Disclosures

- As co-author of the Vineland Adaptive Behavior Scales, Third Edition, Dr. Saulnier receives royalties from Pearson
- As co-author of Essentials of Autism Spectrum Disorders Evaluation and Assessment, Dr. Saulnier receives royalties from Wiley

Learning Objectives

1. Define adaptive behavior & differentiate adaptive behavior from cognition or ability
2. Describe common profiles of adaptive functioning in ASD for individuals with and without cognitive impairment
3. Identify effective treatment strategies for enhancing adaptive functioning
Defining ASD

Criteria for Autism Spectrum Disorder (299.0)

A. Persistent deficits in social communication and interactions across multiple contexts, as manifested by the following currently or by history:

1. Deficits in social-emotional reciprocity
2. Deficits in nonverbal communication behaviors used for social interaction
3. Deficits in developing, maintaining, and understanding relationships, ranging, e.g., from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers

Criteria for DSM-5
Autism Spectrum Disorder (299.0)

B. Restricted, repetitive patterns of behavior, interests, and activities, as manifested by at least TWO of the following, currently or by history:

1. Stereotyped or repetitive speech, motor movements, or use of objects
2. Excessive adherence to routines, ritualized patterns of verbal or nonverbal behavior, or excessive resistance to sameness
3. Highly restricted, fixated interests
4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of behavior
Criteria for DSM-5
Autism Spectrum Disorder (299.0)

C. Symptoms must be present in early childhood (but may not become fully manifest until social demands exceed limited capacities)

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning

E. Disturbances are not better explained by intellectual disability or global developmental delay.

Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger’s disorder, or PDD-NOS should be given the diagnosis of ASD.

Clinical Specifiers for ASD (299.0)

1. With or without accompanying intellectual impairment
2. With or without accompanying language impairment (“no intelligible speech” vs. “phrase speech”)
3. Associated with a known medical or genetic condition or environmental factor
4. Associated with another neurodevelopmental, mental, or behavioral disorder (can now include ADHD)
5. With Catatonia

Severity Levels for ASD (299.0)

Level 1: Requiring Support
Level 2: Requiring Substantial Support
Level 3: Requiring Very Substantial Support
Current Epidemiological Statistics for ASD

www.cdc.gov/ncbddd/autism

IN THE GENERAL POPULATION:
- 1 in 68 (More prevalent than all childhood cancers combined)
- Male-Female Ratio: 4-5 times higher in boys
- Median Age of Diagnosis: 4-5 years
- Much later for disadvantaged populations
- When ASD can be reliably diagnosed: 18-24 months when diagnosed by experienced clinicians
- Comorbidity with Intellectual Disability: 32%

IN SIBLINGS OF CHILDREN WITH ASD:
- ASD: 1 in 5 (~20% risk)
- Broader Autism Phenotype (“shadow symptoms”): 1 in 5
- Non-ASD developmental delays: 1 in 10

Comprehensive Diagnostic Evaluations for ASD

Diagnostic Evaluations are Two-Fold:
1. Need for conducting a thorough developmental history
   - Parent/Caregiver report
   - Teacher report (older children)
2. Need for conducting direct testing with the child
   - Profile of developmental/cognitive skills
   - Profile of speech/language/communication skills
   - Profile of adaptive behavior
   - Direct observations of social-communication, play/interaction skills, & restricted, repetitive and unusual behaviors (i.e. diagnostic assessment for autism symptomatology)

Assessment of Adaptive Behavior
Defining Intellectual Disability in the DSM-5

- Deficits in cognitive functioning ("scores of approximately two standard deviations or more below the mean")
- Deficits in adaptive functioning (e.g., communication, daily living, social participation, and independent living)
- Onset in the developmental period

Severity Levels: Defined by adaptive functioning rather than IQ level (different from DSM-IV)
- Mild
- Moderate
- Severe
- Profound

Differentiating Cognitive Ability from Adaptive Functioning

- **Cognitive ability** is generally defined as an individual’s repertoire of skills that are either innate or acquired.
  - Skills that an individual is capable of performing

- **Adaptive Behavior** is generally defined as performance of skills that are necessary for personal and social sufficiency.
  - Skills an individual *does* perform, *independently*, in daily activities and routines

Characteristics of Adaptive Behavior

- Age-related
- Defined by the expectations/standards of others
- Defined by typical performance, not ability
- Modifiable (can change over time)
- Adequate is the appropriate goal
The Autism Spectrum

Levels of Cognitive Functioning

- Cognitive Impairment
- Seizures
- Childhood Disintegrative Disorder
- PDD-NOS
- "High Functioning" Autism
- Asperger Syndrome
- Psychiatric Comorbidities

The Autism Spectrum

Levels of Adaptive Functioning

- Daily Living Skills (ADLs)
  - Dressing
  - Bathing
  - Toileting
  - Feeding
  - Mobility
  - Medical management
- Functional Independence
  - Social Awareness
  - Emotional Awareness
  - Personal Care
  - Career Development
  - Community Navigation
  - Financial Management

Adaptive Communication:
"High Functioning" ASD

VIDEO
Adaptive Communication: Typical Development

VIDEO

Vineland Adaptive Behavior Scales
(Sparrow, Balla, & Cicchetti, 1984 & 2005; Sparrow, Cicchetti, & Saulnier, 2016)

1. Interview Form*
2. Parent/Caregiver Form
3. Teacher Form

*Semi-structured interview with a caregiver is considered the Gold Standard

Domains of Functioning (birth – 90 years)
- Communication: Receptive; Expressive; Written
- Daily Living: Personal; Domestic; Community
- Socialization: Interpersonal; Play/Leisure; Coping
- Motor: Fine; Gross Motor
- Maladaptive Behavior Index

Profiles of Adaptive Behavior
Profiles of Adaptive Behavior in ASD

Historically
Adaptive skills are often delayed & found to fall significantly below age & IQ in ASD
Volkmar et al., 1987; Carter et al., 1998; Klin et al., 2007

More Recently
Standard scores are found to be higher than IQ in children with intellectual disability & ASD
Perry et al., 2009; Kanne et al., 2010

Of Concern
The gap between cognitive ability and adaptive functioning appears to widen with age
Klin et al., 2007; Saulnier & Klin, 2007; Kanne et al., 2010

Adaptive skills fall significantly below cognition in 2 independent samples of boys ages 8 to 18 years

Older age group has significantly lower adaptive skills across all Vineland domains than the younger age group

Longitudinal Gap between Cognitive Potential and Adaptive Behavior – High Cognition

(Saulnier, Chawarska, & Klin, IMFAR 2011)
Longitudinal Gap between Cognitive Potential and Adaptive Behavior – Low Cognition

When does this gap begin?
(Bradshaw, Kliman, Gillespie, Klin, & Saulnier, in preparation)

What Predicts “Good Outcome”

- Best predictors of good outcome = intact IQ and functional language by age 5
  Paul & Cohen, 1984; Howlin et al., 2004
- The majority of adults fail to achieve independent levels of employment and living, & fail to develop successful relationships
  Bills et al., 2005; Eaves & Ho, 2008; Howlin et al., 2004
- Adaptive skills may be a better predictor of positive adult outcome than IQ and language level, alone
  Farley et al., 2009
The Impact of ASD Interventions on Adaptive Behavior

How do we translate test results into meaningful recommendations for treatment, intervention, and functional independence into adulthood?
IDEA Eligibility

*Eligibility is not automatic with a diagnosis of ASD!*

- The needs of the child must demonstrate an inability/impairment regarding “access to the general curriculum”
- This calls for attention to *social & adaptive functioning* in addition to academic functioning

Vineland-II Assessment Scores & Interpretation

9 Year-old Male with Autism; Full Scale IQ = 119

<table>
<thead>
<tr>
<th>Domain and Subdomain</th>
<th>Standard V-Score</th>
<th>Percentile Rank</th>
<th>Age Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>81</td>
<td>10</td>
<td>Moderately Low</td>
</tr>
<tr>
<td>Receptive Expressive</td>
<td>10</td>
<td>Low 3</td>
<td>3 years, 7 month</td>
</tr>
<tr>
<td>Written</td>
<td>14</td>
<td>Adequate 8</td>
<td>8 years, 10 month</td>
</tr>
<tr>
<td>Daily Living Skills</td>
<td>85</td>
<td>16</td>
<td>Moderately Low</td>
</tr>
<tr>
<td>Personal Domestic</td>
<td>12</td>
<td>Low 6</td>
<td>6 years, 6 month</td>
</tr>
<tr>
<td>Domestic</td>
<td>13</td>
<td>Adequate 7</td>
<td>7 years, 5 month</td>
</tr>
<tr>
<td>Community</td>
<td>13</td>
<td>Adequate</td>
<td>8 years, 5 month</td>
</tr>
<tr>
<td>Socialization</td>
<td>68</td>
<td>2</td>
<td>Low</td>
</tr>
<tr>
<td>Interpersonal Relations</td>
<td>9</td>
<td>Low 2</td>
<td>2 years, 11 month</td>
</tr>
<tr>
<td>Play and Leisure Time</td>
<td>10</td>
<td>Moderately Low</td>
<td>4 years, 8 month</td>
</tr>
<tr>
<td>Coping Skills</td>
<td>8</td>
<td>Low 1</td>
<td>1 year, 11 month</td>
</tr>
<tr>
<td>Adaptive Behavior Composite</td>
<td>76</td>
<td>5</td>
<td>Moderately Low</td>
</tr>
</tbody>
</table>

Though Communication & DLS may be in “average range”, scores fall 2 SDs below IQ. Socialization scores fall substantially below both age and IQ. Also beware of high Written subdomain scores in comparison to significantly lower Receptive & Expressive scores. This profile often inflates the Communication Domain scores and reflects the affinity for numbers, letters, reading, & writing often observed in ASD.

Writing up Vineland Results in a Written Report

- Provide an overall summary of performance (ABC & Domain Standard Scores)
- Comparison to chronological age expectations
- Comparison to mental-age expectations (i.e., IQ)
- Provide description of Strengths & Weaknesses per subdomains
- Identify topic areas for intervention
  - *Dressing*
  - *Toileting*
  - *Conversation with peers*
Intervention Guidance in the Vineland-3
Written Subdomain

Item Scores of 0/1 are shaded to highlight skills that need improvement.

Use Content Areas to identify intervention targets by topic (e.g., B & C).

Written Subdomain Content Areas:

A = Pre-reading
B = Developing Reading Skills
C = Developing Writing Skills
D = Applying Reading & Writing Skills

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Transition Planning:

National Autism Indicators Report: Transition into Young Adulthood, 2015

- IDEA recommends transition planning to “start before the student turns 16”
- 38% of youth with autism had a transition plan in place by the federally required age
- 60% of parents participated in transition planning
- Over 80% of parents felt planning was useful
- 1/3 of autistic youth who were capable of responding to survey said they wanted to be more involved in transition planning

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Transition Planning (Think “Adaptive Development”)

- START EARLY!!! Upon diagnosis of ASD
- Focus on individual’s areas of strength & interest
- Ensure that circumscribed interests/perseverations do not become all-consuming & interfere with functioning
- Goals need to be included in the IEP
- Goals need to be age/capacity appropriate and measurable
- Involve the individual in the planning
- Identify necessary accommodations
- Expose the individual to a variety of activities that will prepare for successful college and/or vocational placement, as well as independent and successful community living and social relationships
- MAKE EVERYTHING FUNCTIONAL & MEANINGFUL!!!
Recommended Resources

Adaptive Living Skills Curriculum
(Bruininks, Morreau, Gilman, & Anderson)
- Employment Skills
- Community Living Skills
- Home Living Skills
- Personal Living Skills

Infancy – 40+ years

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Thank you for attending!

Questions?