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Social Work Assessment of Adaptive Functioning Using the Vineland Adaptive Behavior Scales

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ABSTRACT. The assessment of client adaptive functioning is often an important component of a comprehensive social work evaluation. The Vineland Adaptive Behavior Scales (VABS) are the most commonly used quantitative measures of adaptive functioning for clients meeting the criteria for a wide range of disorders. We review the development of the VABS and current knowledge pertaining to the instrument’s reliability and validity. We conclude that the ability to administer and interpret the VABS is an important skill for clinical social workers to acquire. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: getinfo@haworthpressinc.com <Website: http://www.haworthpressinc.com>]

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A client’s level of adaptive functioning can have profound implications on the course of his or her life. According to the *Diagnostic and Statistical Manual of Mental Disorder* (American Psychiatric Association, 1994), adaptive functioning refers to the following:

How effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting. Adaptive functioning may be influenced by various factors, including education, motivation, personality characteristics, social and vocational opportunities, and the mental disorders and general medical conditions that may coexist with Mental Retardation. (p. 40)

Cohen (1988) conceptualized adaptive functioning as the perceived congruity between an individual’s performance and the expectations of society. Furthermore, he identified two main purposes for measuring a client’s level of adaptive functioning. The first reason for the measurement of adaptive functioning is the identification, classification, and the diagnosis of clients along a continuum of social competency-incompetency. The second purpose behind a quantification of adaptive functioning is that it provides an empirical basis for the planning and evaluation of treatments and interventions.

Clients who receive services from social workers in clinical practice would benefit from a practitioner’s thorough understanding of the impact that the level of adaptive functioning has on their lives. Although adaptive functioning is usually mentioned in conjunction with mental retardation, studies have shown that an assessment of adaptive functioning may often be indicated for members of other client populations. For example, Pearson and Lachar (1994) demonstrated the necessity of assessing the adaptive functioning of elementary school children with emotional disturbances or learning disabilities. Assessments of adaptive functioning have also been conducted with persons who are hearing impaired in order to determine their propensity for independent living (Dunlap & Sands, 1990). Sholle-Martin and Alessi (1988) found that children who were hospitalized for psychiatric disturbances in a short-term treatment and diagnostic center had significantly lower levels of adaptive functioning than a normal standardization sample. August, MacDonald, Realmuto, and Skare (1996) found that children with hyperactivity/attention problems and conduct prob-
lems were likely to develop poor levels of adaptive functioning in the future. Vostanis, Grattan, Cumella, and Winchester (1997) utilized a measure of adaptive behavior when assessing the psychosocial characteristics of homeless families. Brady, Tucker, Harris, and Tribble (1993) found that adaptive functioning was a significant predictor of white students’ academic achievement as measured by grade point average. Considering the wide scope of social work practice, it appears that clinical practitioners in a variety of fields will come into contact with clients for whom an assessment of adaptive functioning may be beneficial.

There exists, however, a paucity of information in the professional literature specifically concerning social work assessment of adaptive functioning. For example, the term ‘adaptive functioning’ is not mentioned in the only social work text dealing with assessment (Jordan & Franklin, 1995). As noted earlier, assessing adaptive functioning can provide professionals with vital information for the planning and evaluation of intervention strategies (Cohen, 1988). Furthermore, adaptive behavior is often more responsive to intervention than other aspects of client functioning that are frequently measured, such as intelligence (Atkinson, 1990b, Williams, 1996). A focus on adaptive functioning, as opposed to psychopathology, is also quite congruent with the current emphasis in our field on dealing with clients’ strengths. Consequently, social workers need to familiarize themselves with methods of assessing adaptive functioning in order to provide appropriate treatments to clients who can benefit from training in adaptive behaviors. Among the most widely used instruments today in the assessment of adaptive functioning are the Vineland Adaptive Behavior Scales (VABS).

The VABS are a valuable instrument for assessing adaptive functioning and evaluating clinical practice. In a survey of the testing practices of practicing school psychologists Stinnet, Harvey, and Oehler-Stinnet (1994) found that the VABS were rated as the single most important clinical tool for the assessment of adaptive functioning. In another report on the assessment practices of 10 distinguished programs for preschool programs with autism, eight of them reported using the VABS. These programs also indicated that they found the VABS to be a helpful measure of changes in adaptive functioning (Harris, Handleman, Belchic, & Glasberg, 1995). Gaskell, Dockrell, and Rehman (1995) used the instrument to measure the efficacy of a
community care program for clients with maladaptive behaviors and mild learning disabilities over a three year period. Through the use of the VABS, they found a statistically significant decrease in the occurrence of maladaptive behaviors. Another example of the VABS use as a measurement instrument for program evaluation is Unruh and Dupree’s (1998) utilization of the scales to measure the effects of an intervention designed to enhance the cognitive and academic performance of special education preschool children with communication impairments.

In addition to the instrument’s value in both assessment and practice evaluation, the VABS have also proven to be indispensable in the conduct of research across a variety of fields. Rosenbaum, Saigal, Szatmari, and Hoult (1995) used the VABS to summarize the functional outcomes of extremely low-birthweight children, and they suggested that the VABS become the standard measurement instrument for all neonatal follow-up programs. Fletcher, Levin, Lachar, Kusnerik, Harward, Mendelsohn, and Lily (1996) utilized the VABS in a study which demonstrated the importance of measuring adaptive functioning to determine the extent of pediatric closed head injury. According to Fletcher et al. (1996), the VABS and other measures of cognitive and adaptive functioning are more sensitive to the severity of closed head injury than parent-based scales which measure psychopathology. A later study utilized the VABS as a tool to determine the relationship between the depth of brain lesions and the functional outcome of children with closed head injuries (Levin, Mendelsohn, Lilly, Yeakley, Song, Scheibel, Harward, Fletcher, Kufera, Davidson, & Bruce, 1997). In the field of genetics, researchers utilized the VABS to measure the relationship between mutation size and cognitive/behavior deficits in males with fragile X mutation (Fisch, Carpenter, Howard-Peebles, Maddalena, Simensen, Tarleton, Julien-Inalsingh, Chalfoux, & Holden, 1995).

The VABS were also employed by researchers who were attempting to develop a profile of the cognitive, adaptive, and behavioral characteristics of people with Williams syndrome, a genetic disorder characterized by mental retardation, dysmorphic facial features, short stature, and cardiovascular anomalies (Greer, Brown, Pai, Choudry, & Klein, 1997). Payne, McGee-Brown, Taylor, and Dukes (1993) developed a family environment checklist to select participants for educational preschool programs, and scores from the VABS were used as a basis
for comparison when testing their scale’s validity. Psychologists also used the VABS to determine the relationship between social skills, facial emotion recognition, and quality of life for adults with mild to moderate mental retardation living in a large residential facility (Simon, Rosen, Grossman, & Pratowski, 1995).

The preceding examples highlight the instrument’s interdisciplinary utility as an important tool in the arenas of both practice and research. It would seem logical that social workers who practice in the fields of health care, mental health, and school social work would frequently encounter clients for whom adaptive functioning is an issue. By familiarizing themselves with the VABS, social workers in these fields of practice will increase their assessment repertoire and enhance their treatment strategies. They will also become more adept at both consuming and producing research related to the field of adaptive functioning.

**OVERVIEW OF THE VINELAND ADAPTIVE BEHAVIOR SCALES**

The Vineland Adaptive Behavior Scales (VABS) are the product of extensive revisions of the original Vineland Social Maturity Scale published by Edgar A. Doll in 1936. Cohen (1988) suggested that Doll set the stage for later studies of adaptive functioning by establishing the following ideas:

Social competence refers to the progressive development or maturation of the human organism; (b) adaptive behavior can be quantified by sampling representative performance at successive age levels; (c) adaptive behavior differs from measures of intelligence that it samples actual day-to-day performance of basic living skills rather than innate or perceived intellectual or academic abilities; (d) adaptive behavior scales must not only yield a measured total competence, which he expressed as a social quotient, but must also provide a description or analysis of the components of competence; and (e) reliable data about an individual can be gathered by interviewing a third party informant (e.g., parent, primary care provider, teacher) rather than through direct observation or by formalized testing. (p. 44)
Doll included the following categories for measurement on his scale: self-help general, self-help dressing, self-help eating, self-direction, socialization, locomotion, and occupation. After the passage of the *Education for All Handicapped Children Act of 1975* (Public Law 94-142) which delineated strict guidelines for the assessment of children with disabilities, further litigation resulted in extensive revisions of the Vineland Social Maturity Scales (Holden, 1984). Ultimately, this legislation resulted in the evolution of the revised Vineland Adaptive Behavior Scales.

The present incarnation of the VABS includes three separate versions of the scales: Interview Edition, Survey Form; Interview Edition, Expanded Form; and the Classroom Edition. The Survey Form includes a recording booklet for the 297 items that is available in either English or Spanish in addition to a manual for administration, scoring, and interpretation of the scales. The Expanded Form contains 577 items in both English and Spanish. This detailed version provides a basis for preparing habilitative, educational, and treatment programs through the use of a separate booklet call the Program Planning Report. The Classroom Edition is a questionnaire completed by a school teacher intended for children ranging in age from 3 to 12 years (Holden, 1984).

The VABS are intended for use in assessment of adaptive behavior in both disabled and non-disabled individuals from early childhood to adolescence. It can also be utilized in the assessment of low-functioning adults. Information is gathered through questioning an individual who is familiar with the client’s personal and social behaviors. Adaptive behavior as measured by the VABS consists of “the performance of the daily activities required for personal and social sufficiency” (Sparrow, Balla, & Cicchetti, 1984, p. 6). The VABS is therefore useful whenever an assessment of a client’s daily functioning is indicated, and the four domains of the scales may be utilized simultaneously or independently.

The following is a list of the domains and subdomains measured by the VABS:

a. the communication domain, which includes the subdomains of receptive, expressive, and written communication;

b. the daily living skills domain, which includes the subdomains of personal, domestic, and community living skills;
c. the socialization domain, which includes the subdomains of interpersonal relationships, play and leisure time, and coping skills; and

d. the motor skills domain, which includes the subdomains of gross and fine motor skills.

Both the Interview Edition, Survey Form and the Interview Edition, Expanded Form also have an optional Maladaptive Behavior domain for clients 5 years or older.

**ADMINISTRATION**

Both the Survey and Expanded Forms were designed to be administered in a semistructured interview format to the client’s parent or caretaker (Sparrow et al., 1984). The items within each domain are ordered along a developmental continuum, which gives the interviewer the liberty to choose an appropriate starting point based on an estimate of the client’s social or mental age. It is expected that the practitioner will determine this starting point by utilizing scores from other clinical measures, such as intelligence tests.

Snyder (1985) identified several potential problems inherent in the use of the interview form of the VABS. First of all, interviewee responses are rated subjectively on a graded continuum from “usually” to “never.” Furthermore, there exists “no opportunity” and “don’t know” responses, which can prove difficult to interpret. Finally, the clinician’s interpretation and recording of the interviewee’s responses will be affected by the extent of the interviewee’s level of familiarity with the client.

The Classroom Edition of the VABS is administered to a teacher in the form of a questionnaire. The teacher completes the questionnaire independently, and unlike the Survey and Expanded forms, he/she is required to respond to every question regardless of the child’s age. The teacher is expected to rate the child’s behavior relating to self-care and social skills development based on his/her actual observations of the child’s performance. If a certain behavior has not been observed, the teacher is permitted to make an estimation of the child’s ability based on the student’s prior behavior in other areas. Each domain requires that the teacher report the frequency of the behavior as “usual,” “sometimes,” or never.” There is also space provided so that the
teacher can add comments to his/her responses to the questions. Equal weight is given to both observed and estimated responses when scoring the questionnaire. The teacher’s comments consequently provide valuable clinical information for the interpretation of scores (Snyder, 1985).

**SCORING AND INTERPRETATION**

The scoring and subsequent interpretation of the results obtained from the VABS are the tasks of professionals with training in assessment, test interpretation, and human development. The mechanics of score computation for the VABS can be found in the manual written by Sparrow et al. (1984) which accompanies the test.

The types of scores produced for quantitative interpretation of the four domains include standard scores, national percentile ranks, stanines, and age equivalents. The only quantitative score available for each of the individual subdomains is the age equivalent score. Although the age equivalent is used for comparison, clinicians are dissuaded from using it as the primary interpretive score because of its propensity for inducing typological thinking about clients (Salvia & Ysseldyke, 1985).

It is also possible to develop a comparison between qualitative/Descriptive categories and representative national samples for every section of the three versions of the VABS. For example, both the Expanded Form and the Survey Form allow for comparison of qualitative scores with a national sample of disabled individuals. Snyder (1985) noted that the clinical utility of the scores obtained from the VABS will vary depending upon the purpose of each assessment. In addition to yielding quantitative and qualitative information related to interindividual differences, the scores derived from the VABS also allow for the comparison of a client’s abilities in two separate areas of performance. The disparity between a client’s strength in one area and weakness in another can then be compared to the frequency of that specific intraindividual difference in the national standardization sample. The manual by Sparrow et al. (1984) provides a detailed description of the process for determining intraindividual differences.

There are a few guidelines that practitioners need to consider when attempting to interpret and score the various domains. First of all, the Classroom Edition of the VABS may be used in the assessment of both
gifted children under the age of 3 and lower-functioning individuals from age 12 to 30. The scores derived in these cases, however, can only be reported in the form of age equivalents. Secondly, there is limited utility in interpreting the scores derived from the Maladaptive Behavior Domain in the Survey and Expanded Forms with individuals who do not meet the diagnostic criteria for mental retardation, emotional disturbances, or sensory impairment. Finally, non-disabled individuals below the age of six should not be assessed with the motor skills domain.

RELIABILITY

While testing the VABS, Sparrow et al. (1984) assessed internal consistency or split-half reliability, test-retest reliability, and interrater reliability using the original 15 age group designations of their nationalized standardization sample of 3,000 participants with the exception of the motor skills domain where n = 1,200.

Internal Consistency or Split-Half Reliability

Internal consistency or split-half reliability for the Interview Edition, Survey Form reported ranges from .73 to .94 (median = .89) in the communication domain, .83 to .92 (median = .90) in the daily living skills domain, .78 to .94 (median = .86) in the socialization domain, and .70 to .95 (median = .83) in motor skills. For the adaptive behavior composite, the internal consistency ranged from .89 to .98 (median = .94), and maladaptive behavior part 1 ranged from .77 to .88 (median = .86).

For the seven supplementary developmentally disabled norm groups of 2,844 individuals, the internal consistency reliability were .94 to .99 in the communication domain, .96 to .99 in daily living skills domain, .96 to .98 in the socialization domain, and .90 to .98 in the motor skills domain. Unlike the standardized sample where motor skills were assessed on 40% of the participants, they were assessed on 100% of the participants in the disabled norm groups. The adaptive behavior composite for this group revealed internal consistency reliability ranging from .98 to .99 and maladaptive behavior part 1 ranged from .84 to .90.
Stepped-up estimates of the Survey Form values from the standardization sample using the Spearman-Brown formula were used for the Interview Edition, Expanded Form because of its extended length. The internal consistency reliability posted estimates ranging from .84 to .97 (median = .94) in the communication domain, .92 to .96 (median = .95) in the daily living skills domain, .88 to .97 (median = .92) in the socialization domain, and .83 to .97 (median = .91) in the motor skills domain. In the adaptive behavior composite, the internal consistency estimates ranged from .94 to .99 (median = .97) and .77 to .88 (median = .86) for maladaptive behavior part 1. All of these had excellent split-half reliability with medians above .90, except maladaptive behavior which was still very good.

The stepped-up estimates for internal consistency reliability of the supplementary norm groups for Expanded Form were found to be excellent as well in the same domains: .97 to .99 in communication, .98 to .99 in daily living skills, .98 to .99 in socialization, .98 to .99 in the adaptive behavior composite, and .95 to .99 in motor skills. Again, the range for maladaptive behavior, .76 to .90, was lower but still sufficient.

Test-Retest Reliability

The Survey Form was originally administered to caregivers or parents on a sample of 484 children to investigate test-retest reliability. The same interviewer re-administered the VABS to the identical parent or caretaker 2 to 4 weeks later, with an average interval of 17 days. Intraclass correlation coefficients ranged from .98 to .99 for all domains, and the adaptive behavior composite was .99. In order to examine interrater reliability, 160 caregivers or parents were interviewed by two different testers over a period of 14 days, with an average interval of 8 days. Intraclass correlation coefficients were also excellent and ranged from .96 to .99, with the adaptive behavior composite at .98.

A study by Szatmari, Archer, Fisman, and Streiner (1994) of 83 preschoolers ages 4 to 6 with pervasive developmental disorder included test-retest reliability of the Classroom Edition and Survey Form of the VABS. Pearson correlation tests found the following associations: .83 in the communication domain, .50 in the daily living skills domain, .60 in the socialization domain, .42 in the motor skills domain, and the adaptive behavior composite was .74 ($P < .001$). Teachers consistently ranked the students higher in the four domains.
than the parents, and high levels of parental stress appeared to be the only variable related with this difference.

Voelker, Shore, Hakim-Larson, and Bruner (1997) examined the test-retest reliability of the VABS on 59 children with multiple disabilities between the ages of 4 to 13 years using the Classroom Edition and Survey Form. Pearson correlation tests found the following associations: communication domain \((r = .93)\), daily living skills domain \((r = .88)\), socialization domain \((r = .71)\), motor skills domain \((r = .88)\), adaptive behavior composite \((r = .87)\). However, mean score comparisons found that the special education teachers in the rehabilitative setting systematically classified the subjects higher, and thus, more skilled, than the primary caretakers.

**Standard Errors of Measurement**

Standard errors of measurement for the Survey Form of the standardization sample were computed using standard score units with internal consistency reliability coefficients. They ranged from 3.6 to 7.8 standard score units (mean = 5.4) in the communication domain, 4.1 to 6.1 standard score units (mean = 5.0) in the daily living skills domain, 3.7 to 7.0 standard score units (mean = 5.6) in the socialization domain, and 3.4 to 8.2 standard score units (mean = 6.1) in the motor skills domain. The adaptive behavior composite had standard errors of measurement ranging from 2.2 to 4.9 standard score units (mean = 3.6), which indicates a high reliability of the composite score.

The Expanded Form standard errors of measurement for the standardization sample were computed using standard score units with stepped-up estimated internal consistency reliability coefficients. These ranged from 2.6 to 6.0 standard score units (mean = 4.0) in the communication domain, 2.8 to 4.3 standard score units (mean = 3.5) in the daily living skills domain, 2.6 to 5.2 standard score units (mean = 4.1) in the socialization domain, and 2.4 to 6.2 standard score units (mean = 2.6). Again, these values connote the composite scores high reliability.

**VALIDITY**

**Content Validity**

Sparrow et al. (1984) extensively investigated the validity of the VABS. Content validity is demonstrated by the comprehensive methods utilized in the initial development. The VABS was originally
comprised of 3,000 items which were later reviewed, critiqued, and reduced to approximately 800. After conducting a pilot-test with parents or caretakers, 529 items were selected for a national tryout with 723 parents or caretakers in six states across the United States. These results were extensively analyzed to yield the two versions of the Interview Edition. Only the Survey Form was used in the national standardization sample and due to the results of the earlier tests, a maladaptive component was added. The standardization program ran from September 1981 to May 1982 and consisted of 301 items administered at 35 sites in 24 states.

**Construct Validity**

Construct validity is confirmed by examining developmental progression on scores, domain and subdomain factor analysis, and profiles for the supplementary norm groups’ scores. Since adaptive functioning is age related and developmental, it was expected that an increase in the scores of these behaviors would occur with age and there would be little progression of maladaptive behaviors. The mean raw scores in the 15 age groups of the standardization sample of the Survey Form with n = 3,000 do indeed progress incrementally with age as anticipated, and support the premise that adaptive behavior is age related as assessed by the VABS. The mean raw scores and standard deviations for the Survey Form and Expanded Form of the maladaptive behavior part 1 for the standardization sample with n = 2,000 showed little change, verifying that this area does not maintain the developmental traits that are found with adaptive behaviors.

To establish construct validity, Sparrow et al. (1984) used factor analyses to contribute proof as to the structure of the VABS. The original 15 age groups in the standardization sample were categorized into eight age groups for the domains and subdomains. Principal components analyses were run to ascertain the percentage of difference to attribute to the first main component and validate the fundamental composition of the scale. This was vital in terms of the importance attributed to the adaptive behavior composite score when inferring results of the VABS, and this component was shown to be an appropriate index as signified by the analyses. Next, varimax rotated principal factor analysis and intercorrelation matrices were analyzed for subdomain raw scores for each of the eight age groups. Components analo-
gous to the domains were distinguished by the results and they supported the subdomains into their specific domains.

Since the seven supplementary norm groups were comprised of different developmental disabilities, differences between these groups were anticipated as well as differences between the supplementary groups as compared to the standardization sample. The mean standard scores for all the supplementary norm groups ranged from 19.2 to 73.6 in the communication domain, 19.4 to 77.3 in the daily living skills domain, 20.7 to 82.1 in the socialization domain, and 19.6 to 75.4 in the adaptive behavior composite and all were below the standardization sample mean of 100. Estimated standard scores were used in the motor skills domain for the seven groups since deficits in gross motor and fine motor skills often accompany developmental disabilities. Sparrow et al. (1984) found that five of the supplementary groups were below 100, with estimated mean scores ranging from 20.0 to 85.0. The hearing-impaired and emotionally disturbed groups in residential facilities had estimated scores of 102.6 and 107.8 respectively, which were both in the normal range and expected due to these two types of disabilities.

When compared to the emotionally disturbed and hearing-impaired subjects in residential facilities, the visually impaired participants in residential facilities had the lower mean scores and higher standard deviation in all areas of adaptive behavior. The emotionally disturbed rests had their lowest mean scores in socialization, whereas the hearing-impaired residents had theirs in communication. Again, these results were anticipated for these specific disability groups.

The relationship between the Scales of Independent Behavior (SIBS) and the VABS Interview Edition, Expanded Form was investigated by Middleton, Keene, and Brown (1990) to examine convergent and discriminant validity. The children in the study ranged from ages 3 to 7 years (mean = 65 months) and one participant was identified as behaviorally disabled, five as communication disordered, eight as slow learners, 16 as mildly mentally retarded, and 23 as moderately to severely mentally retarded. A correlation of .83 existed between the SIBS broad independence score and the VABS adaptive behavior composite. However, the domains of motor, socialization, and domestic skills had correlation of .50, .76, and .76, respectively, whereas the domains of communication, personal living, and community living skills had correlation of .92, .95, and .88, respectively.
Criterion Validity

Sparrow et al. (1984) used correlations between the original Vineland and the VABS Survey Form to establish criterion validity. They examined correlation coefficients of the adaptive behavior composite for the Survey Form and of the unadjusted social quotient and deviation social quotient for the original Vineland. The adaptive behavior composite and the unadjusted social quotient had a correlation of .55. The correlation between the adaptive behavior composite and the deviation social quotient was also .55. This was anticipated as there are many differences in the standardization and content of the two scales.

Britton and Eaves (1986) examined the correlation between the Vineland Social Maturity Scales and the VABS Classroom Edition for 54 educable and trainable mentally retarded children ranging in age from 7.5 to 18.0 years with each child’s special education completing both scales. The coefficients were computed from raw scores, and t-tests used developmental ages. The concurrent validity of the two scales was found to be moderate, with a range of .57 to .66.

Bensberg and Irons (1986) investigated the correlation between the VABS Classroom Edition, the VABS Interview Edition, Survey Form, and the American Association of Mental Deficiency Adaptive Behavior Scale–School Edition (ABS-SE) for a group of 44 moderately and severely mentally retarded children ranging in age from 3.8 to 21.9 years with an average IQ of 42.3. Teachers and their aides completed the VABS Classroom Edition and the ABS-SE and a bilingual graduate student interviewed 37 parents using the VABS Survey Form. Pearson correlation coefficients were computed between the VABS (teacher and parent forms) and the ABS-SE, found to be positive and statistically significant at the .05 level or beyond, and discovered moderate to high correlation (.73 to .88).

Perry and Factor (1989) investigated the relationship between the ABS-SE and the VABS Interview Edition, Survey Form for a group of 15 autistic children between 8 to 18 years of age. Correlation between raw scores of three VABS domains and raw scores for the subdomains of the ABS-SE Part 1 were high (.77 to .85) and only moderately correlated with the adaptive behavior composite at .62.
DISCUSSION

The VABS have been shown to have strong reliability and validity when measuring adaptive functioning as it is defined by Sparrow et al. (1984). It is important to note however, that there has been a debate in the literature over the true definition of adaptive functioning. Zigler, Balla, & Hodapp (1984) went as far as to suggest that all measures of adaptive behavior are invalid due to the lack of agreement on the actual construct of adaptive functioning. They recommend discounting the inclusion of adaptive functioning as a criteria for a diagnosis of mental retardation. They also pointed out that the differing definitions of adaptive functioning can produce prevalence rates of mental retardation ranging from 100,000 to 4 million. Kamphaus (1987), however, concluded that the VABS have been beneficial in the development of a definition of adaptive behavior.

Another area of debate in the field of adaptive functioning is the relationship between adaptive behavior and intelligence. The developers of the VABS state that their research indicates that intelligence and adaptive behavior are two distinct areas of functioning (Sparrow et al., 1984). This assertion is supported by Atkinson (1990a), whose study on the correlation between the VABS and the Wechsler Intelligence Scale for Children-Revised suggests that “it would not be unreasonable to interpret . . . the discrepancy as reflective of a real underlying difference between cognitive capacity and day-to-day functioning” (p. 203). Kamphaus (1987), however, suggested that the modest correlations between the VABS and certain prominent intelligence tests are grounds for questioning the validity of the VABS. Atkinson, Bevc, Dickens, and Blackwell (1992) later stated that it is impossible to determine the true relationship between intelligence and adaptive functioning due to the fact that neither construct has an actual zero point, and that the VABS and the intelligence scales were standardized on different samples. They therefore urge caution when attempting to interpret variations in scores from intelligence tests and the VABS.

In spite of the debate taking place over these issues, the authors recommend that clinical social workers familiarize themselves with the administration and scoring procedures of the VABS. The DSM-IV includes adaptive functioning as an integral component in the diagnosis of Mental Retardation. It follows then that, given their role as diagnosticians, clinical social workers should familiarize themselves with this prominent instrument for the assessment of adaptive behav-
ior. Also, as mentioned earlier, deficits in adaptive functioning are present in individuals from a variety of populations. It is therefore likely that practitioners who specialize in fields of practice not limited to developmental disabilities will still encounter clients from whom an assessment of adaptive functioning could be useful. A worker who is conversant in adaptive functioning and the VABS would seem to be in a better position to provide empirically-based assessments and interventions for these clients. Furthermore, the VABS can also be utilized as a reliable and valid method for measuring treatment progress. As demands for accountability in social work practice increase, the VABS could fulfill a useful role by offering support for the efficacy of social work treatment.

Professionals must be trained in the intricacies of interviewing and test interpretation in order to successfully administer the VABS and interpret the results. Unfortunately, course work in test interpretation is generally not required at the MSW level of social work practice. This omission would seem to place social workers at a disadvantage relative to other professionals (such as school psychologists) when attempting to perform an assessment of adaptive functioning. The inclusion of additional assessment course work at the MSW level could provide an opportunity for role expansion for the profession, and it would likely enhance the quality of treatment that social workers provide to their clients.

REFERENCES


