

This is the post-print version of a paper published in Quality of Life Research.

Citation for the original published paper:

Fernández, M., Gómez, L. E., Arias, V. B., Aguayo, V., Amor, A. M., Andelic, N., & Verdugo, M. A. (2019). A new scale for measuring quality of life in acquired brain injury. *Quality of life Research*, 28(3), 801-814. doi: 10.1007/s11136-018-2047-5

## A new scale for measuring quality of life in acquired brain injury

### Abstract

**Purpose.** A common and frequent consequence of an acquired brain injury (ABI) is the diminished quality of life (QoL) of affected people. Because the majority of existing QoL instruments assess the health-related domains, new instruments that allow for the evaluation of the QoL from an integral perspective that takes into account the context and personal factors of the individual are warranted. Hence, the purpose of this study is to develop and validate an instrument with these characteristics.

**Methods.** The CAVIDACE scale is a new 64-item specific instrument to assess QoL in people with ABI based on a third-person perspective. The validation sample comprised 421 adults with ABI, with ages ranging from 17 to 90 years ( $M=53.12$ ;  $SD=14.87$ ). The scale was completed by 97 professionals and 58 family members. Validity evidence based on the internal structure of the scale was provided through confirmatory factor analyses. Reliability was analyzed in terms of internal consistency and inter-rater reliability.

**Results.** The results supported the internal structure of the scale, based on the theoretical and assessment framework in which QoL is composed of eight intercorrelated first-order domains (CFI=.890, RMSEA=.065, SRMR=.071). The internal consistency was good or excellent for the eight domains (ordinal alpha ranging from .81 to .93). The inter-rater reliability was very high (.97).

**Conclusions.** The CAVIDACE scale is found to be a specific instrument with excellent psychometric properties that is helpful for the assessment of QoL in people with ABI, both in clinical practice and for research purposes.

**Keywords.** Quality of life, acquired brain injury, psychometric properties, evidence-based practices, outcome measure, CAVIDACE scale.

## **A new scale for measuring quality of life in acquired brain injury**

After an acquired brain injury (ABI), people may experience a wide range of different impairments (e.g., functional, cognitive, emotional and social) as a consequence of the injury [1]. These changes may affect people's life differently, depending on the cause (i.e., etiology: traumatic brain injury, stroke, tumor, anoxia, or infection), the degree of severity, and the individual's personal characteristics, among others. However, a common and frequent consequence after an ABI is the negative impact that these alterations have on the quality of life (QoL) of injured people, which has been reported to be significantly diminished [2, 3, 4].

The increased rates of ABI over the last years and the situations of disability and dependency that often remain after recovery have made many professionals and researchers to be interested in the personal outcomes of QoL after an ABI [5]. One of the reasons is that considering the personal outcomes in QoL allows professionals to obtain a personal measure to evaluate the efficacy and efficiency of the strategies planned and the interventions conducted. Moreover, planning an intervention based on personal goals and preferences, and appropriate models, makes interventions meaningful for the individual, ensuring the compliance with the rights of persons with disabilities [6]. These aspects highlight the importance of studying QoL in the ABI population. Therefore, the presence of adequate and specific assessment scales becomes a priority.

Currently, there are several instruments available to assess health-related quality of life (HRQoL) in ABI. These instruments are both generic and disease-specific. The Medical Outcomes 36-Item Short Form Health Survey (SF-36) [7] is the most commonly used generic tool to assess HRQoL in people with ABI [8]. Among the specific tools, the European Brain Injury Questionnaire (EBIQ) [9] and the Quality of Life after Brain Injury (QOLIBRI) scale [10, 11, 12] have been developed, validated and adapted specifically for ABI and are widely used in research and professional practice [13]. However, the outcomes obtained from these specific assessment scales focus only on some aspects related to QoL. For example, the EBIQ assessment focuses on only three aspects, cognitive, emotional, and social difficulties; and the QOLIBRI scale is based on a six-domain model in which items refer to "satisfaction" aspects (satisfaction with cognition, self, life and daily autonomy, and social relationships) and "bothered" aspects (feeling bothered by emotions and physical problems).

These HRQoL instruments are self-reported. In patients with ABI, the responses may be influenced, for example, by cognitive deficits, including an altered awareness leading to unreliable assessment [3]. Hence, there is a need for a more reliable assessment of QoL that includes contextual factors in the evaluation [14] and moves the current health-related approach towards a psychosocial approach that may improve professional practices. Based on this approach, the CAVIDACE scale (calidad de vida en daño cerebral in Spanish; quality of life in brain injury in English) was developed. This is a specific tool to assess the QoL of adults with ABI from a comprehensive framework in which the evaluation of an individual's QoL reflects not only the health condition but also the context in which it is involved.

The QoL framework adopted for the development of the instrument was the individual QoL model proposed by Schalock and Verdugo [15]. In this model, QoL is defined as a multidimensional phenomenon composed of eight core domains of personal well-being: emotional well-being (EW), physical well-being (PW), material well-being (MW), self-determination (SD), interpersonal relationships (IR), social inclusion (SI), personal development (PD), and rights (RI). These domains are assessed through domain-referenced indicators and influenced by both personal characteristics and environmental factors. The core domains are the same for all people, although they may vary individually in relative value and importance. The concept encompasses objective and subjective components, and the assessment of QoL domains is based on culturally sensitive indicators [16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26].

This model, backed by many years of research in both the national and international scope, has been widely used in the field of disability, mainly in the intellectual and developmental disabilities [23, 24]. In recent years, it has been expanded and generalized to other diagnostic groups that are at risk of social exclusion and other human service recipients, such as those with mental health problems, substance dependence, and physical and sensory disabilities, the elderly [18], and individuals with ABI [27]. These results reinforce the fact that the core domains of QoL can also be generalized also to other vulnerable groups [28]. The operationalization of the concept in ABIs allows organizations and centers that offer services to individuals with ABI to evaluate personal outcomes and thus to improve the delivery of services and the planning of interventions based on their specific needs [29, 30, 31, 32, 33].

To develop the field-test version of the CAVIDACE scale, a previous study was conducted to obtain a wide pool of adequate items to assess QoL in this population. Authors et al. [27] explained the first

stages of the development of the scale based on an extensive review of the scientific literature, a group discussion with professionals who provide services to people with ABI, and the selection of the most relevant indicators and items. They also describe the procedure of the Delphi study, a methodology to provide content validity for the instrument with the collaboration of 14 experts in ABI. The results of the Delphi study confirmed the content validity of the 120 items that were part of the field-test version of the scale, with very high agreement between the judges ( $M=.82$ ).

The objective of this paper is to describe the validation process of the CAVIDACE scale. To ensure the quality of its measurements, it is necessary to subject the instrument to a validation process, including the process of selecting the most relevant and significant items, as well as the analysis of the psychometric properties of the scores obtained in a heterogeneous sample of people with ABI (i.e., validity and reliability). Valid and reliable instruments are cornerstones of clinical research because they are necessary for the results to be accurately applied and interpreted. In the assessment of QoL, it is particularly important to evaluate the methodological quality of studies in which the measurement properties of the instruments are assessed according to specific standards. Thus, we applied the Consensus-based Standards for the selection of health Measurement Instruments (COSMIN) checklist [34], which is widely used for this purpose [35, 36, 37].

## **Method**

### ***Participants***

The field-test version of the CAVIDACE scale was applied to 421 adults with ABI. The inclusion criteria were a) having suffered an ABI; b) being 16 years or older at the time of the injury; c) currently attending or previously attended rehabilitation centers or specific centers that offer services and support to this population; and d) having signed the consent to participate in the study.

Table 1 summarizes the main sociodemographic and clinical characteristics that describe the sample. According to the sociodemographic characteristics, slightly more than half of the sample were men ( $n=253$ ; 60%). Their ages ranged from 17 to 91 years ( $M=53.12$ ;  $SD=14.87$ ). Half of the sample were married or cohabiting (49.5%), and the most common type of home was the family home (71.4%). According to the clinical data, the date of injury revealed that the mean years since the time of the injury until the present was 8 years ( $M=8.12$ ,  $SD=7.30$ ), and the main causes of the ABI were a cerebrovascular accident (56.3%), followed by a traumatic brain injury (21.9%).

**Table 1**Sociodemographic and clinical characteristics of the ABI sample ( $N=421$ )

		Frequency (%)
Gender	Male	253 (60%)
	Female	168 (40%)
Age (years)	Mean ( <i>SD</i> )	53.12 (14.87)
	Range	17-91
Time since the injury (years)	Mean ( <i>SD</i> )	8.12 (7.30)
	Range	1-57
Etiology of the injury	Cerebrovascular accident	237 (56.3%)
	Traumatic brain injury	92 (21.9%)
	Cerebral anoxia	25 (5.9%)
	Cerebral tumors	32 (7.6%)
	Infection diseases	17 (4%)
	Other	18 (4.3%)

The assessment of QoL was performed by the health professionals or relatives who knew the assessed person well. This involved the following inclusion criteria: knowing the person (a) for at least three months; (b) in different contexts; and (c) for prolonged periods of time. The assessment was conducted by 155 informants: 97 of them were professionals (the average number of scales completed by professionals was 6) who worked at 17 centers and organizations (the average number of scales completed by filled by center was 29) located throughout Spain; and 58 were relatives, including partners ( $n=25$ ), parents ( $n=16$ ), siblings ( $n=8$ ), children ( $n=8$ ), and friends ( $n=1$ ). In relation to professionals, most of the sample were women ( $n=77$ , 79%), and the most common profession was neuropsychologist (24.7%). The professionals knew the assessed people for periods between three months and 19 years ( $M=2.90$ ,  $SD=3.04$ ; in years), and 81.2% of them had regular contact with the assessed person. In Table 2, the main characteristics of the informants are summarized.

**Table 2**Characteristics of the professionals' sample ( $N=97$ )

		Frequency (%)
Gender	Male	20 (21%)
	Female	77 (79%)
Type of informant	Professional	97 (62.6%)
	Relatives	58 (37.4%)
Profession	Neuropsychologist	24 (24.7%)
	Occupational therapist	22 (22.7%)
	Physiotherapist	11 (11.3%)
	Psychologist	9 (9.3%)
	Speech therapist	9 (9.3%)
	Nursing assistant	7 (7.2%)
	Social educator	4 (4.1%)
	Nurse	2 (2.1%)
	Medical	2 (2.1%)
	Social worker	1 (1%)
	Pedagogist	1 (1%)
	Psychopedagogue	1 (1%)
	Others	4 (4.1%)
Frequency of contact	Several times per week	294 (81.2%)
	Once a week	38 (10.5%)
	Once per two weeks	17 (4.7%)
	Once a month	13 (3.6%)

***Instrument***

The field-test version of the CAVIDACE scale included 120 items, formulated as third-person declarative statements and grouped into the eight core domains (15 items per domain) proposed by Schalock and Verdugo. The scale included 12 items that were negatively worded (i.e., EW03, EW04, EW05, EW06, EW08, IR16, PD26, PD27, SD41, SD44, SD45, RI60). The answer format was a four-point scale (*never*=0, *sometimes*=1, *often*=2, and *always*=3). The scale was completed online or in a hard copy version, and the administration time was approximately 30 minutes.

In addition to the 120 specific items for the QoL evaluation, the scale also included the questions about sociodemographic (age, gender, civil status, educational level, employment situation, type of home/center, type of support and level of dependency) and clinical data (years since the injury, location of the injury, length of coma and post-traumatic amnesia in days, etiology of the lesion, length of rehabilitation and comorbidity) of the assessed person. It also contained questions concerning the informant and the center or organization in which he/she provided support. An application manual was available for consultation for any aspect. Finally, in the scale, a series of nuances appeared that help to specify and clarify certain items.

## ***Procedure***

The recruitment of professionals and participating centers, distributed in different Spanish Autonomous Communities, was conducted by email. The details of the study and the main objectives of the research were specified in the email. Likewise, collaboration was requested for the application of the scales to a large sample of adults with ABI and assistance in recruiting additional ABI professionals through snowball sampling. To attract a large sample of professionals for our study, the request for research collaboration was disseminated through conferences and meetings and posted on the website of the Institute on Community Integration (INICO, University of Salamanca, Spain). All professionals who agreed to participate in the study, either by email or by telephone, reported on the potential number of people with ABI that could be evaluated in their centers.

The second step was to inform each participant about the research project and the procedure in detail and set a deadline. Many professionals preferred to complete the scale in the hard copy version ( $n=309$ ), so these were sent by postal mail. For those who preferred to complete the online version of the scale ( $n=180$ ), a link to access to the online survey was emailed. Regardless of the modality of completion, we sent all participants the application manual for the scale. Telephone and email contact was constant throughout the process and used when there were doubts and when information needed to be communicated. After the informants returned the completed scales, if there were incomplete data, we re-requested that information by email and telephone.

The research protocol was approved by the Bioethics Committee of the University of Salamanca. Informed consent was obtained by each of the participating centers at the beginning of the study. Personal and clinical data were collected, stored and protected according to the Organic Law 15/1999 of December 23 for the Protection of Personal Data (LOPD 15/1999), guaranteeing the confidentiality and anonymity of the participants.

### ***Statistical analysis***

Psychometric properties of the 120 items were analyzed to select the eight items per domain with the best properties according to five criteria: (a) the mean value of the scores for each of the items and their standard deviation; (b) the number of missing data; (c) the corrected homogeneity indexes (*CHI*); (d) the distribution of the responses; and (e) the content of the items. Negatively worded items were reversed before the analyses.

The reliability of the scale was assessed in terms of internal consistency and inter-rater reliability. One of the most commonly used indicators of internal consistency is Cronbach's alpha [38]. Because this index has been criticized when it is used for ordinal items [39], we have also calculated the ordinal alpha. Inter-rater reliability was tested to compare pairs of ratings made by different independent professionals applying the scale to the same subjects at the same moment and situation [40]. The most common index to assess this property is the Intraclass Correlation coefficient (ICC), which reflects both the degree of correlation and the agreement between measurements.

To provide evidence of the validity of the construct, the internal structure of the scale was analyzed using confirmatory factor analysis (CFA) as well as convergent validity and discriminant validity.

Statistical analyses were performed using the Statistical Package for the Social Sciences (SPSS, v.24.0), FACTOR 10.7, and MPlus 7.0.

## **Results**

### ***Item reduction***

The analysis of the psychometric properties of the items allowed the selection of those with better functioning within the scale, reducing the initial pool to a more manageable and reliable one. This analysis was based on a series of criteria that were performed by domains.

First, according to the mean and standard deviation criterion, all items with a mean higher than 2.5 were eliminated to decrease the ceiling effect that is often found in the evaluation of QoL. Likewise, items with an excessively low standard deviation were eliminated. This criterion allowed for the elimination of the 16 items with the highest ceiling effect. The second step was to eliminate those items with a large amount of missing data in the responses, considering them irrelevant or not representative.



Only 2 items were eliminated by this criterion because most of them had already been eliminated in the previous step.

The next step was to calculate the *CHI* of the items. This statistical index helps to understand the contribution of each item to the domain to which it belongs. It is calculated by the Pearson product-moment correlation coefficient, using the discrimination index corrected to avoid bias error (i.e., corrected Pearson's item-total correlation). According to the size of the sample, the minimum value for the selection of the items was set at .30. Fourteen items with scores below .30 were eliminated.

We analyzed the distribution of responses to avoid the answers accumulating mainly in one or two response options instead of being distributed in a normal way (i.e., skewness). Fourteen items were eliminated because more than half of the sample was divided between one or two options. Finally, and to avoid compromising content validity, the analysis considered the content of the items to avoid eliminating items especially relevant to this population or items that were duplicated in meaning and content. Ten items were eliminated by this criterion.

The application of these criteria to the set of 120 initial items allowed us to select the eight items by domain with the best psychometric properties, resulting in a scale composed of 64 items. In Table 3, the process of eliminating items according to the mentioned criteria, is summarized. In Table 4, the resume of means, standard deviations, corrected item-total correlation and Cronbach's alpha of items deleted by domains are summarized.

**Table 3**

Eliminated items in the final version of the scale

	1 <sup>st</sup> step <i>M</i> ≥ 2.5	2 <sup>nd</sup> step Missing data	3 <sup>rd</sup> step <i>CHI</i> < 0.300	4 <sup>th</sup> step Skewness	5 <sup>th</sup> step Content
EW	i011	-	i006, i007, i008, i009, i010	i012	-
IR	i024, i025	-	-	i017, i018, i021, i023	i030
MW	i031, i032, i036, i037, i044	-	i045	-	i034
PD	-	-	i048, i057, i060	i047, i049, i053, i055	-
PW	i061, i074	i070, i071	i073	i066	i064
SD	i090	-	-	i083, i087, i088	i080, i081, i085
SI	-	-	i095, i100, i101	-	i093, i096, i097, i099,
RI	i106, i108, i111, i112, i118,	-	i114	i109	-
N items	16	2	14	14	10

EW: emotional wellbeing; IR: interpersonal relationships; MW: material wellbeing; PD: personal development; PW: physical wellbeing; SD: self-determination; SI: social inclusion; RI: rights.

**Table 4**

Properties of the 64 final items of the CAVIDACE scale by domains

Domain	Item	<i>M</i>	SD	Corrected Item- Total Correlation	Cronbach's Alpha if Item Deleted
EW	1	1,62	0,73	0,52	0,77
	2	1,67	1,00	0,49	0,77
	3	2,20	0,78	0,44	0,78
	4	2,11	0,83	0,51	0,77
	5	2,22	0,71	0,52	0,77
	6	2,25	0,82	0,50	0,77
	7	1,73	0,79	0,49	0,77
	8	1,64	1,12	0,58	0,76
IR	9	1,78	0,88	0,56	0,82
	10	2,06	0,82	0,59	0,82
	11	1,45	0,97	0,33	0,85
	12	1,95	0,83	0,50	0,83
	13	1,41	1,06	0,67	0,80
	14	1,31	1,02	0,73	0,79
	15	1,23	1,00	0,66	0,80
	16	1,89	1,02	0,51	0,82
MW	17	2,25	0,82	0,35	0,77
	18	1,98	0,90	0,38	0,77
	19	2,16	1,00	0,41	0,77
	20	2,47	0,75	0,61	0,73
	21	2,27	0,90	0,52	0,74
	22	2,46	0,72	0,57	0,73
	23	2,46	0,63	0,51	0,75
	24	2,53	0,61	0,56	0,74
PD	25	1,30	0,88	0,66	0,73
	26	1,48	0,92	0,50	0,76
	27	1,59	0,97	0,52	0,76
	28	1,28	0,95	0,49	0,76
	29	1,88	0,81	0,45	0,77
	30	0,98	1,02	0,47	0,77
	31	1,99	0,84	0,34	0,78
	32	1,85	0,89	0,49	0,76
PW	33	2,13	0,81	0,53	0,66
	34	2,34	1,03	0,31	0,71
	35	1,83	0,97	0,45	0,68
	36	2,30	0,77	0,35	0,70
	37	2,14	0,90	0,50	0,67
	38	2,35	0,82	0,43	0,68
	39	2,54	0,71	0,39	0,69
	40	2,10	0,78	0,32	0,70
SD	41	1,75	1,00	0,75	0,89
	42	1,95	1,02	0,60	0,91
	43	1,65	1,04	0,77	0,89
	44	1,99	1,10	0,71	0,90
	45	1,80	1,08	0,82	0,89
	46	2,04	1,00	0,74	0,89
	47	1,29	1,07	0,79	0,89
	48	2,04	0,98	0,46	0,92
SI	49	1,35	1,05	0,59	0,87
	50	1,68	0,96	0,63	0,86
	51	1,76	0,95	0,70	0,85
	52	1,60	0,95	0,50	0,87
	53	1,41	0,91	0,62	0,86
	54	1,41	0,89	0,74	0,85
	55	1,32	0,90	0,73	0,85
	56	1,89	0,97	0,58	0,86
RI	57	2,53	0,70	0,42	0,68
	58	2,28	0,78	0,34	0,70
	59	1,82	1,09	0,31	0,72
	60	2,43	0,79	0,38	0,69
	61	2,07	0,97	0,50	0,66
	62	2,47	0,76	0,48	0,67
	63	2,76	0,50	0,35	0,70
	64	2,59	0,63	0,56	0,66

EW: emotional wellbeing; IR: interpersonal relationships; MW: material wellbeing; PD: personal development; PW: physical wellbeing; SD: self-determination; SI: social inclusion; RI: rights.

**Internal consistency**

The Cronbach’s alpha and ordinal alpha values were adequate (Table 5). For the ordinal alpha, coefficients varied between .81 (physical wellbeing) and .93 (self-determination). Except for emotional wellbeing, there was a little internal consistency loss for the rest of the domains, with the greatest value lost in physical wellbeing.

**Table 5**  
Comparison of Cronbach’s alphas for the field-test version and the final version of the scale

		EW	IR	MW	PD	PW	SD	SI	RI
Cronbach , s alpha	Field-test version	.74	.87	.79	.82	.75	.93	.87	.74
	Final version	.80	.84	.77	.79	.71	.91	.87	.71
	Difference	+.06	-.03	-.02	-.03	-.04	-.02	0	-.03
Ordinal alpha	Field-test version	.80	.90	.88	.86	.86	.94	.91	.84
	Final version	.84	.88	.87	.83	.81	.93	.90	.82
	Difference	+.04	-.02	-.01	-.03	-.05	-.01	-.01	-.02

EW: emotional wellbeing; IR: interpersonal relationships; MW: material wellbeing; PD: personal development; PW: physical wellbeing; SD: self-determination; SI: social inclusion; RI: rights.

**Inter-rater reliability**

The analysis of the inter-rater reliability was tested in a sample of 50 adults with ABI. The raters were two independent professionals who applied the CAVIDACE scale to the same subjects in the same period. The ICC value obtained was very high (.969), with its 95% confidence interval ranging between .955 and .980. In Table 6, complete information about the results of the ICC calculation is shown.

**Table 6**  
Results of ICC calculation, single-rating, absolute-agreement, and 2-way random-effects model

	Intraclass Correlation	95% Confidence Interval		F Test with True Value 0			
		Lower Bound	Upper Bound	Value	df1	df2	Sig
Single measures	.969	.955	.980	45.850	49	6223	.000

**Confirmatory factor analysis**

Due to the high number of items that constituted each domain ( $n=8$ ), we used four parcels as indicators or observed variables of each latent variable for the fit analysis of the CAVIDACE scale. Each parcel comprised two items and consisted of the sum of items with asymmetry in opposite directions (positive and negative). In this way, the item with the largest positive asymmetry was assigned to the first

parcel along with the item with the largest negative asymmetry, and the items with the next largest asymmetry were assigned to the second parcel (Table 7).

**Table 7**  
Composition of parcels

	Parcel 1	Parcel 2	Parcel 3	Parcel 4
Emotional wellbeing	i01 (.35)	i07 (.08)	i02 (-.15)	i08 (-.24)
	i06 (-.85)	i04 (-.73)	i03 (-.67)	i05 (-.66)
Interpersonal relationships	i15 (.40)	i14 (.27)	i13 (.21)	i11 (.04)
	i16 (-.53)	i10 (-.33)	i09 (-.18)	i12 (-.08)
Material wellbeing	i18 (-0.51)	i23 (-0.80)	i19 (-.84)	i17 (-.91)
	i20 (-1.36)	i22 (-1.29)	i21 (-1.1)	i24 (-.94)
Personal development	i30 (.72)	i25 (.17)	i28 (.14)	i32 (-.13)
	i31 (-.37)	i27 (-.26)	i29 (-.21)	i26 (-.17)
Physical wellbeing	i40 (-.38)	i35 (-.41)	i33 (-.65)	i37 (-.78)
	i39 (-1.50)	i34 (-1.38)	i38 (-1.16)	i36 (-.86)
Self-determination	i47 (.25)	i43 (-.18)	i41 (-.34)	i45 (-.40)
	i44 (-.65)	i46 (-.64)	i48 (-.57)	i42 (-.56)
Social inclusion	i55 (.34)	i53 (.25)	i49 (.24)	i54 (.21)
	i56 (-.38)	i51 (-.17)	i52 (-.13)	i50 (-.09)
Rights	i59 (-.42)	i61 (-.61)	i58 (-.75)	i64 (-1.35)
	i63 (-2.25)	i57 (-1.46)	i60 (-1.45)	i62 (-1.36)

Note: Asymmetry values are between parentheses.

Next, the fit of four CFA models was compared. These models were specified based on those proposed in Gómez et al. [19]: (a) QoL as a unidimensional construct (M1); (b) QoL as eight first-order correlated factors (M2) [15]; and (c) QoL as eight first-order factors and a general second-order factor of QoL (M3) [41]. Finally, a bifactor model (M4) [42] representing an alternative specification of M3 was estimated. The models were estimated using robust maximum likelihood (MLR) implemented in Mplus 7.0. In the estimation of the models, non-independence between the observations made by the same evaluators was considered (i.e., type=COMPLEX within MPlus). The results are displayed in Table 8. The unidimensional model obtained an unacceptable fit to the data ( $RMSEA=.122$ ,  $CFI=.567$ ,  $SRMR=.108$ ). Compared to the others, the eight correlated first-order factors showed a better fit in general terms than the hierarchical model ( $\Delta RMSEA= -.009$ ,  $\Delta CFI=.046$ ) and was more plausible according to

absolute fit indexes such as AIC ( $\Delta AIC = -283$ ), ABIC ( $\Delta ABIC = -245$ ), and BIC ( $\Delta BIC = -202$ ). The bifactor model was unable to reach convergence. Considering all fit indices, the eight first-order correlated factor model was the best model.

**Table 8**

Standardized factorial loadings for the eight-domain confirmatory model

Model	FP	RMSEA (CI)	CFI	SRMR	AIC	BIC	ABIC
M1 (one-dimensional)	96	.122 (.118-.126)	.567	.108	43947	44335	44031
M2 (eight correlated factors)	124	.065 (.060-.068)	.890	.071	41594	42095	41702
M3 (second order factor)	104	.074 (.069-.078)	.844	.094	41877	42297	41947
M4 (bifactor)				nc			

FP: Free parameters from the base-line model; RMSEA: Root mean square error of approximation; CI: RMSEA confidence interval; CFI: Comparative fit index; AIC: Akaike information criterion; BIC: Bayesian information criterion; ABIC: Sample-size adjusted BIC; nc= no convergence.

Standardized factorial loadings, model-based reliability (McDonald's omega), and an estimation of convergent validity for the factors using the average variance extracted (AVE) are shown in Table 9. The factorial loadings ranged from .46 to .90. Omega indices were between .77 (MW) and .91 (SD). AVE values were close to or greater than .50, suggesting good convergent validity of the factors.

**Table 9**

Standardized factorial loadings for the eight-domain confirmatory model

	EW	IR	MW	PD	PW	SD	SI	RI
Parcel 1	0.737	0.815	0.763	0.601	0.778	0.881	0.821	0.471
Parcel 2	0.753	0.897	0.732	0.770	0.455	0.848	0.851	0.767
Parcel 3	0.767	0.838	0.583	0.646	0.616	0.783	0.712	0.596
Parcel 4	0.677	0.570	0.629	0.788	0.837	0.879	0.859	0.729
AVE	0.54	0.62	0.46	0.50	0.47	0.72	0.66	0.42
Omega	0.82	0.87	0.77	0.80	0.77	0.91	0.89	0.74

AVE: Average Variance Extracted; SI: social inclusion; SD: self-determination; EW: emotional wellbeing; PW: physical wellbeing; MW: material wellbeing; RI: rights; PD: personal development; IR: interpersonal relationships.

Finally, the correlations between the factors (Table 10) showed a range between .31 (PW-SI) and .86 (PD-SD). Discriminant validity was checked by comparing the highest correlation with the square of the AVE value in each factor (see diagonal of Table 10). For a factor to be considered to have adequate discriminant validity, the square of the AVE value must be greater than the highest observed correlation in that factor [43], a condition that was met in most cases.

**Table 10**

Correlations between the eight domains

	EW	IR	MW	PD	PW	SD	SI	RI
EW	<b>.73</b>							
IR	.66	<b>.79</b>						
MW	.34	.44	<b>.68</b>					
PD	.75	.55	.48	<b>.71</b>				
PW	.41	.42	.62	.35	<b>.69</b>			
SD	.63	.49	.38	.86	.19	<b>.85</b>		
SI	.50	.69	.53	.58	.31	.56	<b>.81</b>	
RI	.33	.46	.66	.51	.45	.48	.42	<b>.65</b>

Square root of the AVE is on the diagonal (in bold), and the inter-factor correlations are out of the diagonal. EW: emotional wellbeing; IR: interpersonal relationships; MW: material wellbeing; PD: personal development; PW: physical wellbeing; SD: self-determination; SI: social inclusion; RI: rights.

### Discussion

The main objective of this paper was to describe the development and validation process of the CAVIDACE scale, a QoL measurement instrument to be used with the ABI population to improve personal outcomes and guide support and interventions. The results suggest that the CAVIDACE scale has good psychometric properties.

The internal consistency was good to excellent for all sub-scales, and the values obtained with the field-test version of the scale (120 items) were very similar to those obtained in the final version (64 items). According to the inter-rater reliability analyses, we can conclude that the observers were consistent in their responses, probably because they were all well trained in the administration of the scale and familiar with the QoL model in use.

The results supported the internal structure of the scale based on the theoretical and assessment framework in which QoL is composed of eight intercorrelated first-order domains. This model showed better fit than one-dimensional and second-order models of QoL. However, the final model showed a sub-optimal CFI (.89) according to the most widely used cutoff (.95) [44]. One possible reason for this result is the complexity of the model itself combined with the overly restrictive assumptions of the independent-clusters model of CFA (e.g., that all the cross-loadings are exactly zero) [45]. In such a model, the accumulation of multiple but small and non-substantive errors of specification can lead to a substantial decrease in fit [46]. It would therefore be advisable to explore the above hypothesis by estimating less

restrictive factorial models on larger samples (e.g., by means of exploratory structural equation modeling) [47]. In addition, it is necessary to consider that, paradoxically, sometimes CFI and RMSEA tend to penalize models with better measurement quality (i.e., with higher factor loadings) [48] and that the cutoff values traditionally used to judge fit are largely arbitrary [49].

With respect to convergent and discriminant validity, the self-determination domain stood out, while rights and material wellbeing were the least discriminant. This result, together with the worst fit of the second-order model, suggests that the domains of QoL are empirically separable. Furthermore, these results support the conclusion that the items that make up the scale constitute an appropriate operationalization of the QoL construct for adults with ABI who are attending social services in our country. Thus, it seems to be an appropriate and helpful tool for guiding evidence-based practices whose main utility is to provide the best available evidence to make clinical and organizational decisions [50].

Some limitations of the study should be emphasized. First, the recruitment process of the participants was based on convenience and snowball sampling. These procedures allow us to obtain an appropriate group of a global network of ABI professionals and are effective for recruiting a representative sample of the ABI population, which was especially relevant for our study. Nevertheless, the non-probabilistic nature of the sample suggests caution in generalizing the results to the population. Second, this evaluation is a report from a third person (professionals/relatives). It would be interesting, as a future line of research, to develop a self-report version that captures the perceptions of people with ABI. Third, in this study, we focused on the internal structure and general psychometric properties of the scale. Further evaluation using alternative analytic approaches such as Item Response Theory could be of interest in addition to a testing of the responsiveness and concurrent validity of the CAVIDACE scale.

The scale validation adheres to the majority of methodological standards proposed in the COSMIN checklist [51], covering the following aspects: (a) internal consistency and inter-rater reliability, presented in this paper; (b) content validity through a Delphi study [27]; and (c) construct validity, based on a CFA. Criterion validity and responsiveness were not assessed in this study despite being one COSMIN's standard. This will be pursued in a future line of research.

In conclusion, the results of this study provide support for the good psychometric properties of the CAVIDACE scale, which can be a useful measure of QoL outcomes in the clinical and research contexts



and, therefore, in the personal sphere. With regard to the clinical context, the use of an evaluation scale based on a global and systemic approach that considers the main needs of the person will help professionals plan and guide the provision of services and individualized rehabilitation in a more appropriate manner. In terms of the research context, the results obtained from the application can be considered key and comparable information that will greatly help to improve the understanding of the condition. Finally, considering people with ABI and their relatives as the central axis of the activities will contribute to focusing rehabilitation and support to meet the desires of people with ABI, potentially leading to improvement in the QoL. Future research can validate and adapt the CAVIDACE scale to different languages and contexts.

**Compliance with Ethical Standards:**

Funding: This study was funded by Spanish Ministry of Economy and Competitiveness (Grant PSI2015-65193-P [MINECO/FEDER, UE]).

Conflict of Interest: The authors declare that they have no conflict of interest.

Ethical approval: All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent: Informed consent was obtained from all individual participants included in the study.

## References

1. Turner-Stokes, L., Pick, A., Nair, A., Disler, P. B., & Wade, D. T. (2015). Multi-disciplinary rehabilitation for acquired brain injury in adults of working age. *Cochrane Database of Systematic Reviews*, 2015 (12), 1-67. doi: 10.1002/14651858.CD004170.pub3
2. Blicher, J. U., & Nielsen, J. F. (2008). Does long-term outcome after intensive inpatient rehabilitation of acquired brain injury depend on etiology? *NeuroRehabilitation*, 23(2), 175-183.
3. Dijkers, M. P. (2004). Quality of life after traumatic brain injury: A review of research approaches and findings. *Archives of Physical Medicine and Rehabilitation*, 85, 21-35.
4. Wolters, G., Stapert, S., Brands, I., & Van Heugten, C. (2010). Coping styles in relation to cognitive rehabilitation and quality of life after brain injury. *Neuropsychological Rehabilitation*, 20(4), 587-600.
5. Bullinger, M. (2002). Quality of life in patients with traumatic brain injury-basic issues, assessment and recommendations. *Restorative Neurology and Neuroscience*, 20(3, 4), 111-124.
6. Verdugo, M. A., Navas, P., Gómez, L. E., & Schalock, R. L. (2012). The concept of quality of life and its role in enhancing human rights in the field of intellectual disability. *Journal of Intellectual Disability Research*, 56(11), 1036-1045.
7. Ware Jr, J. E., & Sherbourne, C. D. (1992). The MOS 36-item short-form health survey (SF-36): I. Conceptual framework and item selection. *Medical Care*, 30(6), 473-483.
8. Findler, M., Cantor, J., Haddad, L., Gordon, W., & Ashman, T. (2001). The reliability and validity of the SF-36 health survey questionnaire for use with individuals with traumatic brain injury. *Brain Injury*, 15(8), 715-723.
9. Sopena, S., Dewar, B. K., Nannery, R., Teasdale, T. W., & Wilson, B. A. (2007). The European brain injury questionnaire (EBIQ) as a reliable outcome measure for use with people with brain injury. *Brain Injury*, 21(10), 1063-1068.
10. von Steinbüchel, N., Wilson, L., Gibbons, H., Hawthorne, G., Höfer, S., Schmidt, S., ... QOLIBRI TASK Force. (2010). Quality of life after brain injury (QOLIBRI): Scale development and metric properties. *Journal of Neurotrauma*, 27(7), 1167-1185.
11. von Steinbüchel, N., Wilson, L., Gibbons, H., Hawthorne, G., Höfer, S., Schmidt, S., ... QOLIBRI TASK Force. (2010). Quality of life after brain injury (QOLIBRI): Scale validity and correlates of quality of life. *Journal of Neurotrauma*, 27(7), 1157-1165.

12. Truelle, J. L., Koskinen, S., Hawthorne, G., Sarajuuri, J., Formisano, R., Von Wild, K., ... Bullinger, M. (2010). Quality of life after traumatic brain injury: The clinical use of the QOLIBRI, a novel disease-specific instrument. *Brain Injury*, *24*(11), 1272-1291.
13. Nichol, A. D., Higgins, A. M., Gabbe, B. J., Murray, L. J., Cooper, D. J., & Cameron, P. A. (2011). Measuring functional and quality of life outcomes following major head injury: Common scales and checklists. *Injury*, *42*(3), 281-287.
14. Gómez, L. E., Verdugo, M. A., Arias, B., & Navas, P. (2010). Consideraciones conceptuales y metodológicas sobre el desarrollo de escalas multidimensionales de calidad de vida centradas en el contexto [Conceptual and methodological recommendations about the development of multidimensional quality of life scales focused on the context]. *Siglo Cero*, *41*(2), 59-80.
15. Schalock, R. L., & Verdugo, M. A. (2002). *Handbook on quality of life for human service practitioners*. Washington, DC: American Association on Mental Retardation.
16. Gómez, L. E., Arias, B., Verdugo, M. A., & Navas, P. (2011). An outcomes-based assessment of quality of life in social services. *Social Indicators Research*, *106*(1), 81-93.
17. Gómez, L. E., Peña, E., Arias, B., & Verdugo, M. A. (2016). Impact of individual and organizational variables on quality of life. *Social Indicators Research*, *125*(2), 649-664.
18. Gómez, L. E., Verdugo, M. A., & Arias, B. (2010). Calidad de vida individual: avances en su conceptualización y retos emergentes en el ámbito de la discapacidad [Individual quality of life: advances in the conceptualization, and emerging challenges in the disability field]. *Behavioral Psychology*, *18*(3), 453-472.
19. Gómez, L. E., Verdugo, M. A., Arias, B., & Arias, V. (2011). A comparison of alternative models of individual quality of life for social service recipients. *Social Indicators Research*, *101*(1), 109-126.
20. Jenaro, C., Verdugo, M. A., Caballo, C., Balboni, G., Lachapelle, Y., Otbrebski, W., & Schalock, R. L. (2005). Cross-cultural study of person-centred quality of life domains and indicators: A replication. *Journal of Intellectual Disability Research*, *49*(10), 734-739.
21. Schalock, R. L., Verdugo, M. A., Jenaro, C., Wang, M., Wehmeyer, M., Jiancheng, X., & Lachapelle, Y. (2005). Cross-cultural study of quality of life indicators. *American Journal on Mental Retardation*, *110*(4), 298-311.

22. Schalock, R. L., Baker, A., González, J., van Loon, J., Verdugo, M. A., & Wesley, G. (in press). The use of quality of life scores for monitoring and reporting, quality improvement, and research. *Journal of Policy and Practice in Intellectual Disabilities*.
23. Schalock, R. L., & Verdugo, M. A. (2013). The impact of the quality of life concept on the field of intellectual disability. In M. L. Wehmeyer (Ed.), *The Oxford handbook of positive psychology and disability* (pp. 37-47). New York: Oxford University Press.
24. Schalock, R. L., Verdugo, M. A., & Gómez, L. E. (2011). Evidence-based practices in the field of intellectual and developmental disabilities: An international consensus approach. *Evaluation and Program Planning*, 34(3), 273-282.
25. Schalock, R. L., Verdugo, M. A., Gómez, L. E., & Reinders, H. S. (2016). Moving us toward a theory of individual quality of life. *American Journal on Intellectual and Developmental Disabilities*, 121(1), 1-12.
26. Verdugo M. A., Henao, C. P., Córdoba, L., & Arias. V. B. (2017). Dimensionality and internal structure of the Colombian version of the INICO-FEAPS quality of life scale. *Journal of Intellectual Disability Research*, 61(12), 1094-1103.
27. Author et al. 2017. [details removed for peer review].
28. Schalock, R. L., & Verdugo, M. A. (2014). Quality of life as a change agent. In R. I. Brown & R. Faragher (Eds.), *Challenges for quality of life: Application in education and other social contexts* (pp. 60-72). New York, NY: Nova Science.
29. Gómez, L. E., Verdugo, M. A., Arias, B., Navas, P., & Schalock, R. L. (2013). The development and use of provider profiles at the organization and systems level. *Evaluation and Program Planning*, 40, 17-26.
30. Verdugo, M. A., Gómez, L. E., Arias, B., Navas, P., & Schalock, R. L. (2014). Measuring quality of life in people with intellectual and multiple disabilities: Validation of the San Martín scale. *Research in Developmental Disabilities*, 35(1), 75-86.
31. Schalock, R. L., & Verdugo, M. A. (2012). The transformation of disability organizations. *Journal of Intellectual and Developmental Disabilities*, 51(4), 273-286.
32. Schalock, R. L., & Verdugo, M. A. (2012). *A leadership guide for today's disabilities organizations: Overcoming challenges and making change happen*. Baltimore, MD: Paul Brookes Publishing Co.

33. Schalock, R. L. (2018). Six Ideas That Are Changing the IDD Field Internationally. *Siglo Cero*, 49(1), 21-23.
34. Mokkink, L. B., Terwee, C. B., Knol, D. L., Stratford, P. W., Alonso, J., Patrick, D. L., ... de Vet, H. C. (2010). The COSMIN checklist for evaluating the methodological quality of studies on measurement properties: A clarification of its content. *BMC Medical Research Methodology*, 10(1), 22.
35. Luquiens, A., Whalley, D., Crawford, S. R., Laramée, P., Doward, L., Price, M., ... Falissard, B. (2015). Development of the alcohol quality of life scale (AQoLS): A new patient-reported outcome measure to assess health-related quality of life in alcohol use disorder. *Quality of Life Research*, 24(6), 1471-1481.
36. Thoomes-De Graaf, M., Scholten-Peeters, G. G. M., Schellingerhout, J. M., Bourne, A. M., Buchbinder, R., Koehorst, M., ... Verhagen, A. P. (2016). Evaluation of measurement properties of self-administered PROMs aimed at patients with non-specific shoulder pain and “activity limitations”: A systematic review. *Quality of Life Research*, 25(9), 2141-2160.
37. Terwee, C. B., Mokkink, L. B., Knol, D. L., Ostelo, R. W., Bouter, L. M., & de Vet, H. C. (2012). Rating the methodological quality in systematic reviews of studies on measurement properties: a scoring system for the COSMIN checklist. *Quality of Life Research*, 21(4), 651-657.
38. Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. *Psychometrika*, 16(3), 297-334.
39. Elosua Oliden, P., & Zumbo, B. D. (2008). Coeficientes de fiabilidad para escalas de respuesta categórica ordenada [Reliability coefficients for ordered categorical response scales]. *Psicothema*, 20(4), 896-901.
40. Koo, T. K., & Li, M. Y. (2016). A guideline of selecting and reporting intraclass correlation coefficients for reliability research. *Journal of Chiropractic Medicine*, 15(2), 155-163.
41. Wang, M., Schalock, R. L., Verdugo, M. A., & Jenaro, C. (2010). Examining the factor structure and hierarchical nature of the quality of life construct. *American Journal on Intellectual and Developmental Disabilities*, 115(3), 218-233.
42. Reise, S. P. (2012). The rediscovery of bifactor measurement models. *Multivariate Behavioral Research*, 47(5), 667-696.

43. Fornell, C. G., & Larcker, D. F. (1981). Evaluating structural equation models with unobservable variables and measurement error. *Journal of Marketing Research*, 18(1), 39-50.
44. Hu, L., & Bentler, P. M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modeling: A Multidisciplinary Journal*, 6(1), 1-55.
45. Morin, A. J., Arens, A. K., & Marsh, H. W. (2016). A bifactor exploratory structural equation modeling framework for the identification of distinct sources of construct-relevant psychometric multidimensionality. *Structural Equation Modeling: A Multidisciplinary Journal*, 23(1), 116-139.
46. Marsh, H. W., Morin, A. J., Parker, P. D., & Kaur, G. (2014). Exploratory structural equation modeling: An integration of the best features of exploratory and confirmatory factor analysis. *Annual Review of Clinical Psychology*, 10, 85-110.
47. Asparouhov, T., & Muthén, B. (2009). Exploratory structural equation modeling. *Structural Equation Modeling: A Multidisciplinary Journal*, 16(3), 397-438.
48. McNeish, D., An, J., & Hancock, G. R. (2018). The thorny relation between measurement quality and fit index cutoffs in latent variable models. *Journal of Personality Assessment*, 100(1), 43-52.
49. Lai, K., & Green, S. B. (2016). The problem with having two watches: Assessment of fit when RMSEA and CFI disagree. *Multivariate Behavioral Research*, 51(2-3), 220-239.
50. Verdugo, M. A. (2018). Conceptos clave que explican los cambios en las discapacidades intelectuales y del desarrollo en España [Key concepts and principles that explain changes in the provision of supports for intellectual and developmental disabilities in Spain]. *Siglo Cero*, 49(1), 35-52.
51. Mokkink, L. B., Terwee, C. B., Patrick, D. L., Alonso, J., Stratford, P. W., Knol, D. L., ... de Vet, H. C. (2010). The COSMIN checklist for assessing the methodological quality of studies on measurement properties of health status measurement instruments: An international Delphi study. *Quality of Life Research*, 19(4), 539-549.