



## An evaluation of the Aberrant Behavior Checklist for children under age 5

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### ABSTRACT

Severe problem behaviors such as self-injury and aggression are frequently observed in young children under age 5 with intellectual and developmental disabilities (IDD). Although early identification of problem behavior is critical to effective intervention, there are few standardized measures available that identify severe problem behavior in this population. The Aberrant Behavior Checklist-Community (ABC-C; Aman & Singh, 1994) is a rating scale that measures the severity of a range of problem behaviors commonly observed in individuals with IDD. While it has been used with children under 5, investigations into the fit of the ABC-C for this population are sparse. The purpose of the present study was to report on ABC-C scores in a sample of 97 children under age 5 with problem behavior. Analyses included evaluating differences in scores between age groups, comparing sample norms to established norms for older children, and conducting a confirmatory factor analysis. Results indicated differences in mean scores based on age with younger children generally scoring higher on some subscales of the ABC-C. Furthermore, the original 5-factor structure of the ABC-C was not fully supported. In general, the ABC-C may over- or underestimate behavior problems in younger children; therefore more extensive investigation into the utility of the ABC-C for children under age 5 is warranted.

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Young children with intellectual and developmental disabilities (IDD) are at risk for developing severe problem behavior such as self-injury, aggression, disruption, and tantrums. Prevalence estimates for severe behavior problems range from 13% to 30% in children with IDD, and are higher for children with an autism spectrum disorder (ASD) (Sturme, Seiverling, & Ward-Horner, 2008). These behavior problems can persist into adolescence and adulthood, often having deleterious effects on learning and social opportunities, and if severe enough, may result in extensive use of psychotropic medications or more restrictive environments. Early identification of certain behavior problems such as stereotypy and self-injurious behavior (SIB; e.g., head banging) can be complicated, though, as topographically similar behaviors frequently are observed in typically developing children (deLissovoy, 1961). Therefore, assessment measures are needed to not only identify behavior problems in young children, but also classify and monitor the severity of these behaviors in order to distinguish children who are at greatest risk for developing chronic behavior problems. Unfortunately, there are few available measures that adequately assess the severity of problem behavior in children with or at risk for IDD under the age of 5 years.

The Aberrant Behavior Checklist (ABC) is one of the few empirically developed scales designed to measure psychiatric symptoms and behavioral disturbance exhibited by individuals with IDD across 5 domains: Irritability, Agitation, & Crying; Lethargy/Social Withdrawal; Stereotypic Behavior; Hyperactivity/Noncompliance; and Inappropriate Speech (Aman &

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Singh, 1986). The ABC originally was developed to assess the effectiveness of psychotropic medication, and has been used extensively in pediatric, as well as adult behavioral and psychiatric research due to its high reliability and validity (Aman, Singh, Stewart, & Field, 1985; Bihm & Poindexter, 1991; Matson, Cooper, Malone, & Moskow, 2008; Paclawskyj, Matson, Bamburg, & Baglio, 1997). Although the ABC was developed for use with individuals living in institutions and residential settings, revisions to the measure have made it more applicable for home and school settings; the commonly used measure is now the Aberrant Behavior Checklist-Community (ABC-C) version (Aman & Singh, 1994).

Perhaps due to the lack of available measures, the ABC-C has been utilized with children under the age of 5 (for this paper “young children” will refer to this age group), to evaluate behavioral and psychopharmacological treatment effects (Brown, Aman, & Haverkamp, 2002; Chadwick, Piroth, Walker, Bernard, & Taylor, 2000). The ABC-C also has been used to track the persistence of emerging problem behavior over several years for young children (Berkson, Tupa, & Sherman, 2001; Green, O’Reilly, Itchon, & Sigafoos, 2005). For example, Green et al. (2005) administered the ABC-C every six months over a three-year time span to teachers of 13 preschool children with previously identified developmental disabilities. Each of the children emitted some form of problem behavior at the beginning of the study. Results of the repeated administration of the ABC-C showed that for nine of the children who exhibited some of the highest levels of problem behavior, their scores on the ABC-C remained elevated across the three years of measurement.

Despite its use with young children for assessment and treatment purposes, little is known regarding the (1) norms of the ABC-C, and (2) appropriateness or sensitivity of the ABC-C for this population, as the factor structure of the ABC-C has not been extensively evaluated with this population. When factor analyses have been conducted, sample sizes typically have been small (Sigafoos, Pittendreigh, & Pennell, 1997) or included large age ranges (e.g., ages 3–23 years; Freund & Reiss, 1991; Rojahn & Helsel, 1991). This has made it difficult to draw more specific conclusions about the appropriateness of the ABC-C for these young children.

Thus, although the ABC-C is used with young children, there are several issues regarding its utility with this population. A primary concern is the developmental appropriateness of the items. The ABC-C was developed and normed with adults, therefore the items may only sample behavior problems commonly associated with adults with IDD. Behaviors which are concerning for young children may not be accounted for, and behaviors which are not relevant to young children may be overrepresented. Therefore, scores on the ABC-C for young children may be susceptible to false negative results. For example, it is likely that for younger children, lower scores may be obtained for certain subscales (e.g., Inappropriate Speech or Hyperactivity) because specific items (e.g., “talks excessively” or “inappropriately noisy and rough”) may not be appropriate due to the child’s developmental level. This may affect the sensitivity of the measure for tracking changes in problem behavior in this and other domains across time.

A secondary concern is that due to the potential developmental inappropriateness of certain items, the traditional 5-factor ABC-C structure may not be adequate for this population; research in this area has not yet provided conclusive results. Sigafoos et al. (1997) evaluated the factor structure of the ABC-C for 32 children less than 6 years of age, as rated by parents and teachers. Results showed that the scores from both groups of raters were highly correlated, but more importantly, items loaded on the original 5-factors. Although these initial findings favor the appropriateness of the ABC-C with this population, there is a need for independent replication of these procedures to establish utility.

In summary, while there is a large body of research supporting the effectiveness of the ABC-C with a variety of populations, the research support for using the ABC-C with younger children is not sufficient. The current study had four goals. First, ABC-C mean scores were compared for 2 groups of children under the age of 5: one group were referred to a clinic for the treatment of multiple behavior problems while a second group included children from a research project investigating the emergence of self-injurious behavior. Second, the scores of the combined sample were compared to established norms for children ages 6–10 years (Brown et al., 2002) to evaluate differences. Third, a confirmatory factor analysis was conducted to determine the fit of the 5-factor structure of the ABC-C with scores from the current study sample. Fourth, individual items were examined regarding the frequency of endorsement across different age groups.

## 1. Method

### 1.1. Participants

Demographic information for the study sample is summarized in Table 1. Ninety-seven children under the age of 5 years and their primary caregivers participated; 73 children (75.3%) were male, and 24 children (24.7%) were female. The study sample was comprised of two distinct groups. A majority of the sample, 65 children (mean age = 3.08 years, range = 0.80–4.50), were referred to a hospital-based outpatient clinic for severe behavior problems over a 14-year time span (1997–2010). The other 32 children (mean age = 2.49 years; range = 1.35–4.81) were recruited over a 5-year time span (2004–2008) for a clinic and home-based research study that specifically examined the emergence of SIB in young children (R01HD046722; Kurtz, Chin, Huete, & Cataldo, 2012). For the purposes of this paper, these two participant groups will be referred to as *clinic sample* and *research sample*, respectively. *Combined sample* will be used to refer to all participants (i.e., clinic sample plus research sample). Approximately 45.4% ( $n = 44$ ) of the combined sample had some previously documented level of developmental delay or intellectual disability; many had not been formally evaluated or diagnosed due to their young age. Approximately 13.4% ( $n = 13$ ) of participants were diagnosed with an autism spectrum disorder (ASD).

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