Historically, adaptive behavior assessment has been applied widely in the field of mental retardation. Deficits in adaptive behavior, in addition to subaverage intellectual functioning, were included in the first definition of mental retardation by the American Association on Mental Deficiency in 1959 (Heber, 1961), now called the AAMR, and have been included in ever official definition since. Special education legislation, beginning with the Education for All Handicapped Children Act in 1975 and continuing with the current Individuals with Disabilities Education Act (IDEA) and its 1997 re-authorization, also defined mental retardation in terms of limitations in intelligence and adaptive behavior.

Concerns about bias in intelligence testing and the use of intelligence test scores to classify children in special education programs have resulted in a number of court cases with implications for adaptive behavior assessment. The use of intelligence tests to classify minority children as having mental retardation and the disproportionate numbers of minority children in special education programs for mental retardation led to a number of lawsuits in the 1960s, 1970s, and 1980s. Although the outcomes of cases such as Larry P. v. Riles and Marshall v. Georgia differed in their opinions about bias in intelligence tests, all cases placed great emphasis on the importance of assessing adaptive behavior in the classification and diagnosis of mental retardation.

The 1960s and 1970s also saw increased emphasis on the use of adaptive behavior assessment for planning and implementing interventions for individuals with mental retardation. Large numbers of individuals in residential facilities for mental retardation were, as a result of many lawsuits, transitioned to less restrictive, community programs. Adaptive behavior assessment became important to identify strengths and limitations in adaptive skills and to plan needed
Interventions for persons leaving a residential facility and entering a community program.

Current Perspectives

**Diagnosis and Classification**

Criteria for diagnosing and classifying mental retardation emphasize adaptive behavior. Three definitions of mental retardation currently are used for children and adults: the AAMR (1992) definition, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (American Psychiatric Association, 1994) definition, and the definition in the regulations of the Individuals with Disabilities Education Act (IDEA) Amendments of 1997 (1999). Table 1 reports the three definitions.

The 1992 AAMR manual on mental retardation included some changes from previous editions and has been met with some controversies. According to Gresham, MacMillan, and Siperstein (1993, 1995), the current AAMR manual increases the IQ cutoff score to 75, in comparison to a score of 70 used in the previous edition. One concern regarding this change is the possibility of the increase in the number of individuals eligible for the diagnosis of mental retardation. The change in IQ score could also lead to the potential for renewed overrepresentation in programs for children with mental retardation, especially for minority children (Gresham et al., 1993, 1995; Matson, 1995). A second change in the current AAMR definition from previous versions is the identification of 10 adaptive skill areas and an emphasis on limitations in at least 2 of the 10 adaptive skill areas for a diagnosis of mental retardation. However, the AAMR does not specify a criterion or cut-off score for an adaptive skills limitation (Matson, 1995). The current AAMR definition also eliminated the classification of levels of mental retardation (mild, moderate, severe, and profound) and, instead, identifies four possible intensities of needed supports for individuals with mental retardation: intermittent, limited, extensive, and pervasive. Vig and J edrysek (1996) expressed concern that the elimination of levels of impairment may restrict family understanding of a child's disability and predictions about a child's rate of progress and response to intervention.

In response to the criticisms about the current definition of mental retardation, Luckassen, Schalock, Snell, and Spitalnik (1996) and Reiss (1994) noted that the current, 1992, definition of mental retardation by the AAMR emphasizes a new "support" model of mental retardation, instead of a deficiency model. In addition, they argue that the new definition provides a more flexible role for professional decision making by providing an upper limit range of 70–75 for IQ scores to be used in the diagnosis of mental retardation and not by setting specific scores for adaptive skills limitations. Most important, the cur-

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<th>Table 1. Definitions of mental retardation</th>
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<td>American Association on Mental Retardation (1992)</td>
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| American Psychiatric Association (1984)   | "The essential feature of Mental Retardation is significantly subaverage general intellectual function (Criterion A) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety (Criterion B). The onset must occur before age 18 years (Criterion C)."
| Individuals with Disabilities Education Act Amendments of 1997 (1999) | "Mental retardation means significantly subaverage general intellectual functioning, existing concurrently with deficits in adaptive behavior and manifested during the developmental period, that adversely affects a child's educational performance." (p. 12422). |

Adaptive Behavior
rent AAMR definition focuses on the interaction of a
person's characteristics and his or her environments.
As seen in Table 1, the DSM-IV (American Psychi-
atric Association, 1994) definition is similar to the
AAMR (1992) definition. The main criteria for men-
tal retardation in DSM-IV are subaverage general
intelligence accompanied by limitations in adaptive
functioning in two adaptive skills areas. However,
unlike the AAMR criteria, subaverage intelligence is
operationalized as an IQ score of approximately 70
or below in the DSM-IV. The DSM-IV also maintains
the degrees of severity of mental retardation (mild,
moderate, severe, and profound), in contrast to the
AAMR use of intensities of support (intermittent,
limited, extensive, and pervasive).
In addition to the definitions provided by the
AAMR and DSM-IV, mental retardation is a qualify-
ing disability for special education under the IDEA
Amendments of 1997. Similar to other definitions,
IDEA defines mental retardation as subaverage intel-
ligence existing concurrently with deficits in adaptive
behavior, as noted in Table 1. IDEA describes mental
retardation as manifested during the developmental
period and negatively affecting a child's educational
performance. Unlike the AAMR and DSM-IV, the
IDEA definition has a broad focus upon adaptive
behavior rather than a list of specific adaptive skill
areas and does not require deficits in at least 2 of 10
adaptive skill areas.
IDEA Amendments of 1997 also emphasize the
importance of adaptive behavior assessment in the
definition of developmental delay and identification
of needs for services for children experiencing devel-
opmental delays. For children aged 3–5, states and
local school districts may identify developmental
delays in one or more of the following areas: physi-
cal development, cognitive development, communi-
cation development, social or emotional develop-
ment, or adaptive development.

**Assessment Linked to Interventions for Functional Skills**

Assessment of adaptive skills should be an integral
part of school psychologists' data collection about
children's skills and behaviors in multiple environ-
ments. Data from adaptive behavior assessment
should be used, along with data from other sources
and about other behavior domains, to design, imple-
ment, and monitor interventions. The current chaps-
ter is based on the ideal that goals of assessment and
intervention for children with learning and behavior
problems or disabilities should include increases in
the daily adaptive skills needed to function more
effectively and independently. Although adaptive
behavior assessment is a required component of the
assessment of children with disabilities such as men-
tal retardation and developmental delays, school psy-
chologists should not use adaptive behavior
assessment to merely document a diagnosis. Com-
prehensive adaptive behavior assessment has impli-
cations for important interventions for all children
experiencing problems. School psychologists should
use adaptive behavior assessment data to plan inter-
ventions that actually improve children's indepen-
dence and expand children's skills.

The AAMR (1992) manual, as well as other
resources, focused upon adaptive skills as functional
daily living skills that represent important goals of
training and interventions. Functional daily living
skills are skills that are frequently used during an indi-
vidual's daily routine and that occur naturally in
home, school, work, and community environments
(Schleien, Green, & Hayne, 1993). Acquisition of func-
tional skills allows an individual to become independent
in important environments and settings. Assessment of
functional skills should include (a) identification of
the individual's strengths, (b) evaluation of the skills
needed in the environments in which the person cur-
rently participates, and (c) analysis of the skills
needed to function in the next, least-restrictive envi-
rnment to assist in transition. For example, func-
tional skills needed in a preschool setting may be
different from skills needed in an elementary school.
Assessment requires evaluation of the child's current
skills, the skills needed in the preschool setting, and
the skills needed in the elementary setting. For an
older adolescent student, the demands of the high
school setting may be quite different than the
demands of the work setting that the student will
enter following high school. Assessment requires
analysis of the students' skills, the high school setting,
and the work environment.

The AAMR (1992) addressed the need for assess-
ment of an individual's level of functional skills and
identification of supports and services that can be
used for an intervention related to functional, daily-
living skills. The AAMR recommends that the pur-
pose of assessment should be determined before
assessment (e.g., to measure progress of an intervention). Once the function is determined, then a broad assessment should be planned and conducted and assessment information should be analyzed. The assessment can be conducted through a number of methods, including the use of structured interviews, norm-referenced adaptive behavior scales, and direct observation. The assessment information should be translated into a description of needed supports to provide interventions for the student's limitations and weaknesses. While these supports and interventions are being delivered, the student's progress should be monitored for progress or any needed modifications in the intervention.

Interventions to increase functional, daily living skills require prioritizing of goals for interventions. The first step in assessment for identifying intervention priorities is to determine whether the child adequately has the skill and chooses not to use it or whether the skill is not in the child's repertoire of behaviors. The next step is to determine if a discrepancy exists between the actual skills of the child and the expected performance in the child's current or next environments, and to then evaluate whether this discrepancy is socially significant in terms of quality of life for the child (AAMR, 1992). The highest priority for interventions are these skills that have the most social significance for the child.

Depending on the needs and developmental levels of children, different functional skills may be targeted for intervention. For example, interventions for children with milder disabilities in the elementary school tend to focus more on readiness skills such as following directions, developing self-help skills, and interacting with peers. Young children may benefit from interventions that expose them to association with other children in the regular classroom and are more performance-oriented. For children with more severe disabilities, goals for functional skills typically revolve around preparing them to live life as independently as possible. Intervention goals for older children may focus more on functional academics and functional pre-vocational skills. For students leaving secondary programs, transition goals may include adaptive skills needed in job training programs and the workplace. Dunn (1997) concluded that post-school outcomes can be improved for young adults with appropriate assessment and planning for transition.

Several types of interventions have been shown to be effective for increasing functional skills, including the following: modeling, in which the student duplicates a task performed by another person; behavior rehearsal, in which the student practices a learned task over and over; and coaching procedures, which use direct verbal instruction with discussion of the desired behavior (Elliot, Sheridan, & Gresham, 1989). Interventions for older students may include community-based instruction. McDonnell, Hardman, Highpower, Keller-O'Donnell, and Drew (1993) found that community-based instruction is an effective technique for generalization of classroom-learned skills to natural settings. Other interventions that may be effective with older students include problem-solving training and self-motivational methods, such as self-instruction, self-management, and self-monitoring (Hughes, 1992; Mita, 1992). The AAMR emphasized that, "Rather than simply scheduled for instruction in discrete blocks of time, basic motor, language, and social skills are taught as they occur or are needed, naturally embedded within routine activities (AAMR, 1992, p. 131).

BASIC CONSIDERATIONS

Assessment Methods

A number of different methods can be used to assess adaptive behavior, including traditional, norm-referenced rating scales, and alternative methods.

NORM-REFERENCED INSTRUMENTS

There are a number of standardized, norm-referenced adaptive behavior scales. Table 2 contains brief descriptions of several instruments that are used in school settings. The norm-referenced assessment instruments listed in Table 2 are rating scales used primarily with parents and teachers as informants about children's adaptive skills. Norm-referenced rating scales have a number of advantages in the assessment of daily, adaptive skills. They focus on adaptive skills that occur in naturalistic settings, such as home, school, and community, and they provide comprehensive assessments of a large number of adaptive skills. They obtain information from multiple perspectives and multiple sources of information and include important individuals, such as parents and teachers, in the assessment process. They provide a developmental reference for children's adapt
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<td>Adaptive Behavior Scale, Scales of Independent Behavior, Revised</td>
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Table 2. Examples of norm-referenced adaptive behavior scales for use with children in school settings.
Adaptive Behavior

tive skills by comparing the adaptive behavior ratings for the targeted child and a norm group of children of the same age.

LIMITATIONS OF NORM-REFERENCED SCALES AND ALTERNATIVE ASSESSMENT METHODS

In spite of the advantages of rating scales in assessing adaptive behavior, rating scales have a number of limitations that should be taken into account in adaptive behavior assessment, and rating scales should be supplemented with other data collection procedures (Gresham & Elliott, 1990). For example, ratings of informants may simply provide an assessment of the informant’s perceptions of a relative summary of the individual’s general adaptive behavior, instead of an exact frequency of behaviors. Rating scales may be limited to skills that can be assessed through a rating scale or questionnaire completed by an informant and may not assess all possible adaptive skills. Respondents’ ratings on the scales may reflect their own expectations and standards for adaptive skills, and the expectations may differ between respondents and between settings. Respondents also may be influenced by characteristics of the client, including appearance, ability, academic performance, and background.

School psychologists should integrate multiple methods of assessment and collect data from multiple sources of information, given the limitations of norm-referenced rating scales. Alternative methods that may be useful in a comprehensive assessment of adaptive behavior include informal interviews, structured observations, social skills assessment, and sociometric techniques. Parents, teachers, supervisors, and others, as well as children themselves, should serve as sources of information in data collection about adaptive behavior.

Structured, naturalistic observations focus on direct and systematic observation of an individual in a setting, such as the classroom, home, playground, and place of work (see Hintze, Volpe, and Shapiro, this volume). Social skills assessment provides identification of important acquisition and performance deficits that may be affecting children’s social interactions (see Gresham, this volume). Sociometric techniques, such as peer rating and peer nominations, can be useful in determining the impact of adaptive behavior deficits on the perceptions of peers. Another assessment technique, direct testing of a client’s adaptive skills, may provide objective data about what a child is able to do in a structured testing environment and can supplement rating scales and their focus on an informant’s perception of what a child does.

Research suggests that correlations between parent- and teacher-ratings of individuals’ adaptive skills are low to moderate. Research findings suggest that correlations between parent and teacher ratings are higher when disabilities are more severe, but even for children with severe disabilities, parent and teacher scores on adaptive behavior scales may differ significantly (Hundt, Morrison, Mahoney, Mundy, & Vernos, 1997; Voelker, Shore, Hakim-Larson, & Brurer, 1997). The research suggests that both parent and teachers should be used in adaptive behavior assessment and that evaluation of the reasons for differences between parent and teacher ratings would have great value in decision making and planning interventions. Informal interviews with significant others, including parents and teachers, may provide information about factors that may be related to children’s adaptive behavior and may impact parent and teacher ratings on adaptive behavior scales. For example, different parenting and teaching styles and expectations or children’s behavioral inconsistencies across settings may affect adaptive behavior ratings.

School psychologists should focus on integrating data from multiple methods of assessment and data collection and multiple sources of information in order to obtain the most valid data possible for decision making and planning interventions. For example, a combination of norm-referenced rating scales and informal interviews with parents and teachers may reveal that a child has strengths in self-care skills and weaknesses in communication and self-direction at both home and school. However, parents may report that a child has adequate social skills at home and in the community, and teachers may report that the child has social skills problems in the classroom. Additional interviews with the parents, teachers, and child and systematic observation in the classroom may suggest that the child has fewer social interactions than a typical peer in the classroom and that the limited and infrequent social interactions of the child are characterized by hostile behavior (e.g., raised voice, name calling, shoving) between the child and peers. Thus, the example briefly illustrates the comprehensive nature of the adaptive behavior data provided by multiple assessment methods and sources of
information and the implications of the integrated data for prioritizing interventions.

Practical Implications of Research

Much research has been conducted with adaptive behavior assessment. The research findings about the relationship between adaptive behavior and intelligence and the adaptive behavior strengths and limitations of children with disabilities have important implications for school psychologists.

Adaptive Behavior and Intelligence

Given the requirements to assess both adaptive behavior and intelligence for the diagnosis of mental retardation, many studies have investigated the relationship between scores on adaptive behavior and intelligence measures. The majority of the findings demonstrate moderate correlations between the scores from adaptive behavior and intelligence scales, although there is some evidence (e.g., Brunnink, Woodcock, Westerman, & Hill, 1996; Vig & Jeslysek, 1995) to suggest that the correlations are higher for individuals with more severe disabilities and may vary for different domains of adaptive behavior. The generally modest correlations support the conclusion that adaptive behavior and intelligence are distinct but related constructs. For example, Keith, Fehrmann, Harrison, and Portheim (1987) investigated several possible models for the relationship between adaptive behavior and intelligence. Results supported the model that adaptive behavior and intelligence are separate but related constructs.

The AAMR (1992) noted that, although intelligence and adaptive behavior should be applied equally when making decisions about diagnoses of mental retardation, intelligence test scores have been over-emphasized in professional decision making. The AAMR stressed that there should be a balanced consideration of adaptive skills and intelligence measures. The moderate correlations between adaptive behavior and intelligence scales suggest that scores from the two types of scales will provide distinct types of information. Greenspan and Driscoll’s (1997) distinction between everyday competence and academic competence supports the importance of considering everyday skills, as assessed by adaptive behavior scales, and academic competence, as measured by conceptual IQ tests.

Adaptive Skills of Children with Disabilities: Children with mental retardation, autism, and other disabilities often are assessed with adaptive behavior assessment measures for diagnosis of the disabilities, evaluation of strengths and weaknesses, and determination of needs for intervention. A number of research studies have investigated the adaptive skills of children in different disability categories.

Mental Retardation. As noted throughout this chapter, deficits in adaptive skills are necessary for diagnosis and classification of mental retardation. Research indicates that individuals with disabilities do have important adaptive skills deficits. Research reported in the manuals for the Vineland Adaptive Behavior Scales (Sparrow, Balla, & Cicchetti, 1984) and scales of Independent Behavior-Revised (Bruininks et al., 1996) indicate that individuals with mental retardation have adaptive behavior scores lower than those of individuals with no disabilities. The research also suggests that individuals with moderate to severe mental retardation living in residential facilities have lower adaptive skills than those with mild to moderate mental retardation living in non-residential facilities. Dykens, Hodapp, and Evans (1994) examined the profile of adaptive behavior for children with Down syndrome and found that the children had a weakness in communication relative to daily living and socialization skills. There was also a significant difference between the expressive and receptive skills in the communication domain. Children with Fragile X syndrome demonstrated weaknesses in adaptive behavior in communication and socialization (Freed, Peebles, Aylward, & Reiss, 1993; Bailey, Harton, & Kimer, 1998). Bailey et al. (1998) also found that assessment of children with Fragile X syndrome demonstrated strength in the area of motor skills in relation to their weaknesses in communication and cognition.

Autism. Children with autism may have a number of developmental difficulties, including deficits in communication and social interactions, and may exhibit repetitive or stereotyped activities and resistance to change. Research has demonstrated that children with autism typically have weaknesses in the area of socialization when compared with children with mental retardation or typical development (Carpen-tier & Morgan, 1996; Loveland & Kelly, 1991).
Rodrigue, Morgan, & Gefken, 1991; Stone, Ousley, Hepburn, Hogan, & Brown, 1999; Vig & Jedysek, 1995). Individuals with autism also demonstrate a weakness in the adaptive domain of communication (Stone et al., 1999; Vig & Jedysek, 1995). In addition to specific strengths and weaknesses, Rodrigue et al. (1991) also found that children with autism typically demonstrated overall greater variability in social skills. The research findings support the suggestions of Shriver, Allen, and Matthews (1999) that one area of assessment and interventions for children with autism should include social competence, play, and leisure skills, and self-help/independent living skills.

Other Disabilities. Because many disabilities and disorders can affect adaptive functioning, adaptive skills assessment may be important in identifying strengths and weaknesses of daily functioning for disabilities in addition to mental retardation and autism. For these other disabilities and disorders, it is important to assess adaptive functioning in order to assist with planning appropriate interventions.

Sparrow et al. (1984a) reported that children with emotional disturbances in residential facilities had adaptive behavior scores well below the normative average on the Vineland, and Bruininks et al. (1996) reported that children with behavior disorders demonstrated more maladaptive behaviors on the Scales of Independent Behavior-Revised than did a normal control group. Sparrow and Cicchetti (1987) examined the research related to adaptive and maladaptive functioning of children with emotional disturbances and concluded (1) the severity of adaptive behavior deficits tend to increase with the severity of the disturbance, (2) children with emotional disturbances typically demonstrate the most significant adaptive skill deficits in the areas of socialization and maladaptive behavior, and (3) score patterns in areas such as communication and daily living skills tend to be unpredictable.

Voelker et al. (1997) reported adaptive skills deficits for children with multiple disabilities in cognitive, sensory, and motor areas, and Voelker et al. (1984a) found adaptive behavior scores well below the normative mean for children with hearing and visual impairments in residential facilities. Given the heterogeneous nature of children with low incidence disabilities, such as sensory or physical disabilities, it is more important to focus on the benefits of adaptive behavior assessment rather than typical adaptive behavior profiles. Many children with sensory or physical disabilities may experience few deficits in adaptive skills. Adaptive behavior assessment for children with physical disabilities, in combination with assessments from other areas such as speech and physical therapy, may offer the most useful information for school psychologists. Although adaptive skills assessment of individuals with hearing and visual impairments may not be necessary for diagnosis or classification of the disability, assessment of their daily adaptive skills may assist in identifying needed goals and supports.

BEST PRACTICES
What follows are eight highlights:

1. School psychologists should consider the routine incorporation of adaptive behavior assessment into a comprehensive data-based decision making framework of providing services for children. Adaptive behavior assessment should be viewed as an integral factor in assessment and interventions for daily, functional skills. School psychologists should emphasize that the primary goals of adaptive behavior assessment are to identify needs and develop plans for interventions that enable children to improve their independence and expand important life skills.

2. A number of published, norm-reference adaptive behavior rating scales are available for use by school psychologists and are useful components of comprehensive adaptive behavior assessment. School psychologists should carefully select the scale(s) to be used based on the individual child’s need for assessment and the specific information provided by the scales.

3. Adaptive behavior ratings scale have useful characteristics, but have a number of limitations that should be addressed during decision making. School psychologists should take into account limitations such as the rating scale’s reflection of a relative summary of the individual’s general adaptive behavior, instead of an exact frequency of behaviors, when respondents rate items. School psy-
4. School psychologists should use multiple methods of adaptive behavior assessment, given the limitations of norm-referenced rating scales. Methods such as informal interviews, structured observations, social skills assessment, and sociometric techniques, are valuable during adaptive behavior assessment in order to obtain more detailed information about strengths and weaknesses in a variety of settings and to plan and monitor interventions.

5. Information from both parents and teachers should be used in adaptive behavior assessment of a child. Research suggests that parents and teachers may disagree in their adaptive behavior ratings, perhaps because of differing perceptions or expectations of the two informants or actual inconsistencies in the child’s behavior across two different settings. Discrepancies between parents and teacher can be of great clinical value in assessment and planning interventions, and discrepancies can be followed by informal interviews with parents and teachers to explore the reasons for the discrepancies.

6. School psychologists should collaborate and integrate adaptive behavior data collected by using multiple assessment methods and sources of information and should never rely only on norm-referenced rating scales. Valid decision making and development of effective interventions require the use of comprehensive, integrated data, instead of a single source of information or assessment method.

7. School psychologists must always use a balanced consideration of adaptive behavior and intellectual assessment results when making decisions about a mental retardation classification. An over-emphasis on intelligence test scores violates legal and professional guidelines and does not meet the needs of children. In addition, research has demonstrated that intelligence and adaptive behavior are distinct, but related, constructs and consideration of both everyday competence and conceptual intelligence should be included in decision making for children.

8. Although adaptive behavior assessment is required for the diagnosis of mental retardation and has many implications for interventions for individuals with mental retardation, it has many important uses in the assessment and intervention for other children. School psychologists should incorporate comprehensive adaptive behavior assessment into the assessment and data collection plan for all children experiencing learning and behavior problems and difficulties in functional, daily living skills. Many children who are experiencing problems have concurrent deficits in adaptive skills. Increases in adaptive skills represent important intervention goals for many children.

SUMMARY

This chapter has described adaptive behavior assessment as a component of data-based decision making by school psychologists. The current perspective provided by the AAMR (1992) provides a framework for assessing adaptive skills in order to gather information about an individual’s functional limitations and needs for services. The primary goal of adaptive behavior assessment should be to plan and monitor interventions for students. A number of norm-referenced rating scales of adaptive behavior are available, and they have many advantages, but a number of limitations. Rating scale assessment should be supplemented with interviews, naturalistic observations, and other techniques for comprehensive adaptive behavior assessment. Research suggests that adaptive behavior and intelligence are distinct, but related, constructs, and supports the need to gather data about both everyday competence and conceptual intelligence. Adaptive behavior assessment is required for individuals before they can receive a diagnosis of mental retardation, but also has important uses for assessment and interventions for children with other disabilities, including children with autism, emotional or behavior disorders, and physical or sensory disabilities.

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moderate, or no developmental disabilities. Topics in Early Childhood Special Education, 17, 419-434.

Individuals with Disabilities Education Act Amendments of 1997 (1999). Assistance to States for the Education of Children with Disabilities and the Early Intervention Program for Infants and Toddlers with Disabilities; Final Regulations; 34 CFR Parts 300 and 303; Federal Register, 64(48).


Adaptive Behavior


In addition to the chapters on intelligence testing and adaptive behavior assessment, this edited text includes outstanding chapters on early childhood assessment and transition assessment for adolescents with mental retardation.

ARTICLES

Series of articles criticizing the 1992 AAMR definition of mental retardation and responses from the team that developed the 1992 definition. A review of the articles will allow school psychologists to explore the key and controversial issues in the field of mental retardation. Outstanding articles include:


ANNOTATED BIBLIOGRAPHY


The AAMR manual is an excellent resource to obtain information about all aspects of mental retardation, including assessment, diagnosis, and intervention. The manual emphasizes environmental approaches to assessment and intervention.


The best practices chapter continues to be one of the best resources on adaptive behavior assessment, owing to the outstanding discussion of key issues and the practical recommendations.