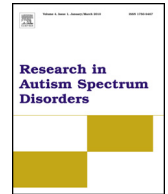




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# Research in Autism Spectrum Disorders

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## The relationship between comorbid psychopathologies, autism, and social skill deficits in young children



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### ABSTRACT

Social skills are important for both social development and integration. However, few studies have looked at these behaviors in the context of severity of autism spectrum disorder (ASD) symptoms and comorbid psychopathology in young children. Three hundred twenty eight infants and toddlers between 18 and 36 months of age diagnosed with ASD were studied. More severe symptoms of ASD and various forms of emotional distress such as tantrums and inattention/impulsivity were associated with greater difficulties in social behavior.

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### 1. Introduction

Autism spectrum disorders (ASD) have core symptoms of rituals and stereotypies, communication, and social skill impairments (Matson, Boisjoli, Hess, & Wilkins, 2010; Matson, González, & Rivet, 2008; Matson, Kozlowski, Hattier, Horovitz, & Sipes, 2012; Matson, Wilkins, Sharp, Knight, et al., 2009; Worley & Matson, 2012). All these deficits can be debilitating. However, communication and social skill impairments may be particularly problematic for integration into society (Brooks & Ploog, 2013; Horovitz & Matson, 2010; Leung, Ordqvist, Falkmar, Parsons, & Falkmar, 2013). Additionally, intellectual disability (ID) also results in social skill impairments (Fisher, Moskowitz, & Hodapp, 2013; Matson, Carlisle, & Bamburg, 1998; Matson, LeBlanc, & Weinheimer, 1999; Matson, Smiroldo, & Bamburg, 1998; Rutter, 1978; Rutter & Bartak, 1971). ASD and ID overlap a good deal, thus further compounding the issue of social and other deficiencies (Coe et al., 1999; Klin, Jones, Schultz, Volkmar, & Cohen, 2002; Matson, Hamilton, et al., 1997; Matson, Kiely, & Bamburg, 1997; Matson, Wilkins, & Ancona, 2008).

It is also well known that a variety of other problems co-occur with ASD and ID. Prominent among these difficulties are challenging behaviors and psychopathology (Mannion & Leader, 2014; Matson & Bamburg, 1998; Matson, Boisjoli, Rojahn, & Hess, 2009; Matson, Cooper, Malone, & Moskow, 2008; Matson, Dempsey, & Fodstad, 2009; Matson, Hess, & Boisjoli, 2010; Matson & Rivet, 2008; Matson, Rivet, Fodstad, Dempsey, & Boisjoli, 2009; Matson, Rush, Hamilton, Anderson, Bamburg, & Baglio, 1999; Matson, Smiroldo, Hamilton, & Baglio, 1997; Matson & Smiroldo, 1997; Paclawskyj, Matson, Bamburg, & Baglio, 1997). What is also becoming more evident with time is the complexity of the interactions of various symptoms of ASD and problems that can occur in conjunction with them (Duncan, Matson, Bamburg, Cherry, & Buckley, 1999; Matson & LoVullo, 2009). Comorbidities within the ASD population have been correlated with increased stereotypies, sleep disturbances, and impairments in adaptive functioning as well as a more severe presentation of the core symptoms of ASD (Matson et al., 2011;

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Mayes, Calhoun, Murray, Ahuja, & Smith, 2011; Yerys et al., 2009). Among these exacerbations, researchers have found that individuals with more severe comorbid symptoms may demonstrate greater socialization deficits (Matson, Worley, Neal, Mahan, & Fodstad, 2010).

These data and the extent to which researchers and clinicians understand them also dictate the types of interventions that are used (Advokat, Mayville, & Matson, 2000; Matson & Boisjoli, 2007; Matson, Mahan, & LoVullo, 2009; Matson et al., 2005; Matson & Wilkins, 2008). Although early intensive behavioral intervention (EIBI) has acquired a substantial evidence base for treating autism symptomology and social skill deficits in particular (Matson & Goldin, 2014), the comprehensive integration of comorbidity treatment into EIBI programs, especially in relation to exacerbated ASD symptoms, is limited. Further, evidence-based treatments for psychopathologies (e.g., stimulant medication for Attention-Deficit/Hyperactivity Disorder; exposure-based therapies for anxiety) require greater research regarding efficacy within the ASD population specifically. Interventions used for comorbidities and behavior problems, particularly medications, have been found to have adverse side effects within individuals with ASD and should be monitored closely (Matson, Mayville, et al., 1998; Reichow, Volkmar, & Bloch, 2013).

The purpose of this study was to address overall social skill strengths and deficits, and to address how these skills are affected by co-occurring behavior problems, ASD, and symptoms of psychopathology. The interaction of these symptoms were studied here in very young children to determine if these patterns begin to emerge very early in a person's life. Behavior problems and psychopathology affect social skills in individuals without ASD; and, comorbidities have been associated with increased social deficits in individuals with ASD (Matson et al., 2011; Matson, Worley, Neal, Mahan, & Fodstad, 2010). Therefore, both symptoms of ASD as well as behavior problems and psychopathology are expected to significantly contribute to socialization impairment in young children with ASD. This information is important in that the appearance of this problem in early life is a significant predictor of these problems later in life (Briggs-Gowan, Carter, Bosson-Heenan, Guyer, & Horwitz, 2006; Cherkasova, Sulla, Dalena, Pondé, & Hechtman, 2013). Children do not “grow” out of these problems.

## 2. Method

### 2.1. Participants

Three hundred twenty-eight infants and toddlers with ASD aged 18–36 months old ( $M = 26.61$ ,  $SD = 4.69$ ) participated in this study. The total sample consisted of 75.3% males ( $n = 247$ ) and 24.7% females ( $n = 81$ ). Of the total participants, 47.3% were Caucasian ( $n = 155$ ), 40.2% were African American ( $n = 132$ ), 1.5% were Hispanic ( $n = 5$ ) and 11.0% were of other or unspecified ethnicity ( $n = 36$ ). Participants were recruited through EarlySteps, Louisiana's Early Intervention System under the Individuals with Disabilities Education Act, Part C. EarlySteps provides services for children with or at risk for a developmental delay from birth to 36 months of age. ASD diagnoses were made by a licensed clinical psychologist according to an algorithm based upon the ASD criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)*.

### 2.2. Measures

#### 2.2.1. Baby and Infant Screen for Children with aUtism Traits-Part 1 (BISCUIT-Part 1)

The *Baby and Infant Screen for Children with aUtism Traits (BISCUIT)* is an informant-based assessment intended for use with infants and toddlers aged 17–37 months (Matson, Wilkins, Sevin, et al., 2009). The *BISCUIT* consists of three parts that assess for ASD symptomology, comorbid psychopathologies, and challenging behaviors, respectively. The *BISCUIT-Part 1* measures ASD symptoms and includes 62 items administered to the caregiver. Caregivers are instructed to rate items on a 3-point Likert scale comparing the child to same-aged peers. A rating of 0 indicates “not different; no impairment;” a rating of 1 indicates “somewhat different; mild impairment;” and, a rating of 2 indicates “very different; severe impairment.” Factor analysis specified three factors of the *BISCUIT-Part 1*: socialization/nonverbal communication, repetitive behaviors/restricted interest, and communication (Matson, Boisjoli, et al., 2010). Evidence for strong psychometric properties has been found for the *BISCUIT-Part 1*. The overall correct classification rate is 0.89 and an internal reliability of 0.97 (Matson, Wilkins, Sevin, et al., 2009). Sensitivity and specificity rates were found to be adequate (Matson, Wilkins, Sharp, et al., 2009). The *BISCUIT-Part 1* will be used as a measure of ASD severity.

#### 2.2.2. Baby and Infant Scale for Children with aUtism Traits, Part 2 (BISCUIT-Part 2)

The *BISCUIT-Part 2* assesses for comorbid symptoms that commonly occur with ASD in young children and consists of 57 items. As in the *BISCUIT-Part 1*, caregivers are instructed to rate each item on a 3-point Likert scale to the extent it has been a recent problem for the child being assessed. A score of 0 indicates “not a problem or impairment;” a score of 1 indicates “mild problem or impairment;” and, a score of 2 indicates “severe problem or impairment.” The *BISCUIT-Part 2* consists of five subscales including Tantrum/Conduct Behavior, Inattention/Impulsivity, Avoidance Behavior, Anxiety/Repetitive Behavior, and Eat/Sleep Problems. The Tantrum/Conduct Behavior, Inattention/Impulsivity, Avoidance Behavior, and Anxiety/Repetitive Behavior subscales were used in the current study. The *BISCUIT-Part 2* has developed age-based cut-off scores specific to a diagnostic population; these cut-off scores indicate level of impairment (i.e., No/Minimal Impairment, Moderate Impairment, Severe Impairment) experienced by the child related to each comorbid subscale (Horovitz & Matson, in press). The *BISCUIT-Part 2* demonstrates psychometric strength; an internal consistency of 0.96 has been observed (Matson, Wilkins, Sevin, et al., 2009).

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