Concurrent Validity of the Task-Oriented Assessment Component of the Bay Area Functional Performance Evaluation With the American Association on Mental Deficiency Adaptive Behavior Scale

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Key Words: activities of daily living • task performance and analysis • tests, by title, Bay Area Functional Performance Evaluation

This study was designed to test the concurrent validity of the revised Task-Oriented Assessment (TOA) component of the Bay Area Functional Performance Evaluation (BaFPE) (Bloomer & Williams, 1979) with Part 1 of the American Association on Mental Deficiency Adaptive Behavior Scale (ABS) (Nihira, Foster, Shellhaas, & Leland, 1969, 1974) and to develop a means of interpretation for the numeric scores on the TOA. Because the TOA measures functional abilities, we aimed to develop a narrative description of the TOA score, associating scores with performance levels in activities of daily living and other functional activities.

Ten previous studies have tested the validity of the BaFPE, eight of which used the original rather than the revised version of the evaluation, thus the need for the present study. The ABS was selected for this study because it provides measures of functional performance for specific behaviors, unlike other widely used tests of functional performance such as the Barthel Index (Mahoney & Barthel, 1965). Although the Barthel Index has a higher reliability than the ABS (Granger & Greer, 1976), it is narrower in scope, measuring only self-care and mobility.

The BaFPE

The BaFPE, first published in 1979 (Bloomer & Williams, 1979) and revised in 1987 (Williams & Bloomer, 1987), was developed to assess general functional performance in patients receiving psychiatric occupational therapy. A comprehensive review of the development of the BaFPE was documented by Houston, Williams, Bloomer, and Mann (1989). Normative data for the BaFPE was recently published (Mann, Klyczek, & Fiedler, 1989). The BaFPE has two separate parts, the Task-Oriented Assessment (TOA), which assesses goal-directed and task-oriented activity, and the Social Interaction Scale (SIS), which assesses socially appropriate behavior.

The TOA

The TOA involves the completion of five tasks rated on a 5-point scale. These tasks are Sorting Shells, in which 10 categories of shells are sorted by size, shape, and color; Money and Marketing, in which the cost of items on a shopping list are calculated, a check is cashed, and change is calculated; Home Drawing, in which a floor plan for a house is drawn by following specific instructions; Block Design, in which a block design is duplicated from memory or with use of a cue card; and Draw a Person, in which a picture of a person doing something is drawn.

The authors of the BaFPE stated that the five tasks are not intended to reflect essential life skills, but rather to provide clinicians with information to evalu-
ate the functional parameters underlying the task-oriented behavior of patients (Houston et al., 1989). The 12 functional parameters rated by the five tasks are grouped into Cognitive, Performance, and Affective components. The parameters grouped in the Cognitive component are (a) Memory for Written/Verbal Instructions, (b) Organization of Time and Materials, (c) Attention Span, (d) Evidence of Thought Disorder, and (e) Ability to Abstract. The parameters grouped in the Performance component are (a) Task Completion, (b) Errors, and (c) Efficiency. The parameters grouped in the Affective component are (a) Motivation or Compliance, (b) Frustration Tolerance, (c) Self-Confidence, and (d) General Affective and Behavioral Impression.

The TOA has a Qualitative Signs and Referral Indicators section, which includes items that allow the rater to check for signs of an organic disorder that are observable during all five tasks. The scoring of this section is not included in the BaFPE-TOA total score, but if the signs exceed a certain number, further testing for organic disorders is indicated.

**BaFPE Reliability and Validity**

The initial interrater reliability tests completed on 62 patients and 20 nonpatients was .99 for the TOA and .93 for the SIS (Bloomer & Williams, 1979). Field testing of the BaFPE completed on 51 patients and 50 nonpatients in 1981 showed interrater reliability of .86 to .99 for the TOA and .69 to .91 for the SIS (Houston et al., 1989). In a later study involving 91 patients tested by four pairs of therapists, interrater reliability ranged from .93 to .98 for the revised TOA (Williams & Bloomer, 1987).

Two of the 10 validity studies on the BaFPE-TOA tested the revised version. Thibeault and Blackmer (1987) tested correlations between the revised BaFPE-TOA and three subtests of the Wechsler Adult Intelligence Scale (Wechsler, 1955). They reported that the correlation between the BaFPE-TOA and the Picture Completion subtest of the Wechsler scale was .58; of the Block Design subtest, .67; and of the Digit Symbol subtest, .60. All were significant ($p < .001$).

A study of the correlation between the revised BaFPE-TOA, the Global Assessment Scale (Endicott, Spitzer, Fleiss, & Cohen, 1976), and the revised Allen Cognitive Level Test (Allen, 1985) showed significant correlations between the TOA and the Global Assessment Scale and a correlation of .63 between the TOA and the Allen Cognitive Level Test (Newman, 1987).

The ABS

The American Association on Mental Deficiency Adaptive Behavior Scale (ABS) was first published in 1969 (Nihira et al., 1969) and revised in 1974 to combine the separate forms for children and adults (Nihira et al., 1974). A public school version is available, which is identical to the 1974 version except for the elimination of some items to conform to the public school setting (Lambert, Windmüller, Cole, & Figueroa, 1975). The ABS assesses the adaptive behavior of persons with mental retardation and emotional disturbances (Miller, 1972). Adaptive behavior is defined as the ability to cope with the demands of the environment (Nihira, Foster, & Spencer, 1968). The ABS was standardized on 2,800 persons from 10 institutions for persons with mental retardation.

**ABS Components**

The ABS comprises two parts. Part 1 consists of 66 items in the following 10 behavior domains, which measure personal independence skills and behavior: (a) Independent Functioning, (b) Physical Development, (c) Economic Activity, (d) Language Development, (e) Numbers and Time, (f) Domestic Activity, (g) Vocational Activity, (h) Self-Direction, (i) Responsibility, and (j) Socialization. Part 2 of the ABS consists of 44 items in 14 domains measuring such maladaptive behaviors as violent, antisocial, and stereotyped behavior. Three types of question formats with different scoring procedures are used in the ABS. In the first type, the rater selects which statement most accurately describes the person's level of functioning; in the second type, the rater checks multiple responses; and in the third type, the rater checks items according to frequency of appearance of various behaviors.

Although total scores on the ABS may be used to attain a profile that allows comparison of the individual to a reference group, this practice has been questioned due to the multidimensional nature of the adaptive behavior construct (Roszkowski, 1982). Instead, scores from specific items, subdomains, or domains may be used to define a group's program needs or performance objectives, or the test results can be useful in obtaining information about the more qualitative aspects of functioning. Bortner (1978) reported that the ABS was useful in describing a person's performance in daily living skills and his or her social and interpersonal behavior.

**ABS Reliability and Validity**

Miller (1972) reported interrater reliability for the 24 scales ranging from .40 to .86 and a high face validity. In a later review by Bortner (1978), interrater reliability on Part 1 ranged from .71 to .93 with a median of .86, and on Part 2 from .37 to .77 with a median of .57.

Roszkowski (1982) tested the ABS for internal consistency, a measure of whether several parts of a
test yield the same information. This analysis, which was completed on 428 persons with mental retardation, revealed an internal consistency of .85 for Part 1 and .79 for Part 2.

Botner (1978) indicated that two types of validity have generally been reported on the ABS—factor studies and correspondence of scale scores to diagnostic labeling. Taylor, Warren, and Slocumb (1979) summarized some of the factor-analytic studies that have been completed on the ABS. Nihira (1969a, 1969b) delineated three major dimensions for Part 1: personal self-sufficiency, community self-sufficiency, and personal-social responsibility.

Other researchers have studied the dimensions of adaptive behavior by comparing elementary school children with and without mental retardation (Lambert & Nicoll, 1976), by examining adaptive behavior with noninstitutionalized adults with mental retardation (Guarnaccia, 1976), and as a measure of psychiatric impairment (Foster & Nihira, 1969).

Finally, other research has focused on the clinical effectiveness of the ABS for service evaluation (Eyman & Call, 1977), educational programming (Cunningham & Presnall, 1978; Gersten, Crowell, & Bellamy, 1986), and special education (Malone & Christian, 1975) and for developing individualized education programs for clients with mental retardation (Schachter, Rice, Cormier, Christensen, & James, 1978).

We expected certain TOA task and functional parameter scores to correlate somewhat higher with various ABS domain and subdomain scores. For example, we expected a high correlation between the TOA Money and Management task and the ABS domain of Economic Activity and subdomains of Money Handling/Budgeting and Shopping Skills.

Method

Subjects

The sample consisted of 67 psychiatric inpatients tested at five hospitals in western New York and Ontario, Canada, over a period of 1 year (1987 to 1988). During the study period, all patients referred to occupational therapy at these facilities were asked to participate in the research. Of the 67 subjects, 73% were men and 98% were Caucasian. The mean age was 30.8 years (range = 14 to 69 years). Fifteen percent of the subjects had completed elementary school, 54% had completed high school, and 21% had received an associate's, bachelor's, master's, or doctoral degree.

The most prevalent conditions diagnosed among the subjects were eating disorders (46%), mood disorders (16%), and schizophrenia or other psychotic disorders (15%). Other diagnoses (less than 10% each) were psychoactive substance-use disorder, anxiety disorder, adjustment disorder, and personality disorders.

Prior to admission, 45% of the subjects were employed, 20% were students, 15% were unemployed, 7% were receiving a disability pension, 6% were homemakers, and 3% were retired. Occupational role prior to admission was unknown for 4% of the sample.

Procedure

The TOA of the BaFPE and Part 1 of the ABS were administered to the subjects within 14 days of hospital admission. Part 2 of the ABS was not administered because it relates more to maladaptive behaviors than to the specific adaptive performance of activities of daily living that are measured in Part 1, such as eating, cleanliness, travel, and economic activity. Each test lasted approximately 1 hr. In some facilities, the subjects were told that the testing results were to be used for research purposes only. In others, the administration of these tests was part of the regular evaluation procedure, thus the results were used for evaluation and treatment planning as well as for this study.

Eight raters administered the tests. All had attended BaFPE administration workshops, had previous experience using the BaFPE in clinical practice, and had either participated in a 1-day research training workshop conducted by one of the authors of the BaFPE or had reviewed a BaFPE administration and scoring videotape.

Administration and scoring was completed following standard procedures for the BaFPE-TOA (Williams & Bloomer, 1987) and the ABS (Nihira et al., 1974). ABS ratings were based on measures of general performance in each of the 10 domains of Part 1 following recommended procedures (Nihira et al., 1974). Demographic data were obtained from medical records and through interviews with the patients.

Each scoring record was reviewed and proofed for mathematical accuracy to guard against scoring errors, which are reported to be common to the ABS (Sprent, 1979). The data were inputted to a dBASE III PLUS file (Ashton-Tate, 1986) and translated to a Statistical Package for the Social Sciences (SPSS) (SPSS, Inc., 1984) file where Pearson product-moment correlations and a one-tailed test of significance were performed.

Results

The correlation of the total TOA score and the total ABS Part 1 score was significant (r = .32, p < .05). Table 1 shows correlation coefficients for the five task and three component scores of the TOA and the 10 domain and 21 subdomain scores of the ABS.

In testing the strength of these relationships, we found correlations ranging from −.19 (not signifi-
### Table 1
Correlations Between Part 1 of the AAMD ABS and the BaFPE-TOA

<table>
<thead>
<tr>
<th>Independent Domain</th>
<th>Sorting Shells</th>
<th>Sorting Money/IB</th>
<th>Home Drawing</th>
<th>Block Design</th>
<th>Draw a Person</th>
<th>Cognitive Component</th>
<th>Performance Component</th>
<th>Affective Component</th>
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Note. AAMD ABS = American Association on Mental Deficiency Adaptive Behavior Scale (Nihira, Foster, Shellhaas, & Leland, 1969, 1974); BaFPE-TOA = Bay Area Functional Performance Evaluation-Task-Oriented Assessment (Bloomer & Williams, 1979). *p < .05. **p < .01.

Part 1 of the ABS correlated significantly with the Affective component of the TOA.

**Discussion**

The ABS has received fairly wide acceptance as a measure of functional performance, primarily because of its good face validity. It evaluates behaviors that are so specific that clinicians tend to accept the results. For example, in determining independence in eating, the examiner evaluates the client's use of table utensils, ability to eat in public, ability to drink, and table manners.

A broad range of interrater reliabilities have been reported, ranging from as low as .40 to as high as .93 (Bortner, 1978; Miller, 1972). If the reliability of the
ABS is, on the average, only fair, then one would not expect a high correlation of the scores on the ABS with another test. We found low to moderate correlations between the BaFPE–TOA subtask scores and component scores and the ABS Part 1 domain and subdomain scores. Although low reliability may lower the correlations, the correlations may be low simply because there is low concurrent validity. Future concurrent validity research on the BaFPE–TOA should be designed to ensure observation of actual performance of activities of daily living. This would not preclude use of the ABS, but would require the rater to base decisions on actual observations over a specified period of time during which the BaFPE–TOA is also administered. This may increase the reliability of the ABS, because ratings would not depend on the client’s self-report or the care provider’s reports.

In addition to testing the concurrent validity of the TOA, this research aimed to develop a means of interpretation for the numeric scores on the TOA. The BaFPE measures functional abilities, and we had hoped that the BaFPE score could be associated with performance levels in activities of daily living and other functional activities. Because we found low concurrent validity between the TOA and ABS, however, the strength of many of the relationships was too weak between ABS items (for actual tasks, such as eating) and BaFPE task and component scores to develop a narrative interpretation of the BaFPE scores. Thus, we were unable to say that a given BaFPE score correlates or is associated with the ability to complete certain activities of daily living.

Some interesting patterns in the correlations did emerge, however, as shown in Table 1. For example, a correlation of .43 ($p < .01$) was found between the TOA Shell Sorting and Money and Marketing tasks and the Economic Activity domain of the ABS. The Shopping Skills subdomain correlated higher with Shell Sorting than with Money and Marketing, whereas the Money Handling/Budgeting subdomain correlated higher with Money and Marketing than with Shell Sorting. Although included within the Economic Activity domain, skills needed for shopping require more decision making than do skills needed for managing money. Thus, Shopping Skills correlated more highly with the Shell Sorting task, which also requires decision making, than with the Money and Marketing task, which involves more calculations than decisions. Because the ABS is used as a measure of adaptive behavior, the high correlation between these items on the two tests suggests that the TOA (or at least the cognitive component of the TOA) may provide an indication of a client’s adaptive behavior and not just a measure of performance of task-oriented skills. Such generalizations should not be made from such a limited sample, but the results do suggest that further study of the TOA’s potential to measure actual adaptive performance is indicated.

Other significant correlations ($r = .51$, $p < .01$) were found between the ABS subdomains of Comprehension and Social/Language Development and the Cognitive component of the TOA. The Cognitive component comprises measures of the client’s comprehension and memory of task instructions. One must be careful, therefore, when making comparisons between specific items. Although it might have seemed that Shopping Skills as a subdomain of Economic Activity would correlate more highly with the Money and Marketing task than with other TOA tasks, this was not true. With a larger sample, perhaps more definitive statements could be made regarding the correlations between specific items that may not be self-evident.

Finally, some interesting correlations were found between the ABS Socialization domain and the TOA Shell Sorting task ($r = .58$, $p < .01$), the Cognitive component ($r = .48$, $p < .01$), and the TOA total score ($r = .47$, $p < .05$). The ABS Socialization score comprises measures of the client’s cooperation and interaction with others, consideration for and awareness of others, participation in group activities, and social maturity. This may suggest that good social skills may be a better indicator of success on performance tests than other particular skills or that social skills in general are a reflection of task performance.

Future research may determine that interpretation of the TOA may be more successful when completed similarly to interpretation of the ABS. That is, instead of drawing profiles from TOA parameter or task scores to compare the individual to a reference group, therapists may use scores from specific items, tasks, or parameters to define a specific client group’s program needs or performance objectives. For example, the therapist could administer the TOA to all clients in a day treatment program and compare the total group’s parameter scores and develop a treatment plan to address problem areas. If, for example, the clients as a group tended to perform poorly on the Memory for Written/Verbal Instructions and the Organization of Time and Materials parameters of the TOA, the therapist could develop task groups that would facilitate the development of those skills.

Additionally, the test results may be used to obtain information about the more qualitative aspects of functioning. Clinicians receive much information from watching a person perform the TOA tasks. In fact, some clinicians reported that the final score was not their ultimate goal in using the TOA. Because TOA tasks range in degree of structure from very structured (e.g., Sorting Shells) to very unstructured (e.g., Draw a Person), insight can be gained into a client’s performance and needs. The therapist can...
learn more about how a client approaches tasks and deals with structured versus unstructured tasks in a more global or qualitative sense than he or she could through quantitative measures (e.g., through test scores).

Future research could be directed toward the testing of the predictive validity of the BaFPE, perhaps with a focus on its ability to predict successful community placement with consideration of quality of life.

Acknowledgments

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