

An-Najah National University

Faculty of Graduate Studies

**Validation of the Vineland Adaptive Behavior Scale in Arabic
Language within a Palestinian Context**

**By
Ciwar Abd El Qadir**

**Supervisors
Dr. Denise Ziya Berte
Co-Supervisors
Dr. Ali Barakat**

**This Thesis is Submitted in Partial Fulfilment of the Requirements for the
Degree of Master of Clinical Psychology, Faculty of Graduate Studies, An-
Najah National University, Nablus- Palestine.**

2019

**Validation of the Vineland Adaptive Behavior Scale in Arabic
Language within a Palestinian Context**

**By
Ciwar Abd El Qadir**

This Thesis was defended successfully on 16/6/2019 and approved by:

Defense Committee Members

Signature

- | | |
|---|-------|
| 1- Dr. Denise Berte / Supervisor | |
| 2- Dr. Ali Barakat / Co-Supervisor | |
| 3- Dr. Linah Albanna / External Examiner | |
| 4- Dr. Zaher Nazzal / Internal Examiner | |

الشكر والتقدير

الحمد لله رب العالمين

أشكر الله تعالى على فضله حيث أتاح لي إنجاز هذا العمل بفضله، فله الحمد أولاً وآخراً.

وأسمى أيات الشكر والعرفان أقدمها إلى كل الأساتذة الأفاضل، على عطائهم الدائم الذي لا ينضب، دعمهم

ومساندتهم لي في بحثي، وأخص بالذكر الدكتورة الفاضلة دينيز بيرت، والدكتور الفاضل علي بركات.

كما وأتوجه بالشكر والامتنان لمعهد النجاح للطفولة والقائمين عليه على دعمهم لانجاز هذا البحث.

بالإضافة أنقدم بخالص شكري وتقديري للمدرسة الأمريكية وللأطفال وذويهم الذين شاركوني بكل حب وعطاء لإتمام

هذا البحث.

وأخيراً كل الشكر والتقدير لعائلتي الغالية التي لم تتوان أبداً في الوقوف بجانبي، وتقديم الدعم والنصيحة، فلا ولن

أوفيههم حقهم على ما بذلوه من أجلي

الإقرار

أنا الموقع أدناه مقدم الرسالة التي تحمل العنوان:

Validation of the Vineland Adaptive Behavior Scale in Arabic Language within a Palestinian Context

أقر بأن ما اشتملت عليه هذه الرسالة إنما هي نتائج جهدي الخاص، باستثناء ما تمت الإشارة إليه
حيثما ورد، وأن هذه الرسالة ككل، أو أي جزء منها لم يقدم من قبل لنيل أية درجة علمية أو بحث
علمي أو بحثي لدى أية مؤسسة تعليمية أو بحثية أخرى.

Declaration

The work provided in this thesis, unless otherwise referenced, is the
researcher's own work, and has not been submitted elsewhere for any other
degree or qualification.

Student Name:

اسم الطالب:

Signature:

التوقيع:

Date:

التاريخ:

TABLE OF CONTENTS

Subject	Page
الشكر والتقدير	iii
Declaration	iv
List of Tables	vi
List of Figures	viii
Abstract	ix
Chapter 1: Introduction	1
Chapter 2: Theoretical background and Literature Review	28
Chapter 3: Methods	30
Chapter 4: Results	43
Chapter 5: Discussion	101
Chapter 6: Conclusion and Recommendations	114
References	117
Appendix A: IRB	132
Appendix B: Parent Information Letter	140
Appendix C: Informed Consent Form	141
Appendix D: Vineland Adaptive Behavior Scale – Second Edition	143
Appendix E: Developmental Profile of the Portage Program	144
Appendix F: Parents Satisfaction Survey	173
الملخص	ب

LIST OF TABLES

No.	Table	Page
1.	Frequency of participants by gender	42
2.	Frequency of participants in control and high-risk groups by gender	43
3.	Descriptive data of participants age	43
4.	Means and Standard Deviations of Portage and VABS domains among all participants	45
5.	Paired samples t - test within the Portage and the VABS Domains among all participants	46
6.	Means and Standard Deviations of Portage and VABS domains among control group	47
7.	Paired samples t - test within the Portage and the VABS Domains among control group	48
8.	Means and Standard Deviations of Portage and VABS domains among high-risk group	48
9.	Wilcoxon Signed Ranks Test within the Portage and the VABS Domains among high-risk group	49
10.	Means and Standard Deviations of Portage and VABS domains among male participants	50
11.	Paired samples t-test within the Portage and the VABS Domains among male participants	51
12.	Means and Standard Deviations of Portage and VABS domains among female participants	51
13.	Paired samples t-test within the Portage and the VABS Domains among female participants	52
14.	Paired samples t-test within the Portage and the VABS Domains among male participants of control group	53
15.	Paired samples t-test within the Portage and the VABS Domains among female participants of control group	54
16.	Wilcoxon Signed Ranks Test within the Portage and the VABS Domains among male participants of high-risk group	55
17.	Wilcoxon Signed Ranks Test within the Portage and the VABS Domains among female participants of high-risk group	55
18.	Descriptive data of two groups of age	56
19.	Means and Standard Deviations of Portage and VABS domains among first group of age (2 to 5 years and 11 months) of all participants	57
20.	Paired samples t-test within the Portage and the VABS Domains among first group of age (2 to 5 years and 11	58

	months) of all participants	
21.	Means and Standard Deviations of Portage and VABS domains among second group of age (6 – 9 years) of all participants	59
22.	Paired samples t-test within the Portage and the VABS Domains among second group of age (6 – 9 years) of all participants	60
23.	Paired samples t-test within the Portage and the VABS Domains among first group of age (2 – 5 years and 11 months) participants of control group	61
24.	Paired samples t-test within the Portage and the VABS Domains among second group of age (6 – 9) participants of control group	62
25.	Wilcoxon Signed Ranks Test within the Portage and the VABS Domains among first group of age (2 to 5 years and 11 months) participants of high-risk group	63
26.	Wilcoxon Signed Ranks Test within the Portage and the VABS Domains among second group of age (6 – 9 years) participants of high-risk group	63
27.	Test of Normality of the Vineland Adaptive Behavior Scale domains and Adaptive Behavior Composite Scores with Normal Curve among all participants	64
28.	Test of Normality of the Vineland Adaptive Behavior Scale domains and Adaptive Behavior Composite Scores with Normal Curve among control group.	68
29.	Test of Normality of the Vineland Adaptive Behavior Scale domains and Adaptive Behavior Composite Scores with Normal Curve among high-risk group.	74
30.	Test of Normality and Histograms of the Vineland Adaptive Behavior Scale subdomains among all participants.	80
31.	Test of Normality and Histograms of the Vineland Adaptive Behavior Scale subdomains among control group	86
32.	Test of Normality and Histograms of the Vineland Adaptive Behavior Scale subdomains among high-risk group	93
33.	Results of Parents Satisfaction Survey	100

LIST OF FIGURES

No.	Figure	Page
1-5	Histograms of the VABS-II domains (Communication, Daily-Living Skills, Socialization and Motor Skills) and Adaptive Behavior Composite Scores with Normal Curve among all participants.	65
6-15	Histograms of the VABS-II domains (Communication, Daily-Living Skills, Socialization and Motor Skills) and Adaptive Behavior Composite Scores with Normal Curve among control group.	68
16-25	Histograms of the VABS-II domains (Communication, Daily-Living Skills, Socialization and Motor Skills) and Adaptive Behavior Composite Scores with Normal Curve among high-risk group.	74
26-36	Histograms of the VABS-II subdomains among all participants.	80
37-47	Histograms of the VABS-II subdomains among control group.	87
48-58	Histograms of the VABS-II subdomains among high-risk group.	93

**Validation of the Vineland Adaptive Behavior Scale in Arabic
Language within a Palestinian Context**

By

Ciwar Abd El Qadir

Supervisors

Dr. Denise Ziya Berte

Co- Supervisors

Dr. Ali Barakat

Abstract

Today there is an emerging need for psychological assessment instruments which can be used within and across cultures and countries. The purpose of this investigation was to determine whether an Arabic version of the Vineland Adaptive Behavior Scale–II (VABS-II) can be employed to measure adaptive behaviors of children in the Palestinian context. This was a non-experimental study design with a convenient sample looking at the correlation of the scores on the two tests domains; VABS-II and Portage scale domains. Two samples of participants were analyzed; a convenient sample was compiled with a total of 56 male and female children (ages 2-9) including a group of high-risk children who were referred to a local multi-service center for neuro-developmental concerns ($N = 26$). The control group consisted of children attending a local private elementary school in northern West Bank territories ($N = 30$). Results showed that in the five developmental domains tested (Cognition, Communication, Socialization, Motor Skills, and Independent Living Skills) there were significant differences in some domains among the control group. Slight differences

were noted in the areas of cognition and motor skills for some sub-groups possibly related to differences in the scope of tasks utilized in each test. However, there were no significant differences among the high-risk group. The implication of these findings is that the Arabic version of VABS-II is an appropriate scale for assessing adaptive and maladaptive behaviors in a Palestinian context as it meets the standard of previously validated measures while adding scales of interest not available in the Portage, including an overall Adaptive Behavior Scale, a Maladaptive Behavior Scale, standardized T-Scores, and comprehensive full age standardized scales for ages birth to 90. Further investigation needs to be explored to assess the VABS-II efficiency in older and younger populations not included in this study.

Chapter 1

Introduction

1. Introduction

Envision your daily life activities, for example, caring for basic independent living needs (e.g., cleaning, eating, dressing and toileting), communicating with people, making choices, caring for your health, sustaining meaningful relationships and having friends. Those activities are combined under the concept of adaptive behaviors and skills. In this context, adaptive behavior is defined as the collection of conceptual, social, and practical skills that have been learned by people to enable them to function in their everyday lives in a specific environment or culture (Schalock et al., 2010). That is to say, adaptive behavior is the performance of daily activities required for personal and social self-sufficiency across a variety of life situations, including self-care, community mobility, home maintenance, establishing and maintaining relationships, and communicating needs and feelings (Sparrow, Cicchetti, & Balla, 2005).

Over the years, the assessment of adaptive behavior has received much interest from researchers, related to clinical use for differently abled populations and the critical task of understanding and measuring functional life skills with strength based/ standardized perspective in the diagnostic field (National Research Council, 2002). Adaptive behavior has been an integral, although sometimes unstated, part of the long history of examining intellectual deficits and clarifying their definition. During the 20th century, understanding adaptive behavior assessment became

increasingly important when diagnosing intellectual deficit and developing interventions for persons with cognitive delays (Oakland & Harrison, 2011). The role of defining and categorizing adaptive behaviors has expanded, given the increased recognition that adaptive behavior describes vital aspects of functioning for all persons and may constitute the ultimate developmental outcome in psychology (Oakland & Harrison, 2011).

1.1 Background and Significance

There are a number of templates to assess the level, quality, and pattern of adaptive functioning, each with its own strengths and weaknesses. For example, the Adaptive Behavior Assessment System-2nd Edition (ABAS-II) is an assessment of an individual's daily living skills for children and adults. The ABAS-II includes 10 skill areas including, communication, community use, functional academics, health and safety, home or school living, leisure, self-care, self-direction, social, and work (Harrison & Oakland, 2003). The ABAS-II assists professionals in making diagnoses and classifications, identifying a person's strengths and limitations, planning and monitoring intervention programs, and in their research and evaluation activities (Harrison & Oakland, 2003). However, although evidence is provided regarding internal consistency, no information is provided in the manual or the technical report (Harrison & Oakland, 2003b) regarding subtest specificity for the 10 skill areas or the domain scores. In addition, ABAS-II provides no factor analytic support for the skill areas utilized (Rust & Wallace, 2004).

Another method is the Portage Evaluation, which is part of a holistic intervention system, in which children are assessed on five developmental scales: motor, language, self-help, socialization, and cognition (Sbordone & Long, 1996). This scale can be used both for an initial assessment and to provide the information necessary to select appropriate future teaching objectives for the child (Cameron, 1997). Still, the Portage evaluation method is limited for very young children (from birth to 9 years old) and is highly dependent on linguistic capacities. Many of Portage items are unsuitable for older youth and adults and no standardized scales are available after age 9 (Sbordone & Long, 1996).

The Vineland Adaptive Behavior Scale-II (VABS-II) is among the most widely used scale in psychological evaluation, practice and research (Balboni, Pedrabissi, Molteni, & Villa, 2001). The VABS-II assesses an individual's development of personal independence and social responsibility by gathering information about day-to-day activities necessary to take care of one-self and to get along with others (Sparrow, 2011).

The VABS-II is applicable whenever an assessment of an individual's daily functioning is required. The scales have been used in a variety of clinical, educational, and research settings (Sparrow, Cicchetti & Balla, 2005). In addition, VABS-II Survey forms are well suited for evaluation and diagnosis of Intellectual Deficit. The system is also designed to aid in the clinical diagnosis of a variety of disorders and

disabilities, including autism spectrum disorders, various genetic disorders, developmental delays, emotional and behavioral disturbances, and a wide range of other mental, physical, and injury-related conditions (Sparrow, Cicchetti & Balla, 2005). The VABS–II may also be used in many types of research projects in which the development and functioning of individuals with and without disabilities are investigated. Because it does not require the presence or ability to cooperate of the individual being assessed, the VABS-II is useful for research about mental and physical disabilities, infant development, and parent-child relationships. Moreover, VABS-II helps in determining eligibility or qualification for special services, planning rehabilitation or intervention programs and tracking and reporting progress (Sparrow, Cicchetti & Balla, 2005).

It is necessary for researchers and clinicians to have access to valid measures of concepts of interest in their own cultures and languages to conduct cross-cultural research and/or provide quality client care (Sousa & Rojjanasrirat, 2011) because of cultural variations the norms on standardized instruments may differ across countries. When conducting an assessment it is important to understand that cultural context is a crucial aspect of explaining thoughts, feelings, and behaviors (Groth-Marnat, 2009). According to AAMR (1992), cultural, linguistic, communication and behavioral factors are important components of an individual's adaptive skills. Whether an instrument is appropriate is based on a number of considerations, including the individual's or group's level of acculturation, language preference, language proficiency, availability of translation of the

instrument, whether the construct is the same for the individual's or group's culture, availability of norms, and availability of possibly more appropriate alternatives specific to the individual's or group's culture (Groth-Marnat, 2009). For example, in Fombonne and Archard (1993) a study that was conducted in France, it was found that average scores on the Vineland Scale in their sample were comparable to the test norms developed in the United States. However, a study conducted to examine the applicability of Vineland norms to a sample of second grade children in Norway, had differing results. The Norwegian children obtained mean scores on the Vineland Adaptive Behavior Scales – survey form that were lower than means for the normative sample in the United States (Smith, Eikeseth & Lande, 2006). This investigation provides preliminary support for the idea that norms on the Vineland may differ across countries. These differences may be as a result of cultural factors that are unique to a particular population.

1.2 Aim of the study

The aim of this investigation was to determine whether the VABS–II could be employed to measure adaptive behaviors of children in the Palestinian context equally to other previously validated scales. In other words, to validate a translated version of the VABS–II (VABS-II - Arabic Version) and to insure that the measure is culturally relevant, predictive and equivalent to the results of both clinical observation and a previously validates second measure of development, Portage Arabic Version, on

children. In addition to determine if the VABS -II, due to its additional data points (such as a Maladaptive Behavior Scale standardized T-Scores) and its comprehensive age range (birth to 90 years of age) will add utilization benefits for the Palestinian community to which it is applied.

1.3 Problem statements

This investigation was conducted in order to determine if the VABS–II, in its Arabic version, is equal to or better than the comparison scales of the Portage Scale in measuring adaptive behaviors of children in the Palestinian context.

1.4 Research Questions

Based on the above background, the current investigation focused on the following three research questions.

- ***Research Question 1: Does the Vineland Adaptive Behavior Scale -II record similar results and population patterns as the Portage I when applied to a sample of high risk and control group of children in the West Bank territories of Palestine?***
- ***Research Question 2: Are there age, gender or risk category differences noted in the application of the Vineland Adaptive Behavior Scale II?***
- ***Research Question 3: Does the sample of Vineland Adaptive Behavior Scale-II scores fall into a normal curve pattern such as the original validation data reveals?***

- ***Research Question 4: Does the Vineland Adaptive Behavior Scale-II add relevant information for professionals working with school aged children and beyond?***
- ***Research Question 5: Are the parents satisfied with the Vineland Adaptive Behavior Scale – II process?***

1.5 Significance of the study

This study has increased the number and variety of internationally standardized validated scales and the knowledge of general development in understanding the process of early childhood development, identifying individual and community needs and providing a structure for appropriate diagnosis of both children and adults in Palestine. In addition, it provides critical information on the utilizability of the VABS-II in a Palestinian context.

Chapter 2

Theoretical background and Literature Review

2.1 Adaptive behavior

2.1.1 Adaptive behavior definition

Adaptive behavior refers to the ways that individuals meet their personal needs as well as manage the natural and social demands in their environments (Nihira, Leland & Lambert, 1993). It is defined as the collection of conceptual, social, and practical skills that have been learned by people to enable them to function in their everyday lives in a specific environment or culture (Schalock et al., 2010). Necessary skills for functioning daily include the ability to care for one's self, communication skills, and social skills (Baroff & Olley, 1999).

Adaptive behavior” refers to the functioning of an individual in his or her environment. As such, adaptive behavior draws together a person’s cognitive and personality characteristics. Assessments of adaptive behavior typically focus on domains such as communication, self-care skills, and interpersonal relationships.

In other words, "adaptive behavior" refers to the functioning of an individual in his or her environment. As such, adaptive behavior draws together a person’s cognitive functioning, daily life skills, motivation, and personality characteristics. Usually, adaptive behavior assessments focus

on domains such as communication, self-care skills, and interpersonal relationships (Mervis & Klein-Tasman, 2000).

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) published by the American Psychiatric Association (2013), adaptive functioning refers to how effectively individuals meet developmental and sociocultural standards for personal independence and social responsibility. The construct of adaptive behavior was primarily developed within the field of intellectual and developmental disabilities and thus has its roots firmly planted in the area of understanding norms regarding disabilities, specifically, intellectual disability. Thus, adaptive behavior assessment first became important when diagnosing intellectual deficit and developing interventions for persons with intellectual deficits (Oakland & Harrison, 2011). In this context, adaptive behavior is a required diagnostic criterion of all systems defining intellectual and developmental disabilities (Schalock et al., 2010; World Health Organization, 1992). Adaptive skills are also the core component of the functional legal definition of "developmental disabilities" (Public Law 106-402: Developmental Disabilities Assistance and Bill of Rights Act, 2000) and are as such in need of a critical standardized methodology in determining levels of functioning.

However, several writers have clarified that adaptive behaviors refer to behaviors typically expected in one's community which make it a unique challenge to create globally accepted measures (Brodsky & Galloway,

2003; Stevens & Price, 2006; Bonnie & Gustafson, 2007; Schalock et al., 2007)

2.1.2 The development of Adaptive Behavior

Adaptive skills are developmental, which means that an individual acquires these skills differentially over age and experience. These behaviors typically become more complex as children age, and more is expected of them (Horn, 1996).

Adaptive behavior is a broad domain of development that refers to a child's ability to function independently in his or her environment. It has been defined as the degree to which individuals meet standards of personal independence and social responsibility appropriate for their chronological age and cultural sub-group (Grossman, 1983). That is to say, age related expectations and cultural context are central to the concept of adaptive behavior (Grossman, 1983; Reschly, 1982). Therefore, the assessment or measurement of adaptive skills is defined by the expectations or standards of other people. There are general developmental guidelines, but typically adaptive skills are culturally specific and determined by what a society agrees that children should be capable of by a certain age (Horn, 1996).

The increase in diversity of the population worldwide and the need for cross-cultural and multinational research suggests a great need for cross-culturally reliable and validated research instruments or scales (Beaton, Bombardier, Guillemin & Ferraz, 2000; 2002; Sousa, Zauszniewski, Mendes & Zanetti, 2005). If a measurement is not

appropriate for the population it is applied to, it may result in a measure that is incorrect and may even exhibit bias against the group or individual it is evaluating. Bias in testing refers to the presence of systematic error in the measurement of certain factors among certain individuals or groups unrelated to the factor of study (Groth-Marnat, 2009).

In this context, according to Eckensberger (1972), cross-cultural research in psychology is the explicit, systematic comparison of psychological variables under different cultural conditions in order to specify the antecedents and processes that mediate the emergence of behavior differences. Thus, the most crucial issue in test construction when addressing the question of multi-cultural use, is validity. Validity assesses that the test is accurate for a specific context and that it continues to measure the same psychological characteristics across populations. A test that is valid for clinical assessment should measure what it is intended to measure and should also produce information useful to clinicians (Groth-Marnat, 2009).

2.1.3 Adaptive Behavior assessment

Adaptive behavior assessment scales play an important role in helping practitioners diagnose, plan treatment or rehabilitative supports, and/or determine an individual's level of independence (Dixon, 2007). This assessment of adaptive functioning which is usually based on caregiver report is intended to determine how well the individual manages in everyday life situations in terms of functional communication skills, getting

along with people, self-help/ daily life skills, and independence (Perry, Flanagan, Geier & Freeman, 2009).

Moreover, adaptive behavior assessment has been important in a data-based, decision-making model of psychological, educational, social, and rehabilitative services (Oakland & Harrison, 2011) and it has been applied widely in the field of intellectual deficit (Harrison & Boney, 2008). Tassé et al. (2012) have provided a thorough explanation on the use of the adaptive behavior construct and its contribution to a broader understanding of intellectual disability. Over the years, adaptive behavior assessment use saw an increased emphasis in order to plan and implement interventions for individuals with intellectual deficit (Harrison & Boney, 2008). This type of assessment should be an integral part of school psychologists' data collection about individual's skills in multiple environments. Comprehensive assessment of adaptive behavior by school psychologists is an important process to identify person's strengths and needs and to focus on important goals for intervention programs. In other words, data gathered from this assessment should be used, along with data from other sources and about other behavior domains, to design, implement and monitor interventions (Harrison & Boney, 2008). Furthermore, this type of assessment assists in transition planning and may help ensure the individual/student has the necessary skills to be productive when he or she has left the school environment. Therefore, the use of a formal adaptive behavior measure allows the assessment team to determine the student's

level of functioning in daily tasks required to be successful in the home, community, and workplace.

A number of assessment scales have been constructed for the purpose of measure adaptive behaviors. However, while scales abound, research using adaptive assessment scales have primarily been limited to three primary tools: the Vineland Adaptive Behavior Scales, the AAMR Adaptive Behavior Scales, and the Scales of Independent Behavior. These scales have been through multiple revisions and have been the topic of considerable amounts of research (Dixon, 2007).

2.1.3.1 The Vineland Adaptive Behavior Scales (VABS)

There are a number of available instruments that measure the adaptive performance of children (Kamphaus, 1987; Keller, 1988) in the U.S. and other western countries. One of the most popular measures, which include the full spectrum of human development from infancy to adulthood range, is the Vineland Adaptive Behavior Scales (VABS) (Sparrow, Balla, & Cicchetti, 1984; Sparrow, Balla, & Cicchetti, 2005). The VABS (Sparrow et al., 1984) is a well validated measure of developmentally significant behaviors in persons with severe and profound intellectual deficit. The VABS-II Survey forms represent a substantial revision of the VABS (Sparrow et al., 1984). The VABS-II were designed to address adaptive behavior, or the personal and social skills necessary for everyday independent living across the life span (birth-90 years) (Cicchetti, Carter & Gray, 2013). It has demonstrated adequate psychometric properties across

the 4 domains, 11 subdomains, and the adaptive behavior composite contained in the scale across a variety of populations.

The purpose of the VABS-II is to measure adaptive and maladaptive behavior and to assess personal and social sufficiency of individuals from birth to adulthood (Sparrow, Balla & Cicchetti, 2005). This form, VABS-II, helps in clarifying diagnosis of intellectual and developmental disabilities of youth through a semi-structured interview with a primary caregiver (Sparrow, Balla & Cicchetti, 1984). The scale measures personal and social skills used for everyday living. Thus, psychologists and other professionals use it to identify individuals who have intellectual deficit, developmental delays, brain injuries and other impairments (Sparrow, Balla & Cicchetti, 2005) and to determine appropriate educational settings, residential venues, and specialized services as well as specific treatment goals and discharge criteria.

The VABS consists of four forms: (1) Survey Interview – administered to a parent or caregiver in a semistructured interview format. (2) Parent/Caregiver Rating Form – covers the same content as the Survey Interview in a rating scale format. (3) Expanded Interview – administered in a semistructured interview format; designed to provide a more comprehensive assessment. (4) Teacher Rating Form (Sparrow, Cicchetti & Balla, 2006).

There are 4 domains (and 11 sub-domains) of adaptive behavior assessed by the VABS: (1) communication (receptive, expressive, written),

(2) daily living skills (personal, domestic, community), (3) socialization (interpersonal relationships, play and leisure time, coping skills), and (4) motor skills (gross and fine). A composite score is provided by scores obtained in the 4 domains (and 11 sub-domains) known as the Adaptive Behavior Index. Maladaptive behaviors are also assessed via a checklist of problematic or diagnostically relevant behaviors. A standard score, age equivalent, and qualitative label are obtained for the adaptive behavior composite and for each adaptive domain. The scales were revised in 1984 and 2005 to provide updated valid and reliable norm-referenced data (Sparrow et al., 1984, 2005).

The VABS are useful for diagnosis, qualification for special programs, progress reporting, program and treatment planning, and research (Sparrow et al., 1984, 2005). The VABS have been successfully applied for use in a variety of diverse populations over the past three decades, including their role as a gold standard for validating other scales (Middleton Keene & Brown, 1990) and in international studies for extending their use from the US to other cultures and contexts (Fombonne and Achard, 1993). The VABS is dependent on a caretaker interview and includes developmental milestones from birth, which makes it ideal for use with very young children (Irwin, Carter & Briggs-Gowan, 2002; Raggio and Massingale, 1993; Stone, Ousley, Hepburn, Hogan & Brown, 1999), making it a popular scale for use with developmentally impaired infants and preschoolers. It has also been extensively used with youth diagnosed with autism spectrum disorders (Venter, Lord & Schopler, 1992) and in

establishing baseline functioning measurements for individuals with suspected genetic disorders (Szatmari et al., 2002). As a whole, measuring adaptive behaviors plays an important role in both research and practice related to Autism Spectrum Disorder. The VABS-II (Sparrow, Cicchetti, Balla, 2005) is one of the best known measures of adaptive behavior available to clinicians and researchers working with children and youth with an ASD as the evaluation is not dependent on the cooperation of the participant in clinic-based environments.

2.2 Portage Program

2.2.1 Portage Program description

The American Portage Project began in Portage, Wisconsin, in 1969 by David E. Shearer. The Portage Project was initially developed to provide services to young children identified with disabilities within a rural community (Shearer and Shearer, 1972). Portage was designed to be a home-based intervention program for families with children from 0 to 6 years of age with special educational needs (Bluma, Shearer, Frohman, & Hilliard, 1976; Cameron, 1997). The aim of the Portage Program is to stimulate the development of children with a developmental age between 0 and 6, change the behavior of the child, and provide support for the parents (Bluma et al., 1976).

In the early 70's, the Portage Project offered home-based services that supported parents as their children's first, most valuable and influential teacher. Over the years and by way of documented experiences of best

practices with children, parents, new legislation, and continued research, the Portage Project model has consistently evolved resulting in an increase of quality programming and enhanced services within the field of early childhood education and more specifically, early intervention programs (CESA 5, 2003).

Portage is an internationally used early intervention program which includes a guide with an assessment scale and a method of working in a team (Shearer & Shearer 1972; Bluma et al. 1976; Blunden 1982; Cameron 1982).

2.2.2 Portage Program Assessment

Portage is one of the most successful models of assessment and intervention for young children. Originally developed in rural areas of the USA, it is now used and adapted in many developed and developing countries. The essence of the Portage program lies in its involvement of the family both in assessment, decision making and day to day teaching of the child in the home setting (Bluma et al., 1976).

One form of assessment for the Portage program is the Developmental Profile (Alpern et al., 1980) which is used for the sharing of information with parents, to pass on information to the child's next educator, group assessments and for curriculum planning. The Portage assessment scale provides a detailed description of developmental achievements. The Portage assessment scale is not a standardized test. However, the scale can be used to provide a measure of developmental

level, which can be a single measure of a person's development (Bluma et al., 1976).

The Developmental Profile (Alpern & Shearer, 1980) was used to assess the development of children prior to their entrance into the program and twice yearly thereafter in the following areas: motor; self help; social; cognitive; and language. The Developmental Profile's items correspond to and sample the developmentally sequenced activities found in the five areas emphasized in the Portage Program. Thus, the developmental profile can be considered a criterion-references measure to the Portage Program. In addition, inasmuch as the profile also provides age equivalents for the items, the measure also may be used informally as a norm-referenced measure.

2.3 Comparison VABS-II with the Portage Assessment Scale

Although the Portage assessment scales evaluate similar developmental domains as the VABS-II, the VABS-II offer more advantages than the Portage in measuring adaptive behavior skills. Firstly, the VABS-II assesses individuals across the life span while the Portage assessment is limited to evaluate children from birth to 9 years old only. Secondly, VABS-II provides more information; it provides a profile of adaptive behaviors and maladaptive behaviors. However, the Portage is limited to measuring developmental adaptive skills only and it is a screening tool. Thirdly, the VABS-II has more questions and is more specific. In addition, VABS-II forms well suited for evaluation and

diagnosis of children with various disorders and disabilities. Finally, the VABS-II evaluate individual what an individual actually does, rather than what he or she is able to do in a specific condition or session.

2.4 Validation study

2.4.1 Validity definition

The term "validity" in psychology, is often discussed in terms of its application to psychometrics, or the study of psychological measurement. Validity refers to the extent to which a concept or measurement accurately corresponds to the “real world” representation of symptoms or functioning level (Offit, 2013). Validity in research refers to how accurately an investigation answers the study question or the strength of the assumed conclusions. For outcome measures such as surveys or tests, validity refers to the accuracy of measurement (Sullivan, 2011). That is to say that validity describes how well one can legitimately trust the results of a test as interpreted for a specific purpose (Cook & Beckman, 2006). For example, in West (1985) an investigation examining an Arabic validation of the Beck Depression Inventory was conducted to assess how well the Arabic-BDI measured the depression variable in an Arab context.

The approach of the current study is to determine the validity of the VABS-II after it was translated in Arabic and applied in the Palestinian context. In this study, validity refers to how well the VABS-II tool actually measures the underlying factors of interest as compared to measures previously validated and presently utilized.

2.4.2 Cross cultural validation

Cross-cultural research has been present for years in the social sciences and its importance has gained recognition in the health sciences, especially with the growing role of health-related quality-of-life research. Cultural issues have been examined in several studies (epidemiologic studies; health-related beliefs, attitudes, and behaviors studies; health administration; and health economics) (Sperber, 2004).

The adaptation of assessment instruments for new target populations is required when the new target population differs appreciably from the original population with which the assessment device was derived and is used in terms of culture or cultural background, country, experience and language. Most cross-cultural adaptations of assessment instruments involve the translation of an instrument from one language into another (Geisinger, 1994). Translation is the most common and basic method of preparing instruments for cross-cultural research (Sperber, 2004). The process of translation is a critical task in cross cultural research. Several methods have been proposed when validating translated psychometric instruments. As described in the study of Kojima et al. (2002), a Japanese version of the BDI-II was created and examined for its psychometric properties. In the study they used back translation techniques, which consist of an initial translation to the target language, followed by a translation from the resulting document back into the target language to insure linguistic integrity. This method is utilized to insure and preserve

equivalence in cross-cultural adaptation of the instrument. Another example is a study that was conducted by Kempen et al. (2007) in which they carried out a cross-cultural validation of the Falls Efficacy Scale International (FES-I). A German and Dutch versions of the FES-I were created to test their psychometric properties and to compare its results with the English version of FES-I. A previous study was conducted by Almadi et al. (2012), in which an Arabic version of the Perceived Stress Scale was developed and its validity and reliability were evaluated. A translation process with cross-cultural considerations was employed to produce an Arabic version of the Perceived Stress Scale. They adopted the repeated forward–backward translation procedure (Meadows et al., 1997) for the translation of the PSS into Arabic.

In the current study, a variety of techniques were utilized including native speaker translation, bilingual expert review, and back translation. The VABS-II items will be translated from English to Arabic and back translated to English as well as will be reviewed by field experts.

2.4.3 Determining validity of an assessment instrument

To investigate a validity of an assessment tool there are different sources of evidence to build the case that the instrument measures what it is supposed to measure in the community in question (Kane, 2002). Evidence can be found in content, response process, relationships to other variables, and predicted outcomes (Sullivan, 2011).

In the present study, evidence will be evaluated by relationships to other variables. Relationship to other variables includes correlation of the new assessment instrument results with other performance outcomes that have been previously validated and are utilized in the target population. In other words, the new measure is compared to the currently accepted measurement in the population of interest; the instrument results are compared to the subject/sample's performance on the accepted "gold standard" (Sullivan, 2011). In this context, this research will investigate whether the VABS-II, in its Arabic version, can be employed to measure adaptive behaviors of children in the Palestinian context by comparison of the adapted version of the instrument with the currently utilized and previously validated measure that assesses similar factors and the only available measurement standard, which in this case is the Portage Assessment Scale.

2.5 Review of the literature

Today there is an emerging need for psychological assessment instruments which can be used within and across cultures and countries. In the Middle Eastern countries, this need is accentuated as so few measures exist and even fewer have been properly validated with any scientific investigation.

Anytime a psychometric instrument is used with a population that differs qualitatively from the one for which it was originally developed, it

is necessary to determine its continued validity and usefulness in the new population, even if the test itself remains unchanged (Geisinger, 1994).

In this regard, previous studies were conducted in order to investigate whether an instrument is appropriate to the cultural group of the respondents. Memari and others (2013), for example, conducted a study to translate and adapt the Autism Treatment Evaluation Checklist (ATEC) into the Persian language and to investigate its reliability and validity in an Iranian autistic sample. Their study sample was 134 children with autism spectrum disorders. They used the ADI-R instrument as a comparison to the ATEC. Each subscale of ATEC was examined with its equivalent from ADI-R in order to evaluate the construct quality and validity. The results showed good content validity and internal consistency. In relation to construct validity, there was significant correlation between ATEC subscales and raw data obtained from Autism Diagnostic Interview-Revised (ADI-R). The Intraclass Correlation Coefficient for the test-retest reliability was excellent for all the subscales and also for total scores. Concluded, that cross-cultural adaptation of ATEC was successful. The psychometric properties were verified and indicated that the adapted questionnaire is valid and reliable to use in Iranian culture.

Fava (1983) conducted a study to examine the validity of the CES-D self-rating scale for depression in northern Italy. The scale was used with 40 individuals diagnosed with depression and 40 control subjects that were matched. In this study, the Hamilton Rating Scale for Depression (HRSD)

(Hamilton, 1960) was used as an additional test of concurrent validity. The scale was given in its Italian translation prepared by the author. The Italian translation had been given to 10 bilingual American residents in Bologna, who retranslated it into English, without knowing the original, to confirm its accuracy (Fava, 1983). The results show that the CES-D is a valid measure in that it sensitively discriminates between depressed patients and normals and presents satisfactory correlations with the observer rating scale (HRSD) in both groups. The scale in its Italian translation is likely to be helpful in the assessment of depression of Italian immigrants in North America and Australia; especially in who's English is poor. Another example is a previous study of Montazeri et al. (2003). Their research aimed to test the validity of the Iranian version of the Hospital Anxiety and Depression Scale (HADS). HADS is a widely used instrument to measure anxiety and depression in cancer patients. In this study the scale was translated from the English language version into Persian (in an Iranian context). The aim of this study was to translate, validate and use the questionnaire in studies of the quality of life in cancer patients in Iran. The 'forward-backward' procedure was applied to translate the HADS from English into Persian (Iranian language). In addition, the validity of the HADS was examined using the known groups' comparison and convergent analysis. In general the Iranian version of the HADS was found to be acceptable to almost all patients (99%). Validity as performed using known groups' comparison analysis showed satisfactory results. Both anxiety and depression subscales discriminated well between sub-groups of patients

differing in clinical status as defined by their disease stage. This preliminary validation study of the Iranian version of the HADS proved that it is an acceptable, a reliable and valid measure of psychological distress among cancer patients.

VABS data are based on observable behaviors, which make it by definition appropriate for assessment with various cultural populations (Pearson Education, Inc., n.d.). However, cultural context is still a crucial dimension of adaptive behavior and any measure thereof (Reschly, 1982). According to Thompson et al. (1999), what is adaptive behavior must be understood in the context of the individual's relevant daily and social life, which is determined by age, culture and context.

Culturally competent assessment practices require the consideration of the developmental norms and impact of cultural practices or language differences among examiners, examinees, and informants that may affect the validity of the clinical information collected and interpreted (Reschly, Myers, Hartel & National Research Council, 2002). Thus, the question arises is whether the construct of adaptive behavior in a non-western culture can be effectively measured by western instruments regarding multiple differences among cultures; In other words, whether the questions and standardized scores are relevant and appropriate to the cultural group of the respondents and the way they are raised up. For example, learning how to ride a bicycle may be different among different communities/places. In the place where there is a space for riding and driving the bikes provide

an opportunity to acquire this skill. Another example, visiting and meeting friends is also cultural depending and family perspective. These skills relate to the "fit" of the child within and across multiple settings. The acquisition of adaptive behavior may also appear to have a more immediate, concrete impact, particularly from the family's perspective (Horn, 1993). Adaptive behavior should include skills that reflect chronologically-age appropriate skills that meet the demands of children's multiple and unique environments (Horn, 1993).

In regard to utilize the VABS-II in a non-western culture and to examine whether the VABS-II could be successfully adapted to measure adaptive behaviors in various cultures previous studies were conducted using multiple procedures (Goldberg, Dill, Shin, & Nhan, 2009; Zhang, Wheeler & Richey, 2006; Tombokan-Runtukahu and Nitko, 1991).

Previous study of the utilizability of the VABS in the context of Indonesia was investigated by Tombokan-Runtukahu and Nitko (1991). In their study it was examined if the construct of adaptive behavior, which has been developed and operationalized in western countries, could be successfully operationalized/adapted in a nonwestern country, in particular in the Indonesian context. The VABS was translated into the Indonesian language. Forty-three children with mental retardation were matched on the basis of age, gender, and SES with 43 children of normal intelligence. Parents and teachers of all children were interviewed by the senior author using the IVABS. The senior author administered the Raven Progressive

Matrices Test (CPM) (Raven, 1962) individually to the children during school hours by removing them from their classrooms. To study the stability of parents' ratings, each parent participating in the study was interviewed a second time, two weeks after the first interview. The second interview focused only on the IVABS. The correlations were evaluated. They concluded that the domain of adaptive behavior can be successfully applied and operationalized in an Indonesian setting.

Another previous study of cultural validity in VABS (interview edition) was conducted by Zhang et al. (2006). In their study, they examined the qualities of cultural validity in four assessment instruments designed for young children with autism from a Chinese cultural perspective. The VABS was one of these four assessment instruments. Some of the VABS items do not work well as screening indicators of children with autism. Some of the questions cannot be performed because of the way most Chinese children are raised up. With the examination item by item, the authors find out several items from the assessment scales are not suitable for the children and families from the traditional Chinese culture, and may need to be adapted before using.

As described in the study of Goldberg et al. (2009), a Vietnamese version of the VABS and its psychometric properties were examined in Vietnamese population. In this study, the scale was administered to 120 Vietnamese mothers of non-disabled preschool-age children enrolled in kindergarten programs. Information on the performance of the Vietnamese

version of VABS was also obtained from 31 mothers of preschool-age children with intellectual disabilities who were enrolled in an early intervention program in Hue City. These children were identified as having intellectual disability/delays by teachers in kindergarten programs the children were attending or by records of community health clinics. In order to investigate the construct validity, inter-correlations between sub-domains for non-disabled Vietnamese sample on the VABS – Vietnamese version. In addition, to address the capabilities of this version of the VVABS to discriminate between differing groups of Vietnamese children, the Non-Disabled Vietnamese (NDV) children group and Disabled Vietnamese (DV) children group, comparisons were undertaken. The 11-sub-domain scales, the 4 domain scales, and the adaptive behavior scales were compared for the NDV and DV groups. The results showed that the Vietnamese version of VABS has psychometric properties comparable to that of the VABS standardization sample (Sparrow et al., 1984, 2005).

In this regard, the Portage Program has also been translated and validated across several countries or cultures (Brue and Oakland, 2001; Cameron, 1997; Oakland, 1997; Sturmey et al, 1992). The Portage Program seemingly has had universal appeal. It has been translated into approximately 30 languages and used in more than 60 countries (Bijou, 1991).

2.6 Summary and research questions

In conclusion, based on the background and the literature review, exploration of VABS would be beneficial. Therefore, this research will investigate whether the VABS-II, in its Arabic version, can be employed to measure adaptive behaviors of children in the Palestinian context by comparison of the adapted version of the instrument with similar test that assess similar factors, which is the Portage assessment scale.

Chapter 3

Methods

3.1 Translation

Most cross-cultural studies use instruments that have been developed in one language and translated into another. The traditional method of translation includes initial translation, expert review and back translation. Any one method alone is not sufficient to ensure equivalence (Bontempo, 1993).

After stressing the need for qualified translators, Hambleton and Patsula (1998) suggested that a rigorous instrument adaptation process would involve at least three steps: (a) translating the test from a source to target language, (b) translating the test back into the source language (back translation), and (c) using independent teams of qualified translators to review the original, back-translated, and target language versions of the instrument to examine equivalence and resolve discrepancies.

The VABS-II was translated from its origin language, English, into Arabic by English expert as well as mental health professional. The translated version was reviewed by field experts including mental health and educational practitioners. The Arabic version was tested for months with children at a local multi-service center for neuro-developmental concerns, the An-Najah Child Institute (ACI). Lastly, after clinical testing and several changes by the staff in the ACI, the scale in Arabic version was

back translated and approved. Statistical validation of the VABS-II Arabic Version is the goal of this investigation.

3.2 Overview of design

This study design is a non-experimental with a convenient sample looking at the correlation of the scores on the two tests domains.

3.3 Study population and sampling

This study included a convenient sample total of 56 ($N = 56$) Palestinian children, within the ages 2-9 ($M = 5.808$, $SD = 1.515$). Of the 56 participants 31 were male and 25 were female (see Table 1). All participants participated on a voluntary basis.

The sample included a group of 26 high-risk children who were referred to a local multi-service center for neuro-developmental concerns. The second group consisted of 30 children who are attending a local private elementary school in Nablus (see table 2).

As the test itself will determine the diagnostic standing of the groups, it is not a control group per say, but instead one group with differential risk for developmental delay, which insure that a full range of children are included. After diagnosis the groups (high scoring and low scoring) were separated to see if there were significant differences in the way the scale predicts development scores on the second scale. However this grouping cannot be done preemptively as diagnosis is based on the scale itself. In addition each child will serve as a control for themselves as each will

receive all measures. Children whose age is within the age of 2 to 9 were solicited for participation in the study. Non-referred children were selected from class lists in a local private elementary school with kindergarten and nursery. Parents whose children fit the research criteria have been given information about the study including an approved Consent for Participation Form. Those who agree to participate were included in the study. Arabic was the first language of all participants and all gave informed consent.

Data on referred children, meeting the criteria of the study, age and availability, were selected from the archival files of a local treatment center and included after testing was completed.

A Parent Information Letter (Appendix B) describing the study was distributed to parents of children within the required age range. Interested parents were given an Informed Consent Form (Appendix C).

All participants were assured that their educational status or services would not be affected in any manner due to their participation with this program.

3.4 Selection criteria

Age 2 – 9 (see table 3).

Available and willing caretaker.

3.5 Design for sampling

Convenience sampling that is a specific type of non-probability sampling method that relies on data collection from population members who are conveniently available to participate in study. This method is the only ethical model for the current study as forced participation is not possible.

3.6 Instruments

Research participants completed a guided interview using both, the Arabic versions of the VABS-II and Portage Assessment Scale. Both the targeted child and a selected parent or caretaker participated in the session.

1- Vineland Adaptive Behavior Scale – Second Edition (Sparrow, Balla & Cicchetti, 2005).

The VABS-II is designed to measure adaptive behavior of individuals from birth to age 90. Because adaptive behavior refers to an individual's typical performance of the day-to-day activities required for personal and social sufficiency, these scales assess what a person actually does, rather than what he or she is able to do. The VABS-II assesses adaptive behavior in four domains: Communication, Daily Living Skills, Socialization, and Motor Skills. It also provides a composite score that summarizes the individual's performance across all four domains. It provides standard scores in each of the domains and an overall Adaptive Behavior Composite. Maladaptive behaviors are also assessed via a

checklist of behaviors marked as present or absent (sparrow, Balla & Cicchetti, 2006). The VABS-II Survey Interview Form items are scored according to whether the activity described by the item; usually or habitually performed without physical helps or reminders (score 2), performed sometimes or partially without physical help or reminders (score 1) and never or very seldom performed or never performed without help or reminders (score 0). A score of N/O for no opportunity is assigned when the activity is not performed because of limiting circumstances. A score of DK for don't know is assigned when the respondent has no knowledge of whether the individual performs the activity. On a subdomain, a basal is established when the individual usually or habitually performs all the activities described in four consecutive items (that is, the individual receives a score of 2 on four consecutive items). The basal item is the highest item in the highest set of four consecutive items receiving a score of 2. Similarly, a subdomain ceiling is established when four consecutive items are scored 0, and the ceiling item is the lowest item in the lowest such set of four consecutive items with scores of 0 (Sparrow, Balla & Cicchetti, 2005).

Reliability coefficients for the origin version of VABS were obtained from test-retest and inter-rater reliability studies conducted during the national standardization period. Results indicate excellent reliability for subdomains, domains, and the Adaptive Behavior Composite, as well as good to excellent reliability for 95% of individual items and moderate reliability for the remaining 5% (e.g., the criteria of Cicchetti & Sparrow,

1981, and Fleiss, 1981). Studies investigating construct, concurrent, factorial, differential, and predictive validity of the VABS were also successfully conducted (Sparrow et al., 1984a, 1984b, 1985).

In this study, a translated version of the VABS-II from English into Arabic (Appendix D) was used.

2- Developmental Profile (Alpern & Shearer, 1980) of the Portage Program (Bluma, Shearer, Frohman & Hilliard, 1976)

Portage is an internationally used early intervention program which includes a guide with an assessment scale and a method of working in a team (Shearer & Shearer, 1972; Bluma, Shearer, Frohman & Hilliard, 1976; Blunden, 1982; Cameron, 1982; Tiilikka & Hautamaki, 1989). One form of assessment for the Portage Project is the Developmental Profile which is used for the sharing of information with parents, to pass on information to the child's next educator, group assessments and for curriculum planning.

The Developmental Profile (Alpern & Shearer, 1980) was used to assess the development of children prior to their entrance into the program and twice yearly thereafter in the following areas: motor; self help; social; cognitive; and language.

The Portage scale can be used to evaluate the developmental level, and its reliability and validity have proved to be good in studies of intellectually impaired populations (Arvio, Hautamäki and Tiilikka, 1993). In the assessment stage items on each checklist are completed through

observation or through eliciting the behavior. For example, the first item on the cognitive scale is "cloth on face". A cloth is put on the child's face and if he or she removes it by any means, the item is passed (Sbordone & Long, 1996). The assessment can be made by any trained professional, not only by psychologists.

In this study, the Portage scale in Arabic Version (Appendix E) was used as a comparison tool to the VABS–II Arabic Version. This program was designed in the United States in 1969 and translated into several languages, including Arabic.

This scale is used all over Palestine and in the Arab community. The Portage has been used in some Arab countries for more than 25 years (Al Khateeb & Hadidi, 2010). It was introduced to the Arab world in 1984 in the Gaza strip, Palestine. The Portage materials were translated into Arabic and hundreds of home visitors were trained. Starting in the early 1990s, many other Arab countries (e.g. Egypt, Yemen, Saudi Arabia, Lebanon, Jordan, United Arab Emirates, Oman, Qatar, Bahrain, Morocco, & Kuwait) began to implement this Project (United Nations Educational, Scientific & Cultural Organization, 2007).

The Portage project of the Early Intervention Program has proved effective in developing countries for children with disabilities and providing them with the basic skills and expertise that have a significant impact on educational and developmental aspects. When translated into Arabic, few modifications were necessary to meet cultural differences.

Portage home-based model of early education intervention for parents of developmentally delayed children, Arabic version, is appropriate for children from birth to 9 years old. Assessment of Child Developmental Profile is written and codified by Alpern-Boll (Alpern & Boll, 1972). The baseline credit is obtained from the blocks or the box whose items have been completed and passed which is considered higher value than any other box. The additional credit is consist of the total number of months which are separated of the items that the child passed it successfully and between the blocks of failure and success. The child age in each domain is the sum of the baseline credit and the additional credit.

3. Parents Satisfaction Survey .

The parents satisfaction survey (Appendix F) included 5 questions on a scale from 1 to 5 (1 Very Helpful; 2 Moderately Helpful; 3 Neutral; 4 Moderately Problematic; 5 Problematic). In addition, three opened question were asked.

This survey was completed in the last session with receiving and explaining the results for the parents.

3.7 Procedure

A meeting with the director of the selected school was conducted to obtain an agreement for organizing this study. Children from class lists were selected to participate in the research and a parent information letter (Appendix B) was given to the selected children. The participant families

were provided with information that enabled them to make an informed decision as to whether they wanted to participate in the research study. They were provided with a description of the scale and the purpose of the research. Also, they were informed that they have the right to withdraw any time and that the data will be collected for the purpose of the research only with insuring confidentiality. In addition, the participants were informed with information about the time that they would take for completion the study.

Children and parents that agreed to be included in the study were provided with an informed consent form (Appendix C). They then participated in one interview session including both the Portage 1 and the VABS–II Arabic Version interview. At least one caretaker and the identified child attended. The interview session was scheduled through school counselor contact with the participating families. Each evaluation lasted no more than two hours (mean time for completion was 1 hour). The evaluation sessions and the test scoring were conducted by the primary investigator, who is a master level clinical psychology student under the supervision of a doctoral level licensed clinical psychologist. A report of the VABS-II results was prepared for each child and reviewed by PhD in clinical psychology.

Upon completion, each parent received one session with clinical staff explaining the results and any service recommendations with appropriate

referral. Moreover, the parents were asked to complete a parent's satisfaction survey.

The high-risk group included information and scores of children who were referred to a local multi-service center for neuro-developmental concerns. Children who fit with the study criteria were selected to use their archival data and files.

3.8 Statistical Analysis

The VABS-II results in six scaled scores including a composite score for the areas of: Communication, Independent Living Skills, Socialization, and Motor Skills as well as a total score of adaptive behavior and maladaptive behavior. A variety of statistical tests related to the examination of prediction of the concurrent scores on the Portage Assessment tool was completed to examine the relationship between the tests on the two scales by comparing Portage domains results and VABS-II domains results among all participants. In addition, in this study it was examined whether the VABS-II record similar results as the Portage scale over two different groups of children; high risk group and control group. Moreover, age (two groups of age; first group of children aged from 2 – 5 years and 11 months and the second group is of children aged 6 – 9 years) and gender (male and female) differences were examined among all participants and over each group of children separately; high-risk group and control group.

The data was analyzed using the SPSS main frame program. The scores of both tests among the control group were compared using the age equivalent score compared on a paired samples t-test as used in the study of Nahcivan (2004). The paired samples t-test is a statistical test that compares the means of two related groups to determine whether there is a statistically significant difference between these means. However, the scores of both tests among the high-risk group will be compared using the age equivalent score compared on a Wilcoxon signed-rank test. The Wilcoxon signed-rank test is the nonparametric test equivalent to the dependent t-test. As the Wilcoxon signed-rank test does not assume normality in the data, it can be used when this assumption has been violated and the use of the dependent t-test is inappropriate. It is used to compare two sets of scores that come from the same participants.

Moreover, this study examined whether the sample of VABS-II scores fall into a normal curve pattern such as the original validation data reveals. This research question was examined also using the SPSS main frame program. The standard scores of VABS-II of all domains and subdomains were tested by a test of normality of Shapiro-Wilk (1965). This test was developed by Shapiro and Wilk (1965) and has been found to be the most powerful test in most situations. It is the ratio of two estimates of the variance of a normal distribution based on a random sample of observations. In addition, the data were presented by Histogram with Normal Curve among the whole population and over the two groups' separately; control group and high-risk group.

3.9 Ethical Considerations

Ethical approval was obtained from the Institutional Review Board (IRB) of An-Najah National University (see appendix A). Children attending a local private elementary school in Nablus were solicited for participation in the study and high-risk children who had been referred to a local multi-service center for neuro-developmental concerns were included via their archival data in the study. Parents whose children fit the research criteria were given information about the study including an approved Consent for Participation Form. The participant families were provided with information that enabled them to make an informed decision as to whether they wanted to participate in the research study. They were provided with description of the scale and the purpose of the research with an informed consent. Also, they were informed that they had the right to withdraw any time without penalty and that the data collected would be used for the purpose of the research only with insuring confidentiality. In addition, the participants were informed about the time that will take for completion the study. All participants were assured that their educational status or services will not be affected in any manner due to their participation with this program.

Permission to perform the study was obtained from the local school where the study was conducted (The American Academy School – local private elementary school in Nablus-Palestine) and from An-Najah Child Institute – Department of Clinical Psychology, Nablus-Palestine.

The evaluation sessions and the test scoring of children from the local school were conducted by the primary investigator, who is a master level clinical psychology student under the supervision of a doctoral level licensed clinical psychologist. These sessions were conducted in the school. Upon completion, the parents were invited to last session and provided with report describing both results of the VABS and Portage assessments by a master level clinical psychology student under the supervision of a doctoral level licensed clinical psychologist. A report of the results was prepared for each child and reviewed by PhD in clinical psychology.

The evaluation sessions of children who were referred to a local multi-service center for neuro-developmental concerns were conducted in the center by employees/staff from the field and their reports were reviewed by PhD in clinical psychology.

Table 1: Frequency of participants by gender (n=56).

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	31	55.4	55.4	55.4
	Female	25	44.6	44.6	100.0
	Total	56	100.0	100.0	

Chapter 4

Results

56 children were tested and included in this study, ranging in age from 2 to 9 years old, male and female. The sample included a group of 26 high risk children who were referred to a local multi-service center for neuro-developmental concerns. The second group consisted of 30 children who are attending a local private elementary school in Nablus.

Table 2: Frequency of participants in control and high-risk groups by gender.

		Control Group		High Risk Group	
		Frequency	Percent	Frequency	Percent
Valid	Male	15	50.0	16	61.5
	Female	15	50.0	10	38.5
	Total	30	100.0	26	100.0

Table 3: Descriptive data of participants age.

	N	Minimum	Maximum	Mean	Std. Deviation
Chronological Age	56	2.250	8.667	5.80804	1.514742

In the current study a number of research questions were examined. As the Portage assessment scale provides the developmental level on five developmental scores: motor, language, self-help, socialization and cognition, also the VABS assess adaptive behavior in four board domains of communication, daily living skills, socialization and motor skills and provide a full adaptive behaviors score. The Portage assessment scale provides a child age score in each domain. However, the

VABS provide standard scores for each domain and subdomains and among the adaptive behavior composite. In addition, the VABS provide child age in each subdomain.

In the present study each domain age of the VABS was scored by accounting the average of the subdomains. For example, the communication domain score is an average of 3 subdomains; receptive, expressive and written. However, children who aged less than 3 years old, written subdomain is not applicable for them, thus their communication domain score is an average of 2 subdomains; receptive and expressive. The other domains included the whole subdomains for calculating the average score.

The cognitive ability age in the VABS was assessed by accounting an average score of the 4 domains scores; communication, daily living skills, socialization, and motor skills. Still children who aged more than 7 years old, their cognitive score is about the average of three subdomains; communication, daily living skills and socialization. The motor/physical ability domain of VABS is for two age ranges: individuals' birth through 6 years, and individuals 50 through 90 years, thus children who are aged 7 years old or above were not included in the analysis of physical domain.

In order to examine the first question, whether the VABS–II record similar domains results as the Portage scale, the paired samples/dependent t-test was used. Firstly, it was explored among all participants.

A paired samples t-test was conducted to compare Portage domains results and VABS domains results among all participants. There was a significant difference in the results for Portage Cognitive ($M= 5.079$, $SD=1.918$) and VABS Cognitive ($M= 5.409$, $SD= 2.303$); $t(55) = -2.000$, $p=.050$. In addition, there was a significant difference in the results for Portage Physical ($M=5.163$, $SD=2.013$) and VABS Motor ($M=4.314$, $SD=2.037$); $t(43) = 3.522$, $p=.001$. However, there was no significant difference in the results for other Portage and VABS domains; self-help, communication and social domains (see table 4; table 5).

Table 4: Means and Standard Deviations of Portage and VABS domains among all participants.

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Portage Cognitive	5.07888	56	1.917915	.256292
	VABS Cognitive	5.40863	56	2.302774	.307721
Pair 2	Portage Self-help skills	5.49993	56	2.027834	.270981
	VABS Daily living skills	5.78574	56	2.352721	.314396
Pair 3	Portage Physical	5.16289	44	2.012659	.303420
	VABS Motor	4.31447	44	2.037257	.307128
Pair 4	Portage Communication	5.46423	56	2.218548	.296466
	VABS Communication	5.19616	56	2.392074	.319654
Pair 5	Portage Social	5.34820	56	1.955397	.261301
	VABS Social	5.70785	56	2.634178	.352007

Table 5: Paired samples t - test within the Portage and the VABS Domains among all participants (n=56).

Pairs (Raw scores)	Paired Differences					
	Mean	Std. Deviation	Std. Error Mean	T	df	Sig. (2-tailed)
Pair 1 Portage Cognitive VABS Cognitive	-.329752	1.233736	.164865	-2.000	55	.050*
Pair 2 Portage Self- help skills VABS Daily living skills	-.285810	1.625299	.217190	-1.316	55	.194
Pair 3 Portage Physical VABS Motor	.848420	1.597997	.240907	3.522	43	.001**
Pair 4 Portage Communicati on VABS Communicati on	.268074	1.288618	.172199	1.557	55	.125
Pair 5 Portage Social VABS Social	-.359649	1.587563	.212147	-1.695	55	.096

$p < .01^{**}$, $p < .05^{*}$

In addition, in this study it was examined whether the VABS-II record produced similar results as the Portage scale over two different groups of children; high risk group and control group.

In the control group, there was a significant difference in the results for Portage Cognitive (M= 5.839, SD=1.065) and VABS Cognitive (M= 6.309, SD= 1.706); $t(29) = -2.382$, $p = .024$. In addition, there was a significant difference in the results for Portage Physical (M=6.253,

SD=.871) and VABS Motor (M=5.075, SD=1.854); $t(24) = 3.530$, $p=.002$ for the population whole. Another significant difference was recorded in the results of Portage social (M=6.167, SD=1.003) and VABS social (M=6.917, SD=1.719); $t(29) = -3.368$, $p=.002$

However, there was no significant difference in other domains results over the control group (see table 6; table 7).

Table 6: Means and Standard Deviations of Portage and VABS domains among control group (n=30).

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Portage Cognitive	5.83890	30	1.064514	.194353
	VABS Cognitive	6.30915	30	1.705850	.311444
Pair 2	Portage Self-help skills	6.27770	30	.958292	.174959
	VABS Daily living skills	6.44632	30	1.657560	.302628
Pair 3	Portage Physical	6.25336	25	.871474	.174295
	VABS Motor	5.07508	25	1.854343	.370869
Pair 4	Portage Communication	6.52773	30	1.054126	.192456
	VABS Communication	6.14721	30	2.104913	.384303
Pair 5	Portage Social	6.16663	30	1.002864	.183097
	VABS Social	6.91667	30	1.719174	.313877

Table 7: Paired samples t - test within the Portage and the VABS Domains among control group (n=30).

Pairs (Raw scores)	Paired Differences			t	df	Sig. (2-tailed)
	Mean	Std. Deviation	Std. Error Mean			
Pair 1 Portage Cognitive VABS Cognitive	-.470250	1.081193	.197398	-2.382	29	.024*
Pair 2 Portage Self- help skills VABS Daily living skills	-.168622	1.207796	.220512	-.765	29	.451
Pair 3 Portage Physical VABS Motor	1.178280	1.668761	.333752	3.530	24	.002**
Pair 4 Portage Communicati on VABS Communicati on	.380522	1.417356	.258773	1.470	29	.152
Pair 5 Portage Social VABS Social	-.750033	1.219853	.222714	-3.368	29	.002**

$p < .01^{**}$, $p < .05^{*}$

Table 8: Means and Standard Deviations of Portage and VABS domains among high-risk group (n=26).

	N	Mean	Std. Deviation
Portage Cognitive	26	4.20192	2.298913
Portage Self-help skills	26	4.60250	2.533353
Portage Physical	26	4.39742	2.520092
Portage Communication	26	4.23712	2.572167
Portage Social	26	4.40385	2.348179
VABS Cognitive	26	4.36956	2.488896
VABS Daily living skills	26	5.02353	2.804050
VABS Motor	19	3.31366	1.862610
VABS Communication	26	4.09879	2.260770
VABS Social	26	4.31305	2.839076

Table 9: Wilcoxon Signed Ranks Test within the Portage and the VABS Domains among high-risk group (n=26).

	VABS Cognitive – Portage Cognitive	VABS Daily living skills – Portage Self-help skills	VABS Motor – Portage Physical	VABS Communication – Portage Communication	VABS Social – Portage Social
Z	-.749 ^c	-1.588 ^c	-1.871 ^d	-.851 ^d	-.013 ^d
Asymp. Sig. (2-tailed)	.454	.112	.061	.395	.990
<i>p</i> < .01**, <i>p</i> < .05*					
c. Based on negative ranks.					
d. Based on positive ranks.					

In the results among the high-risk group there was no significant difference over all of the domains of functioning (see table 8; table 9).

Another question was tested, whether the VABS-II predict equally as the Portage scale in female and male among the whole participants and over each group of children separately; high-risk group and control group.

A paired samples t-test was also conducted to compare Portage domains results and VABS domains results among control group and a Wilcoxon test conducted among high-risk group of gender separately; male and female participants.

The results over the male group demonstrate a significant difference in the result for Portage Cognitive (M=5.164, SD=2.138) and VABS Cognitive (M=5.706, SD=2.472); $t(30) = -2.429$, $p = .021$. In addition, there was a significant difference in the results for Portage Physical (M=4.833, SD=2.035) and VABS Motor (M=3.849, SD=1.725); $t(20) = 3.158$, $p = .005$. Another significant difference was recorded in the results of Portage social

($M=5.355$, $SD=2.074$) and VABS social ($M=5.923$, $SD=2.481$); $t(30) = -2.870$, $p=.007$ (see table 10; table 11).

However, there was no significant difference in other domains results over the male group (see table 11).

In the female group, the results showed a significant difference only in the communication domain. The results for Portage communication ($M=5.353$, $SD=1.983$) and VABS communication ($M=4.699$, $SD=1.886$); $t(24) = 4.534$, $p=.000$ (see table 12; table 13)

There was no significant difference in the other results of Portage and VABS domains among the female group (see table 13).

Table 10: Means and Standard Deviations of Portage and VABS domains among male participants (n=31).

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Portage Cognitive	5.16397	31	2.138283	.384047
	VABS Cognitive	5.70633	31	2.472260	.444031
Pair 2	Portage Self-help skills	5.47839	31	2.178434	.391258
	VABS Daily living skills	6.03498	31	2.649994	.475953
Pair 3	Portage Physical	4.83338	21	2.035072	.444089
	VABS Motor	3.84924	21	1.724528	.376323
Pair 4	Portage Communication	5.55371	31	2.420737	.434777
	VABS Communication	5.59673	31	2.696799	.484359
Pair 5	Portage Social	5.35477	31	2.074012	.372504
	VABS Social	5.92297	31	2.481496	.445690

Table 11: Paired samples t-test within the Portage and the VABS Domains among male participants (n=31).

Pairs (Raw scores)	Paired Differences					
	Mean	Std. Deviation	Std. Error Mean	T	Df	Sig. (2- tailed)
Pair 1 Portage Cognitive VABS Cognitive	-.542367	1.242961	.223242	-2.429	30	.021*
Pair 2 Portage Self- help skills – VABS Daily living skills	-.556591	1.582636	.284250	-1.958	30	.060
Pair 3 Portage Physical VABS Motor	.984143	1.428213	.311662	3.158	20	.005**
Pair 4 Portage Communication VABS Communication	-.043022	1.550584	.278493	-.154	30	.878
Pair 5 Portage Social VABS Social	-.568194	1.102137	.197950	-2.870	30	.007**

$p < .01^{**}$, $p < .05^{*}$

Table 12: Means and Standard Deviations of Portage and VABS domains among female participants (n=25).

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Portage Cognitive	4.97336	25	1.641157	.328231
	VABS Cognitive	5.03947	25	2.062924	.412585
Pair 2	Portage Self-help skills	5.52664	25	1.868226	.373645
	VABS Daily living skills	5.47668	25	1.930604	.386121
Pair 3	Portage Physical	5.46374	23	1.988512	.414633
	VABS Motor	4.73924	23	2.239042	.466873
Pair 4	Portage Communication	5.35328	25	1.982765	.396553
	VABS Communication	4.69945	25	1.886210	.377242
Pair 5	Portage Social	5.34004	25	1.839929	.367986
	VABS Social	5.44109	25	2.840855	.568171

Table 13: Paired samples t-test within the Portage and the VABS Domains among female participants (n=25).

Pairs (Raw scores)	Paired Differences					
	Mean	Std. Deviation	Std. Error Mean	t	Df	Sig. (2-tailed)
Pair 1 Portage Cognitive VABS Cognitive	-.066110	1.194226	.238845	-.277	24	.784
Pair 2 Portage Self- help skills VABS Daily living skills	.049960	1.646387	.329277	.152	24	.881
Pair 3 Portage Physical VABS Motor	.724500	1.761569	.367313	1.972	22	.061
Pair 4 Portage Communicati on VABS Communicati on	.653833	.721100	.144220	4.534	24	.000**
Pair 5 Portage Social VABS Social	-.101053	2.032635	.406527	-.249	24	.806

$p < .01^{**}$, $p < .05^{*}$

Among the male participants of control group, there was a significant difference in the scores for Portage physical ($M=6.217$, $SD=0.850$) and VABS motor ($M=4.670$, $SD=0.716$); $t(9) = 5.832$, $p=.000$ and there was a significant difference in the scores for Portage social ($M=6.089$, $SD=1.253$) and VABS social ($M=6.976$, $SD=1.834$); $t(14) = -3.496$, $p=.004$

However, there was no significant difference in the other domains of Portage and VABS among males of control group (see table 14).

Table 14: Paired samples t-test within the Portage and the VABS Domains among male participants of control group.

Pairs (Raw scores)	Paired Differences					
	Mean	Std. Deviation	Std. Error Mean	t	Df	Sig. (2-tailed)
Pair 1 Portage Cognitive VABS Cognitive	-.583111	1.197336	.309151	-1.886	14	.080
Pair 2 Portage Self- help skills VABS Daily living skills	-.348289	1.555052	.401513	-.867	14	.400
Pair 3 Portage Physical VABS Motor	1.545900	.838208	.265065	5.832	9	.000**
Pair 4 Portage Communicati on VABS Communicati on	-.111089	1.857859	.479697	-.232	14	.820
Pair 5 Portage Social VABS Social	-.887133	.982908	.253786	-3.496	14	.004**

$p < .01^{**}$, $p < .05^{*}$

Among the female participants of control group, there was a significant difference in the scores for Portage communication ($M=6.267$, $SD=0.818$) and VABS communication ($M=5.394$, $SD=0.951$); $t(14) = 7.713$, $p=.000$.

There were no significant differences in the other scores for Portage and VABS domains (see table 15).

Table 15: Paired samples t-test within the Portage and the VABS Domains among female participants of control group.

Pairs (Raw scores)	Paired Differences					
	Mean	Std. Deviation	Std. Error Mean	t	Df	Sig. (2-tailed)
Pair 1 Portage Cognitive VABS Cognitive	-.357389	.980075	.253054	-1.412	14	.180
Pair 2 Portage Self-help skills VABS Daily living skills	.011044	.731014	.188747	.059	14	.954
Pair 3 Portage Physical VABS Motor	.933200	2.039933	.526708	1.772	14	.098
Pair 4 Portage Communication VABS Communication	.872133	.437904	.113066	7.713	14	.000**
Pair 5 Portage Social VABS Social	-.612933	1.440828	.372020	-1.648	14	.122

$p < .01^{**}$, $p < .05^{*}$

Among the male participants of high-risk group, there were no significant difference results for Portage and VABS domains (see table 16).

In addition, among the female participants of high-risk group, there were no significant difference results for Portage and VABS domains (see table 17).

Table 16: Wilcoxon Signed Ranks Test within the Portage and the VABS Domains among male participants of high-risk group.

	VABS Cognitive – Portage Cognitive	VABS Daily living skills – Portage Self-help skills	VABS Motor – Portage Physical	VABS Communication – Portage Communication	VABS Social – Portage Social
Z	-1.293 ^c	-1.836 ^c	-1.600 ^d	-.259 ^d	-.672 ^c
Asymp. Sig. (2-tailed)	.196	.066	.110	.796	.501
<i>p</i> < .01**, <i>p</i> < .05*					
c. Based on negative ranks.					
d. Based on positive ranks.					

Table 17: Wilcoxon Signed Ranks Test within the Portage and the VABS Domains among female participants of high-risk group.

	VABS Cognitive – Portage Cognitive	VABS Daily living skills – Portage Self-help skills	VABS Motor – Portage Physical	VABS Communication – Portage Communication	VABS Social – Portage Social
Z	-.357 ^c	-.714 ^d	-.771 ^c	-1.172 ^c	-.866 ^c
Asymp. Sig. (2-tailed)	.721	.475	.441	.241	.386
<i>p</i> < .01**, <i>p</i> < .05*					
c. Based on positive ranks.					
d. Based on negative ranks.					

The current study also dealt with examining differences among two groups of age; first group of children aged from 2 – 5 years and 11 months and the second group is of children aged 6 – 9 years (see table 18). The study examined age differences among the whole participants and over each group of children separately; high-risk group and control group. In other words, this study tested whether the VABS-II predict equally scores as the Portage scale in two groups of age over the whole population and over the high-risk group and the control group.

Table 18: Descriptive data of two groups of age.

		Frequency	Percent	Valid Percent	Min	Max	Mean	Std. Deviation
Valid	Group 1:Age 2 – 5 years and 11 months	28	50.0	50.0	2.250	5.917	4.58632	.991618
	Group 2:Age 6 – 9 years	28	50.0	50.0	6.000	8.667	7.02975	.771252
	Total	56	100.0	100.0				

In the first group of age, there was a significant difference in the scores for Portage physical ($M=4.679$, $SD=2.120$) and VABS motor ($M=3.772$, $SD=1.569$); $t(27) = 3.598$, $p=.001$. In addition, there was a significant difference in the scores for Portage communication ($M=4.536$, $SD=2.092$) and VABS communication ($M=4.010$, $SD=1.653$); $t(27) = 2.962$, $p=.006$ (see table 19; table 20)

However, there was no significant difference in the scores for other Portage and VABS domains (see table 20).

Table 19: Means and Standard Deviations of Portage and VABS domains among first group of age (2 to 5 years and 11 months) of all participants.

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Portage Cognitive	4.02082	28	1.702840	.321806
	VABS Cognitive	4.32719	28	1.668505	.315318
Pair 2	Portage Self-help skills	4.60711	28	2.124314	.401458
	VABS Daily living skills	4.74111	28	1.784600	.337258
Pair 3	Portage Physical	4.67861	28	2.120226	.400685
	VABS Motor	3.77236	28	1.569284	.296567
Pair 4	Portage Communication	4.53564	28	2.092236	.395395
	VABS Communication	4.01043	28	1.652086	.312215
Pair 5	Portage Social	4.54164	28	1.890333	.357239
	VABS Social	4.78474	28	2.123585	.401320

Table 20: Paired samples t-test within the Portage and the VABS Domains among first group of age (2 to 5 years and 11 months) of all participants.

Pairs (Raw scores)	Paired Differences					
	Mean	Std. Deviation	Std. Error Mean	t	Df	Sig. (2-tailed)
Pair 1 Portage Cognitive VABS Cognitive	-.306365	.852934	.161189	-1.901	27	.068
Pair 2 Portage Self- help skills VABS Daily living skills	-.134000	1.335213	.252332	-.531	27	.600
Pair 3 Portage Physical VABS Motor	.906250	1.332741	.251864	3.598	27	.001**
Pair 4 Portage Communica tion VABS Communica tion	.525208	.938219	.177307	2.962	27	.006**
Pair 5 Portage Social VABS Social	-.243095	.784623	.148280	-1.639	27	.113

$p < .01^{**}$, $p < .05^{*}$

In the second group of age (6 – 9 years), there was no significant difference in the scores for Portage and VABS domains (see table 21; table 22).

Table 21: Means and Standard Deviations of Portage and VABS domains among second group of age (6 – 9 years) of all participants.

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Portage Cognitive	6.13693	28	1.507146	.284824
	VABS Cognitive	6.49007	28	2.364818	.446909
Pair 2	Portage Self-help skills	6.39275	28	1.486776	.280974
	VABS Daily living skills	6.83037	28	2.414015	.456206
Pair 3	Portage Physical	6.01038	16	1.522081	.380520
	VABS Motor	5.26316	16	2.440592	.610148
Pair 4	Portage Communication	6.39282	28	1.964771	.371307
	VABS Communication	6.38188	28	2.451642	.463317
Pair 5	Portage Social	6.15475	28	1.692977	.319942
	VABS Social	6.63095	28	2.803177	.529751

Table 22: Paired samples t-test within the Portage and the VABS Domains among second group of age (6 – 9 years) of all participants.

Pairs (Raw scores)	Paired Differences					
	Mean	Std. Deviation	Std. Error Mean	T	Df	Sig. (2-tailed)
Pair 1 Portage Cognitive VABS Cognitive	-.353140	1.540115	.291054	-1.213	27	.236
Pair 2 Portage Self- help skills VABS Daily living skills	-.437619	1.884260	.356092	-1.229	27	.230
Pair 3 Portage Physical VABS Motor	.747219	2.026323	.506581	1.475	15	.161
Pair 4 Portage Communicati on VABS Communicati on	.010940	1.537916	.290639	.038	27	.970
Pair 5 Portage Social VABS Social	-.476202	2.119022	.400457	-1.189	27	.245

$p < .01^{**}$, $p < .05^{*}$

Additionally, to testing age differences among all of the participants, this study also examined age differences over each group of children separately; control group and high-risk group.

In the first group of age of control group, there was a significant difference in the scores for Portage Self- help skills ($M=5.804$, $SD=.838$) and VABS Daily living skills ($M=5.368$, $SD=.837$); $t(16) = 2.482$, $p=.025$. In addition, there was a significant difference in the scores for Portage

physical ($M=5.902$, $SD=.791$) and VABS motor ($M=4.466$, $SD=.493$); $t(16) = 7.620$; $p=.000$. Moreover, there was a significant difference in the scores for Portage communication ($M=5.873$, $SD=.718$) and VABS communication ($M=4.840$, $SD=.631$); $t(16) = 8.368$, $p=.000$

However, there was no significant difference in the other scores for Portage and VABS domains (see table 23).

Table 23: Paired samples t-test within the Portage and the VABS Domains among first group of age (2 – 5 years and 11 months) participants of control group.

Pairs (Raw scores)	Paired Differences					
	Mean	Std. Deviation	Std. Error Mean	t	df	Sig. (2-tailed)
Pair 1 Portage Cognitive VABS Cognitive	-.059252	.611691	.148357	-.399	16	.695
Pair 2 Portage Self- help skills VABS Daily living skills	.436137	.724548	.175729	2.482	16	.025*
Pair 3 Portage Physical VABS Motor	1.436265	.777173	.188492	7.620	16	.000**
Pair 4 Portage Communication VABS Communication	1.032647	.508782	.123398	8.368	16	.000**
Pair 5 Portage Social – VABS Social	-.289235	.835446	.202625	-1.427	16	.173

$p<.01^{**}$, $p<.05^{*}$

In the second group of age (6 – 9 years) of control group, there was a significant difference in the scores for Portage cognitive ($M=6.808$,

SD=.687) and VABS cognitive (M=7.815, SD=1.472); $t(12) = -2.728$, $p=.018$. In addition, there was a significant difference in the scores of Portage Self- help skills (M=6.897, SD=.741) and VABS Daily living skills (M=7.857, SD=1.379); $t(12) = -2.710$, $p=.019$. Also, there was a significant difference in the scores for Portage social (M=6.820, SD=.832) and VABS social (M=8.173, SD=1.493); $t(12) = -3.474$, $p=.005$

There was no significant differences in the scores of the other Portage and VABS domains (see table 24).

Table 24: Paired samples t-test within the Portage and the VABS Domains among second group of age (6 – 9) participants of control group.

Pairs (Raw scores)	Paired Differences					
	Mean	Std. Deviation	Std. Error Mean	t	Df	Sig. (2- tailed)
Pair 1 Portage Cognitive VABS Cognitive	-1.007708	1.331882	.369397	-2.728	12	.018*
Pair 2 Portage Self- help skills VABS Daily living skills	-.959462	1.276610	.354068	-2.710	12	.019*
Pair 3 Portage Physical VABS Motor	.630062	2.768046	.978652	.644	7	.540
Pair 4 Portage Communication VABS Communication	-.472256	1.766181	.489850	-.964	12	.354
Pair 5 Portage Social – VABS Social	-1.352615	1.404030	.389408	-3.474	12	.005**

$p<.01^{**}$, $p<.05^{*}$

In the first group of age (2 – 5 years and 11 months) of high-risk group, there was no significant differences in the scores of all Portage and VABS domains (see table 25).

Table 25: Wilcoxon Signed Ranks Test within the Portage and the VABS Domains among first group of age (2 to 5 years and 11 months) participants of high-risk group.

	VABS Cognitive – Portage Cognitive	VABS Daily living skills – Portage Self-help skills	VABS Motor – Portage Physical	VABS Communication – Portage Communication	VABS Social – Portage Social
Z	-1.867 ^c	-1.867 ^c	-.800 ^d	-1.245 ^c	-.445 ^c
Asymp. Sig. (2-tailed)	.062	.062	.424	.213	.657
$p < .01^{**}, p < .05^{*}$					
c. Based on negative ranks.					
d. Based on positive ranks.					

In the second group of age (6 – 9 years) of high-risk group, there was no significant differences in the scores of all Portage and VABS domains (see table 26).

Table 26: Wilcoxon Signed Ranks Test within the Portage and the VABS Domains among second group of age (6 – 9 years) participants of high-risk group.

	VABS Cognitive – Portage Cognitive	VABS Daily living skills – Portage Self-help skills	VABS Motor – Portage Physical	VABS Communication – Portage Communication	VABS Social – Portage Social
Z	-.341 ^c	-.540 ^d	-1.820 ^c	-1.704 ^c	-.170 ^c
Asymp. Sig. (2-tailed)	.733	.589	.069	.088	.865
$p < .01^{**}, p < .05^{*}$					
c. Based on positive ranks.					
d. Based on negative ranks.					

Moreover, this research investigated a final question; whether the sample of VABS-II Arabic Version fall into a normal curve pattern in Palestine as it does in the validation samples previously utilized. In order to examine this question a test of curve normality, the Shapiro-Wilk test was used. In addition, the results were represented by Histogram graphs. The histogram is a traditional way of displaying the shape of a group of data.

The p-value obtained by the Shapiro-Wilk checked the normality assumption of the VABS-II – Arabic Version domains and Adaptive Behavior Composite among all participants were less than 0.05 ($p < 0.05$) among all probabilities. This means that this data are significantly different from normal.

Test of Normality and Histograms of the VABS-II domains (Communication, Daily-Living Skills, Socialization and Motor Skills) and Adaptive Behavior Composite Scores with Normal Curve among all participants.

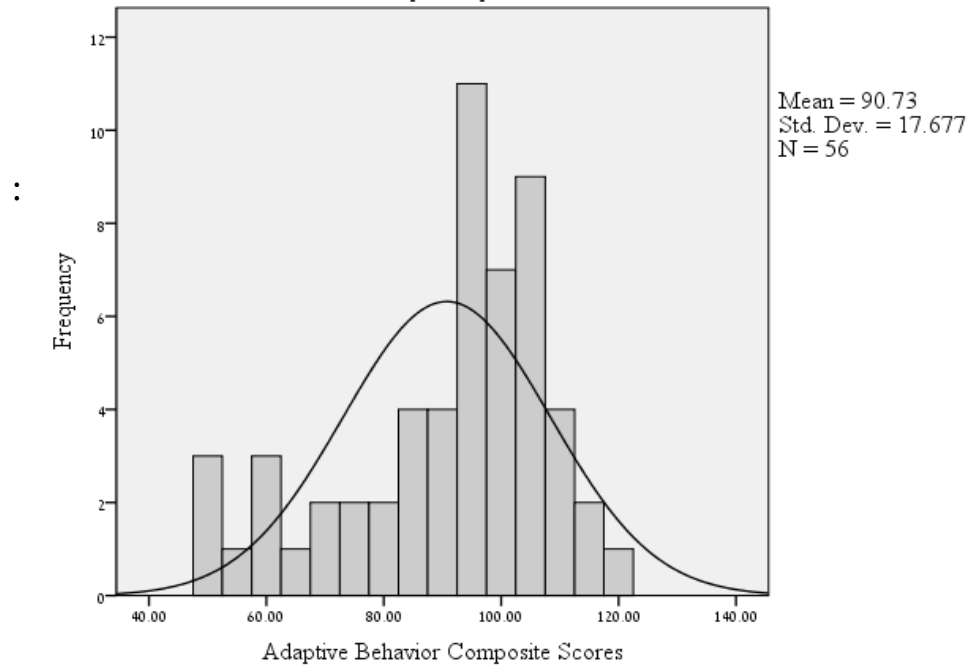
Table 27: Test of Normality of the Vineland Adaptive Behavior Scale domains and Adaptive Behavior Composite Scores with Normal Curve among all participants.

	Shapiro-Wilk			
	Statistic	Df	Sig.	Skewness Statistic
Adaptive Behavior Composite	.916	56	.001	-.853
Communication Domain	.941	56	.009	-.824
Daily-Living Skills Domain	.944	56	.011	-.705
Socialization Domain	.924	56	.002	-.919
Motor Skills Domain	.946	44	.040	-.797

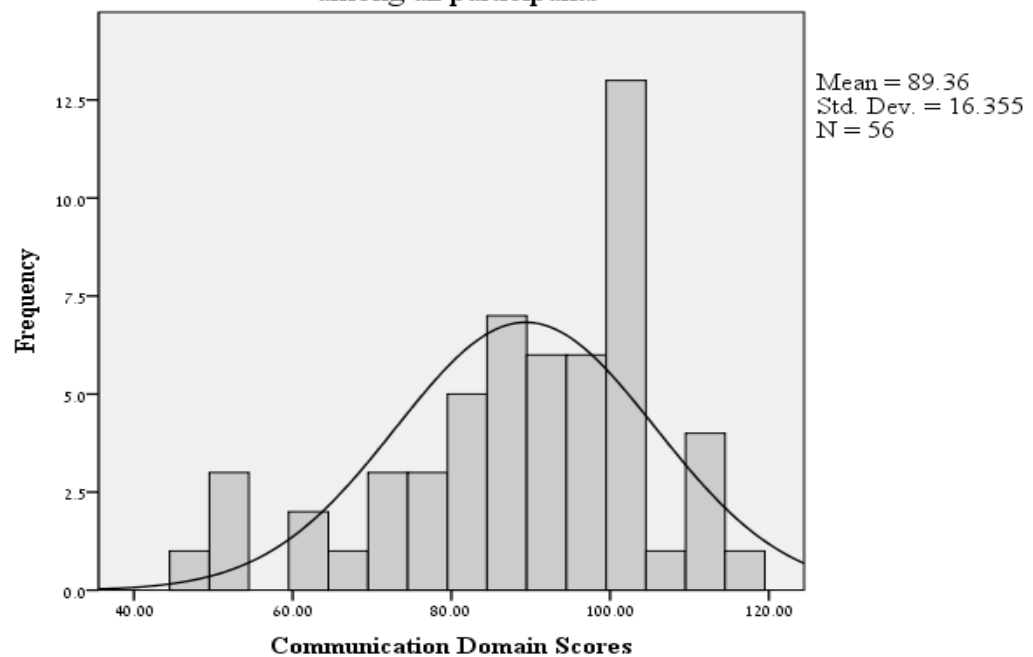
$p > 0.05^*$

Graph 1:

Histogram of Adaptive Behavior Composite Scores with Normal Curve among all participants

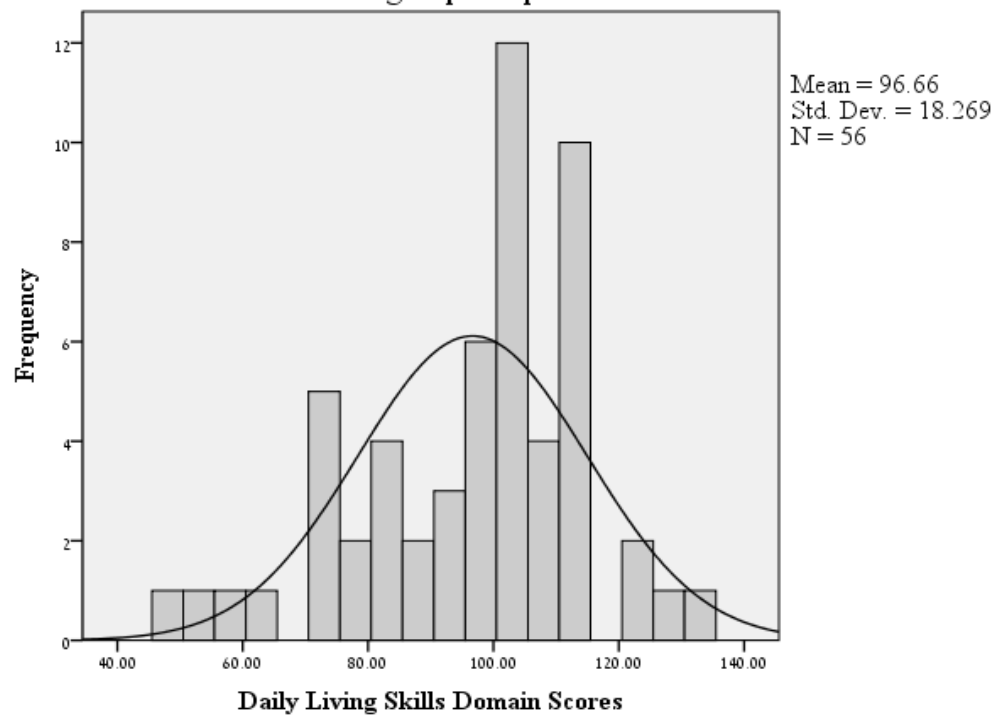
**Graph 2:**

Histogram for Communication Domain Scores with Normal Curve among all participants

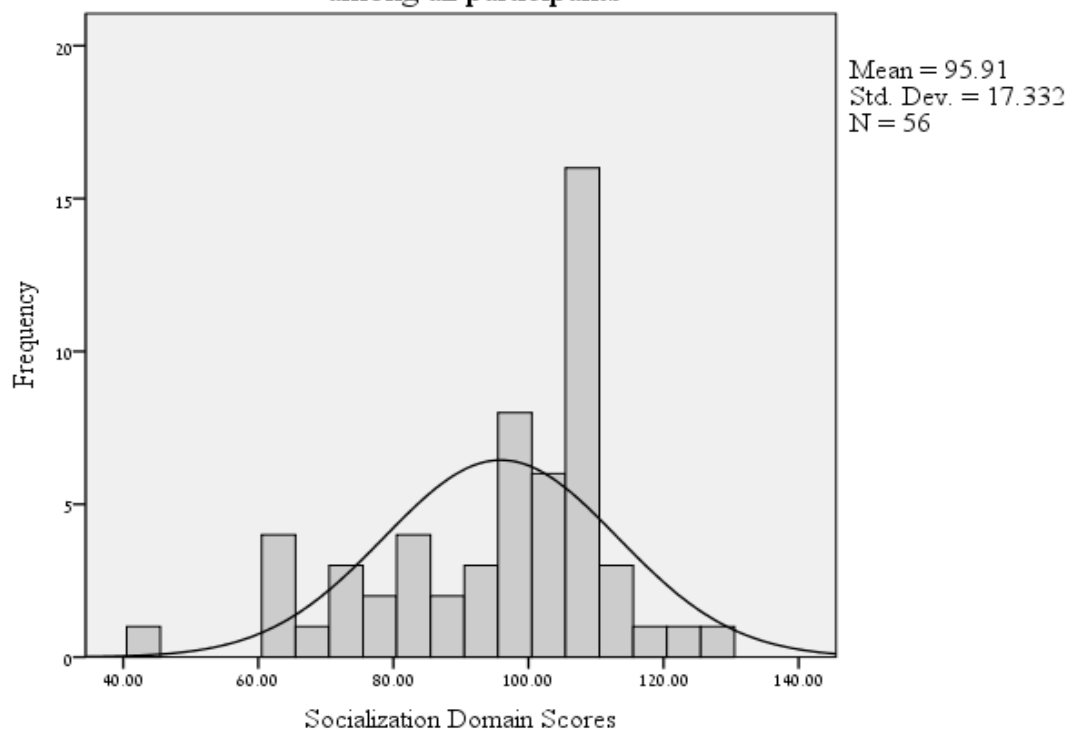


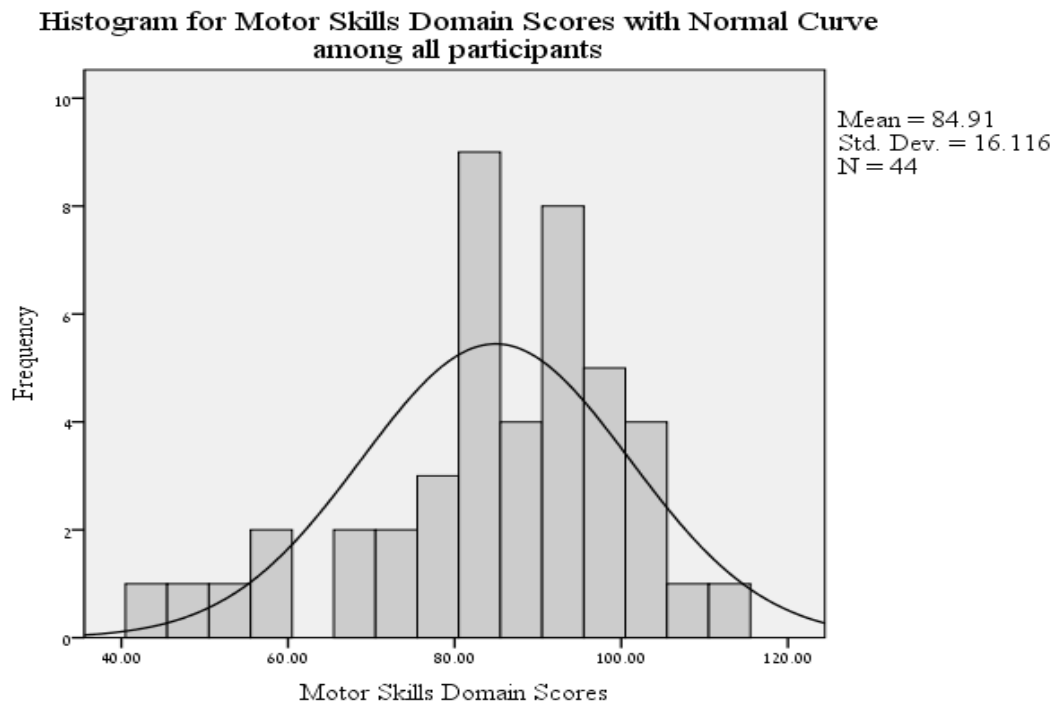
Graph 3:

**Histogram for Daily Living Skills Domain Scores with Normal Curve
among all participants**

**Graph 4:**

**Histogram for Socialization Domain Scores with Normal Curve
among all participants**



Graph 5:

In addition, test of normality was used among control group. The p-value obtained by the Shapiro-Wilks checking normality assumption of the VABS-II domains and Adaptive Behavior Composite Scores among control group were more than 0.05 ($p > 0.05$) among all probabilities. This means that these data are not different from normal.

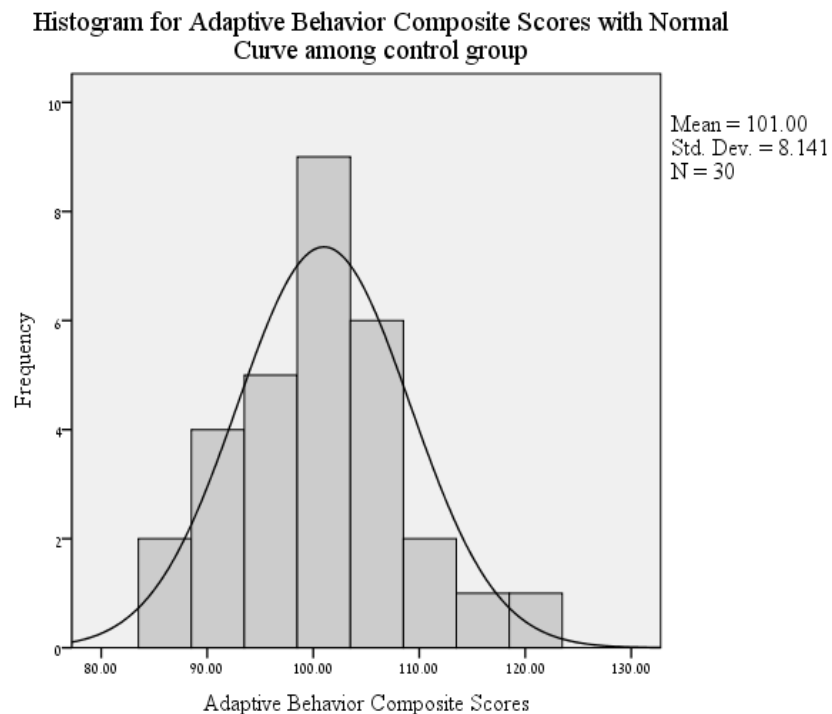
Test of Normality and Histograms of the VABS-II domains (Communication, Daily-Living Skills, Socialization and Motor Skills) and Adaptive Behavior Composite Scores with Normal Curve among control group.

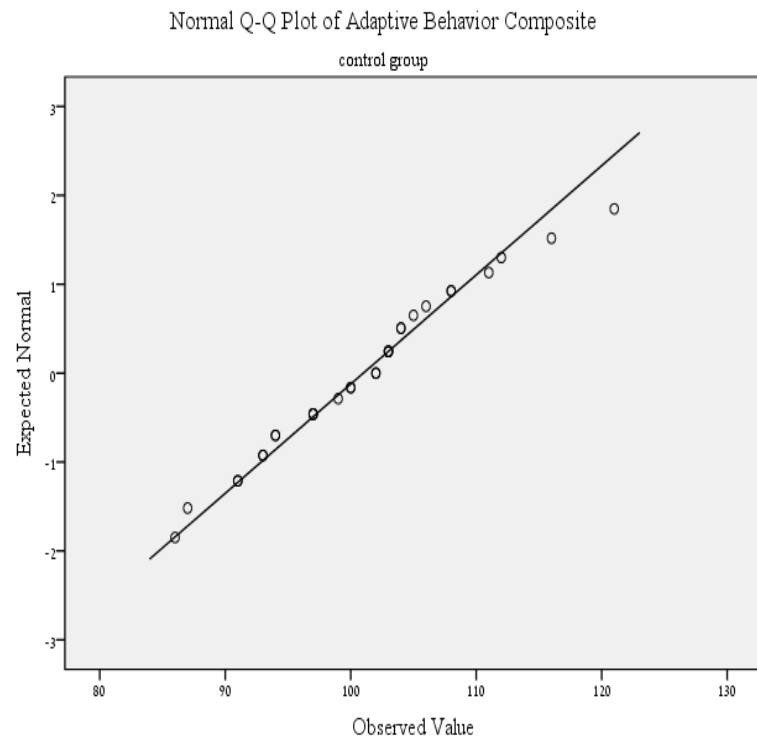
Table 28: Test of Normality of the Vineland Adaptive Behavior Scale domains and Adaptive Behavior Composite Scores with Normal Curve among control group.

	Shapiro-Wilk			
	Statistic	Df	Sig.	Skewness Statistic
Adaptive Behavior Composite	.980	30	.836*	.318
Communication Domain	.978	30	.760*	.077
Daily-Living Skills Domain	.952	30	.192*	.262
Socialization Domain	.966	30	.432*	.391
Motor Skills Domain	.968	25	.606*	.205

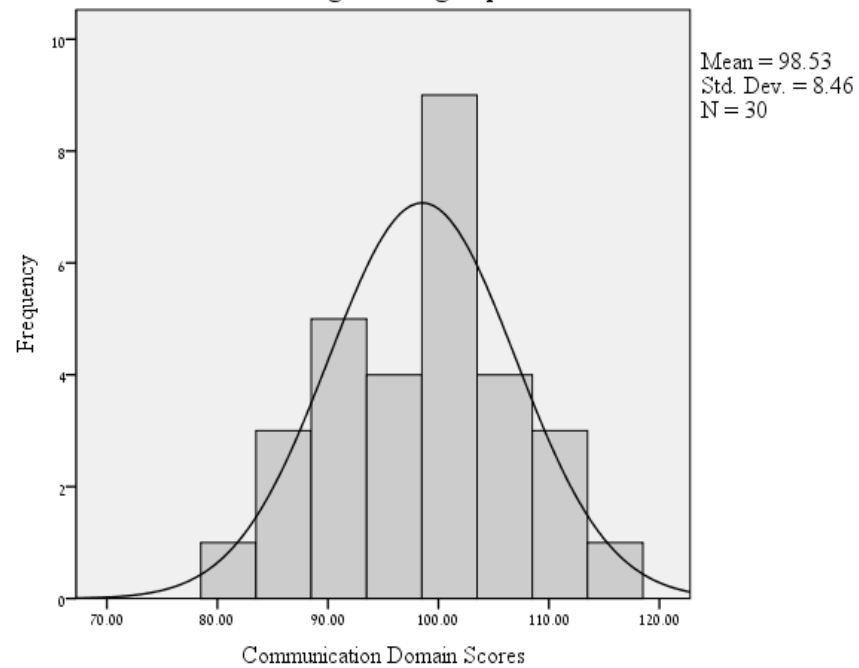
$p > 0.05^*$

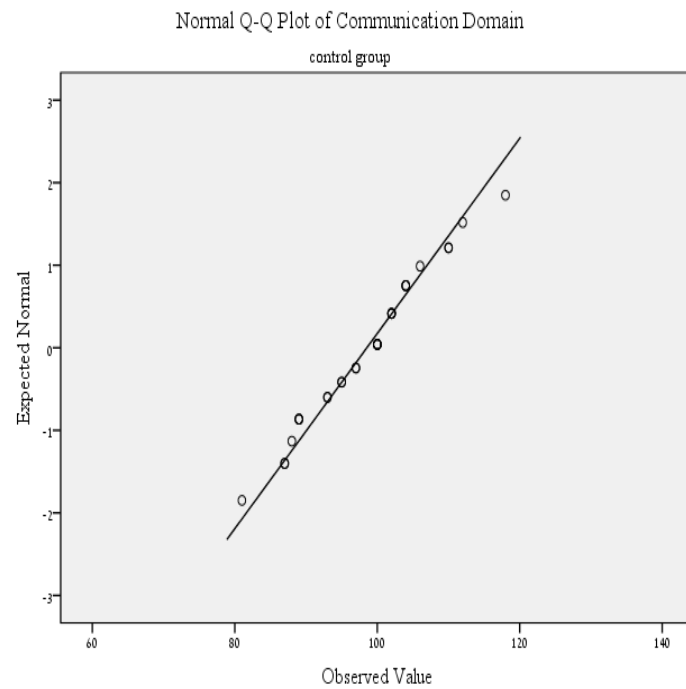
Graph 6:



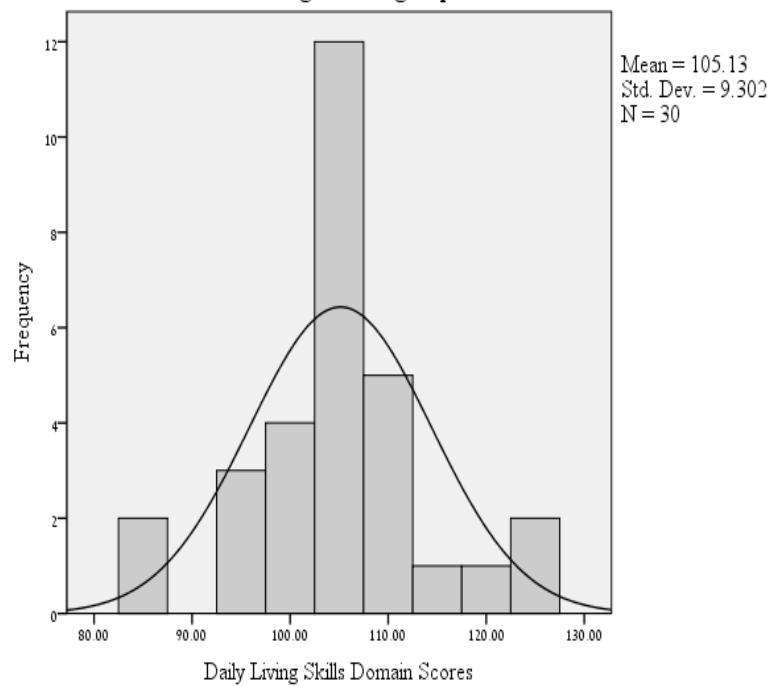
Graph 7:**Graph 8:**

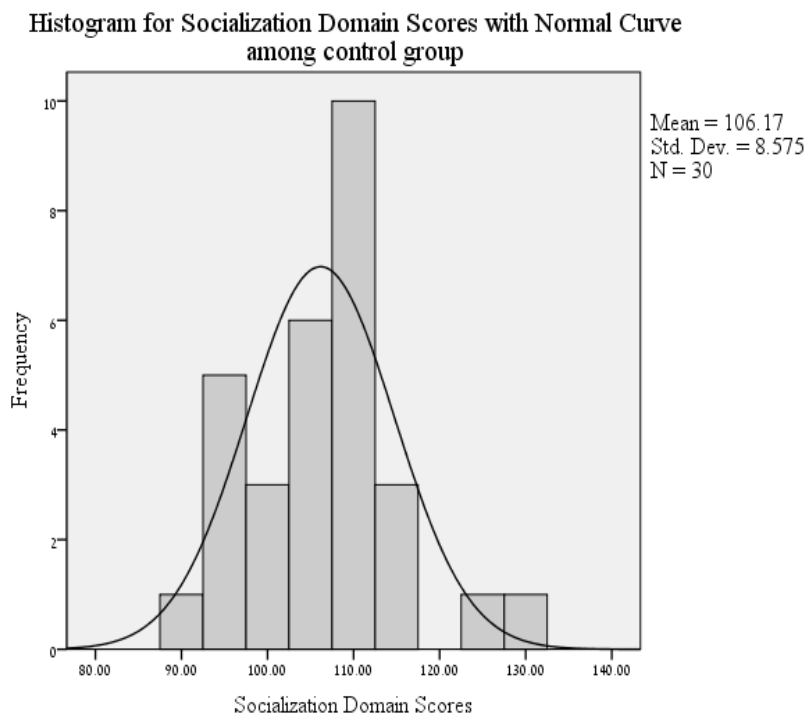
Histogram for Communication Domain Scores with Normal Curve
among control group

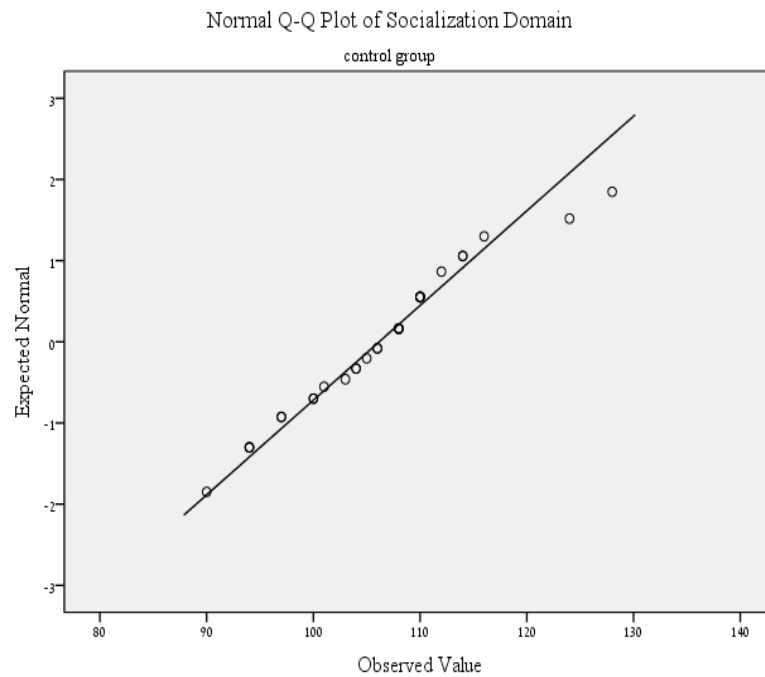
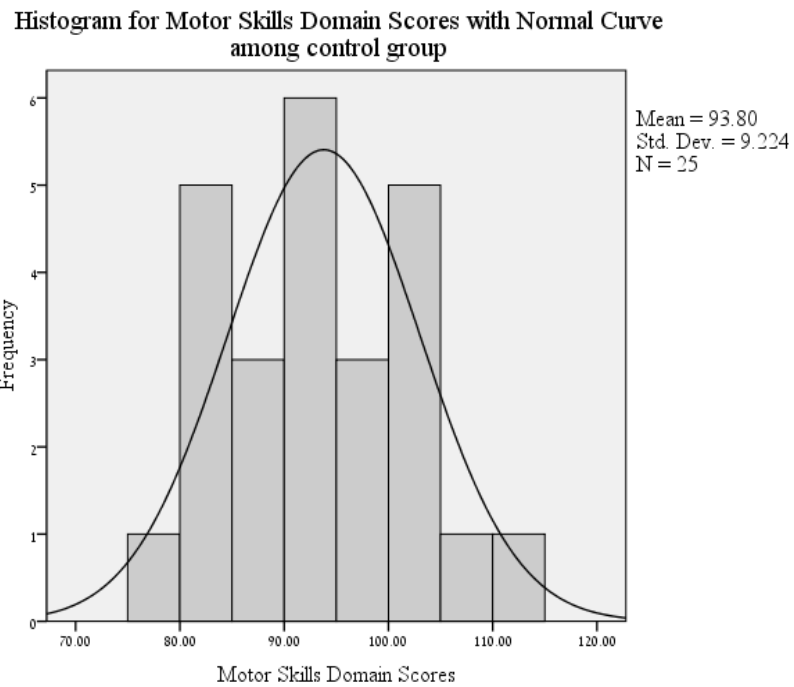


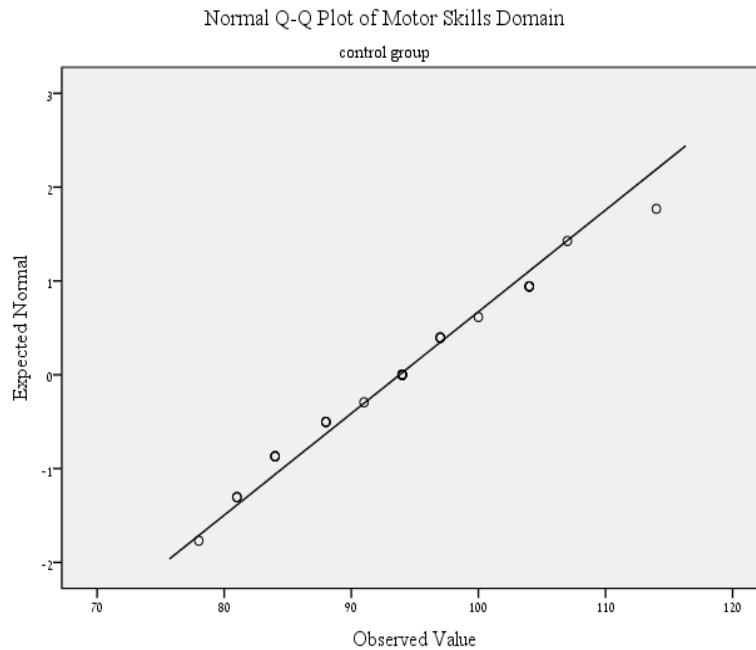
Graph 9:**Graph 10:**

Histogram for Daily Living Skills Domain Scores with Normal Curve
among control group



Graph 11:**Graph 12:**

Graph 13:**Graph 14:**

Graph 15:

The same among the high-risk group, test of normality was used. In contrast to what we expected, the p-value by the Shapiro-Wilk demonstrated more than 0.05 of all probabilities. In other words, these data are not different from normal.

Test of Normality and Histograms of the VABS-II domains (Communication, Daily-Living Skills, Socialization and Motor Skills) and Adaptive Behavior Composite Scores with Normal Curve among high-risk group.

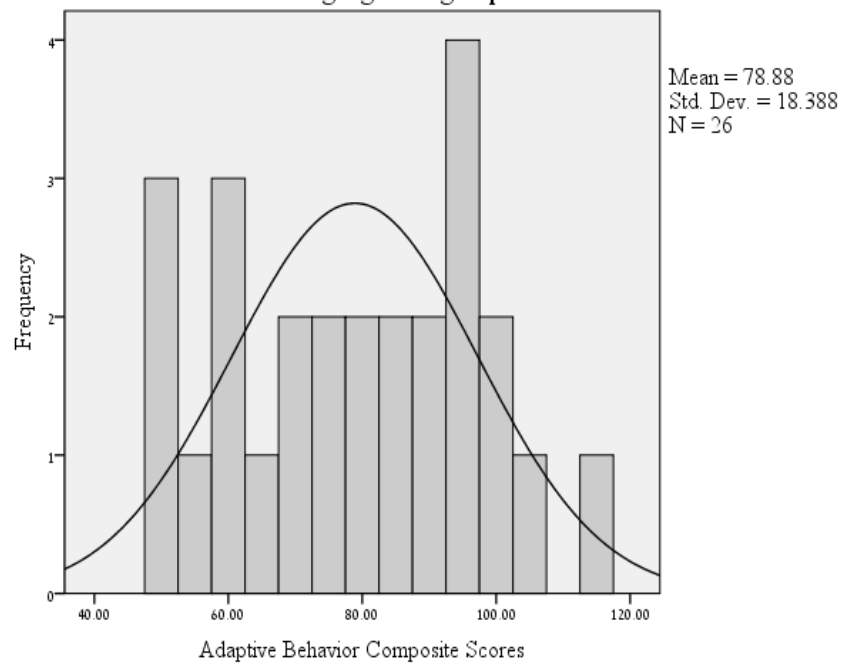
Table 29: Test of Normality of the Vineland Adaptive Behavior Scale domains and Adaptive Behavior Composite Scores with Normal Curve among high-risk group.

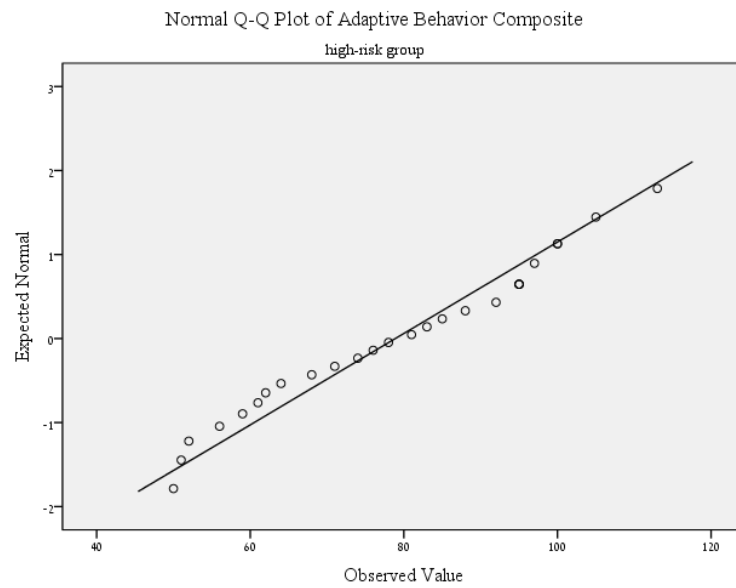
	Shapiro-Wilk			Skewness Statistic
	Statistic	Df	Sig.	
Adaptive Behavior Composite	.957	26	.329*	-.018
Communication Domain	.976	26	.783*	-.119
Daily-Living Skills Domain	.970	26	.628*	.171
Socialization Domain	.934	26	.096*	-.373
Motor Skills Domain	.967	19	.725*	-.348

$p > 0.05$

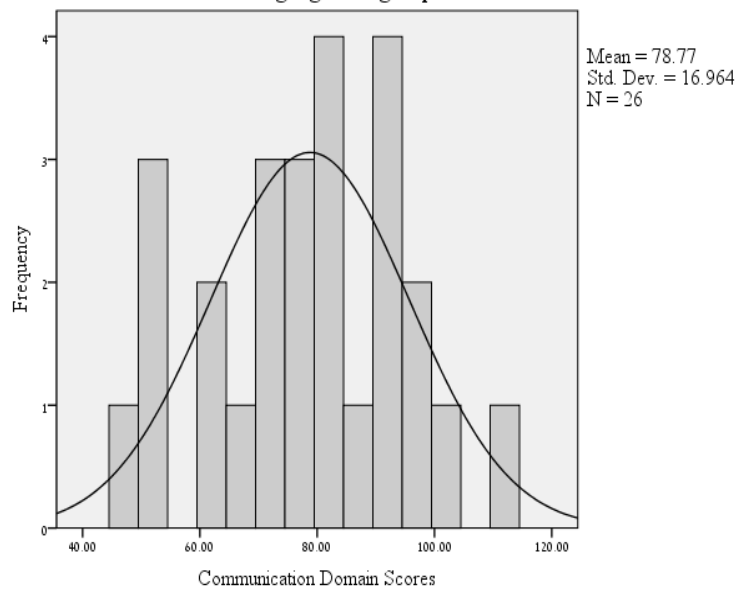
Graph 16:

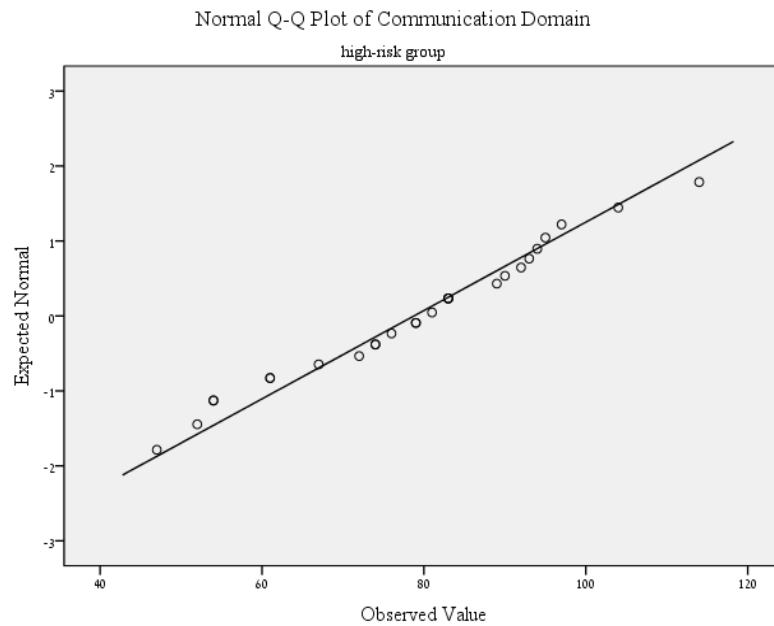
**Histogram for Adaptive Behavior Composite Scores with Normal Curve
among high-risk group**



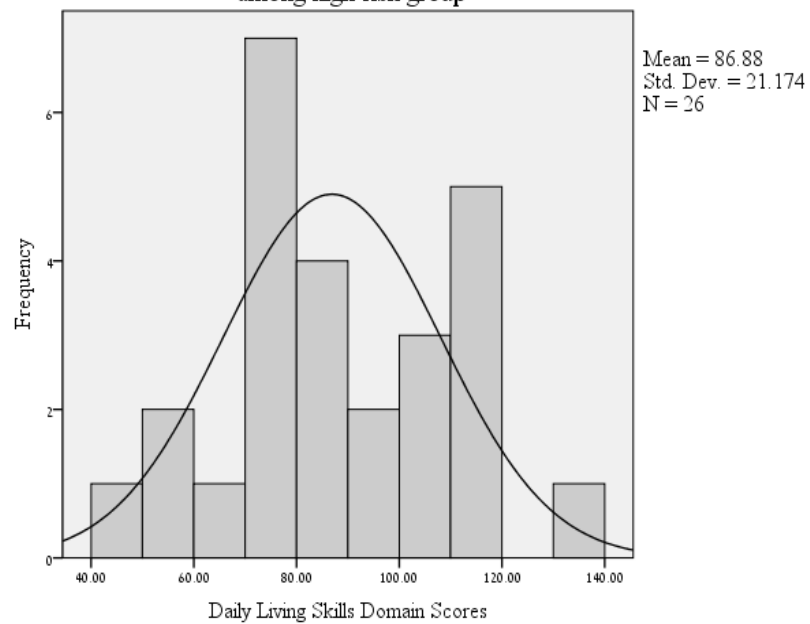
Graph 17:**Graph 18:**

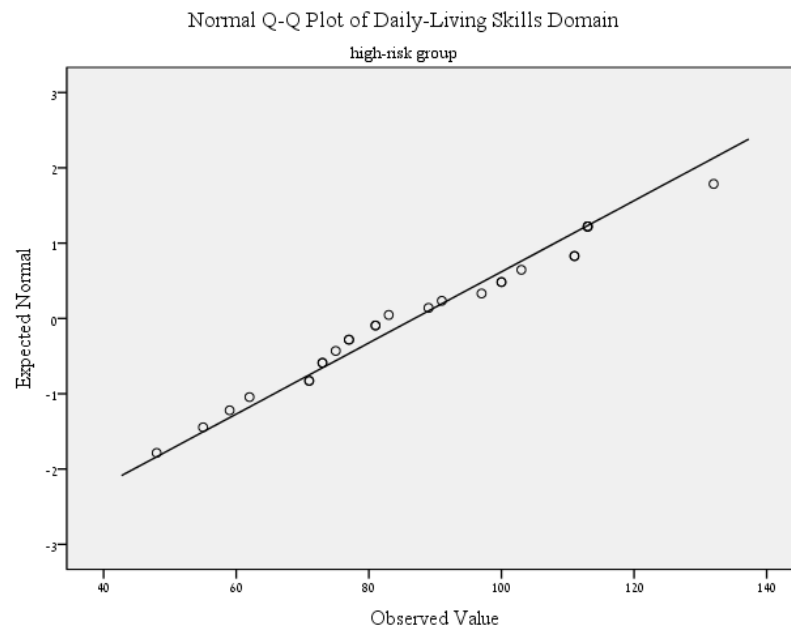
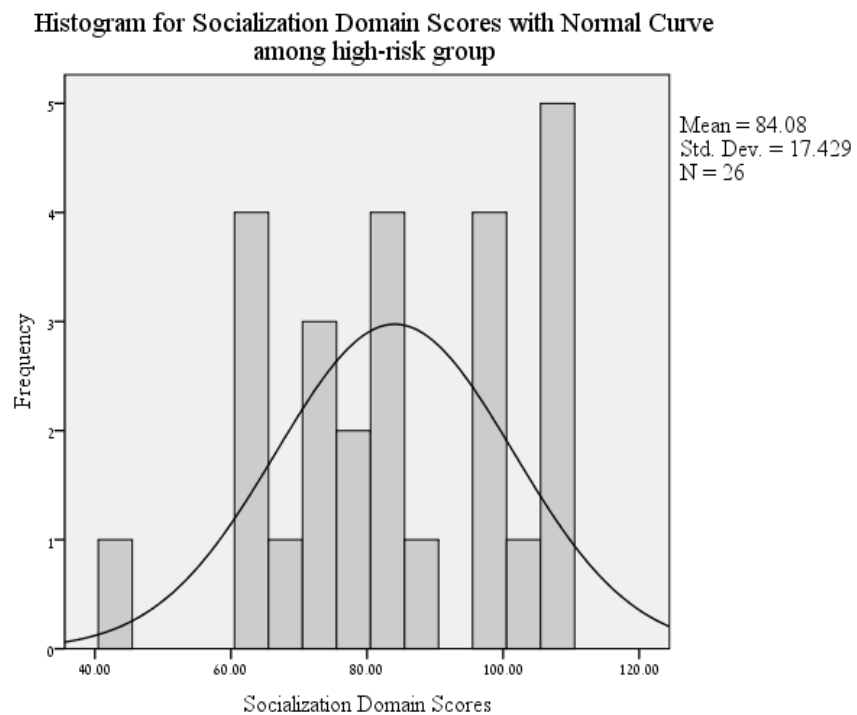
Histogram for Communication Domain Scores with Normal Curve
among high-risk group

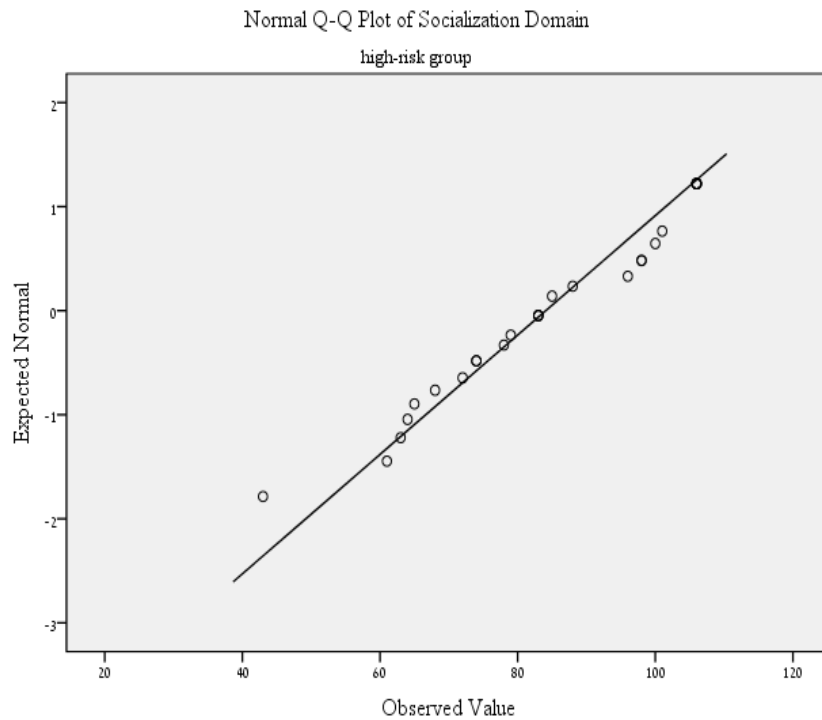
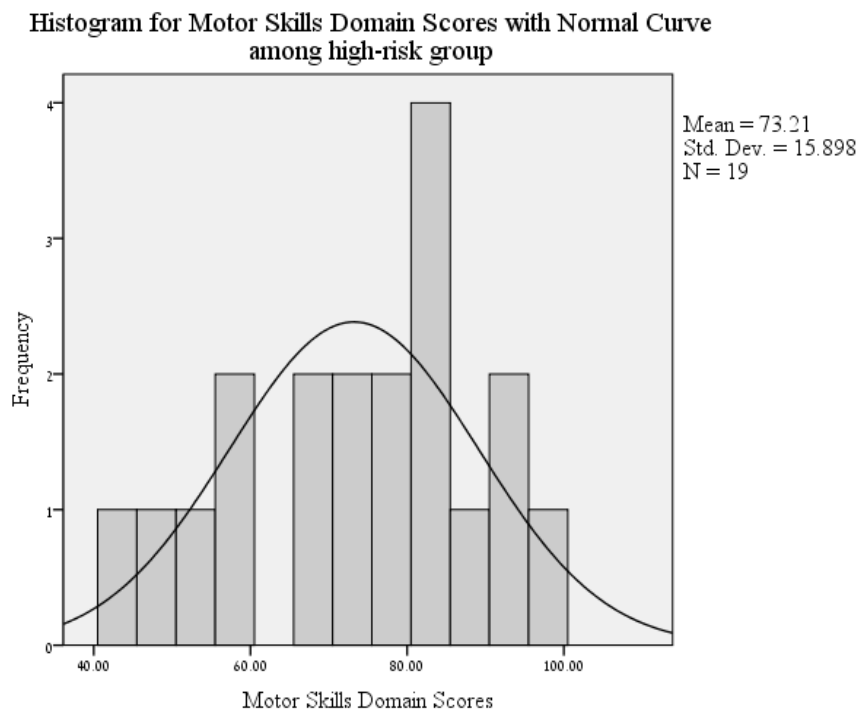


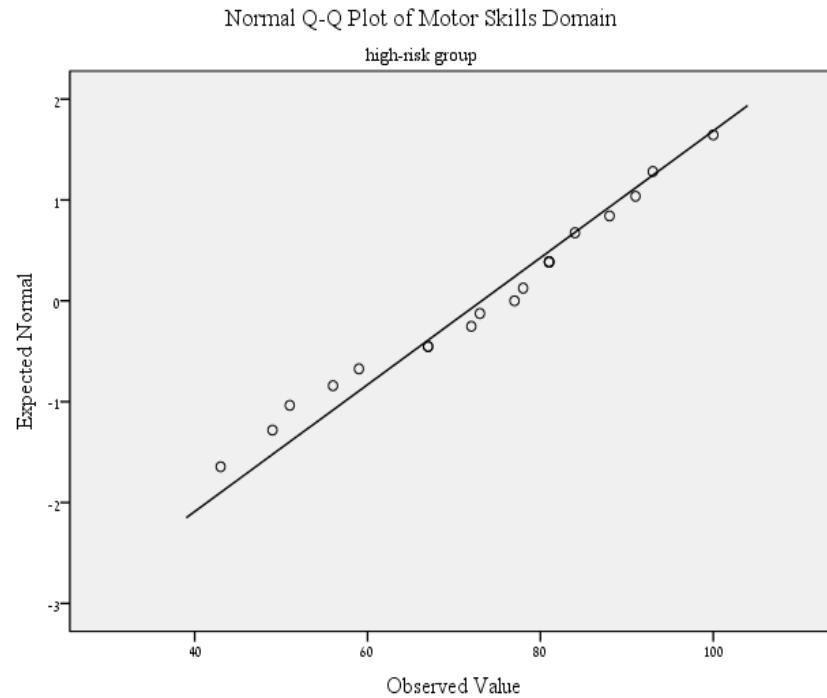
Graph 19:**Graph 20:**

Histogram for Daily Living Skills Domain Scores with Normal Curve
among high-risk group



Graph 21:**Graph 22:**

Graph 23:**Graph 24:**

Graph 25:

Moreover, test of normality results of the VABS subdomains among all participants showed that in the receptive, written, personal, domestic, community and coping skills subdomains the p-values were more than 0.05. So these data are not different from normal. However, the results of the other subdomains; expressive, interpersonal relationships, play, gross and fine motor subdomains, the p-values were less than 0.05. This means that these data are significantly different from normal.

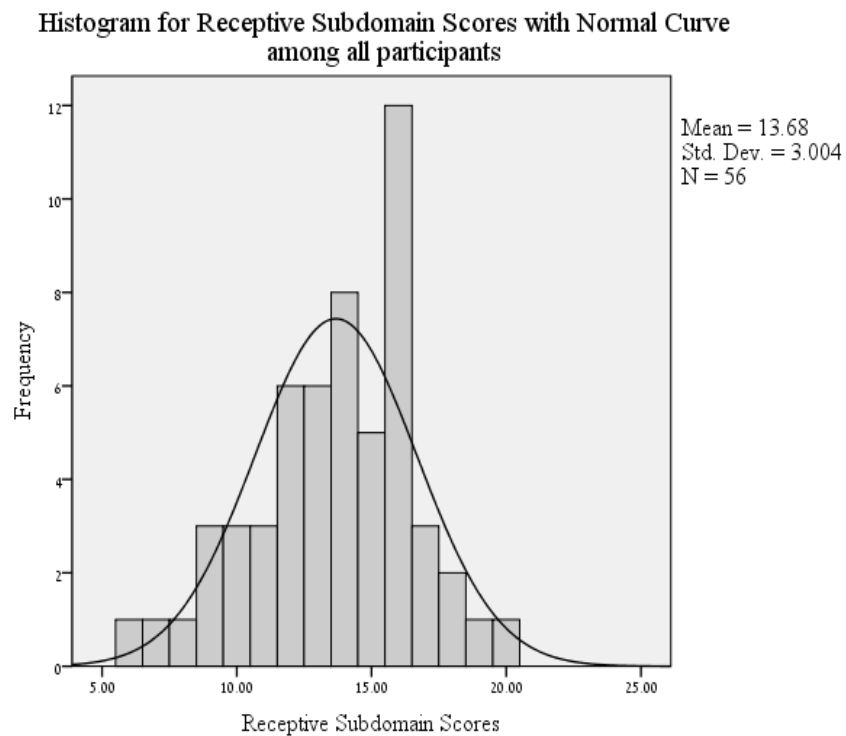
Test of Normality and Histograms of the VABS-II subdomains among all participants.

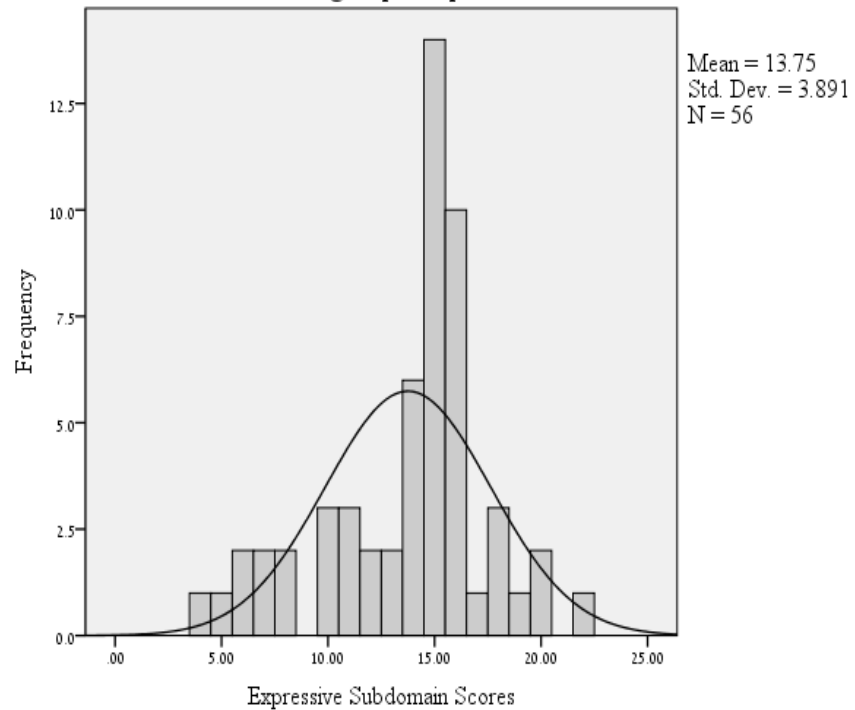
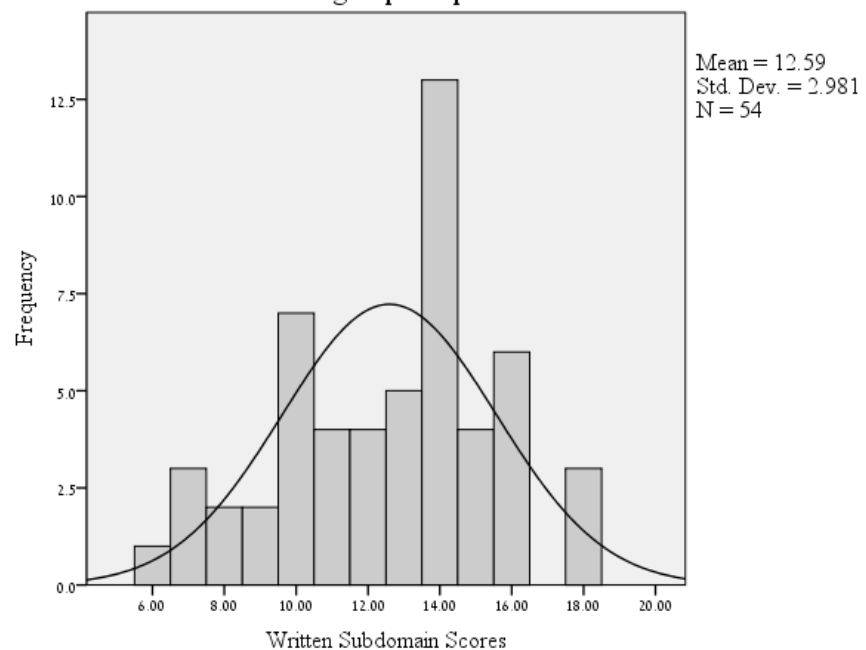
Table 30: Test of Normality and Histograms of the Vineland Adaptive Behavior Scale subdomains among all participants.

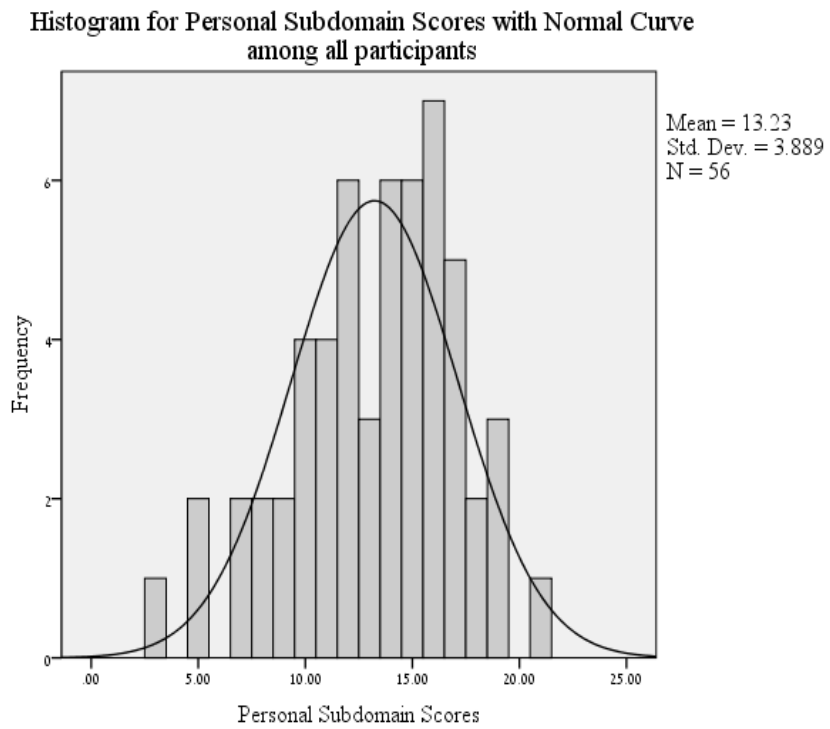
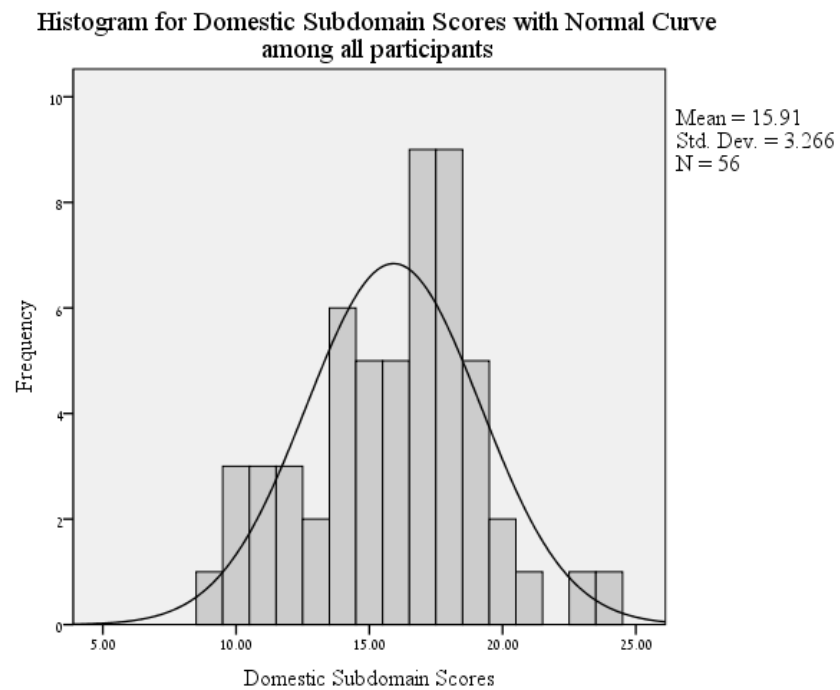
	Shapiro-Wilk			
	Statistic	df	Sig.	Skewness Statistic
Receptive Subdomain	.970	56	.177*	-.446
Expressive Subdomain	.926	56	.002	-.690
Written Subdomains	.959	54	.063*	-.320
Personal Subdomain	.973	56	.241*	-.509
Domestic Subdomain	.971	56	.206*	-.100
Community Subdomain	.964	56	.091*	-.508
Interpersonal Relationships Subdomain	.955	56	.036	-.777
Play and Leisure Subdomain	.886	56	.000	-1.287
Coping Skills Subdomain	.961	56	.070*	-.341
Gross Motor Subdomain	.942	44	.028	-.371
Fine Motor Subdomain	.901	44	.001	-1.054

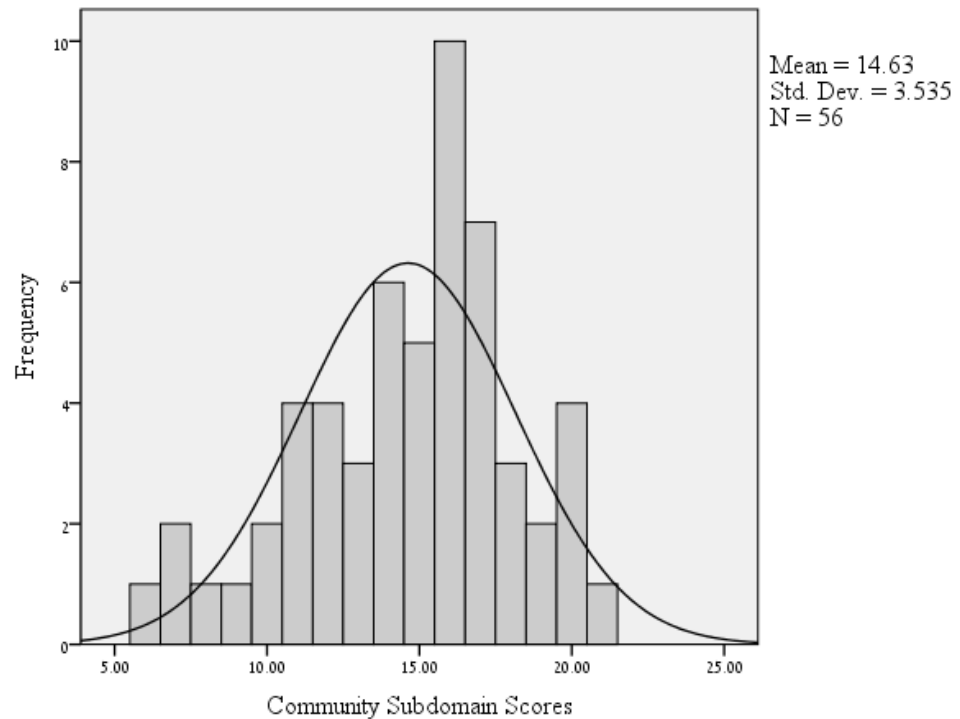
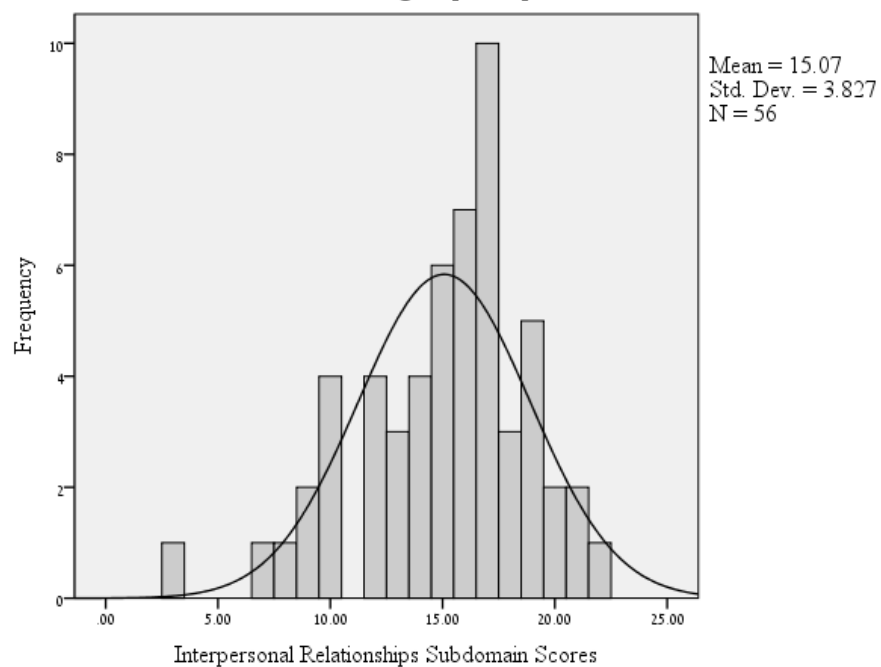
$p > 0.05^*$

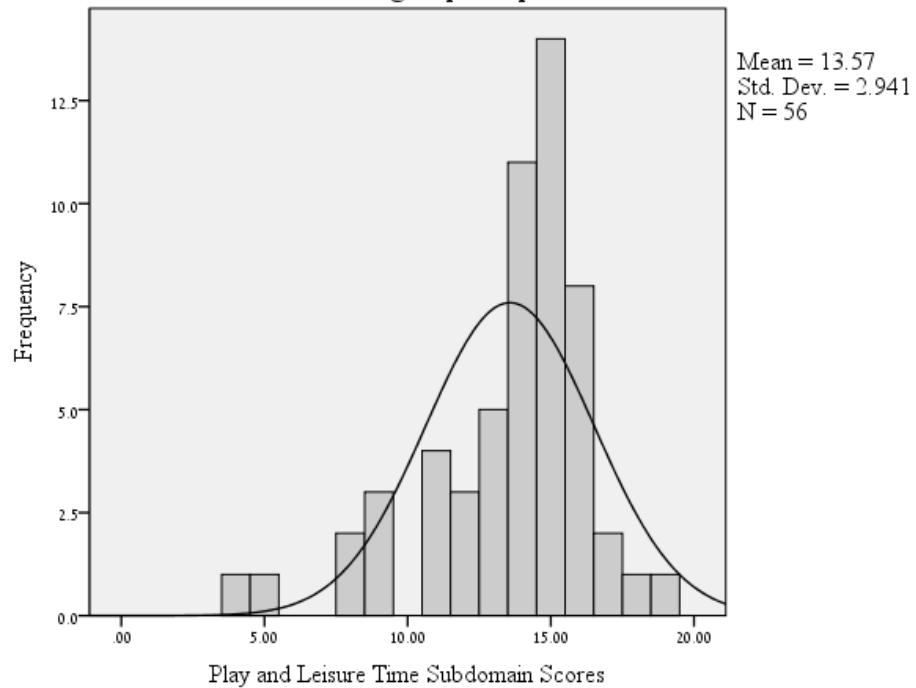
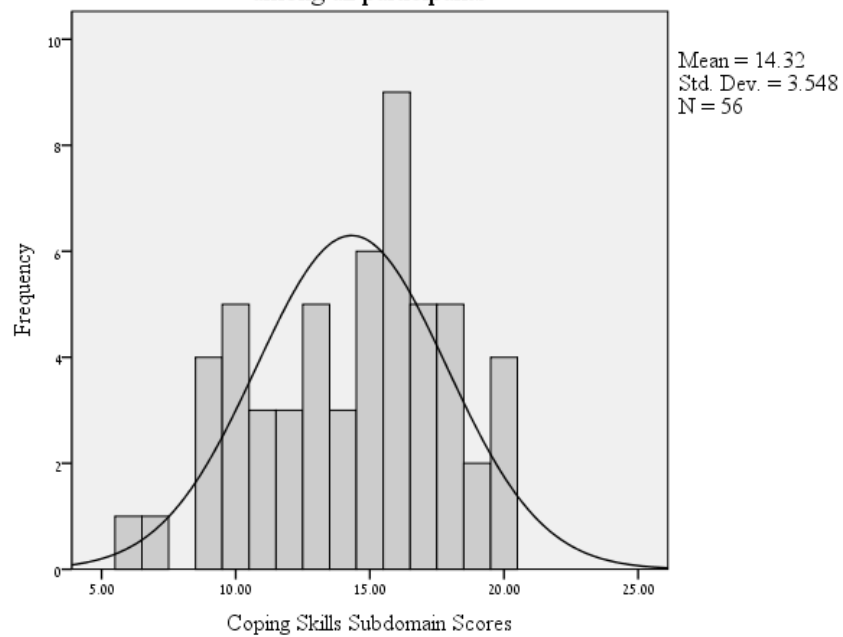
Graph 26:

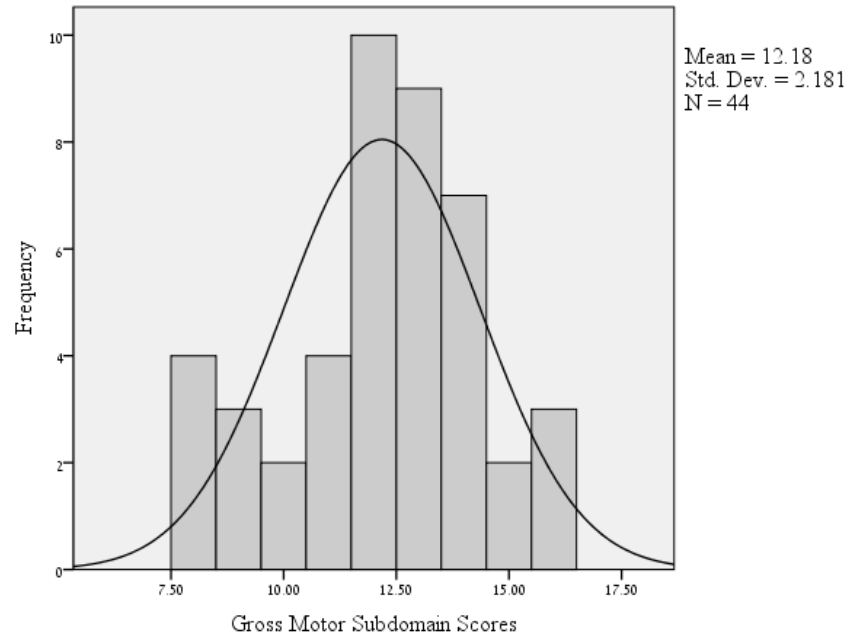
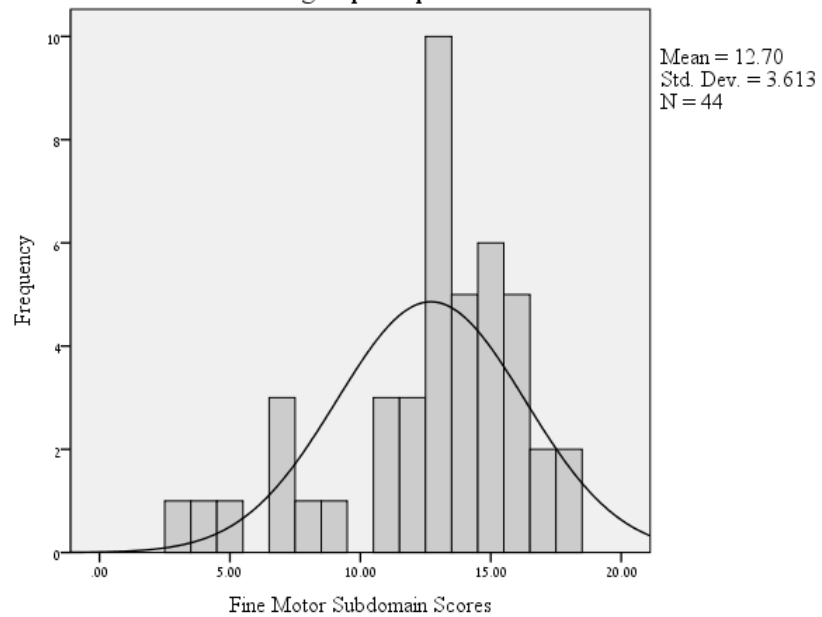


Graph 27:**Histogram for Expressive Subdomain Scores with Normal Curve
among all participants****Graph 28:****Histogram for Written Subdomain Scores with Normal Curve
among all participants**

Graph 29:**Graph 30:**

Graph 31:**Histogram for Community Subdomain Scores with Normal Curve
among all participants****Graph 32:****Histogram for Interpersonal Relationships Subdomain Scores with Normal
Curve among all participants**

Graph 33:**Histogram for Play and Leisure Time Subdomain Scores with Normal Curve among all participants****Graph 34:****Histogram for Coping Skills Subdomain Scores with Normal Curve among all participants**

Graph 35:**Histogram for Gross Motor Subdomain Scores with Normal Curve
among all participants****Graph 36:****Histogram for Fine Motor Subdomain Scores with Normal Curve
among all participants**

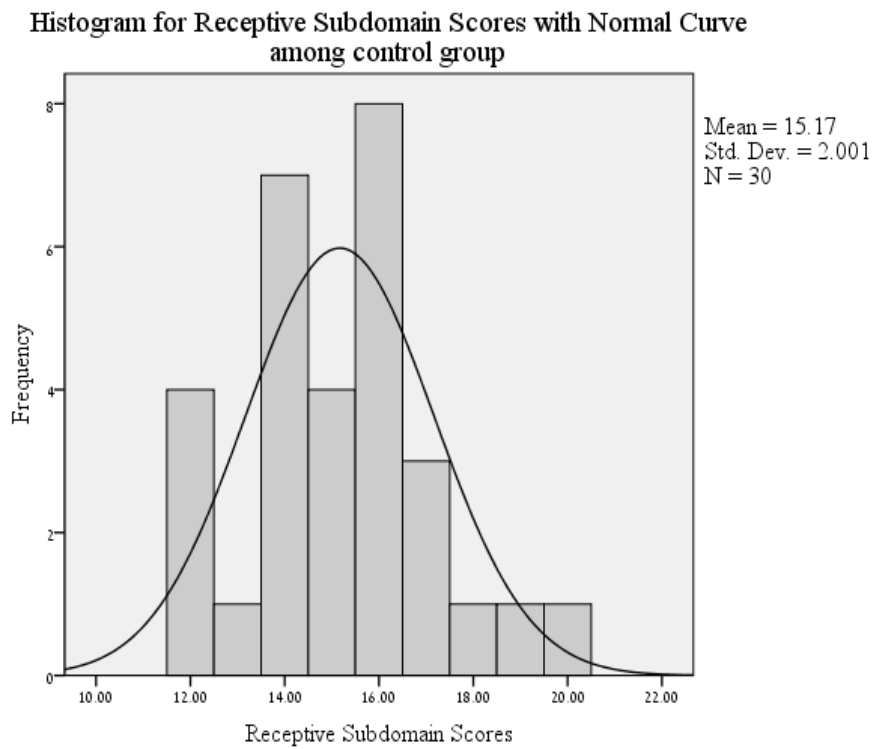
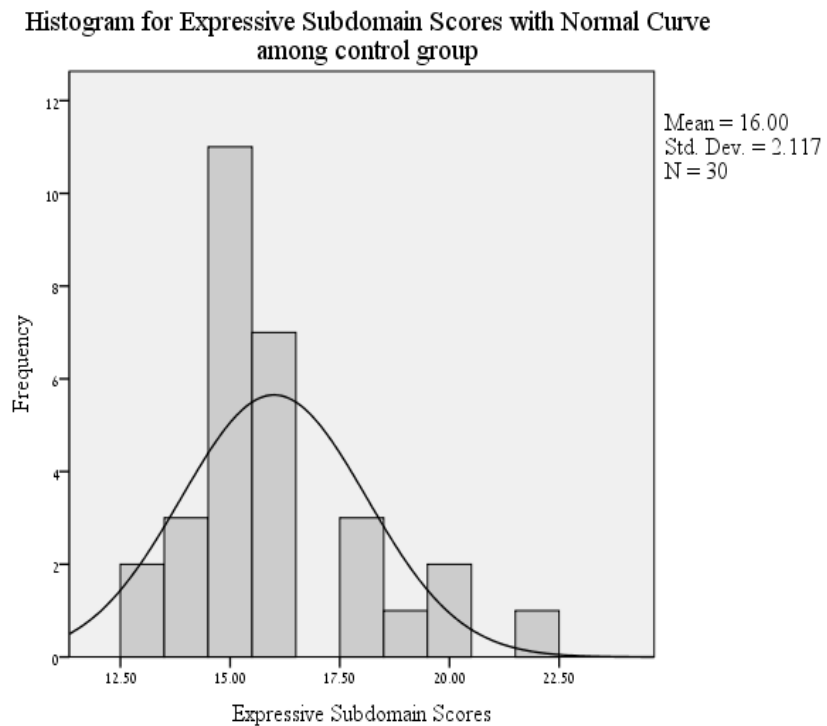
In addition, test of normality results of the VABS subdomains among control group showed different p-values among different subdomains. Data of receptive, written, personal, domestic, community, interpersonal relationships, coping skills, gross and fine motor subdomains are not different from normal ($p>0.05$). However, the other subdomains data are significantly different from normal ($p<0.05$).

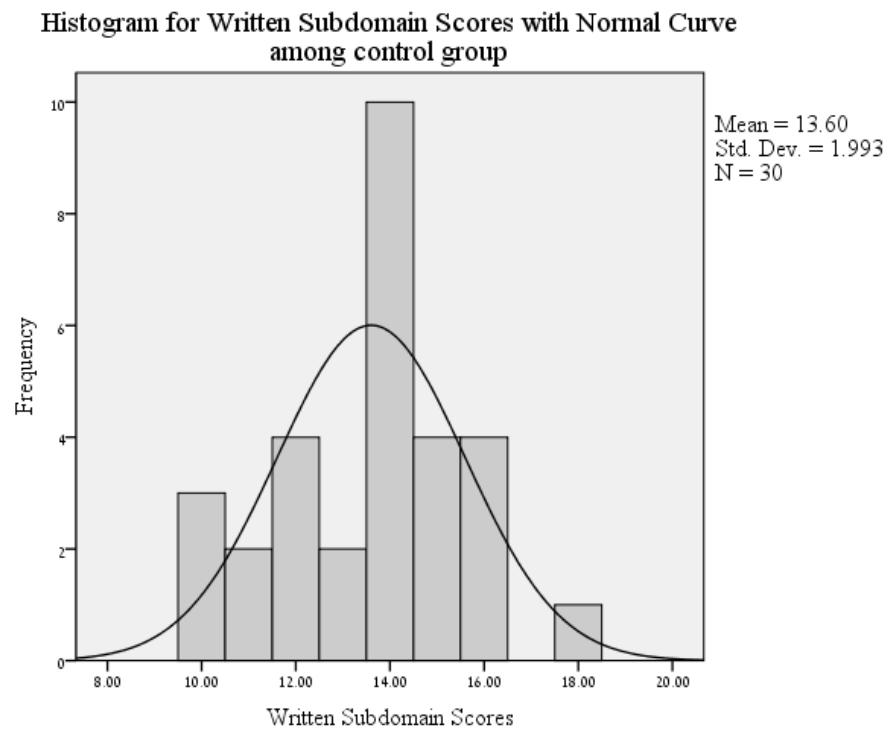
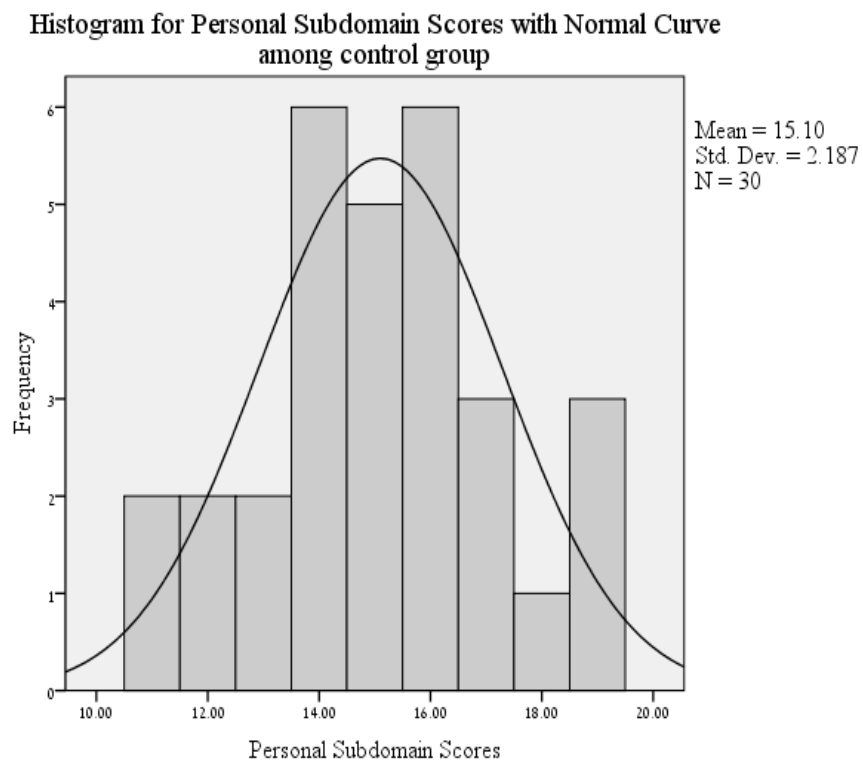
Test of Normality and Histograms of the VABS-II subdomains among control group.

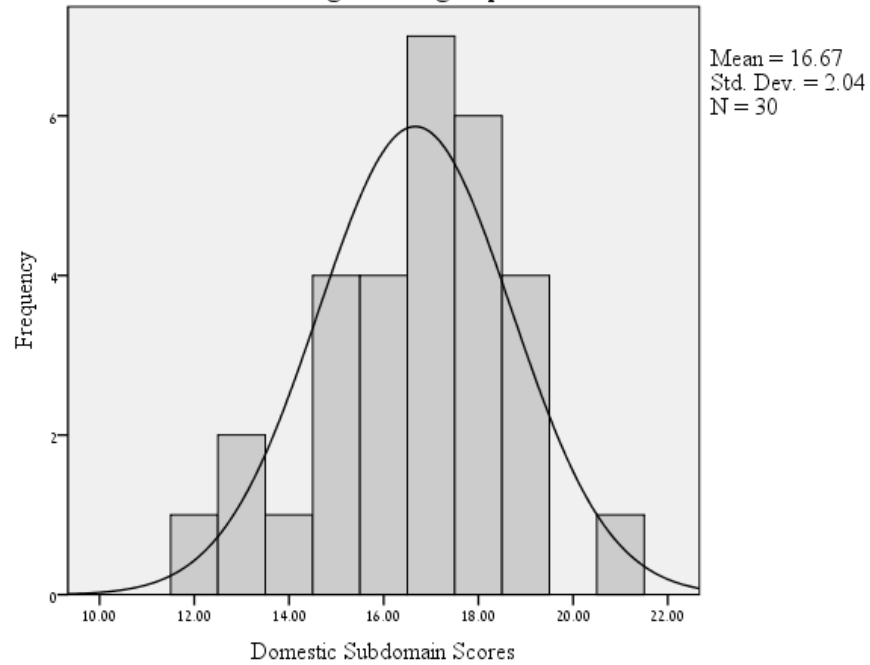
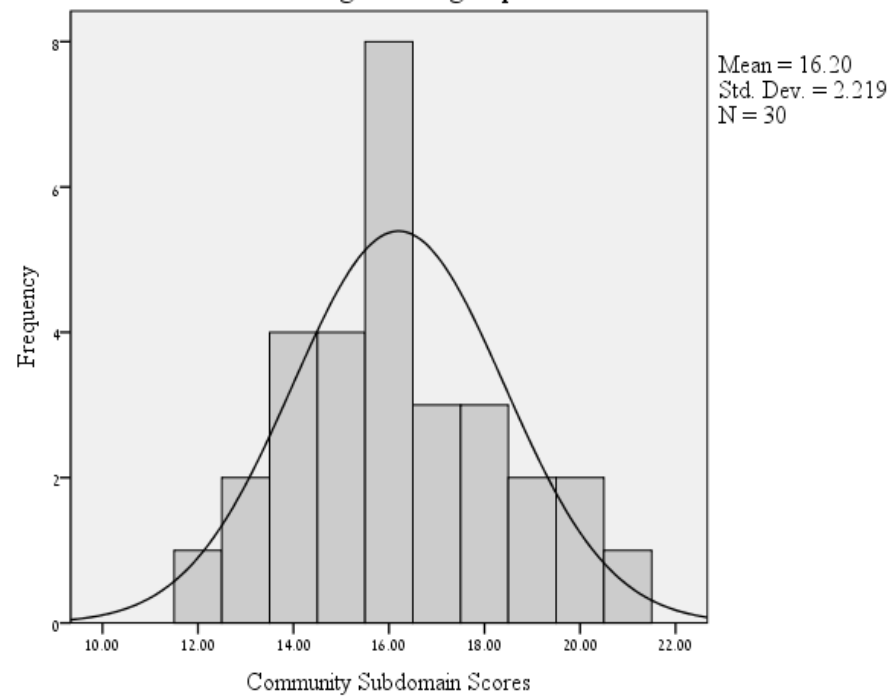
Table 31: Test of Normality and Histograms of the Vineland Adaptive Behavior Scale subdomains among control group.

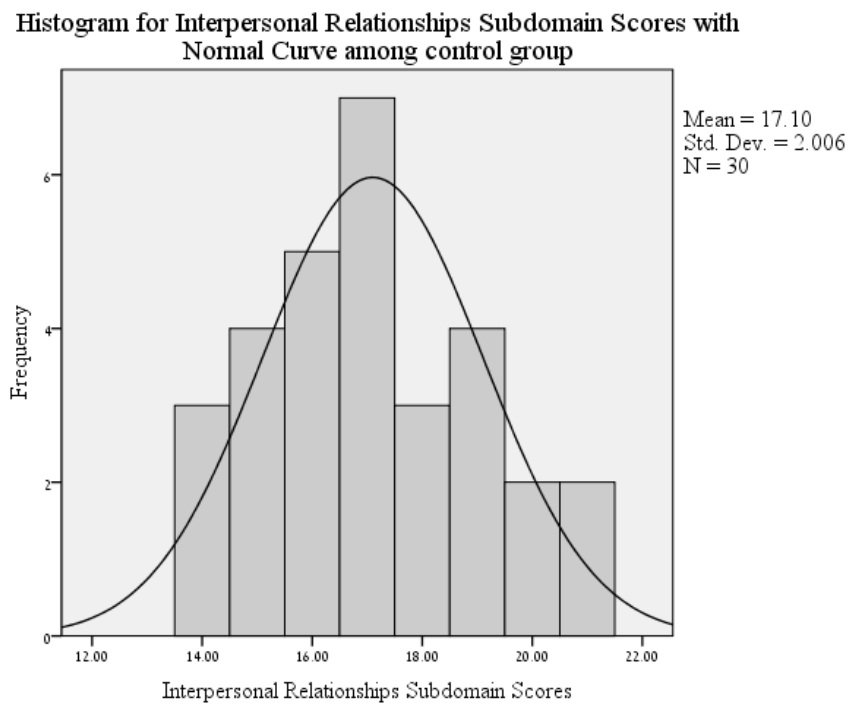
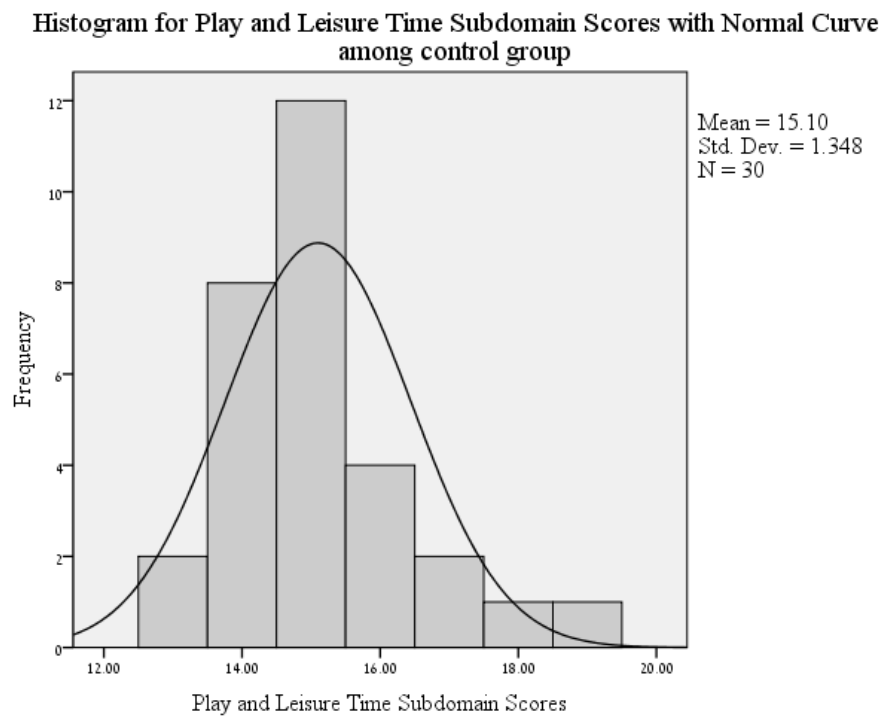
	Shapiro-Wilk			
	Statistic	df	Sig.	Skewness Statistic
Receptive Subdomain	.948	30	.149*	.308
Expressive Subdomain	.867	30	.001	1.191
Written Subdomains	.943	30	.113*	-.186
Personal Subdomain	.961	30	.330*	.012
Domestic Subdomain	.960	30	.302*	-.401
Community Subdomain	.967	30	.469*	.318
Interpersonal Relationships Subdomain	.951	30	.180*	.293
Play and Leisure Subdomain	.886	30	.004	1.073
Coping Skills Subdomain	.958	30	.279*	-.343
Gross Motor Subdomain	.934	25	.108*	.172
Fine Motor Subdomain	.940	25	.146*	.199

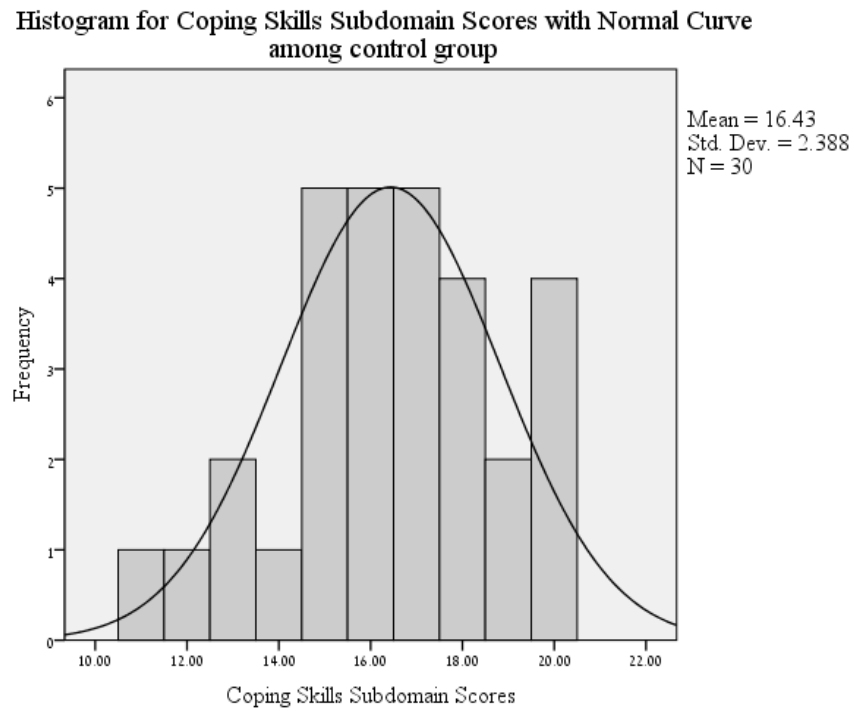
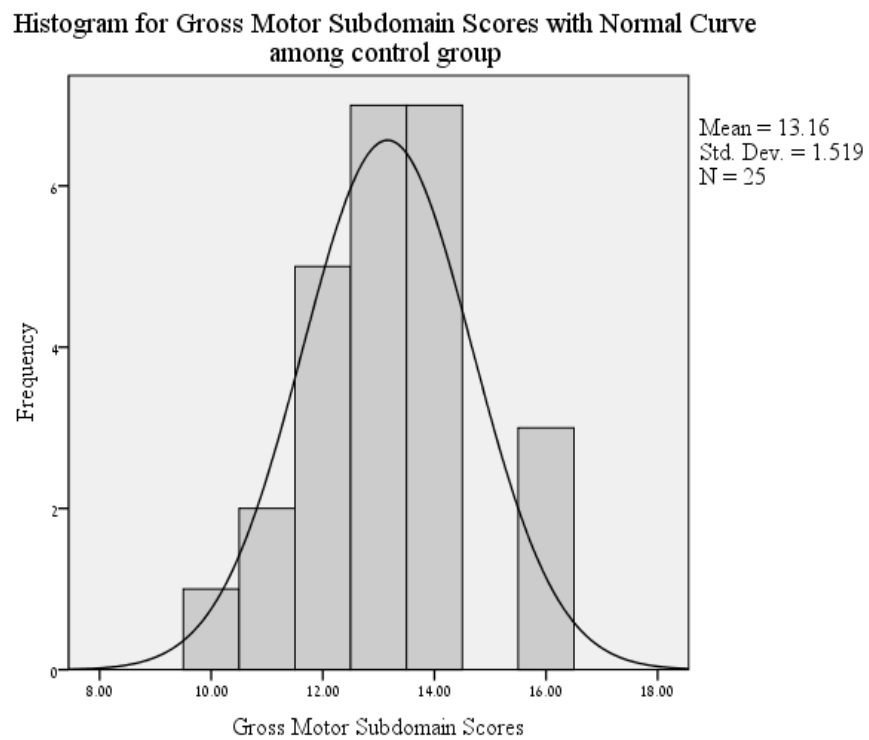
$p>0.05^*$

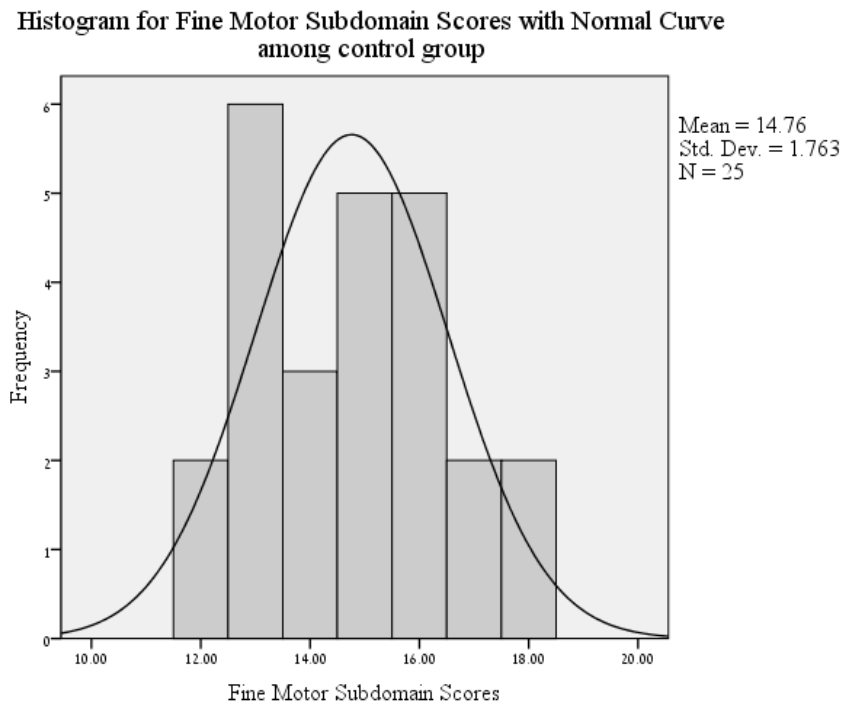
Graph 37:**Graph 38:**

Graph 39:**Graph 40:**

Graph 41:**Histogram for Domestic Subdomain Scores with Normal Curve
among control group****Graph 42:****Histogram for Community Subdomain Scores with Normal Curve
among control group**

Graph 43:**Graph 44:**

Graph 45:**Graph 46:**

Graph 47:

Test of normality results of the VABS subdomains was also used among high-risk group. In contrast to what we expected all of subdomains data are not different from normal ($p > 0.05$).

Test of Normality and Histograms of the VABS-II subdomains among high-risk group.

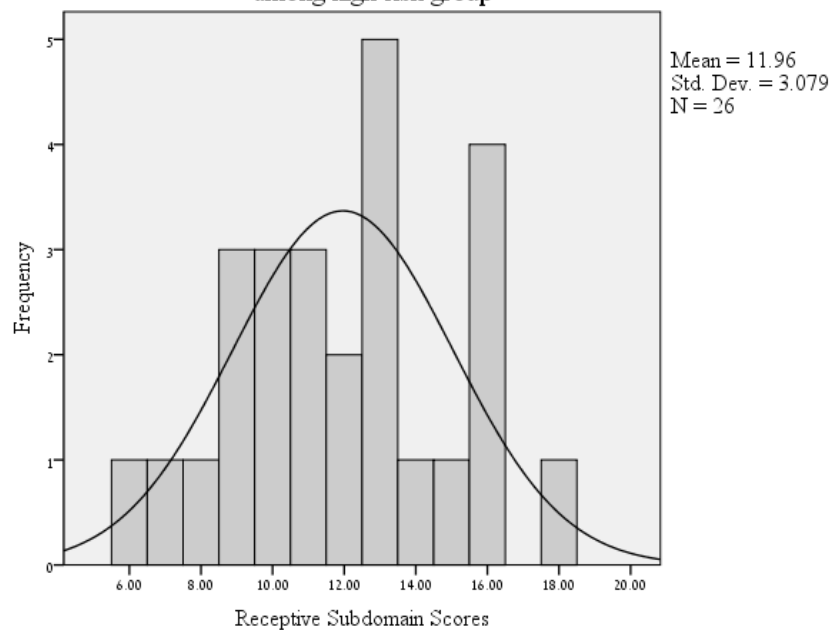
Table 32: Test of Normality and Histograms of the Vineland Adaptive Behavior Scale subdomains among high-risk group.

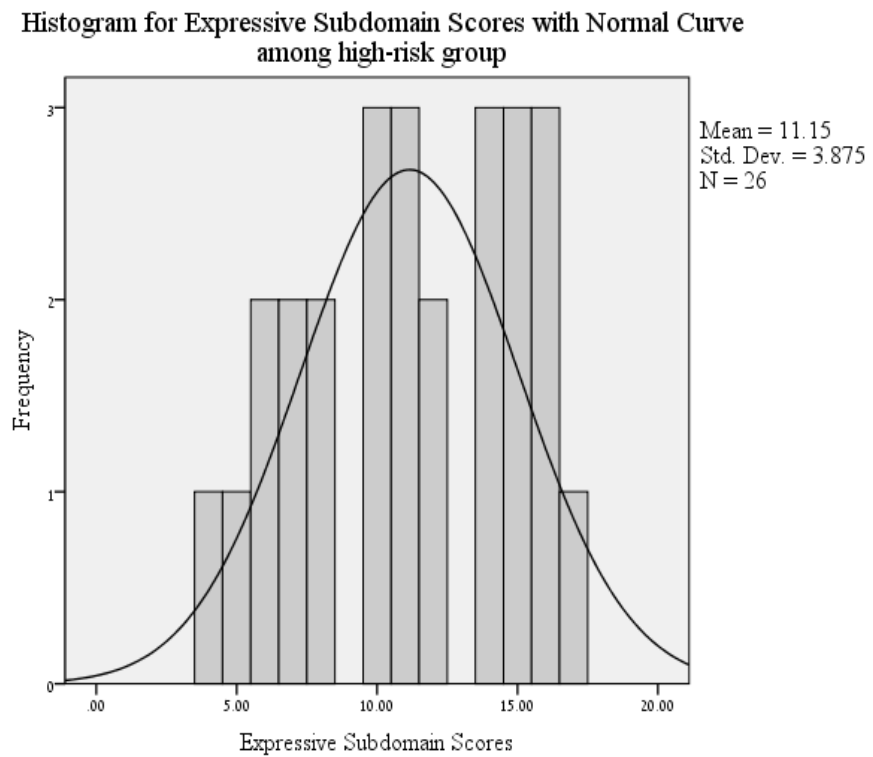
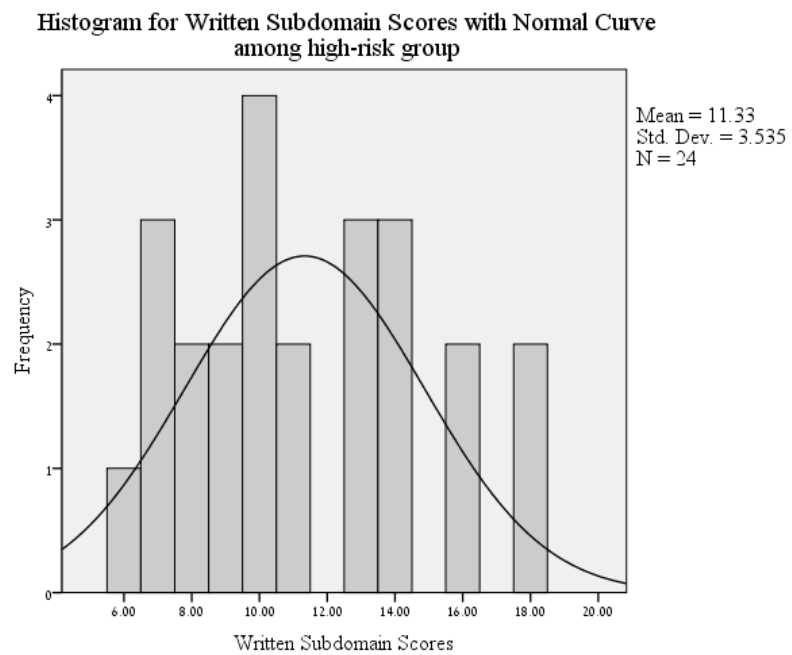
	Shapiro-Wilk			
	Statistic	df	Sig.	Skewness Statistic
Receptive Subdomain	.974	26	.729*	.039
Expressive Subdomain	.943	26	.161*	-.224
Written Subdomains	.946	24	.216*	.389
Personal Subdomain	.974	26	.726*	.386
Domestic Subdomain	.948	26	.214*	.464
Community Subdomain	.964	26	.468*	.126
Interpersonal Relationships Subdomain	.985	26	.962*	-.019
Play and Leisure Subdomain	.935	26	.100*	-.693
Coping Skills Subdomain	.961	26	.411*	.161
Gross Motor Subdomain	.911	19	.078*	.238
Fine Motor Subdomain	.922	19	.124*	-.506

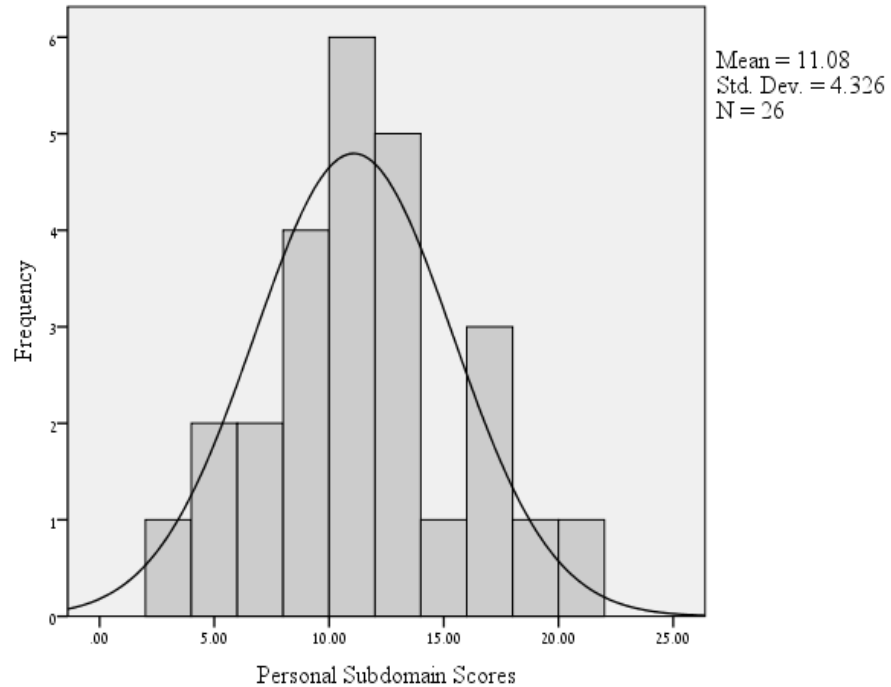
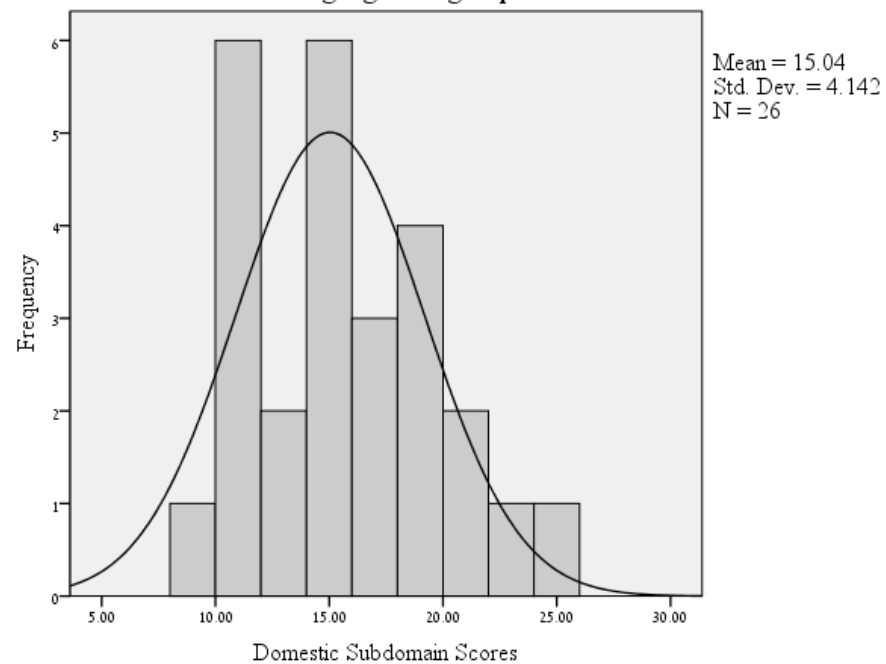
$p > 0.05^*$

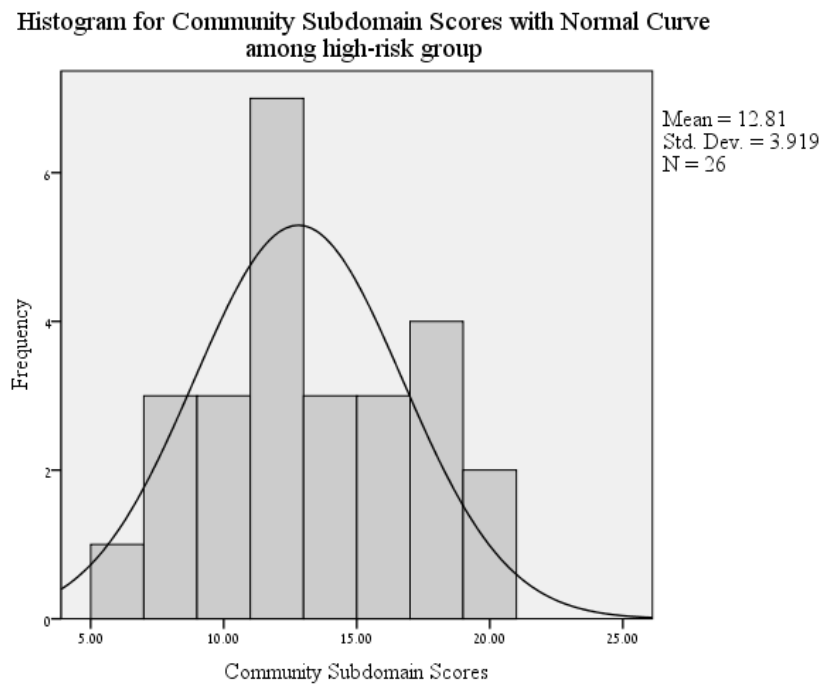
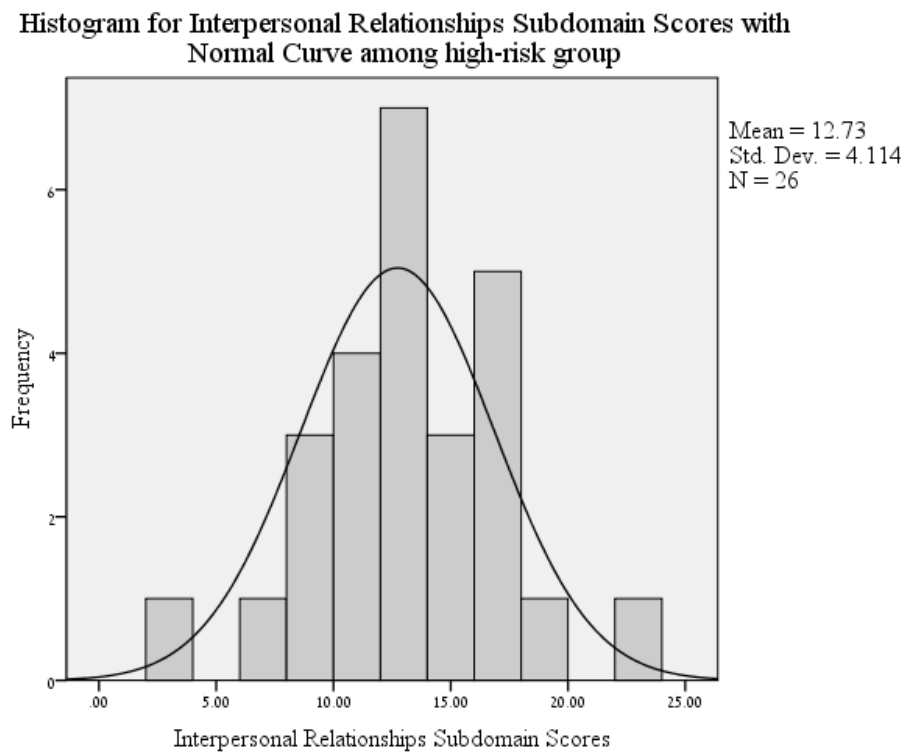
Graph 48:

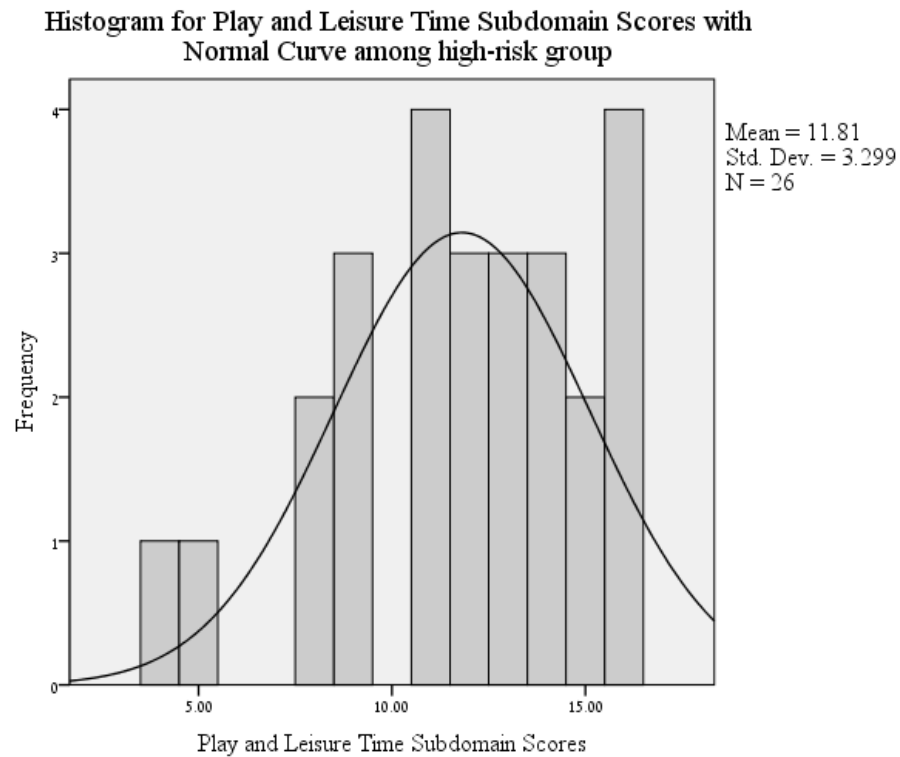
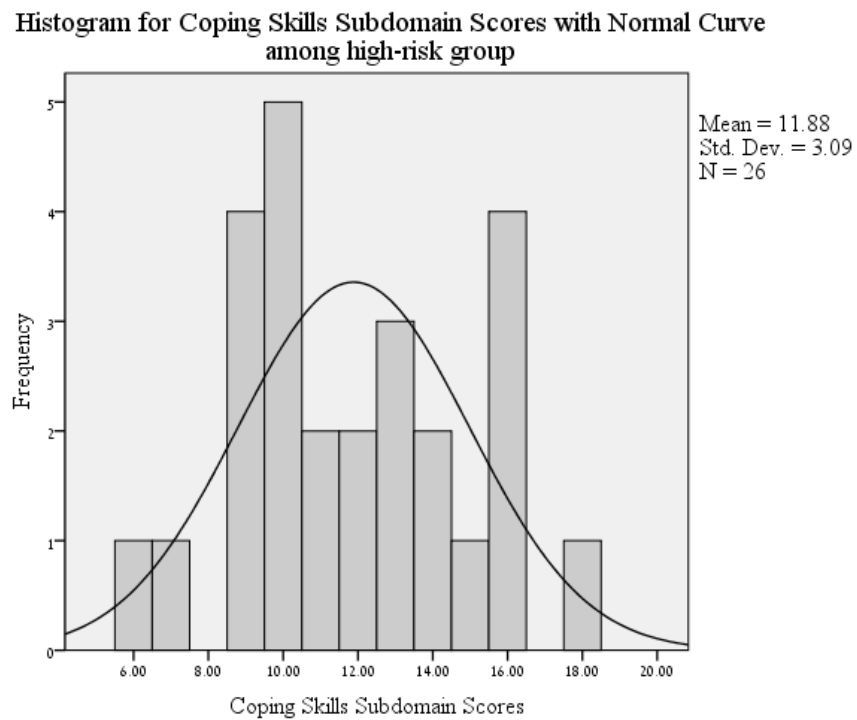
Histogram for Receptive Subdomain Scores with Normal Curve among high-risk group

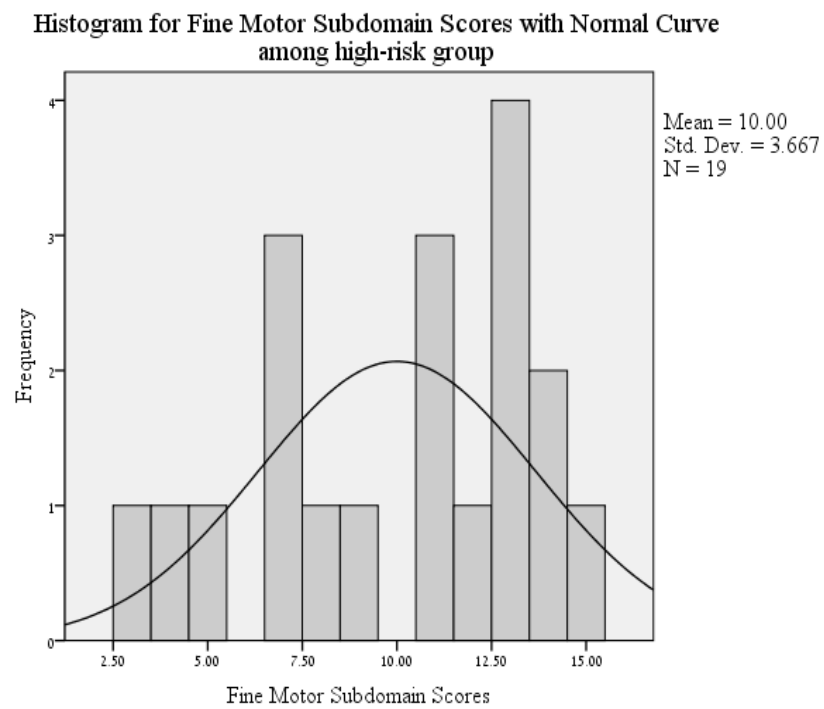
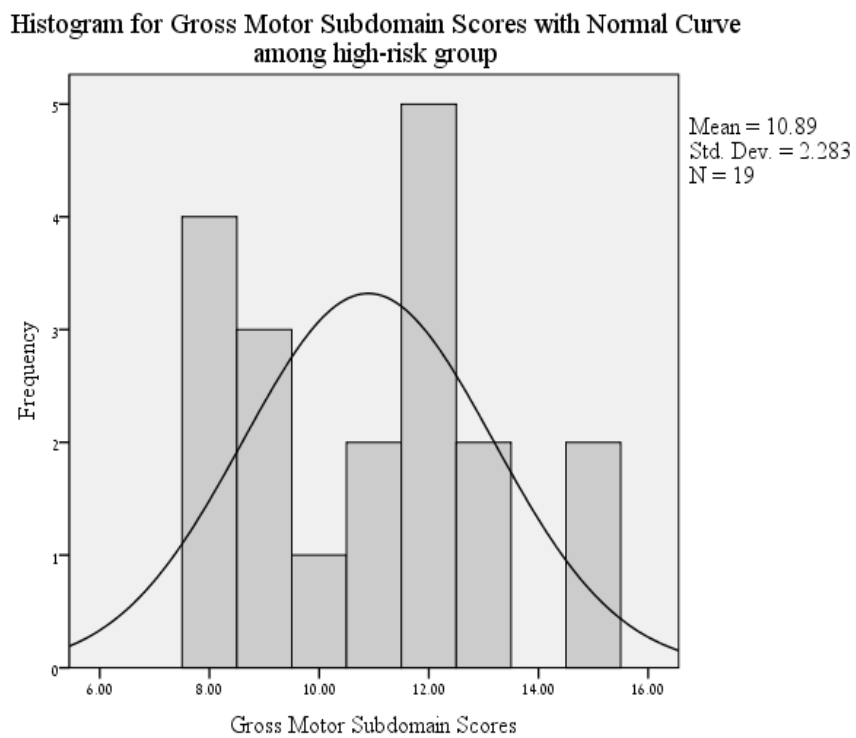


Graph 49:**Graph 50:**

Graph 51:**Histogram for Personal Subdomain Scores with Normal Curve
among high-risk group****Graph 52:****Histogram for Domestic Subdomain Scores with Normal Curve
among high-risk group**

Graph 53:**Graph 54:**

Graph 55:**Graph 56:**

Graph 57:**Graph 58:**

Moreover, this study examined whether the VABS-II adds relevant information for professionals working with children. As the Portage assessment scale provides the developmental level on five developmental scales: motor, language, self-help, socialization and cognition, also the VABS-II assess adaptive behavior in four broad domains of communication, daily living skills, socialization, motor skills and adaptive behavior composite. However, by comparison with the Portage assessment scale, the VABS-II provide a comprehensive profile of each domain by dividing it to several subdomains. VABS-II allow for better understanding of an individual's strengths and weaknesses. Also, it produces an overall composite score which is utilizable as an estimation of intellectual ability. Moreover, it provides a maladaptive behavior domain scores that assess problem behaviors. The maladaptive behavior index groups maladaptive behaviors into internalizing, externalizing and other problem behaviors. These categories are helpful in making clinical diagnosis. For example, a number of children in the current study were scored in the age range in the developmental domains. However, they demonstrate elevated or clinically significant scores on the maladaptive behavior index and on internalizing and externalizing behaviors. The VABS-II provides information of undesirable behavior that may interfere with the individual's adaptive functioning and maladaptive behavior critical items provides clinically important information.

Furthermore, this study investigated the satisfaction of the parents with the VABS-II process. In order to explore this research question a

parent satisfaction surveys were completed by the parents. The survey results showed that 90% of the parents indicated that their general experience during the interview was very helpful. 70% of the parents pointed that the content of the questions was also very helpful, 30% pointed that it was moderately helpful. In addition, 100% of the parents were very satisfied with the way of presenting the findings (written). About the information that included in the findings, 90% of the parents indicated that are very helpful. 80% of the parents pointed that the length of the interview was very suitable (see table 33).

Table 33: Results of Parents Satisfaction Survey.

	(1) Very Helpful	(2) Moderately Helpful	(3) Neutral	(4) Moderately Problematic	(5) Problematic
1. General experience during the interview	90%	10%	0%	0%	0%
2. The content of the questions	70%	30%	0%	0%	0%
3. The way of presenting the findings (written)	100%	0%	0%	0%	0%
4. The information that included in the findings	90%	10%	0%	0%	0%
5. The length of the interview	80%	10%	10%	0%	0%

Chapter 5

Discussion

5. Discussion

The validation of constructs and measures is critical to the development of scholarly disciplines and allows for greater empirical testing of theory. Over the last few decades, an attention to the importance of considering cultural and ethnic minority aspects in any psychosocial interventions was called by psychologists and other health professionals. It has been advanced that cultural and social processes must be considered in treatment, prevention, and mental health service delivery (Bernal, Trimble, Burlew, & Leong, 2003; Marín & Marín, 1991; Rogler, 1989, Sue & Zane, 1987).

Whether an instrument is appropriate is based on a number of considerations, including the individual's or group's level of acculturation, language preference, language proficiency, availability of translation of the instrument, whether the construct is the same for the individual's or group's culture, availability of norms, and availability of possibly more appropriate alternatives specific to the individual's or group's culture (Groth-Marnat, 2009).

The present study examined several research questions. First, this study focused on examining whether the VABS–II record similar results as the Portage assessment scale when applied to a sample of high risk and control group children in Palestine. Second, this study examined gender

and age differences in the application of the VABS-II. Moreover, it was asked if the sample of VABS-II scores fall into a normal curve pattern such as the original validation data reveals. Finally, it was examined whether the VABS-II add additional information for professionals working with children and the parent satisfaction with the VABS-II.

In regard the first research question of this study, differences were emerged in the cognitive and physical domains among the whole sample testing. However, in self-help, communication and social domains were no differences between the two assessment scales among the whole sample. In the results among the control group, differences between the two scales were found in three domains; cognitive, physical and social domains. While, there were no differences in self-help and communication domains. However, a look at the results for the high-risk group, there are no differences demonstrated in all of the developmental domains; no differences in cognitive, self-help, physical, communication, social and motor domains.

In addition, gender differences were examined amongst the whole participants, control group and high-risk group in this study. Among all male participants, there were differences in the cognitive, physical and social domains. In the male participants of control group, there were differences in the physical and social domains. However, among male participants of high-risk group there were no differences in all domains. In the results amongst all female participants there was a difference in the

communication domain. The same among female of control group, it was found a difference in the communication domain. Nevertheless, among female of the high-risk group there were no differences in all domains.

Age differences were also examined amongst the whole participants, control group and high-risk group. The participants were divided into two groups of age; first group 2 – 5 years and 11 months and second group 6 – 9 years old. In the first group of age of all participants, differences were founded in physical and communication domains. In first group of age participants of control group, there were differences in self-help, physical and communication domains. However, in first group of age of high-risk there were no differences. In the second group of age of all participants there were no differences between scores of two scales domains. In second group of age participants of control group, differences in cognitive, self-help and social domains were appeared. While in this group of age among high-risk group there were no differences in all domains.

Therefore, the results of this study indicated that the differences between the Portage scale domains scores and VABS-II domains scores rise from participants of the control group. The *t* test results yielded some significant differences ($p < 0.05$) among the control group. However, the Wilcoxon test results among the high-risk group participants showed that there were no significant differences.

There are several possible explanations for this finding. The Portage assessment stage items are completed through observation or through

eliciting the behavior by the children themselves (Bluma, Shearer, Frohman & Hilliard, 1976). However, in the VABS-II, the information regarding children adaptive behaviors is provided by the parents (Sparrow, Balla & Cicchetti, 2005). These findings can be explained by the possibility that children of the high-risk group are less cooperative in the testing setting which causes the parents to provide information for both of the scales; Portage and VABS-II. In other words, it is possible that in the high-risk group, the Portage and the VABS-II items information are based on the same interviewed parent whereas children of the control group, the Portage was completed by the children while the VABS-II by the parent.

In addition, the control group contains various and different children. They are different in all kinds of fields and they have no unified and specific profile, they may have strengths in some areas while have a weaknesses in the other. This may make it more difficult to predict equal scores among two different scales. In addition, in contrast to control group, high risk group is a group of children who were referred for neuro-developmental concerns. For those children the possibility to have specific profile is higher. Moreover, these assessment tools were designed to use with children who have some difficulties or may be diagnosed with disorder related to developmental issues. This may explain the findings that all of the differences between two scales scores are come from the control group.

Overall, the results demonstrated some significant differences among some developmental domains. Most of the Portage domains assessments are completed by observation or through eliciting the behavior by the children themselves at the setting time while VABS assess what a person actually does, rather than what he or she is able to do (Sparrow, Balla & Cicchetti, 2005). This also may be an explanation of the differences scores between the Portage and the VABS-II as an assessment tool.

In addition, all of the differences that were signed in the results between Portage scale and VABS-II among different domains may be due to the variant content, specify and the number of the items of the two assessment scales domains.

Results over the whole participants indicated differences among two domains; cognitive ability and physical ability domains. However, there were no differences in self-help skills, communication and social domains. A possible explanation for these differences may be due to the variant content, specify and the number of the items of the two assessment scales domains. In this case, a possible explanation for differences in the cognitive age domain is that the cognitive ability of the portage is based on academic abilities while in the VABS-II it is more based on the life skills. Portage cognitive domain determined by measuring the special abilities of pre-school children in terms of cognitive education and other arithmetic such as the child's ability to draw a vertical line or to recognize the concept of numbers 3 and 6 or to indicate colors or draw a plus, triangle or square.

However, VABS-II cognitive domain is based on a survey of behavioral milestones across four major life functioning areas (communication, daily living skills, socialization, and motor skills) and produces an overall composite score which is utilizable as an estimation of cognitive ability.

In addition, in the results it is appeared that among most of the examinations the Portage cognitive ability age mean is less than the VABS-II cognitive ability age, which may also be related to that the Portage refer cognitive age more to academic tasks.

The other difference in the results among the whole participants was within the physical ability domain. This difference in the physical domain was appeared also in the control, male and first group of age groups testing. These differences may be also due to the difference of the questions content and number. In the VABS-II there are more questions and more specific by comparison to the Portage assessment tool. While both of the scales assess physical age, Portage assess it by measuring growth, physical development, muscle strength and the ability to perform a range of motor skills such as jumping on one foot or two feet or using a scissors or throwing a ball, still the VABS-II assess it more specific. Physical ability of the VABS-II include two specific subdomains separately; fine muscles which measures the individual's skills in the use of arms, legs and motor synergies (including sitting, walking, running and play activities), and gross muscles that measures the skills of the individual in the use of hands and fingers (control of objects, drawing, and the use of scissors).

Among the control group, the results showed differences within cognitive, physical and social domains. While, there were no differences in self-help skills and communication domains. In addition to the explanation for differences of cognitive and physical domains across Portage and VABS-II, in the Portage, social age is defined and determined by the child's ability to establish social relations with other relatives and friendship with adults as well as good behavior in the social attitudes faced by the child. However, in the VABS-II, socialization domain separated by three subdomains; interpersonal relationships that measures how the individual interacts with others (responding to others, imitation, expressing emotions, social communication), play and leisure time which measures the individual's skills in play situations and leisure time (play, share, cooperate with others, habits) and coping skills that measures the individual's ability to show responsibility and sensitivity to others (sensory habits, following instructions, apologies, keeping secrets, controlling feelings and taking responsibility).

Therefore, a possible explanation of the social skills domain differences may also come from the content, specify and the number of the items of the two assessment scales. The Portage includes general questions whereas the VABS-II refer to more dimensions of the socialization development age.

In regard the second research question of gender differences, the results among all participants showed differences in different domains.

While in the male group the findings indicated differences in three domains; cognitive, physical and social and no differences in self-help skills and communication domains, in the female group there was only differences in one other domain which is the communication whereas no differences in cognitive, self-help skills, physical and social domains.

Besides the several domains differences among Portage and VABS-II, the VABS-II communication age refer to three subdomains; receptive language which measures what an individual can understand from the spoken language (understanding, listening, focusing and following instructions), expressive language measure what an individual can express in spoken language (facial expressions, beginning of speech, interactive speech, specific concepts, speech skills) and written subdomain that measures what an individual can read or write (reading, reading skills, writing skills). However, the communication age of the Portage scale is determined by measuring the skills of an expressive or receptive language, whether by reference or by delusions, not verbal, and may be verbal or written. The communication domain of the Portage does not refer to the writing skills as the VABS-II. This may explain the difference appeared in the communication domain.

In addition, in the male participants of control group, there were differences in the physical and social domains while there were no differences in cognitive, self-help skills and communication domains. Among female of control group, it was found a difference in the

communication domain. The same as other differences explanation, these differences may also be explained by the variant content, specify and the number of the items of the two assessment scales domains. However, among male and female participants of high-risk group there were no differences in all domains.

The current study also dealt with examining differences among two groups of age; first group of children aged from 2 – 5 years and 11 months and the second group is of children aged 6 – 9 years. The results of this examination among the whole participants of first group age showed differences in two domains; physical and communication and no differences in cognitive, self-help skills and social domains. However, in the second group of age there were no differences in all developmental domains scores.

Among the control group, findings of first group of age showed differences in three domains; self-help skills, physical and communication. However, there were no differences in cognitive and social domains. In addition, findings of the second group of age showed differences in three domains; cognitive, self-help skills and social. While in physical and communication domains there were no differences. Nevertheless, amongst these two groups of age of high-risk group of participants, there were no differences between all domains scores.

These differences that indicated in the findings may also come from the different definition of each domain across each assessment scale; Portage and VABS-II.

Whereas in the VABS-II it is defined as daily living skills, it is defined in the Portage as self-help skills. VABS-II domain of daily living skills is referring to three subdomains: personal skills that measure the child's skills in eating, drinking, using bathroom and dressing, bathing, self-care, and personal hygiene, domestic activities that measure the performance of domestic tasks and community activities that measure the individual's ability to use time, money, telephone, behavior skills, and professional skills. Portage self-help skills are determined by measuring the child's ability to take responsibility and self-reliance in food and clothing and to meet his own needs. The Portage does not refer a major worth in this developmental domain for domestic activities.

It should also be noted, that among the control group of children within the age 6 to 9, in most of the developmental areas the means of the VABS-II were higher than in the Portage. These findings may be due to the fact that the Portage scale is assesses children till the age 9 and the items of the scale are adjusted till this limited age. However, the VABS-II designed to measure adaptive behaviors of individuals till the age 90. That is to mean, that children of this group of age in the VABS-II testing have more possibility to reach questions of activities that target older age than nine years old. While, this possibility not present when those children were

tested by the Portage. This may also explain the differences in the several domains of this group of age in the control group.

Regarding the research question whether the sample of VABS-II scores fall into a normal curve pattern such as the original validation data reveals, test of normality and histograms with normal curve were used among all participants and among each group separately; control and high-risk group.

The data of the test of normality for adaptive behavior composite and domains of the VABS-II showed that when both samples are included then the resulting data curve is significantly different from normal. This may be due to the pre-selected grouping which made 50% of participants as part of a high-risk group, fundamentally changing the normal curve. However, the data for subdomains of the VABS showed different p-values among different subdomains. For example within each sample group the assumption of the normality of the curve was upheld. To say the data of both the control and sample group formed a normal curve within their own populations

Among the control group and high-risk group, data of the adaptive behavior composite and domains of VABS-II, demonstrated that all probabilities are not different from normal. However, test of normality results of the VABS-II subdomains among control group showed different p-values among different subdomains. As expected, results indicated that the data of the domains among the control group were not different from

normal. In addition, most of the data of the subdomains are also were not different from normal. These differences may be related to parents purposefully inflating data or differential cultural expectations such as self-help scores (which tended to be lower as children are less independent).

However, in contrast to what expected, the data resulted from the test of normality among high-risk group are not different from normal. A possible explanation is that the parents may be overcompensating for their high-risk children. In addition, children of high-risk group were tested by several professionals who are used to see variety children who are with different delays. These professionals with their scoring perspective may be an explanation for these results.

In conclusion however, the VABS-II – Arabic form was found to mimic the normal curve well enough to be utilized as a viable measure for adaptive behavior in Palestine and potentially other Arabic speaking cultures with similar cultures and custom.

Moreover, according to the results, the VABS-II add more and relevant information to the child developmental profile. Finally, it was showed by the results that the parents were mostly satisfied with the VABS-II.

Limitations of the study

This study was not without its own set of limitations. This research has a number of limitations.

This study was limited based on the sample profile; the control group sample was a group of specific children who are attending to a local private elementary school in Nablus. In addition, the high-risk group of children who were referred to a local multi-service center for neuro-developmental concerns. This sample may not be a represent of Palestinian children diversity. Thus data collection maybe should include more diverse children. Another limitation was the sample size is a few in relation to the Palestinian population. Another possible limitation was data collection process; some interview evaluation sessions lasted two hours which make some of the parents' impatient and less cooperative. Also, the interview sessions of children of the control group were done in the school, with less privacy and some distractions. The final limitation of this study, there are no many previous validation studies and adaptive behaviors and social skills in the Arab context generally and Palestinian context in particular. These issues, as well as some other related points of interest, are then used as the foundation for setting forth recommendations for future research.

Chapter 6

Conclusion and Recommendations

6.1 Conclusion

Based on the findings of this investigation, it can be concluded that the VABS-II – Arabic Version is an appropriate scale for assessing adaptive and maladaptive behaviors in a Palestinian context. In the most parts of the developmental domains there were no significant differences especially among the high-risk group of children which are the group of children that we want to use it with. The creation of the Arabic version of the VABS-II offers the Palestinian population an additional appropriate method for assessing children with neuro-developmental concerns. The findings showed that the Arabic version of the VABS-II can be used to identify young children with disabilities and to provide guidelines in offering services appropriate to these children. This finding consists with the research of Goldberg et al. (2009) in their Vietnamese VABS.

The VABS-II can be identified as having several strengths over the Portage scale in measuring behavioral milestones across major life functioning areas in persons. The VABS-II add specificity in item complexity. It is based on a larger number of adaptive behaviors and functioning skills with specific questions as opposed to the Portage, which is a more global rating of adaptive functioning across a smaller number of developmental and adaptive areas. In addition, the VABS-II provides more information; it supplies a profile of adaptive behaviors and maladaptive

behaviors while the Portage is limited to measuring developmental adaptive skills only and it is a screening tool for academic abilities. This adding information is important and useful for professionals to recognize an individual's positive and negative behaviors for diagnosis, qualification for special programs, progress reporting, program and treatment planning.

In conclusion, the VABS-II provides a general assessment of adaptive behavior as well as more specific information useful in further exploration of individual strengths and weaknesses. The VABS-II is applicable whenever an assessment of an individual's daily functioning is required. The scales are used in a variety of clinical, educational, and research settings (Sparrow, Balla & Cicchetti, 2005). In addition, VABS-II assess what a person actually does, rather than what he or she is able to do and it assess adaptive behaviors across the life span and covers more age range; birth to 90 years old. Because of their expanded age range, the VABS-II survey forms can be used to identify strengths and weaknesses and age-related declines in the adaptive functioning of older individuals. VABS-II results can help determine the need for supportive programs to aid in maintaining independent living (Sparrow, Balla & Cicchetti, 2005). Moreover, the fact that the VABS-II is a parent or caregiver structured interview, an opportunity arises to use this scale for evaluation adaptive behaviors among variety individuals. VABS-II Survey forms well suited for evaluation and diagnosis of Intellectual Deficit, they are also designed to aid in the clinical diagnosis of a variety of disorders and disabilities, including autism spectrum disorders, various genetic disorders,

developmental delays, emotional and behavioral disturbances and a wide range of other mental, physical and injury related conditions (Sparrow, Balla & Cicchetti, 2005).

6.2 Recommendations

Overall, this research provides a several results and creates a new research field that deals with the adaptive behaviors in the Palestinian context. Although attempts have been made in this study to document information about the adaptation of the VABS-II in its Arabic version, additional research on the following topics will help to shape and enhance the future use of the VABS-II. Further exploration of this method of adaptation would be beneficial.

To advance understanding of adaptive behavior in the Palestinian context, future research is needed to shed light on its assessment and on what distinguish Palestinian culture. For research forward, future research could investigate VABS-II adaptation comparing to different assessment of adaptive behaviors as a golden standard than the Portage. Thus, the sample may include older individuals and will not be limited by age. In addition, future research could take into account more and various territories in Palestine.

References

- Al Khateeb, J., & Hadidi, M. (2010). **Moqaddema fi attadakhhol al mobakker** [An introduction to early intervention]. Amman: Dar Alfikr.
- Almadi, T., Cathers, I., Mansour, A. M. H., & Chow, C. M. (2012). **An Arabic version of the Perceived Stress Scale: Translation and validation study**. *International Journal of Nursing Studies*, 49(1), 84-89.
- Alpern, G. D., & Boll, T. J. (1972). **Developmental profile**. Aspen, CO: *Psychological Development Publications*.
- Alpern, G. D., & Shearer, M. S. (1980). **Manual, developmental profile II**. Psychological Development Publications.
- American Association on Mental Retardation. (1992). **Definitions, classifications, and systems of supports (9th ed.)**. Washington, DC: Author.
- Arvio, M., Hautamäki, J. and Tiilikka, P. (1993). **Reliability and validity of the Portage assessment scale for clinical studies of mentally handicapped populations**. *Child: Care, Health and Development*, 19, 89-98.
- Balboni, G., Pedrabissi, L., Molteni, M., & Villa, S. (2001). **Discriminant validity of the Vineland Scales: Score profiles of individuals with**

mental retardation and a specific disorder. American Journal on Mental Retardation, 106(2), 162-172.

Baroff, G.S. & Olley, L.G. (1999). **Mental retardation: nature, cause, and management.** Retrieved June 3, 2010, from books.google.com/books

Beaton, D. E., Bombardier, C., Guillemin, F., & Ferraz, M. B. (2000). **Guidelines for the process of cross-cultural adaptation of self-report measures.** *Spine, 25(24), 3186-3191*

Beaton, D. E., Bombardier, C., Guillemin, F., & Ferraz, M. B. (2002). **Recommendations for the cross-cultural adaptation of health status measures.** *New York: American Academy of Orthopaedic Surgeons, 1-9*

Bernal, G., Trimble, J.E., Burlew, A.K., & Leong, F.T.L. (2003). **Handbook of racial and ethnic minority psychology** (pp. 487–503). Thousand Oaks, CA: Sage.

Bijou, S. W. (1991) '**Overview of Early Childhood Programs Around the World**', in J. Herwig and M. Stine (eds) *Proceedings from the Third International Portage Conference*, pp. 5-10. Madison, WI: Cooperative Educational Service Agency.

Bluma, S., Shearer, M., Frohman, A., & Hilliard, J. (1976). **Portage guide to early education.** Portage, MI: Portage Printers.

- Blunden, R. (1982). Psychiatry/mental handicap. Forum 2. **Portage in Britain: tailored to suit.** *Nursing mirror*, 154(8), i-vii
- Bonnie, R. J., & Gustafson, K. (2007). **The challenges of implementing Atkins v. Virginia: How legislatures and courts can promote accurate assessments and adjudications of mental retardation in death penalty cases.** *University of Richmond Law Review*, 41, 810–860.
- Bontempo, R. (1993). *Translation fidelity of psychological scales: An item response theory analysis of an individualism-collectivism scale.* *Journal of Cross-Cultural Psychology*, 24(2), 149-166.
- Brodsky, S. L., & Galloway, V. A. (2003). **Ethical and professional demands for forensic mental health professionals in the post-Atkins era.** *Ethics & Behavior*, 13(1), 3-9.
- Brue, A. W., & Oakland, T. (2001). **The Portage Guide to Early Intervention: An Evaluation of Published Evidence.** *School Psychology International*, 22(3), 243–252.
- Cameron, R. J. (1997). **Early intervention for young children with developmental delay: the Portage approach.** *Child: care, health and development*, 23(1), 11-27.
- Cameron, R. J. (1982). **Working together: Portage in the UK.** *AEP (Association of Educational Psychologists) Journal*.

CESA 5 (2003) **Portage Guide Birth to Six: Activities and Routines for Preschoolers**. Author, Portage, WI.

Cicchetti D.V., Carter A.S., Gray S.A.O. (2013) **Vineland Adaptive Behavior Scales**. In: Volkmar F.R. (eds) Encyclopedia of Autism Spectrum Disorders. Springer, New York, NY

Cicchetti, D. V., & Sparrow, S. S. (1981). *Developing criteria for establishing interrater reliability of specific items: Application to assessment of adaptive behavior*. *American Journal of Mental Deficiency*, 86, 127-137.

Cook, D. A., & Beckman, T. J. (2006). *Current concepts in validity and reliability for psychometric instruments: theory and application*. *The American journal of medicine*, 119(2), 166-e7.

Developmental Disabilities Assistance and Bill of Rights Act of 2000 (PL 106-402) <http://www.acf.hhs.gov/programs/add/DDACT2.htm>

Dixon, D. R. (2007). **Adaptive behavior scales**. *International review of research in mental retardation*, 34, 99-140.

DSM-5 American Psychiatric Association. (2013). **Diagnostic and statistical manual of mental disorders**. Arlington: American Psychiatric Publishing

- Eckensberger, L. H. (1972). **The necessity of a theory for applied cross-cultural research.** *Mental tests and cultural adaptation*, 99-107
- Fava, G. A. (1983). *Assessing depressive symptoms across cultures: Italian validation of the CES-D self-rating scale.* *Journal of clinical psychology*, 39(2), 249-251
- Fleiss, J. L. (1981). **Statistics for rates and proportions (2nd ed.).** New York: Wiley.
- Fombonne, E., & Achard, S. (1993). *The Vineland Adaptive Behavior Scale in a sample of normal French children: a research note.* *Journal of Child Psychology and Psychiatry*, 34(6), 1051-1058.
- Geisinger, K. F. (1994). **Cross-cultural normative assessment: Translation and adaptation issues influencing the normative interpretation of assessment instruments.** *Psychological assessment*, 6(4), 304
- Goldberg, M. R., Dill, C. A., Shin, J. Y., & Nhan, N. V. (2009). **Reliability and validity of the Vietnamese Vineland Adaptive Behavior Scales with preschool-age children.** *Research in Developmental Disabilities*, 30(3), 592-602.
- Grossman, H. J. (1983). **Classification in mental retardation.** Amer Assn on Intellectual&Devel.

- Groth-Marnat, G. (2009). **Handbook of psychological assessment**. John Wiley & Sons.
- Hambleton, R. K., & Patsula, L. (1998). **Adapting tests for use in multiple languages and cultures**. *Social Indicators Research*, 45, 153-171.
- Hamilton, M. (1960). **A rating scale for depression**. *Journal of neurology, neurosurgery, and psychiatry*, 23(1), 56
- Harrison, P., & Oakland, T. (2003). **Adaptive behavior assessment system (ABAS-II)**. San Antonio, TX: The Psychological Corporation.
- Harrison, P. L., & Boney, T. L. (2008). **Best practices in the assessment of adaptive behavior**. *Best practices in school psychology*, 31, 605-615
- Horn, E. M. (1993). **Interventions To Promote Adaptive Behavior Skills: DEC Recommended Practices**.
- Horn, E. M. (1996). **Interventions to promote adaptive behavior skills (pp. 259-286)**. In S. L. Odom & M. E. McLean (Eds.) *Early intervention/early childhood special education: Recommended practices*. Austin, TX: Pro-Ed.
- Irwin, J. R., Carter, A. S., & Briggs-Gowan, M. J. (2002). **The social-emotional development of “late-talking” toddlers**. *Journal of the*

American Academy of Child & Adolescent Psychiatry, 41(11), 1324-1332.

Kamphaus, R. W. (1987). *Conceptual and psychometric issues in the assessment of adaptive behavior.* **The Journal of Special Education, 21, 27-33.**

Kane M. **Validating high-stakes testing programs.** *Educ Meas Issues Pract.* 2002; 1:31–41.

Keller, H. R. (1988). *Children's adaptive behaviors: Measure and source generalizability.* **Journal of Psychoeducational Assessment, 6, 371.**

Kempen, G. I., Todd, C. J., Van Haastregt, J. C., Rixt Zijlstra, G. A., Beyer, N., Freiburger, E., & Yardley, L. (2007). **Cross-cultural validation of the Falls Efficacy Scale International (FES-I) in older people: results from Germany, the Netherlands and the UK were satisfactory.** *Disability and rehabilitation, 29(2), 155-162*

Kojima, M., Furukawa, T. A., Takahashi, H., Kawai, M., Nagaya, T., & Tokudome, S. (2002). **Cross-cultural validation of the Beck Depression Inventory-II in Japan.** *Psychiatry research, 110(3), 291-299.*

Marín, G., & Marín, B.V. (1991). **Research with Hispanic populations.** Newbury Park, CA: Sage

- Meadows, K., Bentzen, N., Touw-Otten, F., 1997. **Cross-cultural issues: an outline of the important principles in establishing cross-cultural validity in health outcome assessment.** In: Hutchinson, A., Bentzen, N., König-Zahn, C. (Eds.), *Cross Cultural Health Outcome Assessment; A User's Guide*, vol. I. European Research Group on Health Outcomes, pp. 34–40.
- Memari, A. H., Shayestehfar, M., Mirfazeli, F. S., Rashidi, T., Ghanouni, P., & Hafizi, S. (2013). ***Cross-cultural adaptation, reliability, and validity of the autism treatment evaluation checklist in Persian.*** *Iranian journal of pediatrics*, 23(3), 269
- Mervis, C. B., & Klein-Tasman, B. P. (2000). **Williams syndrome: cognition, personality, and adaptive behavior.** *Mental retardation and developmental disabilities research reviews*, 6(2), 148-158
- Middleton, H. A., Keene, R. G., & Brown, G. W. (1990). ***Convergent and discriminant validities of the scales of independent behavior and the revised Vineland Adaptive Behavior Scales.*** *American Journal on Mental Retardation*.
- Montazeri, A., Vahdaninia, M., Ebrahimi, M., & Jarvandi, S. (2003). **The Hospital Anxiety and Depression Scale (HADS): translation and validation study of the Iranian version.** *Health and quality of life outcomes*, 1(1), 14

- Nahcivan, N. O. (2004). *A Turkish language equivalence of the exercise of self-care agency scale*. *Western journal of nursing research*, 26(7), 813-824
- National Research Council. (2002). **Mental retardation: Determining eligibility for social security benefits**. National Academies Press.
- Nihira, K., Leland, H., & Lambert, N. (1993). **AAMR Adaptive Behavior Scale-Residential and community**, 2nd edn., Austin, TX: PRO-ED.
- Oakland, T. (1997). **A multi-year home-based program to promote development of young Palestinian children who exhibit developmental delays**. *School Psychology International*, 18(1), 29-39
- Oakland, T., & Harrison, P. L. (Eds.). (2011). **Adaptive behavior assessment system-II: Clinical use and interpretation**. Academic Press.
- Offit, P. A. (2013). *Vaccinations and Autism*. *Encyclopedia of Autism Spectrum Disorders*, 3211-3212
- Pearson Education, Inc. (n.d.). **Publication Summary Form for Vineland Adaptive Behavior Scales**. Retrieved January 18, 2008, from <http://ags.pearsonassessments.com/assessments/technical/vineland.asp>.

- Perry, A., Flanagan, H. E., Geier, J. D., & Freeman, N. L. (2009). ***Brief report: The Vineland Adaptive Behavior Scales in young children with autism spectrum disorders at different cognitive levels.*** *Journal of autism and developmental disorders*, 39(7), 1066-1078
- Raggio, D. J., & Massingale, T. W. (1993). **Comparison of the Vineland Social Maturity Scale, the Vineland Adaptive Behavior Scales—survey form, and the Bayley Scales of Infant Development with infants evaluated for developmental delay.** *Perceptual and motor skills*, 77(3), 931-937.
- Raven, J. C. (1962). **Coloured Progressive Matrices, Sets A, A B, B.** London, Great Britain: H. K. Levis & Co. Ltd. H. K.
- Reschly, D. J. (1982). **Assessing mild mental retardation: The influence of adaptive behavior, sociocultural status, and prospects for nonbiased assessment.** *The handbook of school psychology*. New York: Wiley Interscience.
- Reschly, D. J., Myers, T. G., Hartel, C. R., & National Research Council. (2002). **The Role of Adaptive Behavior Assessment.**
- Rogler, L.H. (1989). ***The meaning of culturally sensitive research in mental health.*** *The American Journal of Psychiatry*, 146(3), 296–303

- Rust, J. O., & Wallace, M. A. (2004). **Book review: Adaptive behavior assessment system.** *Journal of Psychoeducational Assessment*, 22(4), 367-373.
- Sbordone, R. J., & Long, C. (1996). **Ecological validity of neuropsychological testing.** CRC Press.
- Schalock, R. L., Borthwick-Duffy, S. A., Bradley, V. J., Buntinx, W. H. E., Coulter, D. L., Craig, E. M., et al. (2010). **Intellectual disability: Diagnosis, classification, and systems of supports (11th ed.).** Washington, DC: American Association on Intellectual and Developmental Disabilities.
- Schalock, R. L., Luckasson, R. A., & Shogren, K. A. (2007). **The renaming of mental retardation: Understanding the change to the term intellectual disability.** *Intellectual and developmental disabilities*, 45(2), 116-124.
- Shapiro, S. S., & Wilk, M. B. (1965). **An analysis of variance test for normality (complete samples).** *Biometrika*, 52(3/4), 591-611.
- Shearer, M. S., & Shearer, D. E. (1972). **The Portage Project: A model for early childhood education.** *Exceptional children*, 39(3), 210-217.
- Smith, T., Eikeseth, S., & Lande, H. (2006). **The Vineland Adaptive Behavior Scale in a sample of Norwegian second-grade children:**

A preliminary study. Journal of the Norwegian Psychological Association

Sousa, V. D., & Rojjanasrirat, W. (2011). ***Translation, adaptation and validation of instruments or scales for use in cross-cultural health care research: a clear and user-friendly guideline. Journal of evaluation in clinical practice, 17(2), 268-274***

Sousa, V. D., Zauszniewski, J. A., Mendes, I. A., & Zanetti, M. L. (2005). ***Cross-cultural equivalence and psychometric properties of the Portuguese version of the Depressive Cognition Scale. Journal of nursing measurement, 13(2), 87-99***

Sparrow, S. S. (2011). **Vineland adaptive behavior scales.** In *Encyclopedia of Clinical Neuropsychology* (pp. 2618-2621). Springer New York.

Sparrow, S. S., Balla, D. A., & Cicchetti, D. V. (1984). **The Vineland Adaptive Behavior Scales.** Circle Pines, MN: American Guidance Service.

Sparrow, S., Balla, D., & Cicchetti, D. V. (1984a). **The Vineland Adaptive Behavior Scales: Interview edition, Survey form.** Circle Pines, MN: American Guidance Service.

Sparrow, S., Balla, D., & Cicchetti, D. V. (1984b). **The Vineland Adaptive Behavior Scales:, Interview edition. Expanded form.** Circle Pines, MN: American Guidance Service.

- Sparrow, S., Balla, D., & Cicchetti, D. V. (1985). **The Vineland Adaptive Behavior Scales: Classroom edition.** Circle Pines, MN: American Guidance Service.
- Sparrow, S. S., Balla, D. A., & Cicchetti, D. V. (2005). **Vineland Adaptive Behavior Scales Second Edition Survey Forms Manual.** AGS Publishing.
- Sparrow, S. S., Cicchetti, D. V., & Balla, D. A. (2006). **Vineland Adaptive Behavior Scales. Teacher Rating Form Manual.** Pearson.
- Sperber, A. D. (2004). **Translation and validation of study instruments for cross-cultural research.** *Gastroenterology*, 126, S124-S128.
- Stevens, K. B., & Price, J. R. (2006). ***Adaptive behavior, mental retardation, and the death penalty.*** *Journal of Forensic Psychology Practice*, 6(3), 1-29.
- Stone, W. L., Ousley, O. Y., Hepburn, S. L., Hogan, K. L., & Brown, C. S. (1999). ***Patterns of adaptive behavior in very young children with autism.*** *American Journal on Mental Retardation*, 104(2), 187-199.
- Sturmey, P., Thorburn, M. J., Brown, J. M., Reed, J., Kaur, J., & King, G. (1992). **Portage guide to early intervention: cross-cultural aspects and intra-cultural variability.** *Child: care, health and development*, 18(6), 377-394

- Sue, S., & Zane, N. (1987). **The role of culture and cultural techniques in psychotherapy: A critique and reformulation.** *American Psychologist*, 42(1), 37–45.
- Sullivan, G. M. (2011). **A primer on the validity of assessment instruments.**
- Szatmari, P., Merette, C., Bryson, S. E., Thivierge, J., Roy, M. A., Cayer, M., & Maziade, M. (2002). ***Quantifying dimensions in autism: a factor-analytic study.*** *Journal of the American Academy of Child & Adolescent Psychiatry*, 41(4), 467-474.
- Tassé, M. J., Shalock, R. L., Balboni, G., Bersani, H., Borthwick-Duffy, S. A., Sprent, S., Thissen, D., Widaman, K. F., & Zhang, D. (2012). ***The construct of adaptive behavior: its conceptualization, measurement, and use in the field of intellectual disability.*** *American Journal on Intellectual and Developmental Disabilities*, 117(4), 291–303.
- Thompson, J. R., McGrew, K. S., & Bruininks, R. H. (1999). **Adaptive and maladaptive behavior: Functional and structural characteristics.** *Adaptive behavior and its measurement: Implications for the field of mental retardation*, 15-42.
- Tiilikka, P. and Hautamäki, J. (1986). ***Portaat - varhaiskasvatusohjelma.*** Helsinki: The National Welfare Association for the Mentally

Retarded. (The Finnish edition of Portage Guide to Early Education.)

Tombokan-Runtukahu, J., & Nitko, A. J. (1991). **Translation, Cultural Adjustment, and Operationalization of the Construct of Adaptive Behavior.**

United Nations Educational, Scientific and Cultural Organization (2007). **The Portage Project in the Arab world.** Retrieved from www.unesco.org/.../The%20portage%20project%20-GA

Venter, A., Lord, C., & Schopler, E. (1992). ***A follow-up study of high-functioning autistic children.*** *Journal of child psychology and psychiatry*, 33(3), 489-597.

West, J. (1985). ***An Arabic validation of a depression inventory.*** *International Journal of Social Psychiatry*, 31(4), 282-289

World Health Organization (1992). ***ICD-10 Classifications of mental and behavioural disorder: Clinical descriptions and diagnostic guidelines.*** Geneva: Author.

Zhang, J., Wheeler, J. J., & Richey, D. (2006). ***Cultural Validity in Assessment Instruments for Children with Autism from a Chinese Cultural Perspective.*** *International Journal of Special Education.*

Appendices

Appendix A

IRB

PLEASE BE SURE TO COMPLETE ALL SECTIONS

Current Date of Submission: 10/2017

IRB office use only: Date received in IRB office (stamp)

If this is a revision in response to an IRB Report of Action (ROA)-approval pending, indicate the date of the ROA:

Title of Research: Validation of the Vineland Adaptive Behavior Scale in Arabic Language within a Palestinian Context

Principal Investigator: Ciwar Abd El Qadir, Clinical Psychology Master Student

- **Department/School:** An Najah University
- **Room # where mail can be sent:**
- **Phone** 054 564 5878 **E-mail:** ciwara93@gmail.com

Other Investigator: Dr. Denise Ziya Berte PhD

- **Department/School:** An Najah Child Institute/ Department of Clinical psychology

- **Room # where mail can be sent** ACI
- **Phone** 059 572 7944 **E-mail:** denise.berte@najah.edu

Type of Research (please check):

Dissertation _____ (PLEASE NOTE: IRB review of dissertation research requires prior successful proposal defense.)

PhD Defense Date: _____

XX Master's Thesis

Class project _____

all other projects x (ACI sponsored research project)

**** If the primary investigator is a student, check here to indicate that your faculty sponsor has read the entire application, including cover letters, informed consents, and data collection instruments, and asserts that this application is accurate and complete.**

Dates Human Subjects Portion of Research Scheduled: from: 01/02/2017 to 01/06/2017.

Site(s) of Human Subject Data Collection: An Najah Child Institute.

(NOTE: If sites are administratively separate from the University, please submit approval letters, or indicate when they will be forthcoming.)

Funding Agency (if applicable): None at present

I. NATURE OF THE RESEARCH

In the judgment of the Principal Investigator, this research qualifies for which of the following types of review:

Review Type: _____ exempt (category) x expedited (category)
 _____ full Board¹

II. PURPOSE OF RESEARCH

Briefly describe the objective(s) of the research (please keep description jargon free and use 100 words or less; the IRB will file this information in our descriptions of approved projects).

The objectives of this study are to validate a translated version of the Vineland Adaptive Behavior Scale (VABS-Arabic Version) and insure that questions are culturally relevant, predictive and equivalent to the results of both clinical observation and a second measure of development (Portage Version 1) on children between the ages of 4 to 12 years of age. Participants will be a mixed group of children referred to services related to developmental concerns and a normalized group of children of a similar age not pre-selected for developmental concerns.

¹ All research that is either externally funded or greater than minimal risk must be reviewed by the full Board

III. METHODS

Approximate number of subjects: 60

Subjects will be (check only if applicable):

☒ **minors (under 18)**

☐ **involuntarily institutionalized**

☐ **mentally handicapped**

Describe in detail how the subjects will be selected and recruited:

Children presenting at the ACI, whose age is within the age of 4 to 12 will be solicited to use their archival data in the study. Parents whose children fit the research criteria will be given information about the study including an approved Consent for Participation Form. Those agreeing will be included in the study.

All participants will be assured that the services with the ACI will not be affected in any manner due to their participation with this program. The first 15 female and 15 male participants will form the first group.

Further participants will be recruited a specific private local elementary school who has volunteered to partner with the ACI on this project. A letter describing the study will be distributed to parents of children randomly selected within the required age range. Interested parents will call the ACI and be given an Informed Consent Form. The first 15 female and 15 male volunteers will form the school based group.

Describe exactly what will be done to subjects once they have agreed to participate in the project:

All children and parents that agree to be included in the study will then participate in two evaluation sessions (one completing the Portage 1 interview and the other completing the VABS Arabic Version). At least one caretaker and the identified child will attend. Each session will last no more than two hours (mean time for completion is 1 hour).

Upon completion each parent will receive one session explaining the results and any service recommendations with appropriate referral.

What incentives will be offered, if any? The Portage 1 and VABS (Arabic Version) will be given to all 30 children free of charge a value of approximately 300 shekels

IV. RISKS/BENEFITS TO PARTICIPANTS

Identify possible risks to subjects:

(NOTE: These may be of a physical, psychological, social or legal nature. If subjects are vulnerable populations, or if risks are more than minimal, please describe what additional safeguards will be taken.)

There are few risks to the participants in the study.

There will be mental health professionals available for each session.

If emotional reactions to the questionnaires or interviews are noted or further individual support requested participants will be given immediate support and then referred to an appropriate mental health provider as the ACI does not provide services to adults.

What are the benefits and how will they be optimized?

The potential benefits to the children and families are significant. Early identification of developmental concerns is crucial in obtaining appropriate services

For the children presenting with developmental concerns the VABS Arabic Version offers an expanded diagnostic process that is internationally standardized and accepted leading to a deeper understanding of their individual functioning and challenges.

For children with no initial developmental concerns the VABS Arabic Version will offer an in-depth screening of developmental milestones and may indicate areas of both need and strength.

Do benefits outweigh risks in your opinion? Yes X NO

Are there potential legal risks to the Principal Investigator or University? Yes No X

V. INFORMED CONSENT

Describe how participants will be informed about the research before they give their consent. Be sure to submit with this protocol a copy of the

informed consent/assent letter(s) you will use. Please prepare your informed consent letter at the 8th grade reading level or lower as dictated by the needs of the subjects. (See IRB website for required elements of an informed consent.)

Parents will receive written information and if requested a verbal explanation of the VABS Arabic Version.

Participants will receive information verbally about the benefits and potential risks to their participation.

Lastly before participating in the evaluation sessions parents will sign a written consent form that will be verbally reviewed by the evaluator.

VI. PRIVACY/CONFIDENTIALITY

Please describe whether the research would involve observation or intrusion in situations where subjects have a reasonable expectation of privacy. If existing records are to be examined, has appropriate permission been sought; i.e. from institutions, subjects, physicians? What specific provisions have been made to protect the confidentiality of sensitive information about individuals?

Each participant will be given a numeric code, held by the principle investigator in a locked file throughout the research. All data collected will be coded and any identifying information removed.

No information will be given to any outside entity without the written consent of the parent.

Appendix B

Parent Information Letter

الاهالي الاعزاء،

معهد النجاح للطفولة يعمل في الوقت الحالي على التأكد من صلاحية مقياس/اختبار جديد يتعلق في النمو عند الطفل لاستخدامه في فلسطين.

مقياس فاينلاند للسلوك التكيفي (VABS) هو اختبار موحد على الصعيد الدولي والذي تم استخدامه لأكثر من ٨٠ سنة مع احدث اصدار في عام ٢٠٠٥. مقياس فاينلاند للسلوك التكيفي متوفر بعدة لغات ويُستخدم لقياس التطور الذاتي من سن الولادة حتى جيل مئة عام. تم منح معهد النجاح للطفولة إذن من مبتكر VABS لإنتاج الاصدار الرسمي الاول ل VABS في اللغة العربية وللتحقق من صحته (VABSA).

إذا اخترت المشاركة في هذا الاختبار، سوف تشارك أنت وطفلك في جلستين باستخدام مقياسين موحدتين دولياً حول التطور/ النمو. سوف يُطلب منك الاجابة عن اسئلة تتعلق بسلوكيات طفلك وماضيه. وقد يُطلب من طفلك تنفيذ بعض المهام الملائمة لجيله.

بعد جلستي الاختبار، يحق لك بجلسة مع اخصائيين نفسيين، يعملون في معهد النجاح للطفولة، لعرض ومراجعة نتائج الاختبارات بالإضافة الى الاستماع لتوصيات التي قد تتبع النتائج.

إذا كنت ترغب في المشاركة في هذه الدراسة يُرجى التواصل مع إدارة المدرسة

شكرا جزيلا على اهتمامكم

Appendix C

Informed Consent Form

VABS Arabic Version

انا، _____، والد/ة _____

انا اتطوع للتسجيل كجزء من دراسة تهدف للتحقق من صحة مقياس فاينلاند للسلوك التكيفي-النسخه العربيه (VABSA).

انا على علم بما يلي:

1. تشمل هذه الدراسه تقييمين موحدين دوليا حول النمو لدى الاطفال، تمت ترجمتهما للغة العربية ويستخدمان لقياس المستوى التكيفي لدى الطفل حسب العمر البيولوجي. تعد هذه الدراسه لتحديد ما اذا كان هذا المقياس (VABSA) عباره عن اداه مساعده في البيئه الفلسطينية.
2. مشاركتي هي من اختياري (تطوعية) ولن تؤثر على الخدمات التي يتلقاها طفلي من معهد النجاح للطفوله بأي شكل من الأشكال.
3. سأشارك في جلستين للتقييم مع طفلي (لا تزيد عن ساعتين كل جلسة) وسيتم استدعائي لحضور جلسة للحصول ولطرح النتائج على يد اخصائي في الصحه النفسيه، يعمل لدى معهد النجاح للطفوله.
4. سأتلقي مقياس فاينلاند للسلوك التكيفي – النسخه العربيه (VABSA) مجانا.
5. خلال الجلسات سيطلب مني الاجابة على اسئلة حول سلوك طفلي وسجل نموه. قد يُطلب من طفلي تنفيذ بعض المهام التطوريه البسيطه الملائمة لجيله.

6. جميع المواد المكتوبة والمنشورة ستنظر في النتائج ككل ولن تقدم اي معلومات حولي،
حول طفلي، او حول عائلتي كفرد.

7. جميع الاستبيانات سوف يتم تشفيرها بالارقام ولن يتم ادراج اسمي، اسم طفلي واسم
عائلتي.

8. جميع المواد ستكون في منطقة امنة وموثوقة وسيتم فحصها فقط من قبل اعضاء الهيئة
الخاصة بالمشروع.

الفوائد المتوقعة من مشاركتي هي ما يلي:

1. زيادة المعلومات حول النمو في مرحلة الطفولة.
 2. زيادة المعرفة حول مستوى النمو لدى طفلي.
 3. معلومات حول الاحالة اذا لوحظ شيء مقلق بأي مجال من مجالات النمو لدى طفلي.
- لا توجد نتائج سلبية متوقعة من المشاركة في هذه الدراسة.

1. اذا قرر اي شخص انه لا يمكنه الاستمرار بالتزامه بالمشاركة سيتم اخراجه من الدراسة
بدون عواقب.

2. اذا شعر اي شخص بعدم الارتياح او اصبح منزعج بسبب المشاركة سيقدم له الدعم
الفوري من اخصائيين الصحة النفسية وتوصيات لاستمرار خدمات الصحة النفسية
المجتمعية بالشكل المناسب.

انا على علم بالنقاط السابقة وانا اوافق بشكل تطوعي على المشاركة في دراسة VABSA. يمكنني
سحب موافقتي في أي وقت.

الاسم: _____

رقم الهاتف: _____

التوقيع: _____

التاريخ: _____

Appendix D

Parents Satisfaction Survey

إستبيان لقياس درجة الرضا لدى الأهالي

كيف كانت تجربتك العامة خلال المقابلة	مفيد جداً	مفيد نوعاً ما	محايد	غير مفيد	غير مفيد بتاتاً
محتوى الأسئلة	مفيد جداً	مفيد نوعاً ما	محايد	غير مفيد	غير مفيد بتاتاً
طريقة تقديم النتائج (مكتوبة)	مفيد جداً	مفيد نوعاً ما	محايد	غير مفيد	غير مفيد بتاتاً
المعلومات الواردة في النتائج	مفيد جداً	مفيد نوعاً ما	محايد	غير مفيد	غير مفيد بتاتاً
مدة المقابلة	مناسب جداً	مناسب نوعاً ما	محايد	غير مناسب	غير مناسب بتاتاً

أحط بدائرة الإجابة التي تتوافق مع رأيك

أي مشاكل أو معيقات:

أي نقاط قوة تمت ملاحظتها في المقياس:

أي ملاحظات أو إقتراحات للتحسين والتغيير:

شكراً جزيلاً لتعاونكم ☺

Appendix E:**Developmental Profile of the Portage Program**

Vineland-II	
مقاييس فاينلاند للسلوك التكيفي، النسخة الثانية	
الاسم:	_____
العدد الزمني:	_____ تاريخ التقييم: _____
العلامة (ان وجدت):	_____ اعلى علامة مكتملة (ان وجدت): _____
اسم المستجيب:	_____ اسم الفاحص: _____

VINELAND-II SCORE SUMMARY

SUBDOMAIN and DOMAIN SCORES								STRENGTHS and WEAKNESSES		
SUBDOMAIN/ DOMAIN	Raw Score	v-Scale Score Table B.1	Domain Standard Score Table B.2	% Conf. Interval Table C.1/C.2	%ile Rank Table C.3	Adaptive Level Table C.4	Age Equiva- lent Table C.5	Stanine Table C.3	Score Minus Median*	S(trength) or W(eakness)
Receptive				±						
Expressive				±						
Written				±						
Communication	Sum									
Personal				±						
Domestic				±						
Community				±						
Daily Living Skills	Sum									
Interpersonal Relationships				±						
Play and Leisure Time				±						
Coping Skills				±						
Socialization	Sum									
Gross				±						
Fine				±						
Motor Skills	Sum									

Sum of Domain
Standard Scores =

Adaptive Behavior Composite

Standard Score Table B.2	% Conf. Interval Table C.1/C.2	%ile Rank Table C.3	Adaptive Level Table C.4	Stanine Table C.3
67	±	11		

	Raw Score	v-Scale Score Table B.3	% Conf. Interval Table C.6	Level Table C.7
Maladaptive Behavior Index				
Internalizing			±	
Externalizing			±	

Maladaptive Behavior Critical Items

Items (Circle all items scored 2 or 1, and indicate the severity.)

1 _M	2 _M	3 _M	4 _M	5 _M	6 _M	7 _M	8 _M	9 _M	10 _M	11 _M	12 _M	13 _M	14 _M
----------------	----------------	----------------	----------------	----------------	----------------	----------------	----------------	----------------	-----------------	-----------------	-----------------	-----------------	-----------------

* For instructions on how to determine the median score, see Chapter 3 of the Vineland-II Survey Forms Manual.

Domain Strengths/
Weaknesses:

S = Standard Score
- Median ≥ 10
W = Standard Score
- Median ≤ -10

Subdomain Strengths/
Weaknesses:

S = v-Scale Score
- Median ≥ 2
W = v-Scale Score
- Median ≤ -2

Individual:

Date:

Age:

From:

Survey Interview

Parent/Caregiver Rating

VINELAND-II SCORE SUMMARY

SUBDOMAIN AND DOMAIN SCORES									STRENGTHS and WEAKNESSES	
subdomain/ domain	raw score	v-Scale Score table b.1	Domain Standard Score table b.2	% Conf. Interval table c.1/c.2	%ile Rank table c.3	Adaptive Level table c.4	Age Equivalent table c.5	stanine table c.6	Score Minus Median	S(trength) or W(eakness)
Receptive				±						
Expressive				±						
Written				±						
Communication	sum:			±						
Personal				±						
Domestic				±						
Community				±						
Daily Living Skills	sum:			±						
Interpersonal Relationships				±						
Play And Leisure time				±						
Coping Skills				±						
Socialization	sum:			±						
Gross				±						
Fine				±						
Motor Skills	sum:			±						

Sum Of Domain
Standard Scores =

Standard Scores Table b.2	% Conf. Interval Table c.1/c.2	%ile rank Table c.3	Adaptive Level Table c.4	Stanine Table C.3
Adaptive Behavior Composite				

	Raw Score	v-Scale Score Table B.3	% Conf. Interval Table C.6	Level Table C.7
Maladaptive Behavior Index			±	
Internalizing			±	
Externalizing			±	

Domain Strengths/
Weaknesses:
S = Standard Score
Median > 10
W = Standard Score
Median < 10
Subdomain Strengths/
Weaknesses:
S = v-Scale Score
Median > 2
W = v-Scale Score
Median < 2

Maladaptive Behavior Critical Items

Items(Circle All Items Scored 2 Or 1, And Indicate The Severity.)

1 ^s	2 ^s	3 ^s	4 ^s	5 ^s	6 ^s	7 ^s	8 ^s	9 ^s	10 ^s	11 ^s	12 ^s	13 ^s	14 ^s
----------------	----------------	----------------	----------------	----------------	----------------	----------------	----------------	----------------	-----------------	-----------------	-----------------	-----------------	-----------------

معلومات حول المقابلة:

تقديم المجيب عن الأسئلة لاداء الشخص المعنى:

اللغة المستخدمة في المقابلة:

علامات فارقة او مزايا خاصة للمجيب عن الأسئلة:

تقدير العلاقة التي نشأت مع المجيب عن الأسئلة:

تقدير دقة المجيب في الاجابة عن الأسئلة:

ملاحظات عامة:

مؤشر السلوك غير الطبيعي

احتمالات الاجابة: 2=دأما

$$|A| = 1$$
$$a_0 = 0$$

ش = شديد

م = معتدل

تأكد من
التعليقات
في الأسفل

+	3	1	يقوم بساوت جنسي غير ملائم، (يطلع ملايسه امام الناس- يقوم بالهاده السرية في الامكن العامة).
		2	يظهر موسا وتعلقا باشيا، محددة او انشطه معينة (تكرار كلمات محددة او التعلق باداوت معينة)
		3	يجبر عن افكار ليست ذات اهمية او ليس لها معنى (يتكلم عن سماعه لاصوات ما او يعبر عن اوهام وتيمات).
		4	لديه عادات او حركات غريبة (مثل اصدار اصوات متكررة او القيام بحركات غريبة باستخدام اليد).
		5	يفضل الاشياء على الاشخاص باستمرار (على سبيل المثال يعبر الاشياء انتباهها على حساب الاشخاص).
		6	يقوم بتصرفات تؤدي الى اصابته بجروح (يضرب راسه، يعض نفسه، ويخدش نفسه).
		7	يدير او ينفذ مكتباته وممتلكاته الآخرين بشكل متعمد.
		8	يستخدم عبارات وكلاما غريبا جدا اثناء الحديث مع الآخرين (يتحدث مع نفسه على الملأ، يقول كلمات او عبارات ليس لها معنى، يعيد كلمات او عبارات معينة مرارا وتكرارا).
		9	لا يهي ما يدور حوله، يبدو وكأنه ينتمي الى عالم اخر).
		10	يمشي ذهابا وايابا باستمرار.
		11	يخشى الاصوات والاشياء والالوان المألوفة.
		12	يتذكر معلومات غريبة بالتفصيل بعد عدة سنوات.
		13	لا يستطيع اكمال يوم دراسي او يوم عمل بسبب العيء او الم زمّن.
		14	لا يستطيع اكمال يوم دراسي او يوم عمل بسبب مشاكل او اضطرابات نفسه.

ملاحظة: هذا الجزء، المتعلق بالقضايا المدرجة السلوك غير التكيفي لا ينتج علامات حقيقية او درجات خامه لذا يمكن اعتماد خيارات الاجابات اعلاه (= دائمه، 1 = احيانا، 0 = ابدا، م = معتدل، ش = شديد) الى صفحة ملخص العلامات.

تعليقات :

Item Before Basal X 2 =

Basal Item Through Ceiling Item:

DK and/or Missing Total* +

N/O Total +

Sum of 2s and 1s +

Receptive Raw Score =

STM

* If the total of DK and/or Missing is greater than 2, do not score subdomain.

مؤشر السلوك غير التكيفي

اجتهادات الاجابة: 2-15 1-اجابة 1 0-لا بد

تأكد من
الاجابات
في الاسفل

ملاحظات	الاجابة	السلوك	الرقم
		يمسح الإبهام أو الأصابع الأخرى.	1
		يليل سريره أو يستلزم ليس الحفاظ .	2
		يتصرف بالندفاع مع الغرباء (يمسك ايديهم , يمالقهم , او يجلس في احضانهم).	3
		يتنضم اطفالهم.	4
		لديه حركات وتقلصات لا ارادية متكررة (مثل: غمزات العينين, ارتعاش , هز الرأس , الخ) .	5
		يشد على (يجرش) اسنانه خلال الليل والنهار.	6
		يعاني من ضعف في التركيز والانتباه .	7
		لديه نشاط او خمول اكثر من من هم في عمره .	8
		يستخدم ممتلكات المدرسة او العمل لغراض شخصية غير مبررة (مثل: الهاتف, الانترنت , الاجهزة المكتبية , الخ)	9
		يحلف.	10
		يهرب (يفقد لمدة 24 ساعه او اكثر).	11
		يتخرب من المدرسة او العمل .	12
		يتجاهل الآخرين من حوله او لا يعيرهم الانتباه .	13
		يستخدم المال او الهدايا للحصول على المحبة.	14
		يشرب الكحول او يتعاطى المخدرات في المدرسة او في العمل أثناء النهار.	15

تعليقات :

Item Before Basal X 2 =

Basal Item Through Ceiling Item:

DK and/or Missing Total:

N/O Total:

Sum of 2s and 1s:

Receptive Raw Score =

* If the total of DK and/or Missing is greater than 2, do not score subdomain.

مؤشر السلوك غير التكيفي

احتمالات الإجابة: 2=دائماً 1=أحياناً 0=أبداً

تأكد من
تعليمات
في الأسفل

1	يعتمد على الآخرين بشدة (يتمسك بمن يقوم برعايته أو بمدرس أو بالوالد بالاخت)
2	يتجنب الآخرين ويفضل العزلة.
3	لديه اضطرابات في الأكل (يأكل بسرعة قصوى أو ببطء شديد، يخزن الأكل، يبالغ في الأكل، يرفض الأكل).
4	لديه اضطرابات في النوم (يمشي وهو نائم، يهاني من كوابيس متكررة، ينام أكثر من أو أقل من حاجته أو من هم في عمره)
5	يرفض الذهاب للمدرسة أو للعمل بسبب الخوف أو الرفض أو العزلة.
6	بيدي قلقاً وعصبية بالغة.
7	يضحك أو يبكي بسهولة بالغة.
8	لديه قدرة ضعيفة على تركيز نظره (لا ينظر إلى وجوه الآخرين عندما يتحدثون معه)
9	يشعر بالحنن دون سبب واضح.
10	يتجنب التفاعل الاجتماعي والعلاقات الاجتماعية.
11	يفتقد إلى الطاقة الحيوية والرغبة في الحياة.

تعليقات :

مؤشر السلوك غير التكيفي

احتمالات الإجابة: 2=دائماً 1=أحياناً 0=أبداً

تأكد من
تعليمات
في الأسفل

1	مندفع للغاية (يتصرف دون تفكير)
2	يهاني من نوبات غضب (تفجئات مزاجية)
3	يميل للمصيان والمخالفة وعدم اطاعة من يدهم السلطة.
4	يتمكك على الآخرين ويضايقهم بالسخرية منهم
5	يبيدي عدم الاحترام والتقدير للآخرين .
6	يكذب ويفش ويسرق .
7	يميل بشدة الى الاعتداء البدني (يضرب، يركل ، يعض ، إلخ)
8	يعاند ويتجهم .
9	يقول أشياء مخرجة أو يسأل أسئلة تسبب الحراج (مثل: "انت سمير" أو "ما ذلك الشيء الكبير الأحمر على الفك؟" , إلخ)
10	يتصرف بطريقة غير لائقة عند تعامله مع الآخرين .

تعليقات :

Item Before Basal X 2 =

Basal Item Through Ceiling Item:

DK and/or Missing Total: + N/O Total + Sum of 2s and 1s + Receptive Raw Score =

SUM

* If the total of DK and/or Missing is greater than 2, do not score subdomain.

بعد المهارات الحركية		
اجتيازات الاجابة: 2=دائما	1=اجابنا/جزئيا	0=لا/اطلاقا
ع=لا أعرف	استخدام لوحة المفاتيح	الرسم واستخدام المقص
9 ✖	✖	✖
10 ✖	✖	✖
11 ✖	✖	✖
12 ✖	✖	✖
13 ✖	✖	✖
14 ✖	✖	✖
15 >	>	>
16 >	>	>
17 ✖	✖	✖
18 >	>	>
19 ✖	✖	✖
20 ✖	✖	✖
21 >	>	>
22 >	>	>
23 >	>	>
24 >	>	>
25 >	>	>
26 >	>	>
27 >	>	>
28 >	>	>
29 >	>	>
30 ✖	✖	✖
31 >	>	>
32 ✖	✖	✖
33 >	>	>
34 ✖	✖	✖
35 ✖	✖	✖
36 ✖	✖	✖

Item Before Basal X 2 =

Basal Item Through Ceiling Item

DK and/or Missing Total

N/O Total

Sum of 2s and 1s

Receptive Raw Score =

تعليقات :

SUM

* If the total of DK and/or Missing is greater than 2, do not score subdomain.

بعد المهارات الحركية

احتمالات الإجابة: 2=دأجا 1=أحياناً/جزئياً 0=إبداً/أطلاقاً ع=لا أعرف

الجلوس المشي والركض القيام بالنشطة الوقوف النزحف

31	يُثب على قدم واحدة مرة على الأقل دون أن يسقط مع الاستمالة بشيء للحفاظ على توازنه.	0 1 2
32	يتسلق أو ينزل عن أشياء عالية (مثل: سلم بأربع درجات، لوحة الجمبازيوم، الخ).	0 1 2
33	ينزل عن الدرج مع تبديل قدميه مستعيناً بالدرابزين.	0 1 2
34	يركض بخفة مع تغيير سرعته واتجاه حركته.	0 1 2
35	يركب الدراجة الهوائية (ذات عجلات التدريب) لمسافة عشر أقدام على الأقل. يمكن اختيار إجابة (أو يعرف) إذا لم يكن بحوزة الطفل مثل هذه دراجة. أما في حالة عدم ركوها يمكن اختيار الإجابة (0).	0 1 2
36	يلتقط الكرة من على بعد 6 أقدام على الأقل بكتلتا يديه.	0 1 2
37	يُثب للإمام على قدم واحدة بخفة وسهولة.	0 1 2
38	يقفز لمسافة 1.5 متر على الأقل.	0 1 2
39	يلتقط كرة المضرب أو أي كرة بحجم كرة البيسبول من مسافة لا تقل عن 3 أمتار مع التحرك لالتقاطها إن لزم الأمر.	0 1 2
40	يركب الدراجة الهوائية بدون عجلات التدريب دون أن يسقط. يمكن اختيار إجابة (أو يعرف) إذا لم يكن بحوزة الطفل مثل هذه دراجة. أما في حالة عدم ركوها يمكن اختيار الإجابة (0).	0 1 2

المهارات الكبيرة

تمليقات :

Item Before Basal X 2 =

Basal Item Through Ceiling Item:

DK and/or Missing Total*

N/O Total

Sum of 2s and 1s

Receptive Raw Score

SUM

* If the total of DK and/or Missing is greater than 2, do not score subdomain.

بعد المهارات الحركية

احتمالات الإجابة: 2=دأجا 1=أحياناً/جزئياً 0=إبداً/أطلاقاً ع=لا أعرف

التلاعب بالأغراض الرسم واستخدام المقص استخدام لوحة المفاتيح

1	يحاول الوصول إلى الألعاب أو الأشياء.	0 1 2
2	يلتقط الأشياء الصغيرة من على بعد 5.5 سنتيمتر باستخدام كلتا يديه.	0 1 2
3	ينقل الأشياء من يد إلى أخرى.	0 1 2
4	يضغط على الباب أو أشياء تصدر أصواتاً.	0 1 2
5	يلتقط الأشياء الصغيرة بإمهامه وأصابعه الأخرى.	0 1 2
6	يستخرج شيئاً من داخل علبة أو وعاء.	0 1 2
7	يضع الأشياء داخل علبة أو وعاء.	0 1 2
8	يقلب صفحات كتاب أو مجلة الواحدة تلو الأخرى.	0 1 2

المهارات الدقيقة

بعد الممارات الحركية			
اختبارات الإجابة: 2 = دالها	1 = أحيانا/جزئيا	0 = لا/أطلقا	ع = لا أعرف
الجلوس	المشي والركض	القيام بالنشطة	الوقوف
1	يبقي رأسه منتصباً لمدة 15 ثانية عندما يحمل من أحد الوالدين أو من من يقوم برعايته.	0 1 2	0 1 2
2	يجلس لمدة دقيقة واحدة ع الأقل عن طريق المساعدة بواسطة كرسي أو وسادة.	0 1 2	0 1 2
3	يجلس لمدة دقيقة واحدة ع الأقل بدون مساعدة.	0 1 2	0 1 2
4	يرحف على بطنه على أرضية المنزل.	0 1 2	0 1 2
5	يجلس بدون مساعدة لمدة 10 دقائق على الأقل.	0 1 2	0 1 2
6	يرفع نفسه بوضع الجلوس ويبقى دون مساعدة لمدة دقيقة واحدة على الأقل.	0 1 2	0 1 2
7	يرحف على الأرض على اليدين والركبتين دون أن تلمس معدته الأرض.	0 1 2	0 1 2
8	يدفع نفسه للوقوف.	0 1 2	0 1 2
9	يرحف على الدرج ويتسلقه.	0 1 2	0 1 2
10	يمشي خطوتين على الأقل.	0 1 2	0 1 2
11	يقف لوحده من دقيقة إلى ثلاث دقائق.	0 1 2	0 1 2
12	يدرج الكرة أثناء جلوسه.	0 1 2	0 1 2
13	يتسلق وينزل عن أشياء منخفضة (مثل الكرسي وطاولة الوسط والأرائكة).	0 1 2	0 1 2
14	يرحف على الدرج نزولاً.	0 1 2	0 1 2
15	يقف لمدة 5 دقائق على الأقل.	0 1 2	0 1 2
16	يتمشي في أرجاء الغرفة دون التزآن مع السقوط أحياناً.	0 1 2	0 1 2
17	يرمي الكرة.	0 1 2	0 1 2
18	يمشي في أرجاء المنزل دون الحاجة إلى التمسك بأشياء.	0 1 2	0 1 2
19	يصعد وينزل عن كرسي الكبار.	0 1 2	0 1 2
20	يركض دون أن يسقط، ربما بترنح وعدم التزآن.	0 1 2	0 1 2
21	يمشي على الدرج مستعيناً بالدرابزين، وأضعا كلتا قدميه على كل درجة.	0 1 2	0 1 2
22	يركل الكرات.	0 1 2	0 1 2
23	يركض بخفة دون أن يسقط.	0 1 2	0 1 2
24	ينزل عن الدرج وأضعا كلتا قدميه على كل درجة، مستعيناً بالدرابزين.	0 1 2	0 1 2
25	يقفز بكلتا قدميه.	0 1 2	0 1 2
26	يرمي الكرة بغض النظر عن حجمها بكل الاتجاهات.	0 1 2	0 1 2
27	يلتقط الكرة بكلتا يديه من على بعد 60 أو 90 سنتيمتر.	0 1 2	0 1 2
28	يصعد على الدرج بتعديل قدميه وبلاستعانة بالدرابزين.	0 1 2	0 1 2
29	يركب دراجة ذات أربع عجلات ويستخدم البدلات لمسافة لا تقل عن مترين.	0 1 2	0 1 2
30	يقفز للأمام ثلاث مرات على الأقل.	0 1 2	0 1 2

Item Before Basal: X 2 =

Basal Item Through Ceiling Item:

DK and/or Missing Total:

N/O Total:

Sum of 2s and 1s:

Receptive Raw Score =

SUM

تعليقات :

* If the total of DK and/or Missing is greater than 2, do not score subdomain.

البعد الاجتماعي

احتمالات الإجابة: 2=دائمًا 1=أحيانًا/جوزيًا 0=نادرًا/أقل
 لا أعرف
 الأخلاق الاعتدال تحمل المسؤولية الحذر الاجتماعي التحولات
 التحكم بالاندفاعية المحافظة على الأسرار

4-1	1	يتحول من نشاط بيتي إلى نشاط آخر بسهولة .	0 1 2
	2	يقول (شكرا) عندما يعطى شيئا .	0 1 2
	3	يغير سلوكا معينًا اعتمادا على معرفته للشخص الآخر (يتصرف مع الوهل بطريقة تختلف عن تصرفه مع الغرباء) .	0 1 2
	4	يمضغ الطعام وقمه مفلق .	0 1 2
7-5	5	يقول (من فضلك) عندما يطلب شيئا .	0 1 2
	6	يلقي المحادثات بطريقة مناسبة (بقوله وداعا أو إلى اللقاء) .	0 1 2
	7	يفسل يديه ووجهه قبل وبعد تناول وجبات الطعام .	0 1 2
	8	يستجيب للتغيرات الروتينية بطريقة معقولة ومناسبة (يمنع عن التذمر والشكوى) .	0 1 2
8	9	يمر عن اسفه عندما يقترب خطأ مقصود (اصطدام بالآخرين) .	0 1 2
	10	يتجنب اغاظه الآخرين والاستمراء بهم .	0 1 2
	11	يتصرف بطريقة مناسبة عندما يتعرف على الآخرين (يومه برأسه , يتبسم , يسلم , يحيي الآخرين) .	0 1 2
	12	يغير حدة صوته حسب المكان والزمان (في المكتبة , أو خلال مشاهدته فلما أو عرضا مسرحيا .	0 1 2
	13	يمر عن اسفه عند الإساءة إلى مشاعر الآخرين .	0 1 2
	14	يمنع عن الكلام وفي فمه طعام .	0 1 2
	15	يتكلم مع الآخرين دون مقاطعتهم أو الإساءة لهم .	0 1 2
12-9	16	يقبل الاقتراحات والحلول اليتبهم من الآخرين .	0 1 2
	17	يتحكم بمشاعر الغضب عند تغيير خطته لأسباب خارجة عن سيطرته (الطقس السيئ , عطل السيارة) .	0 1 2
	18	يحافظ على الأسرار لكثير من يوم واحد .	0 1 2
	19	يمر عن اسفه عن اقتراف خطأ غير مقصود (مثل ترك شخص ما خارج للامية بشكل غير مقصود) .	0 1 2
	20	يظهر تفهما لحيقة أن المزح أو الاستمراء معافراد العائلة والصدقاء يعتبر من الدعاية والمزح .	0 1 2
13	21	يخبر أحد الوالدين أو من يقوم على رعايته بخطئه (متى سيفادر ومتى أو سيرجع أين سينهب) .	0 1 2
	22	يتجنب المخاطر والمغامرات (القفز عن المرتفعات , القيادة بتمور)	0 1 2
	23	يتحكم بمشاعر الغضب عندما لا يحصل على ما يريد (عندما يحرم من مشاهدة التلفاز أو حضور حفلة ما أو عندما لا يؤخذمقرحاته) .	0 1 2
	24	يحقق ما تم التخطيط له (مثل مقابلة شخص ما إذا وعد بذلك) .	0 1 2
	25	يبتعد عن العلاقات والأحوال الخطيرة والمؤذية (مثل عندما يستمر , به أو يستغل ماليا أو جنسيا	0 1 2
	26	يتحكم بمشاعر الغضب إذا ما تعرض للنقد بناء (عند تصحيح سوء سلوك أو مناقشة عادات أو امتحانات	0 1 2
	27	يحافظ على أسرار الغير لأطول مدة ممكنة .	0 1 2
	28	يفكر مليا بما سيقع قبل اتخاذ القرارات (يمنع عن التصرف بالندفاع	0 1 2
	29	يدرك مشاعر الغضب ويحذر عندما يتعرض لوضاع اجتماعية خطيرة (الدخول إلى غرف الدردشة , أو الاعلانات الشخصية وغيرها) .	0 1 2
	30	يظهر احترامه لمن يعمل معه (لا يشتت انتباههم ولا يقاطعهم , ويصل إلى العمل على الوقت)	0 1 2

مراعاته للآخرين

تمليقات :

Item Before Basal: X 2 =

Basal Item Through Ceiling Item:

DK and/or Missing Total* +

N/O Total +

Sum of 2s and 1s +

Receptive Raw Score =

SUM

* If the total of DK and/or Missing is greater than 2, do not score subdomain.

البعد الاجتماعي

احتمالات الإجابة: 2=دائما	1=أحيانا/جزئيا	0=لا/أطلاقا	ع=لا أعرف
اللعاب	المشاركة والتعاون	الذهاب مع الآخرين	ممارسة الألعاب
التعرف على الايحاءات الاجتماعية			

1	يظهر استجابة لأحد الوالدين أو من يقوم برعايته عند المزاح معه (مثل: يتسعم , يضحك , يصفق) .	0 1 2	1,2
2	يظهر اهتماما بمكان تواجدده (يتحرك هنا وهناك , أو يلمس الأشياء والأشخاص من حوله)	0 1 2	
3	يمارس ألعابا تفاعلية بسيطة مثل : الاستغماية أو عالي وأطي	0 1 2	
4	يلعب بالقرب من طفل آخر (كل يلعب شيئا مختلفا)	0 1 2	1,2
5	يختار اللعب مع أطفال آخرين (أي لا يبقى منعزلا أو بعيدا عن غيره)	0 1 2	
6	يشارك في ألعاب تعاونية مع طفل أو مجموعة أطفال لمدة خمس دقائق	0 1 2	
7	يشارك في ألعاب تعاونية مع طفل أو مجموعة أطفال لمدة تزيد عن خمس دقائق	0 1 2	
8	يواصل اللعب مع غيره من الأطفال مع قليل من الفوضى عند مغادرة أحد الوالدين أو من يقوم برعايته	0 1 2	
9	يشارك غيره في ألعابه وممتلكاته إذا طلب منه ذلك	0 1 2	3
10	يلعب مع غيره مع أقل قدر ممكن من المراقبة	0 1 2	
11	يستخدم أغراض المنزل أو الأشياء الأخرى للقيام بنشاطات قابله للتصديق مثل: اختيار صندوق ما واعتباره منزلا	0 1 2	
12	يحمي نفسه بالابتعاد عن الأطفال الذين يدمرون الأشياء أو يتسببون بأصابته (الأطفال الذين يعضون , يضربون , يرمون الأشياء , أو يشدون الشعر) .	0 1 2	
13	يلعب ألعابا تخيلية سهلة مع الآخرين مثل (بيت بيوت, ألعاب تلبس)	0 1 2	4
14	يبحث عن الآخرين لمصاحبتهم أو اللعب معهم (يدعو الآخرين إلى منزله , يذهب إلى منازل الآخرين , يلعب مع الآخرين في الملاعب المختلفة)	0 1 2	
15	يقوم بدوره في الألعاب والرياضات عندما يطلب منه ذلك	0 1 2	
16	يشارك في الألعاب غير الرسمية خارج نطاق المنزل مثل: (القفز بالحبال , الإقطة أو المطاردة)	0 1 2	
17	يشارك الآخرين ألعابه وممتلكاته عندما يطلب منه ذلك	0 1 2	
18	يتبع القوانين ويتقيد بها في الألعاب البسيطة مثل : (السباقات , الألعاب الإلكترونية , مسابقات الرمي)	0 1 2	5,6
19	يتقيد بدوره في الألعاب عندما يطلب منه ذلك	0 1 2	
20	يشارك في ألعاب الورق البسيطة التي تعتمد على الحظ مثل : (صيد السمكة , ألعاب الورق , النرد)	0 1 2	

وقت اللعب والترفيه

Item Before Basal X 2 =

Basal Item Through Ceiling Item:

DK and/or Missing Total: +

N/O Total: +

Sum of 2s and 1s: +

Receptive Raw Score =

SUM

تعليقات: _____

* If the total of DK and/or Missing is greater than 2, do not score subdomain.

العلاقات الاجتماعية			
اجتمالات الاجابة: 2=دائما	1=اجتمالات جزئيا	0=ايضا/اطلاقا	ع- لا اعرف
الاستجابة للآخرين	التعرف والتعبير عن المواقف	التقليد	التواصل الاجتماعي
مراعاته للآخرين	الصدقة	المواطنة	
24	يتعرف على ما يحبه الآخرون أو يكرهونه (مثل: "يحب أحمد كرة القدم", "أو "أنا أحب سوزي البيضا").	0 1 2	
25	لديه مشاعر وردود الفعل تجاه المواقف مشابه لمن حوله (مثل: عدم المبالغة أو التقليل من شأن حالة ما).	0 1 2	
26	يحافظ على مسافة مريحة بينه وبين الآخرين في المناسبات الاجتماعية (مثل: لا يقترب كثيرا من شخص يتحدث معه).	0 1 2	
27	يتبادل الحديث عن اهتماماته مع الآخرين (مثل: البرامج الرياضية، المسلسلات، خطط المستقبل، إلخ).	0 1 2	
28	يبادر بالحديث عندما يلتقي بناس يعرفهم بقوله "كيف حالكم؟"، "ماذا هناك؟".	0 1 2	
29	يلتقي مع الأصدقاء بانتظام.	0 1 2	
30	يتجنب قول أشياء محرجة أو وضعية أو يسأل أسئلة وقحة.	0 1 2	
31	لديه توقعات حقيقية ومنطقية من علاقة الصداقة (مثل: لا يتوقع أن يكون صديقاً وحيداً لشخص ما، أو أن يكون صديقه بجواره باستمرار).	0 1 2	
32	يدرك أن الآخرين لا يعرفون أفكاره ما لم يعبر عنها.	0 1 2	
33	يحذر عند الحديث عن خصوصياته.	0 1 2	
34	يتعاون مع الآخرين للتخطيط أو الاشتراك بنشاط ما (كحفلة عيد ميلاد، أو حدث رياضي).	0 1 2	
35	يظهر تفهماً للتلميحات والإيماءات أثناء المحادثات (يدرك أن التناوب يعني اشعر بالملل، أو تغيير الموضوع بسرعة معناه لا أريد الحديث عن هذا الموضوع).	0 1 2	
36	يبدأ حواراً بالحديث عن الأشياء التي تهم الطرف الآخر (مثل: "قال لي أحمد أنه يحب الحاسوب").	0 1 2	
37	يشارك في مواعيد جماعية.	0 1 2	
38	يشارك في موعد أحادي.	0 1 2	

علاقات شخصية متبادلة

Item Before Basal	X 2 =	
Basal Item Through Ceiling Item:		
DK and/or Missing Total		
N/O Total		
Sum of 2s and 1s		
Receptive Raw Score		
	SUM	

تعليمات :

* If the total of DK and/or Missing is greater than 2, do not score subdomain.

البعد الاجتماعي

✓	ع=لا أعرف	0=أبدا/أقل	1=أحيانا/جزئيا	2=دائما
تلك من تعليمات في الأسفل	التواصل الاجتماعي	التقليد	التعرف والتصبير عن المواقف	الاستجابة للآخرين
		المواودة	الصدقة	مراعاته للآخرين

1	ينظر الى وجه ابيه او امه او من يقوم برعايته	0 1 2	1
2	يراقب (يتتبع بعينه) شخصا ما يتحرك بالقرب منه لمدة 5 ثواني أو أكثر	0 1 2	
3	يعبر عن عاطفتين أو أكثر مثل (الضحك، البكاء، الصراخ، إلخ)	0 1 2	
4	يتبسم أو يضحك عندما يقترب منه شخص مألوف	0 1 2	
5	يقوم ب محاولة الاتصال مع الآخرين من خلال التمسك واصدار الاصوات إلخ	0 1 2	
6	يصل الى شخص مألوف عندما يفتح ذراعيه له	0 1 2	
7	يظهر اهتماما تجاه بعض الأشخاص أو الأشياء من خلال (التمسك، الوصول الى الشخص أو الشيء المعني)	0 1 2	
8	يظهر عاطفة للناس المألوفين (من خلال اللمس، العناق، التقبيل)	0 1 2	
9	يحاول تقليد أحد الوالدين أو من يعتني به بواسطة تعابير الوجه (مثل: التمسك، العبوس، إلخ)	0 1 2	
10	يتحرك في الأرجاء بحثا عن أحد الوالدين أو من يقوم برعايته أو شخص مألوف في الجوار	0 1 2	
11	يظهر اهتماما في الأطفال الذين في عمره من غير الأخوة والإخوات من خلال (مراقبتهم أو التمسك لهم)	0 1 2	1,2
12	يقلد حركات بسيطة (مثل: التصفيق والتأنيج للوداع إلخ)	0 1 2	
13	يستخدم الحركات ليعبر عن سمادته أو اهتمامه بالآخرين (مثل: المعانقة، المصافحة، مسك الأيدي، إلخ)	0 1 2	
14	يظهر رغبة في أرضاء الآخرين (مثل: مشاركتهم بالألعاب، مساعدتهم حتى لو لم يكن قادرا على ذلك، إلخ)	0 1 2	
15	يظهر سلوكا يعبر من خلاله عن البحث عن صداقة مع الآخرين في سنه من خلال قوله "هل تريد أن تلعب" أو من خلال مسكه بيد طفل آخر	0 1 2	3,4
16	يقلد حركات معقدة إلى حد ما (مثل: الحلاقة، الاهتمام بالمظهر الخارجي طرق المسامير، إلخ)	0 1 2	
17	يعطي إجابات عندما يسأله شخص كبير مألوف (مثل: "كيف حالك؟"، "يقول: "خير"، "أنت تبدو رائعا" فيقول: "شكرا")	0 1 2	
18	يكرر عبارات سمعها من قبل (مثل: "أنا في البيت يا عزيزي"، أو "لن تحصل على الحلوى ما لم تته طيبك")	0 1 2	
19	يستخدم كلمات ليعبر فيها عن مشاعره (مثل: "أنا سعيد" أو "أنا خائف")	0 1 2	
20	يختار صديقا مقربا أو يظهر اهتماما نحو أشخاص معينين من كلا الجنسين	0 1 2	5
21	يقلد حركات معقدة بعد عدة ساعات من مشاهدتها (مثل: الحلاقة، الاهتمام بالمظهر الخارجي، طرق المسامير، إلخ)	0 1 2	
22	يستخدم كلمات يعبر فيها عن سمادته واهتمامه بالآخرين (مثل: "نعم لقد فزت" أو "هل أنت بخير؟" أو "كيف حالك")	0 1 2	
23	يقوم بحركات معينة إذا استنجد به أحد ما (مثل: يمسك الباب أو يلتقط أغراضا سقطت، إلخ)	0 1 2	

علاقات شخصية متبادلة

Item Before Basal X 2 =

Basal Item Through Ceiling Item:

DK and/or Missing Total +

N/O Total +

Sum of 2s and 1s +

Receptive Raw Score =

SUM

* If the total of DK and/or Missing is greater than 2, do not score subdomain.

تعليقات :

مهارات الحياة اليومية

الأنشطة المجتمعية

أحمدان: ج=2؛ هـ=1

ج=0؛ د=1؛ أ=0؛ ب=0

ع=لا أعرف

تكون من
التعليقات
في الأسفل

	مهارات استخدام الهاتف	القوانين والحقوق والامان	الوقت والتاريخ	مهارات للعمل	التلفاز والراديو
1	مهارات استخدام الحاسوب	③ مهارات مالية	② مهارات في الطعام	① الذهاب للاماكن بشكل منفرد	
< 1	1 بين معرفته الهاتف (يتظاهر انه يتكلم على الهاتف)	2 يتحدث مع اشخاص يعرفهم عبر الهاتف.	3 يستخدم التلفاز او الراديو دون مساعدة/ يجدر للتلفاز ، يبدل المحطات والقنوات، يختار البرنامج.	يمكن اختيار (اعراف) عند عدم وجود راديو أو تلفاز في المنزل.	4 يعدد 10 اغراض على الاقل الواحد تلو الآخر
4	5 يدرك ويظهر سلوكا متسابعا عند ركوب السيارة (يرتبط حزام الامان، ويتجنب تشتيت انتباه السائق)	6 يدرك اهمية المال ووظيفته (يمكن ان يقول : "حتاج الى المال لكي تشترى الاشياء من المتجر"	7 يسير على الصيف (ان وجد) او على جانب الطريق عندما يمضي او عندما يستخدم مصداق ذات عجائب (مثل: السمكة، الدراجة الهوائية وغيرها)	8 يدرك اهمية الوقت ودوره في الحياة (مثلا : يقول : "الساعة تعطيني الوقت" او "متي يمكن ان نذهب")	9 يتبع القوانين او القواعد المنزلية ويعطيها (مثل: لا يرفض في المنزل، لا يقفز على اثاث)
	10 يظهر معرفة بمهارات الحاسوب اللازمة للعاب او تشغيل بعض البرامج.	يمكن اختيار (اعراف) اذا لم يجد جهاز حاسوب في المنزل.	11 ينادي على شخص المطلوب الحديث معه على الهاتف، او يشير الى عدم وجوده في البيت.	12 يتعرف على القطع النقدية المعدنية واجزاءها.	13 ينظر ويمينا ويسارا(على الجانبين) عندما يقطع الشارع.
7	14 يتعرف على ايام الاسبوع عندما يطلب منه ذلك.	15 يحضر فمما بحق الخصومية الفردية سواء له او لغيره (مثل : استخدام الحمام و تغيير الملابس)	16 يحضر فمما لرغم الهاتف المطلوب الاتصال به عند الضرورة او في حالات الطوارئ.	17 يعرف الوقت من خلال ساعة رقمية.	18 يتعرف على قيمة القطع النقدية.
8	19 يتعرف على قيمة العملة الورقية من خلال الأوراق.	20 يحترم اشارات المرور وخاصة (توقف وسر).	21 يشير الى الترويج على الوجدة اذا طلب منه ذلك.	22 يعرف ان قيمة الأشياء تختلف عن بعضها البعض. (مثل: مكي تقود لكفى لشراء سدس وليس قطعة حلوى، او كم سعر قلم الرصاص هذا)	23 يخبر عن الوقت باستخدام النصف والرابع وباستخدام ساعة العقارب.
10	24 يتصل مع الآخرين باستخدام الهاتف المحمول او الهاتف العادي.	25 يطالب وجبة سريعة من مطعم للجولات السريعة.	(يمكن اختيار ا اعرف اذا لم يتناول الطعام في مطعم اللوجبات السريعة).		

Item Before Basal		X 2 =		: اعلیٰ ترین :
Basal Item Through Ceiling Item:				
DK and/or Missing Total +				
N/O Total +				
Sum of 2s and 1s +				
Receptive Raw Score =				
SUM				

* If the total of DK and/or Missing is greater than 2, do not score subdomain.

مهارات الحياة اليومية			
أحداث/الإجابة: 2=دائماً	1=أحياناً/جزئياً	0=أبداً/أطلاقاً	خ=لا أعرف
السلامة في المنزل			
1	يحذر من الإقتراب من الأشياء الساخنة (مثل: المدفأة، الفرن، النار، إلخ)	0 1 2	
2	يساعد في الأعمال المنزلية البسيطة (مثل: تنفيض الغبار، التقاط الملابس، إلخ)	0 1 2	
3	ينقل الأشياء الثقيلة للكسر من على الطاولة	0 1 2	
4	يرتب مكان اللعب أو العمل بعد الانتهاء (مثل: أقلام الألوان، ألعاب التركيب، إلخ)	0 1 2	
5	يبعد ممتلكاته الخاصة عن الآخرين (مثل: ألعاب، الكتب، المجلات، إلخ)	0 1 2	
6	يحذر من استخدام الأدوات الحادة (مثل: المقص، السكين، إلخ)	0 1 2	
7	ينقل الأشياء الحادة من على الطاولة	0 1 2	
8	يساعد في إعداد الطعام الذي يتطلب الخلط والطبخ (مثل: البسكويت، الكعك، المعكرونة، الأجبان، إلخ)	0 1 2	
9	يستخدم أجهزة كهربائية بسيطة (مثل: التوستر، مفتاح الحلب، مفتاح القفالي، إلخ)	0 1 2	
10	يستخدم الميكرويف للتسخين والخبز والطبخ. يمكن اختيار (أو اعرف) إذا لم يوجد فرن الميكرويف في البيت.	0 1 2	
11	يرتب الملابس النظيفة ويضعها في المكان الصحيح (مثل: الجوارير، الخزائن، إلخ)	0 1 2	
12	يستخدم الأدوات مثل: المطرقة، المفك، إلخ.	0 1 2	
13	يفصل الإطابق بيده أو باستخدام الجولبة الكهربائية.	0 1 2	
14	يمسح ويكنس وينفض الغبار عن الأرضيات بشكل كامل.	0 1 2	
15	ينظف الطاولة من الأغراض ويتخلص من الأشياء البلاستيكية ذات الاستخدام الواحد.	0 1 2	
16	يستخدم المنتجات ذات الاستخدام المنزلي بشكل صحيح (مثل: منظف الفسيل، ملمع الإثاث، ملمع الزجاج، إلخ)	0 1 2	
17	يجمع الأغذية الرئيسية التي لا تتطلب الخلط، وإنما تحتاج للطبخ (مثل: الأرز، الحساء، الخضروات، إلخ)	0 1 2	
18	ينظف غرفة أو أكثر إلى جانب غرفة نومه.	0 1 2	
19	يستخدم سكيناً حاداً لتحضير الطعام	0 1 2	
20	يستخدم المدفأة أو الفرن للتسخين والطبخ والخبز (يشغل ويطفأ مفتاح الحرارة، ويتحكم بدرجة الحرارة)	0 1 2	
21	يجوز الطعام باستخدام مكونات تتطلب القياس، الخلط، الطبخ.	0 1 2	
22	ينظف الملابس حسب الحاجة	0 1 2	
23	يقوم بأعمال الصيانة حسب الحاجة (مثل: تغيير المصابيح الضوئية، تغيير كبس المكنسة الكهربائية، إلخ)	0 1 2	
24	يخطط ويجهز لوجبة اليوم الرئيسية.	0 1 2	

النشطة منزلية

Item Before Basal	X 2	
Basal Item Through Ceiling Item		
DK and/or Missing Total		
N/O Total		
Sum of 2s and 1s		
Receptive Raw Score	=	

تعليقات:

* If the total of DK and/or Missing is greater than 2, do not score subdomain.

مهارات الحياة اليومية			
احتمالات الإجابة: 2=د=أ	1=أحياناً/جواباً	0=أبداً/إطلاقاً	ع=لا أعرف
الأكل والشرب • استخدام التواليت • ارتداء الملابس • الاستحمام • الاهتمام بالمظهر الخارجي			
العناية الصحية			
5,6	25	0 1 2	يُنظف أسنانه: اختار الإجابة 2 إذا نظف أسنانه دون مساعدة بوضع مهبون / الأسنان أو استخدام الفرشاة. يمكن اختيار الإجابة 1 إذا احتاج مساعدة. يمكن اختيار الإجابة 0 إذا لم ينظف أسنانه أبداً ولا يتم تذكره.
	26	0 1 2	يُزور الزوار الملابس الكبيرة كل في مكانه.
	27	0 1 2	يفعلني الفم والذئف عند الصعس أو السعال.
	28	0 1 2	يفعلني الزوار الصغيرة من الإمام كل في مكانه.
	29	0 1 2	ربط الرباط المثبت في السفلى مثل: رباط الجكيت
	30	0 1 2	فتح الصنبور وتعديل درجة حرارة الماء باستخدام مفتاح الصنبور للحرارة أو البارد.
	31	0 1 2	يوتدي الملابس الملائمة لحالة الطقس خاصة البارد (مثل المعطف والجزمة والسفرة)
7	32	0 1 2	يستخدم ويجفف نفسه بنفسه . يمكن استخدام الإجابة 2 إذا قام بذلك دون مساعدة. الإجابة رقم 1 إذا قام بذلك مع مساعدة. الإجابة رقم 0 إذا لم يستخدم أبداً دون مساعدة أو دون تذكره.
	33	0 1 2	يجد ويستخدم الحمام المناسب لجنسه (حمام رجال أو نساء)
	34	0 1 2	يفسل ويجفف الشعر بالمنشفة أو مجفف الشعر
	35	0 1 2	يتمم بالجروح البسيطة (الطفيفة) ، يعقم الجرح ويضع الضمادة.
	36	0 1 2	يتناول الأدوية حسب التعليمات .
	37	0 1 2	يستخدم مقياس الحرارة لمعرفة درجة حرارته .
	38	0 1 2	يطلب مساعدة طبية في حالات الطوارئ (مثل: معرفة اعراض الامراض او الجروح الخطيرة مثل ضيق النفس، السكته القلبية، والتزيف) . يمكن اختيار الإجابة (ع) إذا لم يتعرض الشخص إلى حالة طوارئ.
	39	0 1 2	يتبع التعليمات المتعلقة بالعناية الصحية والحميات الخاصة والعلاجات الدوائية.
	40	0 1 2	يمكن اختيار الإجابة (ع) إذا لم يمر الشخص بظروف صحية خاصة.
	41	0 1 2	الاطلاع على العلاجات الطبية (التي يمكن أخذها بوصفة طبية أو بدونها)
	41	0 1 2	يختار مواعيد مناسبة مع الطبيب أو طبيب الأسنان

أمور شخصية

Item Before Basal	X 2 =		
Basal Item Through Ceiling Item:			
DK and/or Missing Total*	+		
N/O Total	+		
Sum of 2s and 1s	+		
Receptive Raw Score	=		

تعليمات :

* If the total of DK and/or Missing is greater than 2, do not score subdomain.

مهارات الحياة اليومية			
0 = لا أعرف	1 = أحياناً / جزئياً	2 = دائماً	احتمالات الإجابة: 2 = دائماً
الأكال والشرب استخدام التواليت ارتداء الملابس الاستحمام الاهتمام بالمظهر الخارجي العناية الصحية			
0	1	2	1
0	1	2	2
0	1	2	3
0	1	2	4
0	1	2	5
0	1	2	6
0	1	2	7
0	1	2	8
0	1	2	9
0	1	2	10
0	1	2	11
0	1	2	12
0	1	2	13
0	1	2	14
0	1	2	15
0	1	2	16
0	1	2	17
0	1	2	18
0	1	2	19
0	1	2	20
0	1	2	21
0	1	2	22
0	1	2	23
0	1	2	24

Item Before Basal	X 2 =	
Basal Item Through Ceiling Item:		
DK and/or Missing Total +		
N/O Total +		
Sum of 2s and 1s +		
Receptive Raw Score =		
	SUM	

* If the total of DK and/or Missing is greater than 2, do not score subdomain.

بعد التواصل

البدأ بالقراءة	مهارات القراءة	مهارات الكتابة	0=إبداء/إطلاق	1=أجبت/جزئيا	2=أجبتا	3=لا أعرف
1	يتعرف على حروف الهجاء ويميزها عن الأرقام.	0 1 2				
2	يتعرف على اسمه بالحروف المطبوعة.	0 1 2				
3	يتعرف على 10 أحرف هجائية مطبوعة على الأقل.	0 1 2				
4	يطبع أو يكتب بالاتجاه الصحيح (من اليسار إلى اليمين بالإنجليزية ومن اليمين إلى اليسار بالعربية , أو من أعلى إلى أسفل في لغات أخرى)	0 1 2				
5	ينسخ اسمه الأول	0 1 2				
6	يتعرف على جميع حروف الهجاء المطبوعة	0 1 2				
7	ينسخ 3 كلمات على الأقل (مثل: قطة، بوى، نحلة)	0 1 2				
8	يكتب اسمه الأول والآخر اعتمادا على ذاكرته	0 1 2				
9	يقرا 10 كلمات على الأقل قراءة جهرية.	0 1 2				
10	يكتب 10 كلمات بسيطة من ذاكرته (مثل: قبة، كرة، إبرة)	0 1 2				
11	يقرا قصص قصيرة قراءة جهرية (قصص بجل من 3-5 كلمات)	0 1 2				
12	يكتب بعض الجمل البسيطة المكونة من 3-4 كلمات (هناك إمكانية للخطأ، الإملائية وتركيب الجمل)	0 1 2				
13	يكتب أكثر من 20 كلمة من ذاكرته، مع إمكانية للخطأ، الإملائية.	0 1 2				
14	يقرا ويستوعب من كتاب بمستوى الصف الثاني الابتدائي على الأقل.	0 1 2				
15	يرتب الكلمات ترتيبا إبداعيا.	0 1 2				
16	يكتب خطابات قصيرة أو رسائل من 3 جمل.	0 1 2				
17	يقرا ويستوعب من كتاب الصف الرابع الابتدائي على الأقل.	0 1 2				
18	يكتب تقارير وإبحاثا ومقالات من صفحة واحدة , مع إمكانية استخدام الحاسوب.	0 1 2				
19	يكتب عناوين مظاريف من مرسل و مرسل إليه	0 1 2				
20	يقرا ويستوعب من كتاب بمستوى الصف السادس على الأقل.	0 1 2				
21	يدقق أو يصحح كتاباته الخاصة قبل أن يسلمها (علامات الترقيم، الواء، النحو أو القواعد)	0 1 2				
22	يكتب مراسلات متقدمة بطول 10 جمل على الأقل يمكن استخدام الحاسوب.	0 1 2				
23	يقرا ويستوعب من كتاب بمستوى الصف الثامن على الأقل.	0 1 2				
24	يقرا قصتين على الأقل من الجرائد أسبوعيا.	0 1 2				
25	يكتب خطابات ورسائل تتعلق بالعمل (طلب معلومات , تقديم شكوى , طلبات ربح) يمكن استخدام الحاسوب.	0 1 2				

الكتابة

Item Before Basal	X 2 =		
Basal Item Through Ceiling Item:			
DK and/or Missing Total*	+		
N/O Total	+		
Sum of 2s and 1s	+		
Receptive Raw Score	=		
	SUM		

* If the total of DK and/or Missing is greater than 2, do not score subdomain.

بعد التواصل

✓ تأكد من تعليمات في الأسفل	ع=لا أحرف	0=إبدأ/اطلأ	1=أحياناً/جزئياً	2=دائماً
	التعبير عن أفكار معقدة	مهارات الكلام	كلام تفاعلي	البدء بالكلام
	تعبيرات قبل النطق			

3	29	يقول اسمه الأول وكنيته ان طلب منه ذلك.	0 1 2
	30	يتعرف على ويسمي اللون كلها (أحمر، أخضر، أزرق، أصفر، برتقالي، أرجواني، بني، أسود).	0 1 2
		اختر الإجابة 2 إذا تعرف على 8-6 لوان، 1 إذا تعرف على 5-2 لوان، 0 إذا تعرف على لون واحد أو أقل.	
	31	يطرح أسئلة باستخدام من؟ أو لماذا؟ (مثل: من ذلك؟ ولماذا يتوجب علي ان اذهب؟)	0 1 2
	32	يستخدم الفعل المضارع	0 1 2
4,5	33	يستخدم أدوات الملكية في الجمل (مثل: هذا كتابه هذه كرة احمد).	0 1 2
	34	يستخدم الضمائر في الجمل بشكل يتناسب مع المذكر والمؤنث دون الاهتمام بقواعد اللغة الأخرى (مثل: هو قد فعل هذا، هم ذهبيوا).	0 1 2
	35	يطرح أسئلة باستخدام متى؟ (مثل: متى موعد الفداء؟ ومتى تستطيع ان اذهب البيت؟).	0 1 2
	36	يستخدم الأفعال الماضية المنتظمة ويمكن استخدام الأفعال غير المنتظمة عند الضرورة.	0 1 2
	37	يستخدم (خلف أو وراء) في الجمل مثل (مشيت امامه، سلمى خلفي).	0 1 2
	38	يلفظ الكلمات بطريقة صحيحة دون تبديل الحروف (مثل: سالي وليس ثالي، راج وليس لاج).	0 1 2
	39	يسرد الجزء الرئيسية من قصة أو حكاية أو أحداث برنامج تلفزيوني دون الحاجة لأدق التفاصيل.	0 1 2
6	40	يذكر تاريخ ميلاده باليوم والشهر الذي ولد فيه.	0 1 2
	41	يتحكم بنبرة الصوت وشدته ونغمته (لا يتكلم بنفس الوتيرة ولا بنفس العلو أو الانخفاض).	0 1 2
	42	يحكي تجاربه بالتفصيل (الأشخاص المعنيين، مكان حدوث الأنشطة، إلخ).	0 1 2
	43	يعطي تعليمات بسيطة (مثل: كيف يلعب لعبة ما، أو كيف يصنع شيئاً).	0 1 2
	44	يستخدم كلمة (بين) في جمل (مثل: الكرة بين السيارات).	0 1 2

اللغة التعبيرية

Item Before Basal	X 2 =	
Basal Item Through Ceiling Item:		
DK and/or Missing Total*	+	
N/O Total	+	
Sum of 2s and 1s	+	
Receptive Raw Score	=	

تعليمات :

SUM

* If the total of DK and/or Missing is greater than 2, do not score subdomain.

بعد التواصل			
احتمالات الإجابة: 2=دأيا	1=أحيانا/جربا	0=لا/أطلاقا	ع=لا أعرف
الفهم	الاستماع والحضور	اتباع التعليمات	تأكد من التعليمات في الأسفل
1	يحرك عينيه وراسه نحو الصوت	0 1 2	
2	ينظر باتجاه الوالد أو من يقوم برعايته عندما يستمع لصوته	0 1 2	
3	يستجيب عند سماع صوت (يلفت نحو المتحدث أو يتسمع بالخب)	0 1 2	
4	يتصرف بشكل يدل على فهمه لما تعنيه كلمة لا أو أي كلمة أخرى بنفس المعنى (يتوقف فجأة عن القيام بنشاط ما)	0 1 2	
5	يتصرف بشكل يدل على فهمه كلمة نعم أو أي كلمة أخرى بنفس المعنى (يستمر في نشاط ما، أو يتسمع بالخب)	0 1 2	
6	يستمع إلى قصة لمدة خمس دقائق على الأقل (يبقى صامتا ويتجنب لراوي القصة)	0 1 2	
7	يشير إلى ثلاثة أعضاء في الجسم على الأقل عندما يطلب منه ذلك (مثل: أنف، فم، يد، قدم)	0 1 2	
8	يشير إلى الأشياء العامة في كتاب أو مجلة عند سماع صوتها أو اسمها (مثل: كلب، سيارة، قنجان، مفتاح الخ)	0 1 2	
9	يستمع للتعليمات	0 1 2	
10	ينفذ التعليمات لأمر واحد أو شيء واحد (مثل: "هات الكتاب"، "اغلق الباب" الخ)	0 1 2	
11	يشير إلى 5 أجزاء فرعية من جسمه عندما يطلب منه ذلك (مثل: أصابع اليد، الكوع، الإصبع، القدم، الخ)	0 1 2	
12	ينفذ التعليمات المكونة من أمرين متتاليين أو أحضار شينين (مثل: "هات اللون والورق"، "اجلس وتناول غذائك" الخ)	0 1 2	
13	ينفذ التعليمات بصيغة إذا... سوف... (مثل: "إذا كنت تريد اللعب في الخارج، ضع أشياءك جانبا" الخ)	0 1 2	
14	يستمع لقصة لمدة 15 دقيقة.	0 1 2	
15	يستمع لقصة لمدة 30 دقيقة.	0 1 2	
16	ينفذ تعليمات ثلثية الأوامر (مثل: "نظف اسنالك وارندي ثيابك ثم رتب سريرك")	0 1 2	
17	ينفذ تعليمات سمعها قبل 5 دقائق	0 1 2	
18	يفهم العبارات التي لا يجب تطبيقها حرفيا (مثل: "زرر شفتيك" أي أغلق فمك، "اقطع الشارع" أي انتقل من رصيف إلى رصيف الخ)	0 1 2	
19	يستمع لخطاب لمدة 15 دقيقة.	0 1 2	
20	يستمع لخطاب لمدة 30 دقيقة.	0 1 2	

لغة الاستقبال

Item Before Basal X 2 =

Basal Item Through Ceiling Item:

DK and/or Missing Total!

N/O Total

Sum of 2s and 1s

Receptive Raw Score =

SUM

* If the total of DK and/or Missing is greater than 2, do not score subdomain.

قبل البدء بالمقابلة، اقرأ الفصل الثاني من المقابلة المسحية الموجودة ضمن الكتيب اليدوي بعناية.

التعليقات /الخطوط العريضة: يمكن رصد استجابات الفرد على كل بند من بنود مقياس السلوك التكيفي بناءً على العمر الزمني. يمكن اختيار علامة (2)، (1)، (0)، (ع = لا أعلم)، (م = لم تسنح الفرصة). (للمزيد حول معايير العلامة المستعملة، انظر الملحق (ج) المرفق في دراسة فاينلاند لمقاييس السلوك التكيفي (2).

- اختر الرقم (2) إذا كان الفرد يقوم بإداء المهمة/السلوك دائماً بمفرده (دون تذكير أو مساعدة جسدية).
- اختر الرقم (1) إذا كان الفرد يقوم بإداء المهمة أحياناً بشكل مستقل أو لفترة جزئية.
- اختر الرقم (0) في حالة عدم قدرة الفرد على أداء المهمة إطلاقاً بشكل مستقل.
- اختر الرمز (م) في حالة لم تسنح الفرصة للملاحظة السلوك أو القيام به.
- اختر الرمز (ع) إذا كان البند يشمل مهارة أو سلوكاً لا تعلم الشخص ما إذا كان يقوم بأدائها أو لا.
- هنالك بعض البنود الفرعية التي لا تنطبق على الأطفال دون سن الثالثة. وفي حالة كون الطفل أقل من هذا العمر يمكن عدم الاستمرار في المقابلة.

سجل كل علامة من العلامات الموجودة في هذا الكتيب وذلك بوضع دائرة حول الرقم المطلوب. وفي حال وجود أي استفسار حول نقطة معينة يمكن وضع إشارة أو تعليق على حين البند المذكور. وعند استكمال المقابلة كاملة، يمكن كتابة التعليقات حول كل بند بالتفصيل.

قواعد حساب العمر القاعدي والعمر السقفي: من المهم تكوين (قاعدة) و (سقف) لكل بعد من أبعاد المقياس. يتم حساب القاعدة عند حصول الفرد على درجة (2) في أربع فقرات متتابعة. في حين يكون السقف مكوناً من أعلى أربعة بنود متتالية يحصل فيها المفحوص على الدرجة صفر. يمكن تعريف بند القاعدة على أنها مجموعة الفروع الأعلى والتي تقابل العلامة رقم 2، أما بند السقف فيعرف على أنه مجموعة الدرجات الأقل وتكافئ العلامة 0. إذا لم يسجل أي بند قاعدي يمكن اعتبار علامة 1 كقاعدة. وأما في حالة عدم الحصول على أي سقف، فيمكن اعتبار البند الأخير من الفروع كسقف.

Appendix F

Parents Satisfaction Survey

اسم الطفل: _____ التاريخ: _____

تاريخ ميلاد الطفل: _____ اسم كاتب التقرير: _____

الشخص الذي تمت مقابلته: _____

صلة القرابة للطفل: _____

العمر الزمني للطفل: _____


برنامج بورتج
 اختبار الصورة الجانبية لتطور الطفل

النتائج و التقارير

الصورة الجانبية لتطور مهارات الطفل

التعليقات	السنة	الشهر	
			العمر الإدراكي
			العمر في المساعدة الذاتية
			العمر الجسمي
			العمر الاتصالي
			العمر الاجتماعي

معهد النجاح للطفولة
 An-Najah Child Institute

قائمة تطور العمر الإدراكي (التعليمي):

شهر	انجز	لم ينجز	ملاحظات
النصف الأول من السنة الأولى (من الولادة حتى 6 اشهر)			
1-			هل يصبح الطفل أكثر نشاطاً أو أقل عندما يدخل أحد في الغرفة أو عندما يلتقطه أحد؟
2-			هل يظهر الطفل الانتباه إلى أداة أو شخص لمدة دقيقة على الأقل؟ لا يتضمن هذا أدوات التغذية مثل زجاجة الرضاعة
النصف الثاني من السنة الأولى (الطفل الرضيع 7-12 شهر)			
3-			هل يظهر الطفل انه يجب أو لا يجب أشخاص معينين أو أماكن أو أدوات معينة؟ لا يشمل الطعام.
4-			هل يبحث الطفل في المكان المناسب عن أداة رفعت بعيداً عن نظره، أم ينساها؟ مثلاً إذا رأى الطفل لعبة تخفي في مكان ما، تحت مائدة أو مخدة هل يبحث الطفل عنها أم سينساها؟
من سنة إلى سنة ونصف (الطفل الرضيع 13-18 شهر)			
5-			هل يخبرش الطفل بقلم الرصاص في محاولة واضحة لرسم علامات؟
6-			هل يستطيع الطفل الإشارة إلى جزء جسمي واحد على الأقل إما على جسمه أو على عروسه (لعبة) عند الطلب؟
7-			من سنة ونصف إلى سنتين (مرحلة ما بعد الرضاعة 1: من 19-24 شهر)
7-			هل يعطي الطفل "واحد كمان" من شيء أو يأخذ "كمان" ملء معلقة واحدة من الطعام إذا طلب منه أحد ذلك؟
8-			هل يذكر الطفل أو يشير إلى 20 أداة أو صورة على الأقل عندما تذكر له الأدوات؟
9-			هل يعرف الطفل نفسه في صورة؟
من سنتين إلى سنتين ونصف (مرحلة ما بعد الرضاعة 2: من 25-30 شهر)			
10-			هل يجمع (يصنف) الطفل الأدوات باللون أو بالشكل أو بالحجم عندما يلعب؟
11-			هل ينسخ الطفل خطاً رأسياً مقلداً خط رسمه شخص كبير؟
12-			هل يقول الطفل كلمات تتعلق بالحجم مثل "كبير"، "صغير" كثيراً وبلاستعمال المضبوط؟ لا يقبل كلمات مثل البيبي؟
من سنتين ونصف إلى ثلاثة سنوات (مرحلة ما بعد الرضاعة 3: من 31-36 شهر)			
13-			هل يفهم الطفل مفهوم العدد "ثلاثة"، بحيث سيغطيك مثلاً ثلاث قطع من الحلوى عند الطلب؟
14-			هل ينسخ الطفل شكل الدائرة بقلم رصاص؟ قد يرسم الحركة الدائرية
15-			هل يشير الطفل إلى لونين على الأقل بشكل مضبوط عند الطلب؟ ليس من الضروري أن يذكرهما.
من ثلاث سنوات إلى ثلاث سنوات ونصف (مرحلة ما قبل المدرسة 1: من 37-42 شهر)			
16-			هل يعد الطفل إلى ستة؟ (يعد 6 أشياء، موضوعة أمامه بشكل صحيح إذا طلب منه ذلك)
17-			هل يعرف الطفل أن أنشطة معينة تحدث في أوقات مختلفة في اليوم؟ مثلاً هل يعرف الطفل أن الفطور وجبة الصباح وأنه يجب عليه في الليل أن ينام؟
18-			هل يرسم الطفل إشارة (+) بخط رأسي وخط متقاطع أفقي بعد أن يرسمه شخص كبير؟
4 سنوات (مرحلة ما قبل المدرسة 2: من 43-54 شهر)			
19-			هل يرسم الطفل شخص (رأساً يشابه رأساً وقسم آخر من الجسم على الأقل) عندما يطلب منه ذلك؟
20-			هل يميز الطفل أنواع العملة المتداولة بذكرها أو بالإشارة إليها عند ذكرها؟ ليس من الضروري أن يعرف قيمة الأنواع المختلفة
21-			هل يرسم أو ينسخ الطفل مربعا؟ يجب أن يكون للمربع زوايا قائمة وأن تكون جوانبه الأربعة متساوية تقريبا.
5 سنوات (مرحلة ما قبل المدرسة 3: من 55-66 شهر)			
22-			هل يقول الطفل كلمات على نفس الوزن مثل "حطة، بطة"، "هات، بات"؟
23-			هل يرسم الطفل شخصاً (رأس و جسم وذراعان و قدمان- ولو مجرد خطوط) عندما يطلب منه ذلك؟
24-			هل يرسم الطفل أو ينسخ مثلثاً؟ يجب أن تكون أضلاعه متساوية تقريبا
6 سنوات (المرحلة الابتدائية 1: من 67-78 شهر)			
25-			هل يستطيع الطفل أن يخرج 13 أداة من مجموعة أدوات عددها 20؟
26-			هل يعرف الطفل عنوانه؟ بما فيه اسم الشارع، رقم البيت، أو قد يذكر اسم مكان معروف بجوار بيته؟ (العناوين في الريف أقل تحديداً)
27-			هل يجيب الطفل على أسئلة بسيطة عن حقائق رئيسية في قصة سردت عليه؟ (على أن لا تزيد القصة عن عشر جمل تقريبا، و تكون الأسئلة حول أسماء الشخصيات الرئيسية وتتابع الأحداث العامة؟
7 سنوات (المرحلة الابتدائية 2: من 79-90 شهر)			
28-			هل درس الطفل الصف الثاني؟ (المطلوب أن يكون متمكناً من منهاج الصف الثاني في القراءة والكتابة والحساب)
29-			هل يكتب الطفل الحروف بصورة جيدة؟
30-			هل يستطيع الطفل أن يذكر أيام الأسبوع السبعة ويعرف أي الأيام تجيء قبل يوم معين وبعده؟ مثلاً يجب عليه أن يستطيع قول أي يوم يجيء قبل يوم الخميس وبعده.
8 سنوات (المرحلة الابتدائية 3: من 91-102 شهر)			
31-			هل يكتب للطفل بخط الرقعة ولا يستعمل النسخ؟
32-			هل درس الطفل الصف الثالث؟ (المطلوب أن يكون متمكناً من منهاج الصف الثالث في القراءة والكتابة والحساب)
9 سنوات (المرحلة الابتدائية النهائية: من 103-114 شهر)			
33-			هل يستطيع الطفل أن يقول جدول الضرب حتى رقم 6 وبخطأ، قليلة؟ مثلاً 6X3، 9X4، 6X5، إلخ
34-			هل حفظ الطفل ثلاثة أرقام هاتف أو ثلاثة عناوين يستطيع استعمالها عند الحاجة؟

الرصيد القاعدي	سنة	شهر	الرصيد الإضافي	شهر	العمر الإدراكي:	سنة	شهر
----------------	-----	-----	----------------	-----	-----------------	-----	-----

قائمة تطور المساعدة الذاتية:

المرحلة	العمر	سنة	شهر	المرحلة	العمر	سنة	شهر
1	من السنة الأولى (من الولادة حتى 6 اشهر)			26	من 26 - 27	شهر	4
2	من 2 - 3			27	من 27 - 28	شهر	6
3	من 3 - 4			28	من 28 - 29	شهر	8
4	من 4 - 5			29	من 29 - 30	شهر	10
5	من 5 - 6			30	من 30 - 31	شهر	12
6	من 6 - 7			31	من 31 - 32	شهر	14
7	من 7 - 8			32	من 32 - 33	شهر	16
8	من 8 - 9			33	من 33 - 34	شهر	18
9	من 9 - 10			34	من 34 - 35	شهر	20
10	من 10 - 11			35	من 35 - 36	شهر	22
11	من 11 - 12			36	من 36 - 37	شهر	24
12	من 12 - 13			37	من 37 - 38	شهر	26
13	من 13 - 14			38	من 38 - 39	شهر	28
14	من 14 - 15			39	من 39 - 40	شهر	30
15	من 15 - 16			40	من 40 - 41	شهر	32
16	من 16 - 17			41	من 41 - 42	شهر	34
17	من 17 - 18			42	من 42 - 43	شهر	36
18	من 18 - 19			43	من 43 - 44	شهر	38
19	من 19 - 20			44	من 44 - 45	شهر	40
20	من 20 - 21			45	من 45 - 46	شهر	42
21	من 21 - 22			46	من 46 - 47	شهر	44
22	من 22 - 23			47	من 47 - 48	شهر	46
23	من 23 - 24			48	من 48 - 49	شهر	48
24	من 24 - 25			49	من 49 - 50	شهر	50
25	من 25 - 26			50	من 50 - 51	شهر	52
26	من 26 - 27			51	من 51 - 52	شهر	54
27	من 27 - 28			52	من 52 - 53	شهر	56
28	من 28 - 29			53	من 53 - 54	شهر	58
29	من 29 - 30			54	من 54 - 55	شهر	60
30	من 30 - 31			55	من 55 - 56	شهر	62
31	من 31 - 32			56	من 56 - 57	شهر	64
32	من 32 - 33			57	من 57 - 58	شهر	66
33	من 33 - 34			58	من 58 - 59	شهر	68
34	من 34 - 35			59	من 59 - 60	شهر	70
35	من 35 - 36			60	من 60 - 61	شهر	72
36	من 36 - 37			61	من 61 - 62	شهر	74
37	من 37 - 38			62	من 62 - 63	شهر	76
38	من 38 - 39			63	من 63 - 64	شهر	78
39	من 39 - 40			64	من 64 - 65	شهر	80
40	من 40 - 41			65	من 65 - 66	شهر	82
41	من 41 - 42			66	من 66 - 67	شهر	84
42	من 42 - 43			67	من 67 - 68	شهر	86
43	من 43 - 44			68	من 68 - 69	شهر	88
44	من 44 - 45			69	من 69 - 70	شهر	90
45	من 45 - 46			70	من 70 - 71	شهر	92
46	من 46 - 47			71	من 71 - 72	شهر	94
47	من 47 - 48			72	من 72 - 73	شهر	96
48	من 48 - 49			73	من 73 - 74	شهر	98
49	من 49 - 50			74	من 74 - 75	شهر	100
50	من 50 - 51			75	من 75 - 76	شهر	102
51	من 51 - 52			76	من 76 - 77	شهر	104
52	من 52 - 53			77	من 77 - 78	شهر	106
53	من 53 - 54			78	من 78 - 79	شهر	108
54	من 54 - 55			79	من 79 - 80	شهر	110
55	من 55 - 56			80	من 80 - 81	شهر	112
56	من 56 - 57			81	من 81 - 82	شهر	114
57	من 57 - 58			82	من 82 - 83	شهر	116
58	من 58 - 59			83	من 83 - 84	شهر	118
59	من 59 - 60			84	من 84 - 85	شهر	120
60	من 60 - 61			85	من 85 - 86	شهر	122
61	من 61 - 62			86	من 86 - 87	شهر	124
62	من 62 - 63			87	من 87 - 88	شهر	126
63	من 63 - 64			88	من 88 - 89	شهر	128
64	من 64 - 65			89	من 89 - 90	شهر	130
65	من 65 - 66			90	من 90 - 91	شهر	132
66	من 66 - 67			91	من 91 - 92	شهر	134
67	من 67 - 68			92	من 92 - 93	شهر	136
68	من 68 - 69			93	من 93 - 94	شهر	138
69	من 69 - 70			94	من 94 - 95	شهر	140
70	من 70 - 71			95	من 95 - 96	شهر	142
71	من 71 - 72			96	من 96 - 97	شهر	144
72	من 72 - 73			97	من 97 - 98	شهر	146
73	من 73 - 74			98	من 98 - 99	شهر	148
74	من 74 - 75			99	من 99 - 100	شهر	150

الرصيد التراكمي	سنة	شهر	الرصيد الإضافي	شهر	العمر في المساعدة الذاتية:	سنة	شهر
-----------------	-----	-----	----------------	-----	----------------------------	-----	-----

- 1- هل يصدر الطفل أصواتا عندما يلعب؟ يجب عليه أن يلبع بالأصوات (ليس فقط أن يبكي أو يضحك أو يقرقر)
- 2- هل يؤثر الطفل أو يستعمل بعض الأصوات في محاولة تقليد الكلمات أو الحديث كأن يتظاهر بأنه يتكلم؟
- 3- هل ينظر إلى مصدر الصوت عندما يبدأ مثل أحد في الحديث؟
- النصف الثاني من السنة الأولى (الطفل الرضيع 1: 12-7 شهر)
- 4- هل يقاد في بعض الأحيان الكلمات المنطوقة مثل "بابا" أو "ماما"؟ قد لا يعرف الطفل معنى هذه الكلمات.
- 5- هل يستعمل الطفل الحركات أو الإشارات كطريقة للتكلم مثل تحريك رأسه بالثني أو مد يديه ليحمله أحد؟
- 6- هل يرد الطفل على كلام شخص كبير بإشارات مثل إغارة "بأي ياي" عندما يقول الشخص الكبير "بأي ياي" أو تحريك رأسه بالثني والإيجاب عندما يسأله الشخص الكبير سوفا؟
- سنة إلى سنة ونصف (الطفل الرضيع 2: 13-18 شهر)
- 7- هل يستعمل الطفل بعض الأصوات (كلمات حقيقية أو أصوات تشبه كلمات) ليعبر عما يريد؟ ليس مجرد البكاء، والإثنين للحصول على شيء.
- 8- هل يذكر الطفل اسم خمسة أشياء على الأقل؟ (ليس بالتقليد ولا تحسب أسماء الأشخاص) يجب أن ينطق الأسماء بطريقة واضحة بحيث يستطيع شخص غريب أن يفهمها.
- 9- هل ينفذ الطفل الأوامر مثل "اريني، تعال، روح، جيب"؟ مثلا هل يستطيع الطفل أن يشير إلى أصابع قدميه أو يذهب إلى ماما أو يأتي بمعلقة عند الطلب.
- من سنة ونصف إلى سنتين (مرحلة ما بعد الرضاعة 1: 19-24 شهر)
- 10- هل يستطيع الطفل 15 كلمة على الأقل (استعمال مضبوط)؟
- 11- هل يستطيع الطفل أن يفهم بالكلام وبالإشارات أن يريد المزيد؟ يجب أن تكون الإشارات أو الكلمات واضحة وليست مجرد البكاء، والتلويح بيده.
- 12- هل يجمع الطفل كلمتين أو أكثر ليشكل الجمل؟ مثلا "روح أنت"، "أنت أعطي"، "محمد بدو"
- من سنتين إلى سنتين ونصف (مرحلة ما بعد الرضاعة 2: 25-30 شهر)
- 13- هل يكرر الطفل أجزاء من أغاني الأطفال أو يشترك فيها عندما يغنيها الآخرون؟
- 14- هل يقول الطفل (ولا يكرر فقط) أسماء، 20 شيء على الأقل إذا رآها في الصور؟
- 15- هل يستطيع الطفل 50 كلمة مختلفة على الأقل وهو يتكلم؟ يجب عليه أن يستعمل هذه الكلمات ولا يفهمها فقط عندما يستعملها الآخرون.
- من سنتين ونصف إلى ثلاثة سنوات (مرحلة ما بعد الرضاعة 3: 31-36 شهر)
- 16- هل يذكر الطفل اسمه ولقبه أحيانا عند الطلب؟ قد لا يفعل هذا دائما أو حتى معظم الوقت ولكن يجب عليه أن يفعل هذا بعض الوقت.
- 17- هل يستطيع الطفل أن يفهم أغنيته للأطفال وأغنيته عاديته على الأقل؟ (بيتا واحدا على الأقل من كل أغنية)
- 18- هل يحاول الطفل جوابا صحيحا عندما يسأل ما إذا كان ولد أو بنت؟
- من ثلاث سنوات إلى ثلاث سنوات ونصف (مرحلة ما قبل المدرسة 1: 37-42 شهر)
- 19- هل يقول الطفل عادة اسمه ولقبه عندما يطلب الكبار منه اسمه بالكلام؟
- 20- هل يستطيع الطفل أن يروي قصة بالنظر إلى الصور في كتاب؟ يجب أن يقول القصة حسب ما يتمثل في الصور مع أنه قد يحذف أجزاء القصة التي لا تتمثل في الصور
- 21- هل يجيب الطفل على الهاتف و يبلغ الشخص المتصل الرسالة الصحيحة؟ (يجب عليه أن يستمع إلى الكلام من الطرف الآخر وينتظر حتى يتوقف الآخر عن الكلام قبل أن يرد أو يتكلم) ملحوظة: إذا لم يكن الهاتف متاحا فالحذف هذا الرقم وحسب لكل من اتصال 19 واتصال 20 ثلاثة أشهر بدلا من شهرين
- 4 سنوات (مرحلة ما قبل المدرسة 2: 43-44 شهر)
- 22- هل غنى الطفل أغنية مؤلفة من 30 كلمة على الأقل؟ قد تكون كثيرا من الكلمات مكررة في الأغنية ولكن يجب على الطفل أن يفهمها لوحده
- 23- هل يستطيع الطفل أن يشتري شيئا من محل بدون مساعدة؟ يجب عليه أن يقول للبايع ما يريد بالضبط ويدفع ثمنه وينتظر الباقي
- 24- هل يستطيع الطفل أن يقول للآخرين عن عمره (أما بالكلام أو بأصابعه) وعن عمره العام الماضي؟ وما سيكون عمره في العام القادم؟
- 5 سنوات (مرحلة ما قبل المدرسة 3: 55-66 شهر)
- 25- هل يسأل الطفل من وقت لآخر عن معنى كلمة ثم يستعمل هذه الكلمة عندما يتكلم؟
- 26- هل يروي الطفل (دون صور مساعدة) قصة الأجزاء المهمة في القصة؟
- 27- عندما يجادل هل يستطيع الطفل من وقت لآخر المنطق عن السبب والنتيجة؟ قد يستعمل كلمات مثل "لأن" أو "بما أن" وأيضا مثل "استطيع أن أفرج عن التلفزيون وأسهر هذه الليلة لأنه لا يوجد مدرسة غد". بحسب ما لأنه يبين السبب والنتيجة.
- 6 سنوات (المرحلة الابتدائية 1: 67-78 شهر)
- 28- هل يستطيع الطفل أن يقرأ خمس كلمات مكتوبة على الأقل ويفهمها بطريقة ما؟ يجب عليه أن يقرأ الكلمات، أن يذكر الأشياء، لاني رأى ما يدل عليها ومكتوبة فيها مثل غلب الأكل.
- 29- هل يستطيع الطفل أن يجمع رقم هاتف أو يطلب من عامل الهاتف رقما بشكل صحيح عندما يريد أن يكلم أحدا بالهاتف؟
- 30- هل يقول الطفل "بلادي" أو شيئا مثله؟ (دعا، ما أو الأذان أو قصيدة مؤلفة من 25 كلمة على الأقل)
- سنوات (المرحلة الابتدائية 2: 79-90 شهر)
- 31- هل يقرأ الطفل شفويا (يقرا حقيقيا) قصة بسيطة بحيث يستطيع أي شخص يستمع إليه متابعتها هذه القصة؟
- 32- هل يستطيع أن يروي (في 5 دقائق تقريبا) ملخص قصة أو مسرحية أو تمليكية تليفزيونية؟ يجب عليه أن يروي القصة كاملة وليس الأحداث المبكرة فقط، بحيث يستغرق ذلك خمس دقائق تقريبا
- 33- هل يفهم الطفل ثلاث من الإشارات غير اللفظية الأربعة الآتية:
 - هز الكتفين بمعنى "لا أعرف" أو "لست متأكدا"
 - مد اليد لإيقاف سيارة تكتسي
 - دائرة مشكلة من الإبهام والسبابة إشارة إلى 100%
 - الغمز بالعين كتحية ودية أو لكي يشير أنه مزحج
- 8 سنوات (المرحلة الابتدائية 3: 91-102 شهر)
- 34- هل يستطيع الطفل أن يذكر كلمتين عن نفس الوزن؟ (رأس-فأس-كاس) (بطء-خطة)؟
- 35- هل يفهم الطفل أغاني أو يقول البيوت المشهورة من أغنية شعبية؟ لا تحسب أغني الأطفال وأغاني الأعياد
- 9 سنوات (المرحلة الابتدائية النهائية: 103-114 شهر)
- 36- هل استمع الطفل وفهم برنامج راديو غير موسيقي مثل الرياضة أو الأخبار أو دراما لمدة 10 دقائق على الأقل؟
- 37- هل كتب الطفل رسالة وبمضغ بدون مساعدة؟ يجب أن تكون الرسالة مفهومة، قد تتوفر المساعدة للنعوان والمهجنة ولكن ليس الرسالة نفسها
- 38- هل كتب الطفل قصيدة أو أغنية مبتكرة تشتمل على ثلاث سيات أو قافية على الأقل؟ إذا كانت القصيدة أو الأغنية من "الشعر الحر" فيجب أن تكون مؤلفة من 20 كلمة أو أربعة سطور على الأقل

الرصيد القاعدي	سنة	شهر	الرصيد الإضافي	شهر	العمر الاتصالي:	سنة	شهر
----------------	-----	-----	----------------	-----	-----------------	-----	-----

قائمة تطور العمر الاجتماعي:

شهر	أبزر	أم ينجز	ملاحظات
النصف الأول من السنة الأولى (من الولادة حتى 6 أشهر)			
1-			هل يظهر الطفل انه يريد الانتباه إليه؟ يتضمن هذا مد يده إلى أشخاص أو مناعاة أشخاص أو وقف البكاء، عندما يلعب معه أحد (ولكن لا يحمله)
2-			هل يثرثر الطفل أو يصدر أصواتا أخرى قد تعتبر محاولات للحديث؟ لا يتضمن هذا البكاء، للحصول على انتباه أحد أو زجاجة الرضاعة.
3-			هل يظهر الطفل انفعالات سلبية (الغضب، الرض، الخوف أو الارتداد) لأشياء غير مؤلمة من الناحية الجسمية مثل الطعام المكروه أو الغرباء؟
النصف الثاني من السنة الأولى (الطفل الرضيع 7-12 شهر)			
4-			هل يلوح الطفل (بأي يدي) في الأوقات المناسبة؟ أو هل يصفق الطفل مقلداً أو عندما يلعب معه أحد؟
5-			هل يظهر الطفل انه يعرف معنى "لي" (يفهم عندما يقول أحد سيارتي أو أمي)؟
6-			هل يأتي الطفل عند الطلب؟ (25 % من الوقت على الأقل)
من سنة إلى سنة ونصف (الطفل الرضيع 13-18 شهر)			
7-			هل يبقى الطفل مشغول لمدة 15 دقيقة وهو يفعل شيئاً مما يلي: ينظر إلى التلفزيون، يرسم بقلم جيني، ينظر إلى صورة؟ قد يفعل هذا لوحده أو مع أطفال آخرين ولكن ليس بمراقبة الكبار.
8-			هل يأتي الطفل بشي من مكان أو شخص إلى مكان آخر أو شخص آخر؟ يجب عليه أن يستطيع أن يجد الشيء بإرشادات شفوية وينفذ الإرشادات مثل "تعالى به هنا"، "أخضر به إلى ماما".
9-			هل يهتم الطفل بالأشياء، وبالالعاب التي يحبها الأطفال الآخرين؟ قد لا يستطيع الطفل أن يشارك أو يلعب الدور مع أطفال آخرين.
من سنة ونصف إلى سنتين (مرحلة ما بعد الرضاعة 1: من 19-24 شهر)			
10-			هل يشعر الطفل بالفيرة عندما ينتبه أحد إلى أشخاص آخرين خصوصاً أشخاص من العائلة؟ قد تظهر الفيرة كالغضب أو التصرفات الطفولية أو الضوضائية أو طلبه أن يكون مضمول أو تعبيرات الأشياء الأخرى.
11-			هل يستطيع الطفل أن يلعب بلعبة سملة الكسور مثل بالون أو طيارة من الكرتون دون أن يكسرها فوراً؟ قد يحدث أن تنكسر اللعبة ولكن الطفل يجب عليه أن يظهر انه يعرف الطريقة المناسبة التي من المفروض أن يستعمل اللعبة
12-			هل يكتشف الطفل الأماكن الجديدة مثل بيت صديق أو حديقة جارة؟ لا تكفي العين فقط.
من سنتين إلى سنتين ونصف (مرحلة ما بعد الرضاعة 2: من 25-30 شهر)			
13-			هل يذكر الطفل جنسه أو جنس الآخرين؟ مقبول منه إظهار انه يعرف أن ملابس أو أنشطة أو لعبات معينة تناسب جنسا دون الآخر.
14-			هل يحب الطفل أن يساعد والده في البيت؟ (يستمتع بأداء بعض الأنشطة مثل لتقاط الأشياء، عن الأرض أو وضع ورق الشجر في سلة، أو نفخ التراب، أو إعداد مائدة للطعام أو رفعها)
15-			هل يُعبر الطفل بالطلب أو بالإشارات احتياجه إلى الذهاب إلى المرحاض؟ يجب أن تكون الإشارات أكثر من إظهار العصبية وأن تظهر الطفل في حاجة إلى الذهاب إلى المرحاض.
من سنتين ونصف إلى ثلاثة سنوات (مرحلة ما بعد الرضاعة 3: من 31-36 شهر)			
16-			هل يتبع القواعد في ألعاب جماعية يشرف عليه شخص كبير؟ قد تشمل قواعد الجلوس في دائرة أو التتابع أو التوجيهات أو تقليد القائد أو تقليد أنشطة أشخاص الجماعة الآخرين.
17-			هل يستطيع الطفل أن يلعب بالدور؟ يعني هذا أن الطفل يفهم فكرة الانتظاره أن شخصاً يلعب قبله ويسمح للآخرين أن يلعبوا الأول (75 % من الوقت)؟
18-			هل يلعب الطفل بالألعاب بطريقة مناسبة؟ مثلاً لا يجر الطفل عربة على رأسها بدلاً من العجلات ولا يستعمل بندقيّة لعبة ليقطع شجرة و يعرف أن الألعاب من الكرتون لا تستطيع المشي عليه . قد يحدث هذا من وقت إلى آخر ولكن ليس كثيراً أو عادة.
من ثلاث سنوات إلى ثلاث سنوات ونصف (مرحلة ما قبل المدرسة 1: من 37-42 شهر)			
19-			هل يلعب الطفل ألعاباً جماعية مع الآخرين مثل الصيد، الاستغماية، الحجلة، نط الحبل، الجول (كينابور) بدون إشراف المستمر؟
20-			هل يستمر الطفل في العمل لمدة 30 دقيقة على الأقل مع طفل من نفس السن في مهمة واحدة مثل البناء، بالمشعبات، اللعب بالبرل أو بالطين أو لعب المكعبات التجارية أو لعب المدرسة، أو لعب البيت؟
21-			هل يعرف الطفل مفهوم الملكية؟ كأن يطلب إذن من الآخرين قبل أخذ أغراضهم الشخصية
4 سنوات (مرحلة ما قبل المدرسة 2: من 43-54 شهر)			
22-			هل يرسم الطفل شخصاً بحيث يستطيع شخص كبير أن يميز ما رسم؟ ليس من الضروري أن يكون الرسم شخصاً كاملاً (أما رأس) أو جسم أو رأس وعين أو انف أو فم بحيث يستطيع أي شخص كبير تمييزه
23-			هل يسمح للطفل أن يلعب في حارته دون مراقبة شخص كبير؟ لا يعني هذا أن الطفل يسمح له أن يعبر الشارع لوحده.
24-			هل يعرف الطفل استعمال التعبيرات الآتية: "شكراً"، "من فضلك"، "عفواً" في الأوقات المناسبة ؟
5 سنوات (مرحلة ما قبل المدرسة 3: من 55-66 شهر)			
25-			هل سأل الطفل أسئلة عن جسمه مثلاً نبض القلب أو أين يذهب الطعام وفروق جنسية؟
26-			هل يظهر الطفل إدراك شعور الآخرين بقوله مثلاً "هو غاضب، أو هي غاضبة" "هو خائف" و "أنت قلقة" يجب عليه أن يدرك الشعور المضبوط؟
6 سنوات (المرحلة الابتدائية 1: من 67-78 شهر)			
27-			هل يقول الطفل أسراراً إلى صديق ولا يقوله إلى والديه أو إلى أشخاص كبار آخرين؟ لا يعني هذا التصرفات الشاذة فقط بل تعني انه يقول الأسرار إلى طفل آخر ولا يشترك الأشخاص الكبار فيها
28-			هل يستطيع الطفل أن يزرع صديقاً ويلعب معه بدون مراقبة شخص كبير؟ ما عدا التأكد من الكبار عن وجوده مرة في الأسبوع (يجب على الصديق أو يكون أكبر من الطفل بأكثر من سنة)
29-			هل يلعب الطفل ألعاب مثل لعبة السلم والحيّة، أونو، دومينو أو غيرها مع طفل من نفس السن؟ يجب أن يكون الطفل قادر على أن يتتبع القواعد ويلعب بالدور وأن يكون هناك فلان.
7 سنوات (المرحلة الابتدائية 2: من 79-90 شهر)			
30-			هل ينجز الطفل مهمة حقيقية واحدة (مرة في الأسبوع على الأقل)؟ مثل غسل الأطباق و تنظيف الحديقة، أو ترتيب سرير أو إخراج سلة القمامة أو بعض التنظيف أو نفخ التراب؟ يجب أن ينفذ المهمة بشكل جيد وعامة بدون التشجيع أكثر من مرتين.
31-			هل يعرف الطفل أن التصويت هو طريقة إقراء شيء يجب عليه أن يفهم أن تحقق معظم الأشياء مبني على رأي الأغلبية
8 سنوات (المرحلة الابتدائية 3: من 91-102 شهر)			
32-			هل يستطيع الطفل أن يعمل في مهمات متريالية وهو يتبع قائمة مهمات لوحده وينفذها بشكل مقبول دون تذكير على الإطلاق؟
33-			هل يعرف الطفل أن الشمس لن تعطيه سناً بدلاً من السن المخلوع الذي يرميه عادة لها لأنها قصة خيالية وكذلك بالنسبة للجنية والساحرة؟ فهي فقط في القصص والخيال؟
9 سنوات (المرحلة الابتدائية النهائية: من 103-114 شهر)			
34-			هل يخرج الطفل في الحارة؟ يجب عليه أن يبعد عن البيت على بعد 30 متر على الأقل.
35-			هل يفضل الطفل في أحوال كثيرة أن يكون بعيداً عن البيت والعائلة (في ملعب أو عند أحد أصدقائه) حتى يكون مع أصدقائه؟
36-			هل يشتري الطفل بدون مساعدة الأشياء المفيدة مثل الهدايا للآخرين أو المشتريات للعائلة؟ يجب عليه أن يعرف كم من النقود يحتاج إليها وأن يختار الأشياء المناسبة وأن يحصل على مبلغ الشكّة المصبوط.

الرصيد الختامي	سنة	شهر	الرصيد الإضافي	شهر	العمر الاجتماعي:	سنة	شهر
----------------	-----	-----	----------------	-----	------------------	-----	-----

تعليمات خاصة باختبار الصورة الجانبية لتطور الطفل

الأسئلة والبنود الاختبارية المتشابهة والتي يمكن تجربتها في فترة واحدة مع الطفل أثناء تطبيق اختبار الصورة الجانبية- لتطور الطفل وخاصة إذا كان العمر الزمني للطفل والإعاقة تسمح بتجربة جميع البنود، كما أن الاختبار يقيس القدرات الحالية لدى الطفل أثناء تطبيق الاختبار، ولا يعتبر هاما ماذا كانت قدرات الطفل في السابق.

ملاحظات هامة:

- عند قراءة هذه الملاحظات يجب وضع كتاب اختبار الصورة الجانبية لتطور الطفل أمامك
- كما يجب مراعاة عمل الاختبار خلال زيارة منزلية واحدة ولا يجوز عمله على عدة زيارات لأنه اختبار ذكاء وقيس قدرات الطفل في وقت واحد

أولا: في المقياس الجسمي:

- س + ٧ س + ١١ س + ١٨ جميعها أسئلة تتعلق بكيفية صعود الطفل وهبوطه عن السلم في المدرسة في البنود من الممكن اختصار الوقت وتوفيره وتجربتها مرة واحدة مع الطفل ولكن إذا فشل الطفل في س ٧ أو س ١١ فمن الطبيعي أن يفشل في س ١٨ لأنه أصعب واعتقد لذلك يجب مراعاة ذلك
- س + ١٠ س + ١٩ جميعها تتعلق بقدرة الطفل على قذف الكرة لمسافة مع مراعاة المسافة المحددة في كل من هذه الأسئلة
- س + ١٤ س + ١٥ يمكن تجربتهم مرة واحدة وخاصة أن كل من السؤالين يدور حول عملية القفز ومن الممكن أن ترتبط الأسئلة رقم ٣٤ - ٣٣ - ١٧ - ٢٧ ولكن يراعى إذا فشل الطفل في الأسئلة الأولى المذكورة أعلاه س + ١٤ س + ١٥ فلا يجب تجربة الأسئلة التالية لأنها أصعب
- س + ١٦ س + ٢١ س + ٢٩ كل منهم مرتبط ببعضه فالأول قياس قدرة الطفل على مسك المقص بطريقة صحيحة وإذا نجح الطفل في هذا البند يمكن تجربة س ٢١ وهو أن يقص دائرة قطرها ٥ سم وإذا نجح فيه يمكن تجربة السؤال الثالث رقم ٢٩ وهو يقص صورة لحيوان مع مراعاة شروط البند الاختباري
- س + ٢٢ س + ٣٣ كل منهما يتعلق بالنقاط الكرة مع مراعاة التغيير في حجم الكرة فالسؤال الأول كرة كبيرة أما الثاني كرة صغيرة وإذا نجح في البند الأول يمكن تجربة البند الثاني إذا كان عمر الطفل يسمح بذلك

ثانيا: المساعدة الذاتية:

- س + ٦ س + ٨ كل منها يدور حول عملية الشرب من كوب مع اختلاف في شروط السؤال لذلك يجب مراعاة إذا نجح الطفل في س ٦ يمكن تجربة سؤال ٨ وإذا نجح في سؤال ٦ فلا داعي لطرح سؤال رقم ٨
- س + ٩ س + ١٢ س + ١٥ جميعها أسئلة تدور حول أدوات الطعام وهل يعتمد الطفل على نفسه في إطعام نفسه كليا ولا يمكن طرح السؤال الأصعب طالما لم ينجح الطفل في الأسهل
- س + ١٠ س + ١٤ تدور حول قدرة الطفل على التمييز بين الطعام والأشياء التي لا تؤكل وبين ما هو خطر ويجب الابتعاد عنه وبالطبع طرح السؤال الأخير يعتمد على ما قبله
- إذا نجح الطفل في س ١٠ يجب طرح سؤال رقم ١٤
- ولكن إذا فشل في السؤال الأول لا داعي لسؤال رقم ١٤
- س + ١١ س + ١٦ س + ٢٢ مرتبطة ببعضها وتدور حول عملية اللبس والخلع للمعطف ولبس الملابس كليا، وتذكر دائما أن طرح السؤال الأصعب يعتمد على الإجابة السابقة للأسئلة الأسهل وتذكر دائما إذا فشل الطفل في الأسئلة السهلة فلا داعي للأسئلة الصعبة
- س + ١٣ س + ٢١ تدور حول عملية الغسل الجيد والتنشيف وهذه مرتبطة مع بعضها ومن الممكن تجربتها مع الطفل في وقت واحد
- س + ٢٥ س + ٢٧ س + ٢٨ جميعها مرتبطة و تدور حول عملية دهن الجرب على الخبز وعمل ساندويش وطريقة القطع للخبز مستخدما السكين ويمكن تجربتها في لحظة واحدة مع الطفل
- س + ٣٠ س + ٣٥ جميعها مرتبطة ببعضها حيث أنها تدور حول قدرة الطفل على القيام بمهام منزلية مع الاختلاف في شروط السؤالين

ثالثا: المقياس الاجتماعي:

- الإجابة على البنود الاختبارية في هذه المنطقة تعتمد على الملاحظة الدقيقة للمدرسة للتعرف على قدرات الطفل الاجتماعية
- س + ٨ يجب الانتباه إلى أن على الطفل إحضار الشيء المطلوب منه بإعطائه إرشادات شفهية فقط
- س + ٩ س + ١٨ ترتبط ببعضها وفشل الطفل في السؤال الأول يعني فشله في السؤال الثاني ونجاحه في السؤال الأول لا يعني شرطا أساسيا نجاحه في السؤال الثاني لأن السؤال الثاني رقم ١٨ أصعب من السؤال رقم ٩
- س + ١٦ س + ١٧ س + ١٩ جميعها تدور حول الألعاب الجماعية مع اختلاف الشروط فسؤال ١٦ نجاح الطفل فيه
- لا يعني بالضرورة نجاحه في سؤال ١٧ لأنه ربما يلعب ألعاب جماعية ولكنه لا يلتزم بالدور، كما أن فشل الطفل في س ١٦ يعني فشله في س ١٧ لأنه لا يعقل أن الطفل لا يلعب ألعاب جماعية ولكنه يلعب بالدور، أما بالنسبة س ١٩ فهو أصعب من السؤالين السابقين لذلك يجب المراعاة عند اختبار قدرة الطفل.

رابعا: المقياس الأكاديمي:

- س + ٥ المقصود من رسم العلامات هو قدرة الطفل على أن يخبرك وليس أن يرسم علامة + لأنه ورد سؤال يتعلق برسم علامة + وهو رقم ١٨ في المقياس الأكاديمي.
- س + ٢٢ المقصود منه أن الطفل يعيد المقطع) حطة بطة _هات فات (بعد أن تقوم المدرسة المنزلية بتدريدها أمام الطفل
- س + ١٩ س + ٢٣ مرتبطة ببعضها ويمكن تجربتها في وقت واحد فهي جميعها تدور حول قدرة الطفل على رسم شخص مع مراعاة الفروق
- ملاحظة: كل من السؤالين السابقين يرتبطان بسؤال رقم ٢٢ في المقياس الاجتماعي

خامسا: المقياس اللغوي الاتصالي:

- هذا المقياس يقيس مقدرة الطفل اللغوية لذلك يشترط أن يكون النطق للكلمات وأسماء الأشياء والأدوات واضح ولا يقبل ما هو بديل عن اللغة، أما بالنسبة للطفل الأصم حيث أن طريقة تعامله أما بالإشارة أو حركة الشفاه فيشترط إذا لم يكن قادرا على التعامل بحركة الشفاه أن ينجح في البنود الاختبارية بالكتابة مثال لأحد الأسئلة وهو يقول اسمه كاملا إذا استطاع الطفل مجرد كتابة اسمه بمجرد سؤاله فيعتبر نجاح له وإذا لم يعرف فيعتبر فشل.
- س + ٧ المقصود منه أن يقول كلمات أو شبه كلمات ليعبر عما يريد مثل أن يقول (ننه) كتعبير عن رغبته في الأكل، أو (كخة) كتعبير عن رغبته في شرب الماء أو يقول (كخة) كتعبير عن الشيء القذر أو (ككة) للذهاب إلى الحمام
- س + ١٠ س + ١٢ يرتبطان ببعضهما فإذا فشل الطفل في سؤال رقم ١٠ هذا يعني فشله في سؤال ١٢ لأنه أصعب منه ولكن ليس معنى نجاحه في س ١٠ نجاحه في س ١٢ فربما يفشل فيه لأنه أصعب منه
- جميع الأسئلة في المقياس اللغوي تتدرج في الصعوبة وجميعها مترابطة مع بعضها لذلك يجب مراعاة ذلك والالتزام بما يقوله أي بند اختباري

ملاحظة: في حالة عدم مقدرة المدرسة المنزلية أو القائم بالاختبار تحديد الإجابة الصحيحة أو الحكم على المحاولة التي يقوم بها الطفل إما بالفشل أو النجاح فيجب أن يطلب من



برنامج بورتج

معهد النجاح للطفولة
An-Najah Child Institute

نابلس - ص.ب. 7.707 هاتف: 2352570 ، (972) (09) فاكس: 2352575 (972) (09)
Nablus - P.O.Box 7,707 Tel. (972) (09) 2352570 Fax: (972) (09) 2352575
Email: acinaiah@naiah.edu Web Sit: www.naiah.edu

جامعة النجاح الوطنية

كلية الدراسات العليا

التحقق من صحة مقياس فاينلاند للسلوك التكيفي في اللغة العربية ضمن السياق

الفلسطيني

إعداد

سوار سعادته عبد الستار عبد القادر

إشراف

د. دينيز بيرت

د. علي بركات

قدمت هذه الأطروحة استكمالاً لمتطلبات درجة الماجستير في علم النفس الاكلينيكي بكلية

الدراسات العليا في جامعة النجاح الوطنية في نابلس - فلسطين

2019

ب

التحقق من صحة مقياس فاينلاند للسلوك التكيفي في اللغة العربية ضمن السياق الفلسطيني

إعداد

سوار سعادته عبد الستار عبد القادر

إشراف

د. دينيز بيرت

د. علي بركات

الملخص

اليوم هناك حاجة ناشئة لأدوات التقييم النفسي التي يمكن استخدامها داخل وعبر الثقافات والدول. كان الهدف من هذا البحث هو تحديد ما إذا كان من الممكن استخدام نسخة عربية من مقياس فاينلاند للسلوك التكيفي - II (VABS-II) لقياس السلوك التكيفي لدى الأطفال في السياق الفلسطيني. هذه الدراسة كانت دراسة غير تجريبية مع عينة ملائمة تبحث العلاقة بين نتائج الأبعاد في كلا الاختبارين؛ نتائج VABS-II ومقياس Portage. تم تحليل عيّنتين من المشاركين؛ تم جمع وإنتاج عينة ملائمة مجموعها 56 من الذكور والإناث من الأطفال (الذين تتراوح أعمارهم بين 2-9) بما في ذلك مجموعة من الأطفال ذوي خطورة عالية الذين أحيلوا إلى مركز محلي متعدد الخدمات للاضطرابات التطورية العصبية (العدد = 26). المجموعة الضابطة تألفت من أطفال ملتحقين بمدرسة ابتدائية خاصة محلية في شمال الضفة الغربية (العدد = 30). أظهرت النتائج أنه في المجالات التطورية الخمسة التي تم اختبارها (الادراكي، الاتصالي، الاجتماعي، المهارات الحركية، ومهارات الحياة اليومية) كانت اختلافات ملحوظة ذات دلالة احصائية في بعض المجالات لدى المجموعة الضابطة. لوحظت اختلافات طفيفة في المجال الادراكي والمهارات الحركية لدى بعض المجموعات الفرعية التي قد تكون لها صلة بالاختلافات في نطاق المهام المستخدمة في كل اختبار. بينما، لم تكن هناك اختلافات ملحوظة لدى مجموعة الاطفال ذوي خطورة عالية. الدلالات المترتبة على هذه النتائج هي أن النسخة العربية من VABS-II هي مقياس مناسب لتقييم السلوك التكيفي وغير التكيفي في السياق فلسطيني حيث أنه يفي بمعيار المقاييس التي تم التحقق من صحتها سابقاً مع إضافة الفائدة غير المتوفرة في اختبار البورتج (Portage)، بما في ذلك مقياس السلوك التكيفي الشامل، مقياس السلوك غير التكيفي، نتائج -

ج

T الموحدة، ومقاييس موحدة للعمر الشامل والكامل من سن الولادة حتى جيل 90. أبحاث إضافية
تلتزم لاستكشاف المزيد من التحقيقات لتقييم كفاءة VABS-II في الفئات العمرية الأكبر سناً
والأصغر سناً غير المدرجة في هذه الدراسة.

