

Promoting Lives of Quality and
Happiness for Autistic
Adolescents and Adults

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Dr. Gerhardt has an association with the following
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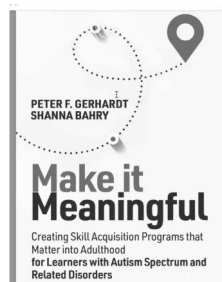


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Dr. Gerhardt is the co-author of
*"Make it Meaningful: Creating
Skill Acquisition Programs that
Matter into Adulthood for
Learners with Autism Spectrum
and Related Disorders."* (2024)
and is paid for sales.

For more information:
<https://www.makeitmeaningful.info/home>



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Note

This talk discusses the support and intervention needs of individuals
on the Autism Spectrum and co-occurring Intellectual Disability (i.e.,
Autism 2 or 3 in DSM-V). While much of what I will discuss can be
applied to support more cognitively able individuals with ASD, they
are not the group with whom I work.

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Quality of Life: It's Going Beyond the Same
Old Shit!

-Natalie Driscoll, Ph.D., BCBA-D.

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Insanity:
Doing the same thing
over and over again
and expecting
different results.

6

This article forever altered my professional life

After Wolfe's seminal article, this is the first real discussion of social validity and compassion in the applied world of behavior analysis. And this was in 1990.

JOURNAL OF APPLIED BEHAVIOR ANALYSIS 1990, 23, 79-89 NUMBER 1 (SPRING 1990)

BALANCING THE RIGHT TO HABILITATION WITH THE RIGHT TO PERSONAL LIBERTIES: THE RIGHTS OF PEOPLE WITH DEVELOPMENTAL DISABILITIES TO EAT TOO MANY DOUGHNUTS AND TAKE A NAP

DIANE J. BANNERMAN, JAN B. SHELTON, JAMES A. SHERMAN, AND ALAN E. HARCHUK
UNIVERSITY OF KANSAS

In the pursuit of efficient habilitation, many service providers exercise a great deal of control over the lives of clients with developmental disabilities. For example, service providers often choose the client's habilitative goals, determine the daily schedule, and regulate access to preferred activities. This paper examines the advantages and disadvantages of allowing clients to exercise personal liberties, such as the right to choose and refuse daily activities. On one hand, poor choices on the part of the client could hinder habilitation. On the other hand, control and legal issues arise when the client's right to choice is abridged. Recommendations are offered to protect both the right to habilitation and the freedom to choose.

DISCUSSION: developmentally disabled, ethics, client rights, choice behavior, mentally retarded

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Transitioning and Quality of Life

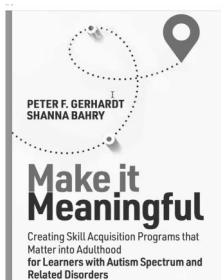
Peter Gerhardt, Ed.D.
Allegro School Training
March 14, 2025

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Quality of Life: It's Going Beyond the Same Old Shit

Natalie Driscoll,
Ph.D., BCBA-D

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Insanity:
Doing the same thing
over and over again
and expecting
different results.

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Straight-up Costs.

- Allegro's 2023-24 tuition was 591.06/day
 - That translates into \$124,122.60/year (210 days)
- If there are 6-hours/day that means that each hour of programming costs: \$98.51
- Is that time and money being used in the best interest of your students, their families, and you?



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My Programing Basics

- Independence is more important than perfection (most of the time).
- Independence v. Interdependence.
- Meaningful goals are congruent with the family's culture, experiences, beliefs, and priorities.
- Double digits time to pivot.

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My Programing Basics


- Adulthood begins in preschool.
- What is the ROI on any particular skill?
- Things you do everyday matter more than what you do once in a while.
- Will the skill still be used 1-year, 3-year, or 5-years down the road?
- Goals should be challenging, ambitious, and somewhat out of the norm.

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My Programming Basics

- Leisure goals need to be forward-thinking and evolve over time while still meeting the needs of the individual.
- Where are you going with this? "In order to..."
- Real life only happens outside of the classroom
- Where are you going with this? "In order to..."
- Life only happens outside of the classroom

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What is quality of life (QoL)?

Of all the potential measurements in the field of ABA services for individuals with IDD, the most challenging is that of Quality of Life (QoL). While there are some near-universal components to a positive quality of life (e.g., food, security, shelter, emotional/social connectedness), there are many more that are highly individualized and idiosyncratic. For example:

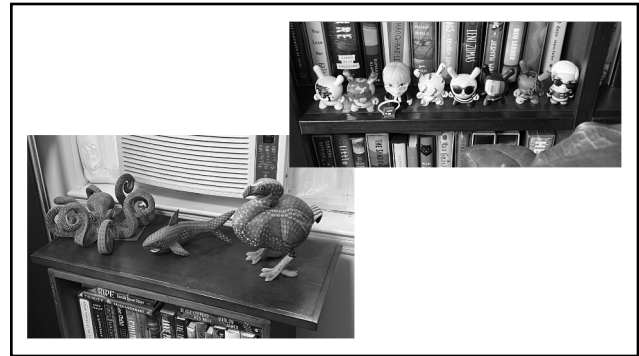
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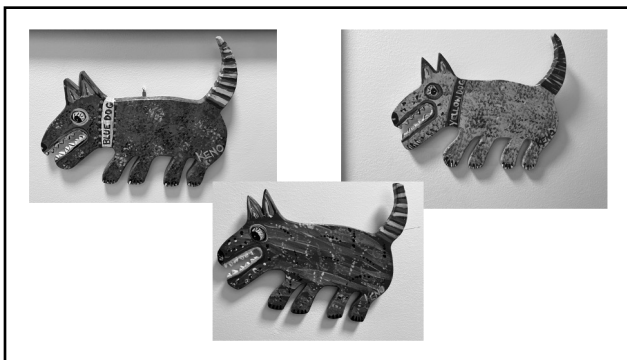
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The most accurate assessment of an individual's QoL is provided by the individual themselves. You don't have to like what I have on my walls, only I do.

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In the 21st century, I think the heroes will be the people who will improve the quality of life, fight poverty and introduce more sustainability.

Bertrand Piccard

WHO Quality of Life Definition (2012)

Quality of Life is an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns.

(<https://www.who.int/tools/whoqol>)

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Core QoL Domains

- Physical well-being and health*
- Psychological well-being and mental health*
- Personal level of independence,
- Preferred social relationships,
- Preferred physical environments,
- Comfort with spirituality/personal beliefs)
- All measured using both subjective and objective measures.

Bonomi AE, Patrick DL, Bushnell DM, Martin M. (2000). Validation of the United States' version of the World Health Organization Quality of Life (WHOQOL) instrument. *J Clin Epidemiol*, 53(1), 1-12.

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More directly we all want or need:

- To be safe from harm
- To have a place to live
- To have a job or the resources needed to keep warm and well fed
- Good physical and mental health
- Intimate relationships
- Friends/Member of a social community
- Interpersonal Respect
- **Choice**
- **Personal competence**

Control over all of these

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Control



The relationship between a sense of control (whether real or perceived) and one's QoL is well established.

"Sense of control is a pivotal contributor to a wide variety of behaviors including intellectual performance and coping with stress and to both mental and physical well-being, which are essential elements of the quality of life." (Abeles, 1991, p. 297).

Abeles, R. P. (1991). Sense of control, quality of life, and frail older people. In *The concept and measurement of quality of life in the frail elderly* (pp. 297-314). Academic Press.

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Choice

Similarly, the relationship between having valued choices and one's quality of life is well established.

Consumer choice is a key concept in developmental disability intervention. The results indicated that consumers who lived in the community and made more choices had higher scores on quality-of-life indicators (Neely-Barnes, et al, 2008).



Neely-Barnes, S., Marcenko, M., Weber, L., Lakin, K. Does Choice Influence Quality of Life for People With Mild Intellectual Disabilities?. *Intellectual and Developmental Disabilities* 2008; 46 (1): 12-26.

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Choice

Choice in the lives of individuals with IDD has been enshrined as a fundamental human right by the United Nations Convention on the Rights of Persons with Disabilities (2006).

Historically, however, individuals with IDD have been denied access to choice-making opportunities, both big and small, that may have impacted their lives (Conrad, 2020).

There is even an argument that poor adult outcomes for individuals with IDD across life domains (e.g., employment, independent living, community integration, etc.) may be the result of never having been adequately prepared to make the choices required be aa self-determined adult (Wehmeyer & Schalock, 2001)

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Competence

The relationship between competence and QoL is more challenging to document. To start with the word competence in the IDD literature is generally used to refer to a small set of behaviors, and not the general concept of competence (e.g. Core competencies). There is research on a positive QoL having a positive impact on the development of competence which is informative. And there is some research that promoting happiness at work improves personal competence (e.g., Jyung, et al., 2021). Still, there is a face-validity argument for the consideration of competence here.

Jyung, M., Choi, I. & Shim, Y. Enjoyment Versus Competence Trade-Off: Happy People Value Enjoyment Over Competence More Than Unhappy People. *Journal of Happiness Studies* 22, 3679-3701 (2021).



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Assumptions Supporting a Face-Validity Argument for Competence & QoL

- **Assumption 1:** The perception of personal competence is, most likely, a highly preferred and, potentially, reinforcing condition.
- **Assumption 2:** Learners with IDD are not able to consistently access the condition of competence under the condition of instruction.
- **Assumption 3:** Increased demonstrations of competence should result in reductions to the response effort required to perform a skill.
- **Assumption 4:** Decreased response effort tends to be associated with increased preference for the now easier task and increased competence.
- **Assumption 5:** Increased competence results in increased access to potential reinforcing conditions.
- **Assumption 6:** Regular access to potentially reinforcing conditions promotes a sense of wellbeing or, in other words, a positive quality of life.
- **Ergo:** Perceptions of, or actual competencies, are integral to positive QoL.

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Factors that can negatively impact adult QoL

- **Adverse Childhood Experiences**
- **Social deprivation**
- **Environment mismatch**
- **Economic factors**
- **Sensory needs** - Sensory difficulties may result in social isolation or communication difficulties.
- **Diet** - A healthy diet supports good health, healthy weight and well-being.
- **Exercise**
- **Religion and culture** - An individual's values, and expectations may be either (+) or (-)
- **Stress** - Chronic stress can hinder brain development and ability to learn or concentrate.
- **Lack of Sleep, relaxation and rest**
- **Duration of AM and PM commute**

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Unconditional Positive Regard (or dense NCR)

- A few years ago, we realized that under typical classroom conditions, most vocal-verbal (potentially reinforcing) praise statements were delivered in response to compliance with a demand or request.
- At that point, we implemented an intervention involving the delivery of vocal-verbal praise statements and enthusiastic positive interactions for one of the students at the Life Skills House.

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Unconditional Positive Regard (or dense NCR).

- The student involved had a long-standing history of significant aggression (i.e., hitting, kicking, grabbing, hair-pulling, and biting). This was initially baselined at five aggressive episodes/day requiring physical intervention. At this point, he had acquired a functional alternative behavior (i.e., ripping up cardboard boxes) that reduced the frequency of aggression toward staff by approximately 50% (i.e., went from 2 episodes/week to 1 episode/week).
- Over the next 24 months, the inter-response interval went from a maximum of 3 days without aggression to just over seven months without aggression. No other variables were changed.

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Happiness



While it may seem overly simplistic, if we are to help others pursue happiness, we first need to identify what makes them happy (Parsons et al., 2012).

Individuals who can communicate their wants and needs are at an advantage, making prioritization of these basic choice-making/communication skills a clear place to both start programming and measure success.

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Happiness



Figuring out what makes one happy may include simply asking the individual, completing a series of activity assessments, or, as we like to call it, doing a "deep-dive" into a particular stimulus. When completing activity preferences, our protocol is to expose an individual to a minimum of 5 opportunities to engage in the activity.

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Adult Outcomes and QoL is a complex and sometimes contradictory topic

- Learning one is autistic earlier in life was associated with a heightened Quality of Life and sense of well-being in adulthood. Conversely, learning one is autistic at an older age was associated with more positive feelings about autism upon learning one is autistic. Study participants expressed both positive and negative emotions about autism and highlighted contextual factors to consider when telling a child about autism (Oredipe, T., et al, 2022).
- A subsequent study by Leung, et al, (2023) used a larger sample (N=300), accounted for potential confounding variables, and investigated different dimensions of QoL. In contrast to Oredipe (2022), the researchers found that the age at which one learned of their autism did not significantly or uniquely predict QoL. Having more autistic characteristics was the strongest predictor of poor quality of life.

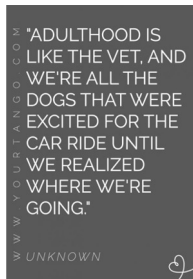
Leung, F.Y., Shah, P., Mason, D., & Livingston, L. A. (2023). Re-examining the association between the age of learning one is autistic and adult outcomes. *Autism*, 13623613231173056.

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Challenges to Promoting Lives of Competence, Dignity, and Quality.

- Whose definition of QoL are we measuring? Some interesting studies indicate that autistic adults (ASD1) had an improved QoL during the pandemic lockdown due to the subsequent reduction in interruptions and unexpected demands or activities.
- It seems highly likely that we are using a very neurotypical standard of QoL that may not be applicable to autistic adults in its entirety.
- While there is a growing body of research on the subject, much of it was done using 3rd party reports, which likely vary in accuracy.
- Studies using 1st-person reports have only been conducted using ASD1 adults.
- While we can incorporate more choices as one strategy to promote a positive QoL, they need to be choices that are important to the adult in question.
- DSP turnover rates hover between 40%-50% annually, with an average hourly pay of \$16/hour. Reasons include a lack of appreciation for their work, limited opportunity for advancement, and inadequate supervision. It is difficult to program for QoL when you down staff and your staff are underpaid and underappreciated.

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But beyond that

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According to Shattuck, et al, (2018):

Based on data from the National Longitudinal Transition Study-2012 (NLTS- 2012) and the National Survey of Children's Health 2016 (NSCH 2016).

- About one in three teens with ASD could not get to places outside the home very well or were not allowed to do so at all.
- Almost two-thirds (64%) of teens with ASD were taking prescription medications, and nearly half (48%) were taking medications for attention, behavior, or mood. These rates were much higher than teens with ID.
- About one in six (16%) did not receive needed healthcare
- One in four households of teens with ASD received at least one form of public assistance.

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2018 National Autism Indicators Report

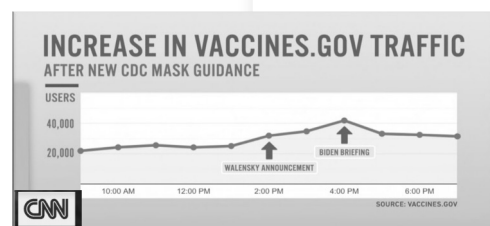
(Shattuck, et al, 2018)

- 23%-33% percent of teens with ASD lived in a household that received Supplemental Nutrition Assistance Program (SNAP, also known as food stamps) within the previous two years.
- Black or African American teens were more likely to have difficulty than their peers in several areas:
 - Communication
 - Self-care and adaptive behaviors
 - Independently getting to places outside the home
- Black or African American teens had the highest rate of taking medication for emotion, concentration or behavior.
- Black or African American teens had the highest rate of unmet health care needs.

Shattuck, P. T., Rast, J. E., Roux, A. M., Anderson, K. A., Benevides, T., Garfield, T., McGhee Hassrick, E., & Kuo, A. *National Autism Indicators Report: High School Students on the Autism Spectrum*. Philadelphia, PA: Life Course Outcomes Program, A.J. Drexel Autism Institute, Drexel University, 2018.

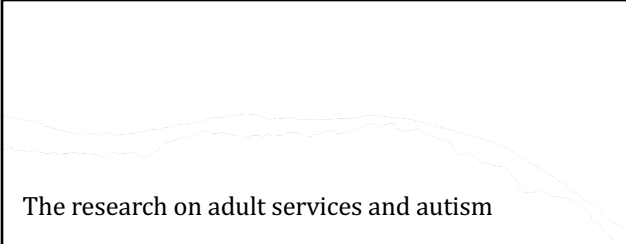
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Please do not make the mistake of thinking this is all outside the realm of our science or the scope of our practice, as it is not. We do big things even if we don't realize we can do big things.



Source: <https://www.cnn.com/2021/05/27/health/vaccination-interest-cdc-mask-guidance/index.html>

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The research on adult services and autism

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Shattuck, P.T., Garfield, T., Roux, A.M. *et al.* Services for Adults With Autism Spectrum Disorder: a Systems Perspective. *Current Psychiatry Reports* **22**, 13 (2020).

- The research has great variability as to how characterizing impairments and severity, sample demographics and socioeconomic status, and co-occurring conditions were identified and reported.
- Healthcare for adults with ASD emerged documenting many autistic adults experience significant barriers to healthcare.
- While most studies included information about sex it was solely binary with no attention to non-binary/transgender gender identities was not presented.
- Individuals who participated in research were predominantly male and white.

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Shattuck, P.T., Garfield, T., Roux, A.M. *et al.* Services for Adults With Autism Spectrum Disorder: a Systems Perspective. *Current Psychiatry Reports* **22**, 13 (2020).


- Research on services for adults on the spectrum remains small and lacks any unifying conceptual framework or consistent methodological approaches.
- Future research needs to explicitly adopt frameworks for understanding, and interventions for improving, systems of care.
- What is needed is a life-course-systems-perspective emphasizing the complex interactions among culture, history, institutions, organizations, policies, funding, and families that impact service accessibility, delivery, coordination, and effectiveness

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In a study published in the open access journal PLoS ONE, Marsack-Topolewski, Samuel, & Tarraf (2021) documented the simple fact that parental caregiver burden was decreased when their adult child with ASD was more independent with daily living skills. The researchers concluded that there is a need for “family-centered interventions to improve the capacity of adults with ASD to perform ADLs independently”. (p.1)

Marsack-Topolewski, C.N. Samuel, P.S. & Tarraf, W. (2021). Empirical evaluation of the association between daily living skills of adults with autism and parental caregiver burden. *PLoS ONE* 16(1) e0244844.

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But poor outcomes continue, at least in part, because:

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Behavior analysts are trained in the effective application of behavior analytic principles to increase or decrease behavior. Unfortunately, we are not trained in identifying which behaviors, beyond the most obvious, to target for increase or decrease.

48

In other words...

Effective, behavior analytic intervention targeting the wrong skill is no better than ineffective intervention targeting the right skill.

Neither results in any socially significant outcome for the student/client/family

49

The practice of behavior analytic intervention in autism does not require the development of, and adherence to, a set of rigid, unyielding, and unalterable instructions governing interactions. In fact, effective practice in ABA & ASD generally requires one to modify interventions in response to a slew of conditions, settings and contingencies while maintaining a commitment to data-based decision-making.

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In other words, evidence-based practice in ABA/ASD is a combination science, experience, and a sophisticated understanding of context. In that way, EBP is sort of, well, "zen-like"

51

Social Validity

"Colleagues, editors, and community members were asking us about the behavioral goals that we had chosen for training the teaching-parents and the youths participating in the community-based, family-style, behavioral treatment program at Achievement Place. **They would ask us: "How do you know what skills to teach? You talk about appropriate skills this and appropriate skills that. How do you know that these are really appropriate?"**" (Wolf, 1978, p. 206)

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Social Validity in ABA

"The suggestion seemed to be that society would need to validate our work on at least three levels:

- 1. The social significance of the goals. Are the specific behavioral goals really what society wants?*
- 2. The social appropriateness of the procedures. Do the ends justify the means? That is, do the participants, caregivers and other consumers consider the treatment procedures acceptable?*
- 3. The social importance of the effects. Are consumers satisfied with the results? All the results, including any unpredicted ones?*

We have come to refer to these as judgements of social validity." (Wolf, 1978, p. 207)

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- In other words, a commitment to providing socially valid behavior analytic intervention requires behavior analysts to go beyond knowing **HOW** to change behavior and knowing:
 - **WHAT** behaviors should be prioritized for change,
 - **WHY** these behaviors should be changed,
 - In **WHAT** context should behavior change be made,
 - **HOW** this particular behavior would most effectively be changed,
 - **WHO** should implement the behavior change procedures,
 - **WOULD** society regard changing the behavior and the method(s) used to change the behavior as ethical and important,
 - To what extent does the individual provide **ASSENT** to change their behavior.

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In their review of articles published in JABA between 1999 and 2016, Ferguson, et al (2018) analyzed 1,209 articles for measures of social validity. Of the 1,209 articles evaluated, only 141 (i.e., 12%) reported measures of social validity. Additionally, of the articles that did not report social validity measures, only 4% recommended future researchers assess the social validity of the goals and procedures. The authors note that these results are comparable to earlier findings documenting that social validity is rarely measured and/or reported within JABA

Ferguson, J.L., Cihon, J.H., Leaf, J.B., Van Meter, S.M., McEachin J. & Leaf, R. (2018): Assessment of social validity trends in the journal of applied behavior analysis, *European Journal of Behavior Analysis*, 20, 146-157.

55

Part of the problem is dissemination of relevant research.

56

"Behavior analysts often emphasize the need to study the effects of ABA procedures in the context of typical practice settings (e.g., Johnston, 1996). However, reviews indicate that the large majority of our research focuses on interventions delivered by study personnel, usually in tightly controlled environments such as laboratories, specialized ABA classrooms, or distraction-free areas set up to provide one-to-one instruction []. This discrepancy may reflect a dilemma that behavior analysts have had trouble resolving: We recognize that conducting studies in practice settings may require sacrificing some scientific rigor because the primary mission of such settings is to deliver services rather than conduct research (Johnston, 1996), yet we regard the quality of many studies in these settings as unacceptable (Johnston et al., 2006)." (Smith, 2013)

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So, there are a variety of external or systems obstacles that impact our ability to improve outcomes.

But if we are going to change outcomes, we will also need to make a few changes to our own behavior starting with:

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We need to provide intervention as if we are running out of time, because we are.



59

Time is not on your side.

- In New Jersey there are:
 - 210 School Days/Year
 - Typical School Day is 6 hours in length
 - If we subtract time spent at lunch, on break, in the bathroom, etc. we conservatively end up with 5 hours of active programming/intervention each day.
 - # of School Days X # of hours/day of intervention = 1,050 hours
 - Across 5 years (ages 16-21 years) that gives us 5,250 hours.
 - Sounds like a lot, doesn't it?

60

Time is not on your side.

- If there are 30 goals/objectives in your student's/client's IEP
 - That results in 150 instructional targets across 5-years
 - 5,250 available hours divided by 150 instructional targets leaves you with 35 instructional hours available for each instructional target.
 - We know there are 5 instructional hours during each school day.
 - This means you only have 7 School Days to provide sufficient intervention to bring each instructional target to mastery, let alone ensure generalization outside of the instructional environment with your student/client.

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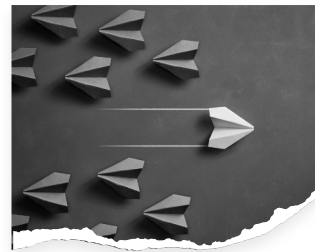


- Given the limited number of intervention hours available, the question then becomes, "What should be my priorities for intervention?" Do I spend 100 hours providing instruction in tacting US currency or do I spend that time teaching the more socially significant skill of shopping independently for preferred items?

62

The numbers don't lie. For outcomes to change we need to prioritize intervention and target those skills with the potential for the greatest positive impact for the student or client.

63



To do this, we need to rearrange the established contingencies supporting our behavior in such a way that the following set of behaviors become reinforced.

64

We need to modify our contingencies of reinforcement, so we stop thinking in terms of "functional skills" and, instead, think in terms of "applied skills"

Functional	Applied
Functional refers to some arbitrary characteristic of the skill	Applied refers to the extent to which the individual will use the skill once acquired.
Mastery of functional skills often translates into "responds to the Sd"	For an applied skill, initiation is occasioned by some environment stimuli.
Functional skills are generally limited to activities of daily living (ADLs)	Applied skills cross instructional domains so long as they are used by the individual
Functional skills are, unfortunately, too often taught outside the natural context	Applied skills are best acquired by practice in the natural context
Functional skills tend to fairly static	Applied skills are more dynamic with some acceptable variations in demonstration between individuals

65

We need to modify our contingencies of reinforcement so that skill acquisition targets are as congruent as possible with the individual's interests, preferences, and idiosyncrasies.

- This really is a permutation of the Premack Principal. In other words, are there characteristics of high probability behaviors that can be accorded low probability behaviors.
- For example, if self-talk occurs at a high frequency when the individual is taking a break, could he/she engage in self talk when acquiring a new, work-related skill (if it didn't interfere with skill acquisition)?
- Or during grocery shopping, don't freak out if the individual puts a bag of Hershey's kisses in the cart. He or she is communicating that Hershey's kisses are a good reason to go shopping in the first place. We refer to this process as "finding value."

66

Modify your contingencies of reinforcement so task analyses are individualized for each student in a way that targets the most efficient, simplest way to complete the chain.

Instead Of This	Try this
Measuring laundry detergent	Use Tide Pods
Sorting laundry	Don't
Laminated/Velcro schedule	Smart Phone
Cooking	Microwaving
Picking out clothes	Pre-organized sets of clothes
Tying shoes	Converse slip-ons
Write full name	Write your initials

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**This, BTW, is
my signature**

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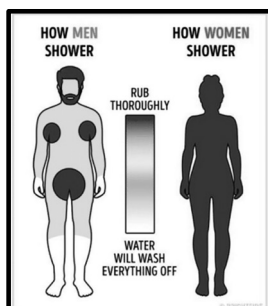
BTW, the web is full of potential short-cuts and accommodations

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We need to modify our contingencies of reinforcement such that insignificant errors do not preclude your student's or client's independence.

- On any given day I think I probably vary somewhere between 70% to 100% accurate implementation of everything I am expected to do. While people may laugh when I screw up, no one ever says "I am sorry, we have to practice that again." or "I am sorry, I don't think you can do that by yourself anymore."
- Your goal should not be trying to teach the perfect chained response. Your goal should be for your student/client to complete the chain in a way that achieves the desired end goal.
- This can be referred to as a "normative mastery"

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71

•It seems we often hold adults with autism to higher standards of competence than we are willing to hold ourselves.

•But in reality, at the end of the day, independence is more important than perfection

72

There are , of course, some exceptions

- COVID19 sanitary protocols
- Street crossing
- Medication self-administration
- Privacy
- Personal safety
- Some aspects of sexual behavior
- Menstrual care
- Etc.

73

We need to modify our contingencies of reinforcement in such a way to (safely) allow for errors when teaching safety skills.



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But it goes without saying, don't be stupid about it. Well, maybe it doesn't go without saying. Touching the hot stove is just an example. It is not a recommendation. Don't be stupid about it.

75

Error-based learning

- "Learning from errors is one of the basic principles of motor skill acquisition" (Seidler, Kwak, Fling, & Bernard, 2013, p.1)
- Simulation-based learning is often used to help mitigate the conflict between developing a medical student's skills and abilities while protecting patients from unnecessary risk. Simulation-based training has been institutionalized in other high-hazard professions, such as aviation, nuclear power, and the military, to maximize training safety and minimize risk (Ziv, et al, 2006).

Seidler, R. D., Kwak, Y., Fling, B. W., & Bernard, J. A. (2013). Neurocognitive Mechanisms of Error-Based Motor Learning. *Advances in Experimental Medicine and Biology*, 762, 1-21

Ziv, Amitai MD, Widge, Paul Reed PhD, Small, Stephen D. MD, Glick, Shimon MD. (2006). Simulation-Based Medical Education: An Ethical Imperative. *Simulation in Healthcare: The Journal of the Society for Simulation in Healthcare*: 252-256

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We need to modify our contingencies of reinforcement in such a way that we can recognize and, ideally, define the concepts below with reference to each student/client and his or her family:

Relationship	Compassion
Partnership	Happiness
Friendship	Joy
Self Esteem	Respect
Competence	Empathy

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EPIC's Critical Skills


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**Critical Skill - Toileting
(Bowel and Urine)**

Goal – Independent use of a bathroom, when necessary, including locking the door; wiping seat, wiping self (if necessary), washing hands, exiting bathroom and return to “location”


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Critical Skill - Dressing

- Goal – Closing door for privacy, independent selection of appropriate clothes, donning clothes in correct order and orientation and checking appearance before opening door and exiting area.

80

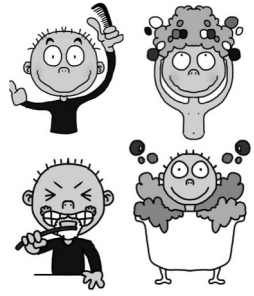


Critical Skill - Independent Eating

Goal – Able to correctly use all appropriate utensils (knife, fork, spoon) to eat a variety of foods neatly and at a culturally accepted pace.

81

Critical Skill – Bathing/Self Care



Goal – To demonstrate the ability to independently bathe/shower and complete relevant self care/hygiene skills (e.g., tooth brushing, grooming, etc.)


82



Critical Skill – Household Participation

Goal – Independent completion of a variety of household chores or, in our field, “ADLs”. The issue is not whether to target these skills but rather, when to target these skills.

83

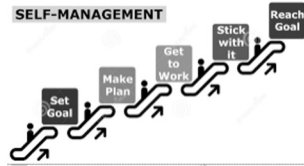


Critical Skill – Able to learn in a group

- Goal – To acquire new skills when presented via dyad or triad instruction at a rate of acquisition similar to that documented via 1:1 instruction.

84

Critical Skill – Self Management



Goal – To demonstrate the ability to identify one's own behavior as either appropriate or inappropriate deliver potential reinforcement in the absence of supervision.

85

Critical Skill – Problem Solving/Variable Responding

Goal – To demonstrate the ability to offer more than one potential solution when presented with a relevant problem or challenge.



86

Critical Skill – Maintain Physical Safety

Goal 1 – Demonstrate the ability to identify and avoid potential "non-human" dangers in the immediate environment.

Goal 2 – Demonstrate ability to discriminate between "safe" and "unsafe" people and respond appropriately.

Goal 3 – Demonstrate a reasonable degree of noncompliance when presented with "privacy requests" from an unapproved person.

Goal 4 – Demonstrate ability to participate in healthcare management activities (e.g., doctor or dentist visits).



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Critical Skill - Communication

Goal – Demonstrate the ability to make one's wants and needs known to naïve listeners across multiple environments.



88

Self-Advocacy

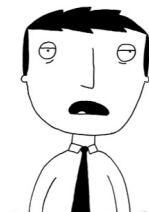


Self-advocacy is the ability to speak-up for yourself and the things that are important to you. Self-advocacy means you are able to ask for what you need and want and tell people about your thoughts and feelings

One of the most important processes but, at the same time, my least favorite label for a process. Why? Because it automatically identifies the person as having a disability even though the general process is what I do challenge a charge on my credit card.

89

ADULTHOOD



"IF YOU'RE NOT TIRED, YOU'RE NOT DOING IT RIGHT."

This was just a VERY brief introduction to the behavior change we, as behavior analysts, need to undertake if adult outcomes in ASD are to improve.

- We didn't even touch on such topics as:
 - Sexuality
 - Working with parents of older individuals
 - Behavior analysis and mental health
 - Healthcare transition
 - Aging and ASD
 - Employment
 - Transportation
 - Quality of Life
 - Leisure
 - And so on..

90

So, with that...

91

- After 40 years, one of the reasons I remain in the field of behavior analysis is that it is not up to me to determine if I was right or not. Only my students and/or clients can do that. As such, I get to check my ego and defensiveness at the door and just focus on the work.
- When working with adults with autism, we are more often a science of probabilities, than a science of certainties. So, get comfortable with probabilities that won't always fall in your favor.

92

Teach your students or clients to wipe after a bowel movement

93

NOTHING IS PERFECT. LIFE IS MESSY. RELATIONSHIPS ARE COMPLEX. OUTCOMES ARE UNCERTAIN. PEOPLE ARE IRRATIONAL.

Adulthood is f*ck*ng complex. It is not that people are irrational (usually), it is just that you have no way of knowing all the relevant variables at any given time.

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A failure is not always a mistake, it may simply be the best one can do under the circumstances. The real mistake is to stop trying.

B.F. Skinner
1904 - 1990

96

Thank you