

ADAPTIVE BEHAVIOUR FROM A SECOND ORDER PERSPECTIVE

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A number of investigators have criticised definitions of adaptive behaviour, Coulter and Morrow (1977), and mental retardation and adaptive behaviour, notably Baumeister and Muma (1975) and Clausen (1972). Coulter and Morrow (1977) conclude quite correctly that the issues regarding conceptions of adaptive behaviour and its measurement are focally reflected in the need to emphasize intervention programming, and that the course of progress in clarifying matters of definition are dictated by sources other than scientific knowledge. They appear, however, to focus their study on more traditional approaches to matters of definition, and to ignore alternatives in the literature which reflect a different point of view.

Baumeister and Muma (1975) in an extensive and searching analysis of this question found the 1973 definition of mental retardation and adaptive behaviour in the **AAMD Manual on Terminology and Classification in Mental Retardation** (Grossman, 1973) wanting, particularly in regard to its generality, its insensitivity to questions of optimal or adequate adaptation, and its disregard for more appropriate and relevant conceptions of social behaviour and development, especially with respect to programmatic and research functions.

In similar vein, Clausen (1972) found the construct of adaptive behaviour exceedingly difficult to define, and he points out that there is a schism in the concern for high-grade retarded persons on the one hand and low-grade persons on the other. He feels that the field of investigation regarding mental retardation and adaptive behaviour is too heterogeneous and cannot be contained or defined by a common denominator.

The present paper explores some of the points of view, above, with emphasis on current conceptions of diagnosis, of direct observation in testing, of established views regarding age, levels, and norms, and of programme development and evaluation. A major theme of this presentation is that the status of current definition suffers, at least in part, because it is conceptualised on the basis of a single level perspective or a "common denominator" rather than in terms of a multidimensional or at least a two-dimensional perspective.

The magnitude of this task and the efforts made regarding it are demonstrated in the work of Grossman and his associates in the current **1977 AAMD Manual**. From a critical standpoint, however, the direction of their efforts should employ a level of generality and perspective which would be flexible and practical enough to include the individual.

Yet the assumptions and implications of the current definition are still too general and are not explicit. The definition of adaptive behaviour in the Manual is as follows:

Adaptive behaviour is defined as the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected for age and cultural group (Grossman, 1977, p.11).

According to the Manual, adaptive behaviour represents what a person "routinely does do" (p. 17); it co-exists with mental retardation, which does not refer directly to etiology or prognosis.

The close relationship between mental retardation and adaptive behaviour is clearly expressed in the definition of mental retardation on page 11:

Mental retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behaviour; and manifested during the developmental period.

The definition is the same as in the 1973 Manual, and it is global in quality, very much like the construct of intelligence, which serves as its model.

Its global character is kept intact since it does not include the more particular, the more personalised aspects of personal history, prognosis, or individual programming. On page 11, for example, we see a further statement of explanation of mental retardation as follows:

Mental retardation as defined denotes a *level* (italics mine) of behavioural performance. . . . (it) is descriptive of *current* (italics mine) behaviour and does not necessarily imply prognosis. Prognosis is related to such factors as associated conditions, motivation, treatment, or training opportunities more than to mental retardation itself (Grossman, 1977, p.11).

How can this be? If learning is to be measured in terms of current status, what a person "routinely does do," or from the cognitive viewpoint "what one can do," and not upon behaviour associated with the opportunity for learning, why, then, are we told on page 12 of the Manual that "adaptive behaviour is a product of the interactions of the *individual's* (italics mine) abilities and skills with the expectations of society and of the opportunities to learn"? Surely, there is some inconsistency here?

Part of the inconsistency is resolved when we realise that diagnosis is a key issue. We are cautioned on page 12 of the Manual that the test administrator must avoid **misdiagnosis** in order to rule out etiological factors of emotional disorder, social conditions, sensory impairment, or any other variable which might distort valid findings of deficit in adaptive behaviour. But it is these factors that contribute to deficiencies in adaptive behaviour particularly at the lower end of the scale. This may make sense in making a theoretical assessment of the individual diagnosis of mental retardation per se, assuming that this may be done, but it makes little sense for purposes of prognostication. If diagnosis has any functional purpose at all, it is because it is a necessary step to prognosis.

The stress upon diagnostic credulity extends to the "Glossary," which provides a number of significant omissions. One notes that there is no definition of target behaviours, of programme development or programme evaluation. And the definition of "profound mental retardation" (p. 149) refers to I.Q. findings with only a cursory statement given to adaptive behaviour, and this on a negative basis, yet an assessment of adaptive behaviour is essential to its definition. References elsewhere in the text provide descriptions of adaptive behaviour by age, as if chronological age constituted an absolute barrier to development. There is, however, no empirical basis for knowing to what extent maturation is a significant variable when training efforts have not been introduced, or that motor impairment may not be a significant factor.

The "Glossary" also includes a definition of "behavioural rating scales" which gives examples of tests in which a third party informant supplies the critical information for classification purposes. But on page 17 we are told that:

Measures of adaptive behaviour cannot be administered directly in offices, but must be determined on the basis of a series of observations in many places over considerable periods of time. For this reason, rating scales consistently show lower reliability than standardised intelligence and achievement tests.

Since the majority of available rating scales do not require measures of adaptive behaviour based upon a series of *in vivo* observations and are administered by interview in offices and in similar places, it is not surprising that their reliability and validity is low. The statement that "rating scales consistently show lower reliability" than other types of tests is certainly open to question when alternatives in testing exist.

If measures of adaptive behaviour should not be administered "directly" in offices, if the integrity of rating procedures is "based upon a series of observations," why not, then, emphasise the fact that observation is a requisite to obtaining measures of adaptive behaviour? If these requisite conditions exist, then, they would have an ultimate effect on the definition of adaptive behaviour. But the conditions inherent in establishing measures of adaptive behaviour itself, which are basic to the definition in the Manual draw from *apriori* presumptions of three key variables of adaptive behaviour said to be essential to the definition of adaptive behaviour. These are *age*, *levels*, and *norms*. And it is these key variables that confuse the issue.

If adaptive behaviour is based upon measures which express the variables of age, levels, and norms, why should lip service be given to the "individual" in the first place, or even more superficially to training, or to the environment? If these are significant, why are they not then included in the definition? That they are important, as indeed they are, is attested to by the statement on page 21:

The tentative nature of adaptive behaviour *levels* (italics mine) requires reconsideration of each individual at frequent intervals. Changes in adaptive behaviour may occur through training or when marked changes are made in the environment, the individual being able to function at a higher level of adaptive behaviour when demands are tailored to capacities. . . . What a given individual routinely does is in part dependent upon opportunity, on other in the environment, and on the development of skills. Consideration of these factors *may* (italics mine) be helpful in the evaluation of adaptive behaviour levels.

The result is that test administrators in residential institutions are often concerned with the task of assigning the retarded individual to a given range or level. There is little consideration given, despite the caveats in the Manual, that retardation or the degree of retardation and the level of adaptive behaviour, may be secondary to trauma, drugs, or sensory deficits. But this is quite consistent with the definition that "Mental retardation (and presumably adaptive behaviour) as defined denotes a level of behavioural performance without regard to etiology" (Grossman, 1977, p. 11).

The unfortunate effect is to insure that psychological testing becomes a mere bookkeeping procedure. By so doing, we contribute to the widespread belief that residential institutions are hopeless places as far as psychological programming is concerned. The bookkeeping function also guarantees the common custom of ignoring programme development, and it insures the practice of "pseudo-programming," which provides minimal face validity to programmes without recourse to objective measures of individual performance.

Yet residential institutions are potentially valuable resources for programme development. Although the majority of retarded persons do not reside in institutions, it is in the institutional-setting that one can study changes in performance in terms of changes in the immediate environment, where one can monitor progress, and evaluate the resources that prepare the individual for community living.

It is said that if you want to understand something, try to change it (Bronfrenbrenner, 1977). The statement refers to the observer's perception of the critical features of the observed in the nature of activity and performance and to the qualities of naturalistic observation. It is the nature of observation, of course, that

concerns us and its application to adaptive behaviour. Direct observation tells us more about the nature of mental retardation and of adaptive behaviour, since it is free from categorical judgments and from the predisposition to view behaviour as independent of the situation in which the person is involved. It can tell us reliably what the person is doing.

Categorical judgments are believed to characterise the person and become transfixed by descriptive classifications, such as, "He is retarded"; "She is autistic"; "They are adaptive behaviours level III." Because the categories are perceived as nomothetic traits, psychometric instruments are often gross screening tests because they classify behaviour by providing items that seem consistent with general laws and principles. Yet test responses are not only a measure of the general characteristics of the person but also his unique background variations, his previously learned capabilities, and the specific stimulus situations currently surrounding him.

What of new situations and the opportunity to learn? The current definition of adaptive behaviour in the Manual avoids concern for situational influences on test behaviour. Bersoff (1973) states the need to focus on situational influences in test construction and the need to extend individual test findings to new situational objectives. Norms, which are obtained from the mass evaluations of large groups, tell us nothing of what evokes behaviour in an **individual**. A great advantage of the operant method, it is claimed, is its idiographic character in the assessment of a single case and the description of the actual environmental events that evoke and consequate behaviour.

We should pay particular attention to the meaning of a test. As Cronbach (1970) tells us, a test is defined as "a systematic procedure for observing a person's behaviour and describing it with the aid of a numerical scale or a category system" (p. 26). These resolutions are often neglected by practitioners and psychometricians in current practice. Perhaps we should return to the original sources.

Binet cited what he termed the psychological method because it makes **direct** observations and measurements of the degree of intelligence (Binet & Simon, 1961, p. 883). Binet and Simon perceived their task in terms of the development of an instrument that would most directly measure, through observation, the behaviour under study. This procedure is quite consistent with Cronbach's definition of a test. Tests, then, derive from the custom which uses direct observation of samples of behaviour, and are not obtained by selecting items from other tests.

What is termed psychosituational assessment (Bersoff, 1973), that is, the gathering of data about behaviour, which is contextualised by its connection to environmental events, which represents the current functioning of the **individual** and appropriate for baselining behaviour change, should be employed toward specific goals of rehabilitation. The objective of psychosituational assessment is the examination and analysis of behaviour as well as the delineation of the immediate antecedent and consequent conditions that evoke, reinforce, and perpetuate the behaviour. The primary concern is that the individual is evaluated as he interacts and is affected by the environment.

In conventional psychological testing procedures, the effort is made to evaluate the person "at a distance" from the conditions that produce the failure and centre the focus of difficulty from within the individual. Hence, the need for the categorical judgments, "He is severely retarded"; "She is schizophrenic"; "They are disturbed." Yet the objectives of these practices are often laudable. They include the goals of identifying the person as retarded or disturbed and providing a "programme" for the individual. The ultimate task is to develop legislation and to encourage budgetary appropriations. Nevertheless, these "programmes" provide vague meanings. Terms

such as institutional commitment and admission to special education classes, etc. represent a broad but superficial programmatic involvement. They are a generic class, representing a first order variety.

Because the term "programme" is associated with the intention of programme involvement, there is gross misunderstanding. What is supposed to happen after placement? Why, expedient programmes will be developed! But more often they are not, and deinstitutionalisation is the answer, or mainstreaming is appropriate!

A first-order test provides a standardised set of questions which assess the presence or absence of a particular skill or knowledge. It may be administered to a group or to individuals. The data furnished by this type of instrument, however, take the form of group norms, and variances established by group differences. By definition, a first-order test, then, is designed to measure the characteristics of the organism to whom the test is administered when these characteristics are compared to average scores of particular groups, which are often but not always expressed in standard deviation units.

With regard to individual interpretation, a number of precautions must be undertaken, especially with intelligence tests, the best example of this class as far as validation and standardisation are concerned. For intelligence tests, and adaptive behaviour scales similar to them, are not especially helpful in the modification of deviant responses, nor are they instrumental in measuring the acquisition of knowledge, in identifying potential skills, or in the development of intervention strategies to be considered. Nevertheless, they are effective in identifying populations, in classification, and in screening individuals. First-order tests are characterised by temporal economy, ease of administration and in interpretation, but they are not particularly sensitive in measuring differences between individuals or the effects of the environment upon learning.

Programmes and tests of a first-order quality are not designed to provide the parameters for individual programmes. In the utilisation of tests of the first-order category, direct care personnel are excluded from the consequences of the information-gathering process, and the psychologist is isolated from those events that evoke failure and maladaptive behaviour. The bookkeeping responsibilities extend the isolation process.

Second-order tests, on the other hand, provide fine-grained measures, often employing methods of direct observation rather than a set of standardised questions. Like first-order instruments, the procedures and the observations themselves can be standardised (Balthazar, 1973, 1976). The observations themselves furnish an item pool and each item is transformed into an individual scale, which in turn establish a baseline measure and an intervention target for programme evaluation. The scales taken together describe many or most of the characteristics of a population or a subpopulation. Tests of this class are designed to measure the antecedent and consequent conditions in a given environment which when modified will eventually modify the behaviour of the individual. They are a criterion-referenced assessment device, which is sensitive to the effects of intervention strategies and the consequences of these strategies as they induce changes in adaptive behaviour.

The aim is to determine and monitor the parameters of interaction, to clarify the do's and don'ts of direct care intervention, as they affect self-care skills and social coping behaviour. What should be done, and when and what should not be done? Stating it briefly, the second-order instrument is designed to shape the individual and the aide and every aide who cares and trains him.

With advances along these lines, the time for more formal programming has come. Formal programming evolves from these initial training efforts, and when the procedures are standardised, they can be placed in a programme library for retrieval purposes. The second-order instrument, since it is narrow-banded, furnishes finite programme goals to assist the individual to move from one skill point to another.

The use of miniature situations suggested by Santostefano (1962, 1968) could also be used to replicate functioning environments and provide the assessor with controlled, natural-like situations, when direct observation is not desirable or possible in real situations. Such studies are important in deinstitutionalisation procedures.

There are limitations, of course, to second-order instruments which measure behaviour. Formats which use percentages as measures, as do most time-sampling schedules, yield misleading data. Time and event-sampling do not always honour natural behaviour units, and unless provision is made, the duration of behaviour is often overlooked.

A number of criticisms are directed to the observational method, especially its time-consuming nature and its tendency to provide ungeneralisable data. Yet nothing could be further from the truth! On the other hand, first-order psychological tests are currently used to generalise to too many situations. They do not predict one accurately.

Tests using observation in a situational-assessment setting, using fine-grained or narrow-banded measures, suffer when they are compared to wide-band instruments such as intelligence or similar tests. However, the objective of testing is to establish validity and reliability as direct measures of behaviour, and the advantages of economy of administration and factorial purity become less important.

It is the second-order test that informs us regarding the evaluation of individual instruction or training, and provides the monitoring of intervention strategies. It furnishes almost immediate feedback, and, most important of all, the second-order test establishes first hand data regarding the current status of the individual's adaptive behaviour. Yet there should be no inherent disagreement between first-order and second-order methodologies. Each is necessary (for different reasons), and considerations of population and classification are essential to both, for each must contribute to programming and to current definitions of adaptive behaviour.

Summary

A critique of the definition given in the 1977 American Association on Mental Deficiency (AAMD) *Manual on Terminology and Classification in Mental Retardation* is given. Since this definition establishes a common denominator, which is generalised and not particularised to all ranges of mental retardation, an alternative point of view is offered that gives particular emphasis on the adaptive behaviour of the mentally retarded individual. This point of view embraces a second-order conception in testing and in evaluation which is more appropriate to the multivariate nature of human adaptation.

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