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Psychometric Validity and Clinical Usefulness of the Vineland Adaptive Behavior Scales and the AAMD Adaptive Behavior Scale for an Autistic Sample[1]

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Two prominent assessment measures of adaptive behavior were compared and evaluated in terms of their psychometric properties and their clinical usefulness for autistic children and adolescents. The AAMD Adaptive Behavior Scale-School Edition (Lambert & Windmiller, 1981) and the Vineland Adaptive Behavior Scales (Sparrow, Balla, & Cicchetti, 1984) were compared in 15 autistic persons aged 8 to 18. Correlations between the two instruments revealed good concurrent validity. The psychometric properties of the tests were similar to those found in samples of mentally retarded persons. The use of adaptive behavior measures for autistic children and adolescents is encouraged. Clinical advantages and disadvantages of the two tests are discussed.

Adaptive behavior is defined as "the effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected for age and cultural group" (Grossman, 1983, p. 1). The concept of adaptive behavior is closely linked, in both theory and practice, to the concept of mental retardation, which is defined as "significantly

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subaverage general intellectual functioning existing concurrently with *deficits in adaptive behavior* [italics added] and manifested during the developmental period" (Grossman, 1983, p. 1). Adaptive behavior is not a static individual attribute, but must be understood within a developmental context. The skills and abilities assessed vary with both age and intellectual level to some extent (Grossman, 1983; Lambert, 1979; Leland, 1978; Mercer, 1978; Nihira, 1976).

Psychometrically acceptable and clinically useful measures of adaptive behavior have many potential applications: (a) Adaptive behavior deficits are, as mentioned above, an integral part of the definition of mental retardation, and, thus, diagnosis and classification represent a major application. This could include the use of adaptive behavior scores (together with other information) to place children in appropriate special education classrooms, to deinstitutionalize mentally retarded persons, and so on. (b) They can be used to identify an individual's areas of strength and weakness, which is helpful in planning educational/treatment/training programs. (c) The effectiveness of programs or interventions can be evaluated by comparing adaptive behavior scores over time. (d) These scores also provide an objective means of comparing an individual's behavior across settings or when evaluated by different people. (e) They offer a common, standardized way of communicating about important practical issues in clinical practice or applied research.

The usefulness of adaptive behavior scales is not limited to the primarily mentally retarded population but may be extended to other exceptional groups such as those with autism and developmental disorders (Meyers, Nihira, & Zetlin, 1980; Sloan & Marcus, 1981). In fact, since most autistic persons are also mentally retarded, and since deficits in adaptive behavior are a defining feature of mental retardation, it follows that autistic persons should routinely have their adaptive behavior as well as their IQ assessed.

In the TRE-ADD program (Treatment, Research, and Education for Autism and Developmental Disorders), we use a measure of adaptive behavior as part of our routine psychological assessment process. The two we have found most useful are the AAMD Adaptive Behavior Scale-School Edition (ABS-SE; Lambert & Windmiller, 1981) and the new Vineland Adaptive Behavior Scales-Survey Form (VABS; Sparrow, Balla, & Cicchetti, 1984).

The purpose of the present study was to evaluate and compare these two instruments. Specifically, we were interested in several questions: (a) Are similar aspects of the two scales highly correlated with each other, that is, are they measuring the same underlying constructs? (b) What is the relationship between adaptive behavior scores and intellectual functioning in this sample? (c) Are the psychometric properties, such as test–retest reliability, of adaptive behavior measures in this autistic sample comparable to those in the mentally retarded samples in the literature? (d) Are there psychometric and/or clinical considerations that recommend one test over the other?

METHOD

Subjects

The subjects were 15 autistic children and adolescents (13 male, 2 female). Their age ranged from 8 to 18 years ($\bar{x}$ = 12.8, SD = 2.7 years). Their IQ ranged from 18 to 82 ($\bar{x}$ = 33.1, SD = 18.0). Four of the children lived in group homes; the remainder lived at home. The diagnosis of autism was made by at least two independent professionals using DSM-III (American Psychiatric Association, 1980) and NSAC criteria (Ritvo & Freeman, 1978).

Measures

The AAMD Adaptive Behavior Scale–School Edition (ABS-SE)

The ABS-SE is a revision of the Public School Version of the ABS (Lambert, Windmiller, & Cole, 1975), which was based on the general form of the ABS (Nihira, Foster, Shellhaas, & Leland, 1974). The ABS-SE is designed so that the booklet may be completed independently by a teacher or parent, *or* the respondent may be interviewed.

The ABS-SE has two parts. Part I is concerned with *adaptive* behavior and is composed of 9 domains, some of which contain subdomains. Part II consists of 12 domains that express *maladaptive* or psychologically disturbed behaviors.

The ABS-SE may be scored in one or both of two ways, depending upon the purpose of the assessment. If diagnosis/placement is the focus, there is a single Comparison score and five factor scores (Personal Self-sufficiency, Community Self-sufficiency, Personal–Social Responsibility, Social Adjustment, and Personal Adjustment). If educational programming is the focus, scores can be calculated for each of 21 specific domains. Norms are based on a standardization sample of 6,500 children and are tabulated, by age, from 3 to 16 (except for the Comparison score which is available only for age 7 and older), and for each of three classification groups (Regular, Educable Mentally Retarded (EMR), and Trainable Mentally Retarded (TMR). Percentile scores are available for each age and classification group for the Comparison score and the 21 domain scores. Scaled scores are provided for the five factor scores.

The Vineland Adaptive Behavior Scales (VABS)

The VABS is an extensive revision of the Vineland Social Maturity Scale (Doll, 1965). There is a Classroom Edition (for ages 3–12) and two Inter-

view Editions, the Expanded Form and the shorter Survey Form, which was chosen for this study. It is administered as a semistructured interview of the parent or staff member by a psychologist, or other trained professional.

The VABS assesses adaptive behavior using five possible domains. The first three domains are always administered: Communication; Daily Living Skills; and Socialization. The Motor Skills domain is used for children under 6 and the two-part Maladaptive Behavior domain is optional for children 5 years and over. The VABS yields standard scores for the domains and subdomains, and a single score, the Adaptive Behavior Composite. Various other derived scores are also available including percentiles, stanines, adaptive levels, and age equivalents. Norms are tabulated by age, from 0 to 18 and over, and are based on a nationally representative sample of 3,000 individuals. There are, in addition, several supplementary norm groups, including mentally retarded adults, emotionally disturbed children, visually handicapped children, and hearing-impaired children.

Procedure

The children and their parent(s) or group-home worker came to our center on two occasions as part of a larger study. The two visits were approximately 3 months apart (77 days to 94 days; $\bar{x} = 84$ days, $SD = 5.6$ days). Data reported here from the first visit consist of the ABS-SE, and from the second visit include the ABS-SE, the VABS, and an IQ test (WISC-R for 2; Stanford-Binet [3rd ed.] for 13). All testing and interviews were done by the same person (the first author) with the exception of one VABS interview which was done by the second author. The same parent or worker served as respondent for all three adaptive behavior measures in all cases except two. In these two cases, the ABS-SE and VABS on the second visit were completed by the same respondent, but the ABS-SE from the first visit was completed by a different person. Obviously, this could affect the test–retest part of the study, so that analysis was performed with and without these two subjects. This made very little difference to the results and, therefore, all analyses reported here include all 15 subjects.

RESULTS AND DISCUSSION

Psychometric Properties

The concurrent validity of the two instruments was assessed by examining the correlations between the two scales as shown in Tables I, II, and III.

Table I. Correlations of ABS-SE and VABS Summary Scores

ABS-SE score	VABS score			
	Communication domain raw score	Daily living skills domain raw score	Socialization domain raw score	Adaptive behavior composite
Total Part I raw score	.77[b]	.83[b]	.85[b]	.62[a]
Total Part II raw score	−.40	−.38	−.44	−.27
Factor 1 (Personal self-sufficiency)	.50	.70[b]	.47	.38
Factor 2 (Community self-sufficiency)	.77[b]	.84[b]	.85[b]	.69[b]
Factor 3 (Personal–social responsibility)	.60[a]	.64[b]	.61[a]	.52[a]
Factor 4 (Social adjustment)	−.43	−.34	−.42	−.24
Factor 5 (Personal adjustment)	−.23	−.44	−.32	−.30
Comparison score	.47	.58[a]	.58[a]	.60[a]

[a] $p < .05$.
[b] $p < .01$.

Table I provides a comparison of the summary scores. It can be seen that the ABS-SE Total Part I Raw Score (total of 9 positive domains) is highly correlated (.77 to .85) with the three VABS domain raw scores but only moderately correlated (.62) with the Adaptive Behavior Composite. This may be partially accounted for by the fact that 6 of the 15 children scored at the "floor" level on the VABS Adaptive Behavior Composite, thus truncating the range and depressing the correlation coefficient. Notice also that the ABS-SE Comparison score (which is a standardized weighted combination of the first three factor scores) is only moderately correlated (.47 to .60) with the four VABS scores. The two single summary scores, the ABS-SE Comparison score and the VABS Adaptive Behavior Composite, were correlated .60. Both of these are standardized scores with rather limited ranges. However, even correlations in the .60s support the concurrent validity of the two tests, and are comparable to those from other studies correlating two adaptive behavior scales using mentally retarded individuals, correlations that are generally in the .40s to .70s (Britton & Eaves, 1986; Pawlarczyk & Schumacher, 1983; Roszkowski, 1980; Sloan & Marcus, 1981; Sparrow et al., 1984).

A more detailed pattern of intercorrelations among individual domains and subdomains may be seen in Table II. In general, scales with similar sounding names (and overlapping content) were quite well correlated. For example, the two Socialization domain scores were correlated .84; and the VABS Daily Living Skills domain was correlated .83 with the ABS-SE Independent Functioning domain.

It is clear that there is a high degree of relationship among the language/communication and socialization areas. In fact, the ABS-SE Language domain is somewhat better correlated with the VABS Socialization domain and subdomains (.78 to .84) than the VABS Communication domain and subdomains (.28 to .83). This is probably, at least partly, a function of this particular sample since socialization and language/communication deficits are characteristic of autism and tend to occur together (Denckla, 1986; Wing, 1982).

Looking at the columns of Table II it can be seen that the ABS-SE Physical Development and Prevocational domains were not significantly correlated with any of the VABS scores. Also, these were the two least reliable domains of ABS-SE in this study and this, of course, limits their validity. The ABS-SE Physical Development domain would, probably, have been correlated with the Motor Skills domain of the VABS, but since our subjects were all over 6 years of age and had no motor impairments, the Motor Skills domain of the VABS was not administered.

Looking at the rows of Table II, it can be seen that the Receptive Language subdomain of the VABS Communication domain was not significantly correlated with any of the ABS-SE scores. That particular subdomain has relatively few items, most of which are at a developmentally early level (12 of the 13 are below a 3-year level). Thus, it should be interpreted cautiously and certainly not thought of as a receptive vocabulary score.

Table II. Correlations of ABS-SE Part I Domain Raw Scores with VABS Raw Scores

	ABS-SE Part I Domain raw score								
VABS raw score	Independent functioning	Physical development	Economic activity	Language development	Numbers and time	Pre-vocational	Self-direction	Respon-sibility	Social-ization
Receptive	.50	.18	−.05	.28	.17	.12	−.02	.44	.36
Expressive	.67[b]	.15	.51[a]	.83[b]	.84[b]	.30	.41	.68[b]	.63[a]
Written	.40	.35	.36	.67[b]	.72[b]	.35	.36	.38	.49
Communication domain	.69[b]	.28	.38	.79[b]	.78[b]	.33	.35	.66[b]	.65[b]
Personal	.77[b]	.17	.50	.69[b]	.62[a]	.34	.37	.63[a]	.32
Domestic	.69[b]	.11	.56[a]	.55[a]	.54[a]	.29	.37	.65[b]	.24
Community	.76[b]	.08	.62[a]	.91[b]	.89[b]	.23	.58[a]	.71[b]	.72[b]
Daily living skills domain	.83[b]	.14	.61[a]	.79[b]	.75[b]	.33	.48	.73[b]	.47
Interpersonal	.80[b]	.07	.45	.79[b]	.76[b]	.21	.51[a]	.70[b]	.75[b]
Play skills	.60[a]	.31	.56[a]	.78[b]	.77[b]	.06	.30	.39	.85[b]
Coping skills	.69[b]	.19	.54[a]	.79[b]	.80[b]	.15	.47	.57[a]	.80[b]
Socialization domain	.75[b]	.18	.54[a]	.84[b]	.82[b]	.16	.46	.61[a]	.84[b]

[a] $p < .05$.
[b] $p < .01$.

Table III. Correlations of ABS-SE and VABS Maladaptive Behavior Scores

	VABS Maladaptive Behavior domain raw scores	
ABS-SE score	Part 1	Total
Part II Domain raw score		
10. Aggressiveness	.60[a]	.68[b]
11. Antisocial vs. social	.66[b]	.56[a]
12. Rebelliousness	.60[a]	.62[a]
13. Trustworthiness	.15	.16
14. Withdrawal vs. involvement	.34	.40
15. Mannerisms	.48	.63[a]
16. Interpersonal manners	.66[b]	.72[b]
17. Vocal habits	.31	.37
18. Habits	.44	.51[a]
19. Activity level	.65[b]	.68[b]
20. Symptomatic behavior	.63[a]	.65[b]
Total raw score Part II	.73[b]	.74[b]
Factor 4 social adjustment	.64[b]	.66[b]
Factor 5 personal adjustment	.67[b]	.75[b]

[a] $p < .05$.
[b] $p < .01$.

Table III shows the correlations among the various indices of maladaptive behavior on the two scales. It can be seen that correlations for summary scores are moderately high (.60s and .70s) but that individual domain correlations vary considerably (from .15 to .72). The ABS-SE domains Trustworthiness, Withdrawal versus Involvement, and Vocal Habits were not significantly correlated with VABS Maladaptive domain scores. Comparing the two columns in Table III, it seems that the inclusion of the second part of the Maladaptive Behavior domain of the VABS (meant to be used only with supplementary norms groups) is generally associated with slightly higher correlations with ABS-SE domains, although this may be partly a function of the increased range that results. The areas covered by the VABS Maladaptive Behavior domain Part 2 and the ABS-SE Factor 5 represent areas of particular concern in an autistic sample (stereotyped behaviors, unusual vocal habits, bizarre mannerisms, etc.), and the two scales were well correlated in this area (.75) despite the rather poor reliability of Factor 5 of the ABS-SE (see below). Correlations between adaptive and maladaptive behavior scores (not shown) were generally low to moderate and negative.

Correlations were also calculated between the scores of each test and CA, MA, and IQ.[3] Very few scores were significantly related to age though,

[3]Correlations of adaptive behavior scores with CA, MA, and IQ are available on request from the authors.

in general, adaptive behaviors were positively correlated and maladaptive behaviors negatively correlated with age. This pattern of results is probably attributable to the relatively restricted age range and high mean age of the subjects in the present study compared to those of the normative samples reported in the manuals.

MA and IQ were highly correlated with the ABS-SE domains, Language Development and Numbers and Time (.76 to .84) and moderately correlated with other Part I domains (.21 to .57). Total raw score for Part I was correlated .65 and the Comparison score correlated .50 with IQ. This is quite similar to the correlations with IQ mentioned in the ABS-SE manual (Lambert, 1981), which ranged from .24 to .55 with the strongest relationships (about .55) observed for the three "cognitive" domains, Language Development, Numbers and Time, and Economic Activity. Roszkowski and Bean (1980), too, found these three domains most strongly related to IQ. Their correlations for Part I domains ranged from .50 to .76. Interestingly, Sloan and Marcus (1981), using an autistic sample, found all Part I domains significantly correlated with IQ, except Physical Development and Economic Activity (the actual correlations are not reported).

All three VABS domain scores, and many of the subdomian scores were significantly correlated with MA and IQ. The Adaptive Behavior Composite was correlated .70 with MA and .76 with IQ. These correlations are substantially higher than those between IQ and VABS scores presented in the manual (.10s to .40s), although the Communication domain was the most strongly correlated in both cases. The Receptive subdomain, unlike the other Communication domain scores, was not significantly correlated with MA or IQ, but recall the caution expressed earlier about this particular subdomain.

Maladaptive behavior scores from both scales tended to be negatively but not significantly correlated with intellectual level. The manuals and other studies have found no consistent relationship between maladaptive scores and IQ (Lambert, Windmiller, Tharinger, & Cole, 1981; Roszkowski & Bean, 1980; Salagaras & Nettlebeck, 1983, 1984; Sparrow et al., 1984).

The test–retest reliability of the ABS-SE was also assessed. As shown in Table IV, the correlations for the summary scores (in the lower portion of the table) are acceptably high (e.g., Total Part I .95, Total Part II .94, Comparison score .88). Correlations for individual Part I domains range from .30 to .98 ($\bar{x}$ = .75). All were significantly correlated at the .01 level with the exception of Physical Development (on which all subjects in our sample scored at the ceiling) and Prevocational Activity (on which there is a bimodal distribution because of the way it is scored). Recall also that these two domains did not correlate well with any of the VABS scores. The correlations for the Part II domains range from .50 to .90 ($\bar{x}$ = .66). The manual for the ABS-SE does not report test–retest reliability (Lambert, 1981). The

Table IV. Test–Retest Reliability of the ABS-SE

	r
Part I domain raw scores	
1. Independent functioning	.88[b]
2. Physical development	.30
3. Economic activity	.90[b]
4. Language development	.96[b]
5. Numbers and time	.98[b]
6. Prevocational activity	.53[a]
7. Self-direction	.80[b]
8. Responsibility	.75[b]
9. Socialization	.67[b]
Part II domain raw scores	
10. Aggressiveness	.88[b]
11. Antisocial vs. social	.68[b]
12. Rebelliousness	.82[b]
13. Trustworthiness	.60[a]
14. Withdrawal vs. involvement	.71[b]
15. Mannerisms	.75[b]
16. Interpersonal manners	.57[a]
17. Vocal habits	.50
18. Habits	.69[b]
19. Activity level	.86[b]
20. Symptomatic behavior	.90[b]
Summary scores	
Total raw score Part I	.95[b]
Total raw score Part II	.94[b]
Factor 1 (Personal self-sufficiency)	.70[b]
Factor 2 (Community self-sufficiency)	.97[b]
Factor 3 (Personal–social responsibility)	.88[b]
Factor 4 (Social adjustment)	.92[b]
Factor 5 (Personal adjustment)	.68[b]
Comparison score	.88[b]

[a] $p < .05$.
[b] $p < .01$.

correlations seen here are slightly lower than those found in other studies of the test–retest reliability of the general ABS, typically using mentally retarded individuals (Isett & Spreat, 1979; Mayfield, Forman, & Nagle, 1984), but the interval between administrations was much longer in the current study (3 months vs. 2 weeks), and different versions of the ABS were used, so it is difficult to evaluate the significance of this. The only type of reliability coefficients reported in the ABS-SE manual are split-half (internal consistency) coefficients for the five factor scores, and it is interesting to note that Factor 5 (Personal Adjustment) had a rather low split-half coefficient (.62). Its test–retest reliability in the current study, similarly, was rather low (.68) compared to the other factor scores.

In general, given the sample size of the current study, and the cautions mentioned above, the test–retest reliability of the ABS-SE over a 3-month period can be said to be acceptable.

Clinical Usefulness

Given the various uses of adaptive behavior scores mentioned in the introduction and that these scales appear to be reasonably reliable and valid, at least in this study, we strongly recommend the use of the ABS-SE and the VABS for this population. However, we cannot make a clear recommendation of one scale over the other. Both are good tests and we have found both useful with our population. Each has advantages and disadvantages, clinically, depending on the client and the purpose of the assessment.

One basis for comparison between the two scales is in terms of *method of administration.* The VABS must be administered in the form of an interview by a qualified professional, whereas the ABS-SE can be done via interview or can be completed independently by teachers, direct care staff, and most parents. Given the reality that cost-efficiency partially shapes clinical practice, the ABS-SE has an advantage in that a professional interview is not required. On the other hand, a much richer source of clinical information is obtained by interviewing the respondent. Informal questioning revealed that parents in this study unanimously preferred the VABS interview to completing the ABS-SE, even though they were quite capable of doing the ABS-SE. When teachers or parents complete the ABS-SE all calculations should be checked carefully, since there are many opportunities for clerical errors (Givens, 1980; Spreat, 1979). It should be noted here that there is also a Classroom Edition of the VABS which is completed independently by the teacher (Sparrow, Balla, & Cicchetti, 1985), but it is inappropriate for our purposes since it is intended only for 3- to 12-year-olds and does not include the Maladaptive Behavior domain.

The *range of norms* is another difference between the tests. The ABS-SE has norms for 3- to 16-year-olds in Regular, EMR, and TMR placements. This represents a definite advantage for clinicians dealing with mentally handicapped children, since the VABS has no norms for mentally retarded children (although it does have norms for mentally retarded adults, for hearing-impaired, visually handicapped, and emotionally disturbed children). However, the VABS has an advantage in that it covers a wider age range (0 to adult), and the age equivalents mentioned above compensate, to some extent, for the lack of appropriate norms for our purposes.

Another area of contrast between the two scales is the variety and adequacy of derived scores available (see Measures section above). The VABS has an advantage over the ABS-SE in terms of the wide variety of derived

scores available (standard scores with bands of error, percentiles, stanines, adaptive levels, and age equivalents). Age equivalents are particularly useful in clinical practice, despite their statistical limitations. However, we have encountered a problem with VABS age equivalents at the low end of the distribution in that the standard scores and the age equivalents are sometimes ordered differently, thus obscuring interpretation of strengths and weaknesses. A further problem we encountered with the VABS was with the Adaptive Behavior Composite and Domain standard scores, on which one third of our sample scored "off the scale" (i.e., below 29). Silvestein (1986) criticized the standard scores of the VABS for another reason, arguing that they are not equivalent across age groups and domains, but Cicchetti and Sparrow's (1986) rebuttal demonstrated that the standard scores vary only as much as can be explained by sampling variability.

The ABS-SE has fewer options and less flexibility in terms of derived scores. As mentioned above, there are two ways of scoring the ABS-SE (Lambert, 1981; Lambert et al., 1981) and, in either case, the client being assessed is compared to EMR and either TMR or Regular age norms. One way of scoring, meant for classification/placement purposes involves the Comparison score and the five factors. Percentiles are provided for the Comparison score and scaled scores for the five factors. The scaled scores are conveniently comparable to other scaled scores (such as those from the WISC-R), but it should be noted that, because of the way they were derived, the five factor scores do not make use of all the items of the scale, and thus some information is wasted. The Comparison score is a weighted combination of the first three factors, and weighs certain areas much more heavily than others (based on the best discriminant function in the normative groups). Depending on the clinical purpose of the assessment, this weighted score may be more or less useful. The second way of scoring, meant for treatment/educational purposes makes use of the 21 domain scores, and the manual provides percentiles by age, for each of the three norm groups, for each of the 21 domains. Strengths and weaknesses are defined as scores above the 90th or below the 10th percentile, respectively (with some exceptions where 85th and 15th percentile are recommended). The percentiles for Part II domains (maladaptive behavior) are difficult to grasp, since high raw scores indicate high levels of maldaptive behavior (e.g., high aggression), but high percentile scores indicate desirable scores (e.g., low aggression) so as to be consistent with Part I.

Standardized measurement of maladaptive behavior is difficult for many reasons, and considerable dissatisfaction has been expressed in the literature concerning Part II of the ABS (Clements, Bost, DuBois, & Turping, 1980; Holmes & Batt, 1980; MacDonald & Barton, 1986; McDevitt, McDevitt, & Rosen, 1977; Searls, Isett, & Bowders, 1981; Sloan & Marcus, 1981; Spreat, 1982; Taylor, Warren, & Slocumb, 1979). These include the fact that items are given equal weighting regardless of severity, for example, choking others and stamp-

ing one's foot (Holmes & Batt, 1980). Attempts to modify the scores by weighting them on the basis of severity have been unsuccessful (Clements et al., 1980; Searls et al., 1981; Spreat, 1982). Also, frequency is scored in a very crude way (frequently, occasionally, or not at all) and these categories may be defined differently by different raters. Furthermore, many of these behaviors occur infrequently or in a small proportion of the sample, leading to very unusual statistical properties which render interpretation of percentile scores very difficult (McDevitt et al., 1977). Some of the same problems apply to the VABS , but it does not attempt to infer sophisticated statistical properties to maladaptive behavior scores but rather classifies them into broad categories of significant, intermediate, and nonsignificant.

Despite these problems, some documentation of behavior problems is very important clinical information in most settings. In the present study (in a sample with rather high levels of behavior problems), the summary scores of the maladaptive scales of the two tests correlated reasonably well, indicating adequate validity of the constructs being measured, and the ABS-SE Part II was sufficiently reliable. Thus, we do not recommend abandoning these scales, as some have, but suggest that they be used with caution, in a descriptive rather than quantitative way.

CONCLUSIONS

This study examined some of the psychometric properties and the clinical usefulness of two adaptive behavior scales, the ABS-SE and the VABS, in a sample of autistic children and adolescents. The psychometric evaluation can be summarized as follows: (a) The concurrent validity of ABS-SE and the VABS was generally good (with a few specific exceptions, as noted). Thus, both tests appear to be measuring essentially the same construct. (b) Intellectual level and adaptive behavior were moderately correlated, as expected. (c) The test–retest reliability of the ABS-SE over a 3-month period was good. (d) Finally, the psychometric properties of the ABS-SE in this autistic sample are very similar to those found in the literature using samples of mentally retarded persons.

We strongly recommend the use of adaptive behavior scales with autistic persons, and encourage those working with other specialized populations to explore their potential value as well. Further, we recommend both the ABS-SE and the VABS measures. In our experience, each has advantages and disadvantages, in terms of method of administration, range of derived scores, and appropriateness of norms. The selection of a scale in a particular instance must be based on practical considerations, characteristics of the client, and the clinical purposes of the assessment.

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