



# PSYCHOLOGY IN INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

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## From the President: "Favorite Things" from the APA Conference

Jan Blacher

University of California - Riverside



Before the memories fade, I'd like to recall some of the highlights of this year's Division 33 APA Program,

where we honored all of our graduate students and early career professionals (ECPs). I asked some of our outstanding presenters to share their "favorite things" about this year's program, and to provide a take-away message from the research that they presented. As you read these, I hope you will conclude that the future is indeed bright for Division 33!

Thanks to everyone who contributed to the program this year, and for your support of Division 33.

**Jessica Bradshaw**, *Graduate Student, Gevirtz Graduate School of Education, University of California-Santa Barbara*

We examined the impact of a brief parent-mediated intervention using motivational procedures of Pivotal Response Treatment (PRT) on improving social engagement for 6-month-old infants exhibiting early sign of autism. Results indicated that each infant exhibited a stable pattern of abnormally

low social engagement prior to onset of intervention. After intervention, all infants showed large gains in social engagement during play with a caregiver. Specifically, they improved in social smiling and social interest during parent-infant interactions. We hope the development of effective early interventions for infants as early as six months can serve as a resource for parents and professionals who might be concerned about early signs of autism. Also, this study suggests that some parent concerns regarding their infant's social behavior are valid and we can help to reduce stress and improve infant behavior through very simple and cost-effective intervention methods. We hope to continue researching the long-term effectiveness of this intervention.

### My favorite thing:

I was particularly impressed with the conversations regarding the intersections of intellectual disability and autism spectrum disorder. These discussions highlighted the importance of continued research efforts in early identification and intervention for not only autism spectrum disorders but for all children showing early signs of developmental delays.

**Willa Marquis**, *Graduate Student, Department of Psychology, UCLA:*

### Project Summary and Take-Away:

There were two main take-away messages from my presentation. First, our findings support previous research

indicating a delay status disparity in sports participation and extend them to a younger, school-aged sample. Second, our study suggests that sports participation may have a special significance for children with Intellectual Disability (ID). The association between mental health outcomes (i.e., externalizing behavior problems) and sports participation differed based on child delay status, and predictive and concurrent relationships between sports participation and social adjustment were present for the ID sample but not for the typically developing (TD) sample. Knowing the challenges associated with clinical treatment of comorbid mental health disorders in children with ID, I think it is important to explore alternative contributors, like sports, to positive adjustment. We are in the process of collecting 15-year data from our longitudinal sample and plan to examine parent and child interview data regarding the significance of

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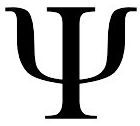
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## From the President: “My Favorite Things” from the APA Conference Jan Blacher

University of California - Riverside

*Blacher continued...*

sports for the mental health and social identities of our teen sample.

### My favorite thing:

One of my favorite experiences from this meeting was attending the symposium "Intellectual Disability and the Death Penalty - The Law and the Science." It was fascinating to hear about the intersection of our field with the legal system and to hear about the widespread implications that our work can have beyond the academic realm. That and the Division 33 social hour, of course!

**Jason Baker, Ph.D.,** *Assistant Professor of Child & Adolescent Studies, California State University-Fullerton*

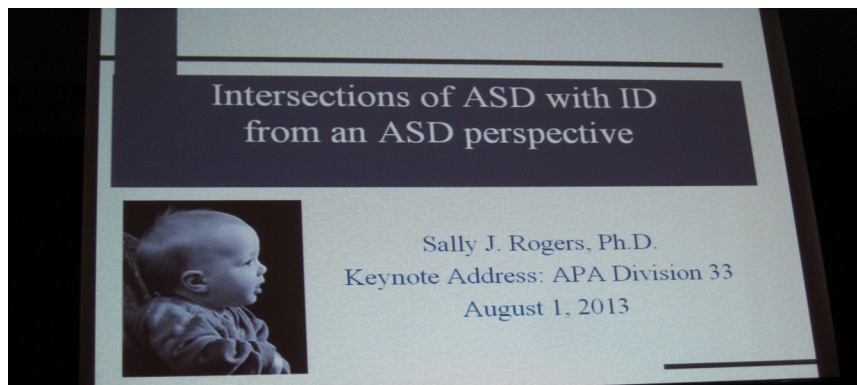
### My favorite thing:

Although not necessarily specific to this year, my favorite thing about APA is by far the people of Division 33. In addition to producing high quality work and fostering an impressive camaraderie among its members, what is most notable about this group is the degree to which everyone cares deeply about how our work can help individuals with intellectual and developmental disabilities and their families.

### Project Summary and Take-Away:

Complex developmental outcomes are often conceptualized as multi-determined by a number of biological, psychological, and environmental factors over time. However, relatively few studies consider these domains simultaneously, particularly in populations characterized by difficulties with known biological underpinnings. Children with fetal alcohol

spectrum disorders (FASD) are at high risk for poor outcomes related to externalizing problems and anti-social behavior, and these difficulties are frequently considered to be a product of permanent neurologic dysfunction. Using a combination of direct neuropsychological testing and careful observation of structured laboratory tasks, our study of a small group of young children with FASD revealed clear, independent contributions of both child (e.g., basic impulse control, emotion regulation) and environmental (caregiver co-regulation) factors to children's ability to resist touching a prohibited object—an index of self-regulation and moral internalization. Indeed, child and environmental factors each predicted approximately one quarter of the variance in children's ability to resist rule violation, underscoring the complex nature of resilience in these children and suggesting diverse avenues for intervention and/or tertiary prevention. We are continuing to augment our sample to permit consideration of more complex interactive models and to further increase confidence in the representativeness of our findings.



## Empirically-Based Practice with Infants and Autism: Proceeding with Caution—Jacobson Award Winner

**Sally Rogers**

The MIND Institute, University of California Davis



Thirteen years ago, John Jacobson wrote: “Why, then, in the case of educational and health-related services for children with autism spectrum disorder (ASD), do we find that most of the services that providers are prepared to offer are based on personal opinion, accumulated subjective consensus, or sometimes ideological positions instead of practices with demonstrated outcomes? Why don’t these educational and clinical services have more to do with the question of whether children are learning?” (Jacobson, 2000). In 2013, the term “evidence-based practices” is increasingly a mantra for psychologists, physicians, and special educators. The Individuals with Disabilities Education Act (IDEA), Part B, provides a legal basis in the U.S. for the required use of evidence-based educational practices for children ages 3-21, and a number of reviews have been published in the past few years that assist practitioners to identify evidence-based practices effective for teaching and changing behavioral patterns of persons with ASD.

However, autism is increasingly being identified in children

younger than 3, and public education services for those children fall under Part C of IDEA. This legal mandate for services for infants and toddlers with disabilities differ from those for older children in several ways, including its focus on support to families, and its requirements for multidisciplinary assessment, service delivery in natural environments, and family involvement and support. In many states, infant/toddler services are delivered by state systems other than education, and services are typically provided to infants and toddlers at home or in daycare settings and directly involve parents or other caretakers. Services often consist of separate, hourly, or weekly visits by professionals like speech and language therapy, occupational and physical therapy, and early childhood special education. Visits often focus on immediate parent concerns, with some direct work with children, some parent coaching, and some parent-professional discussion filling the hour. Too often, this means that there are various professionals doing hands-on treatment with little basis in empirically-based practice, and giving parents advice which is not coordinated among the professionals, with little evidence of treatment benefit (Dunst et al., 2007).

For toddlers and young children with autism, these earliest years hold the potential for enormous growth. Intensive early intervention can result in massive improvements in language ability, rapidly increasing IQ scores, and major improvements in behavior problems. The majority of young children with ASD who receive two years or more of intensive intervention in

both the Lovaas models and the Early Start Denver Model (ESDM) move out of the range of intellectual disability and acquire spontaneous, meaningful language during this preschool period (Dawson et al., 2010; Remington et al., 2007; McEachin et al., 1993). However, these interventions involve many hours a week of therapy by carefully trained personnel for an extended period of time and involve a level of cost and person-power that is typically beyond the ability of the public infant/toddler intervention system to fund.

Over the past several years, funding from Autism Speaks stimulated a new effort to develop interventions for young children with autism that parents and other caregivers could implement during daily routines in children’s natural environments. Parent-implemented interventions fit well within the Part C framework and values, and there is efficacy data for parent-implemented interventions from young children with other disabilities and their families (see Wallace, & Rogers, 2010, for a recent review). A growing body of evidence indicates that parenting styles have long-term effects on the language development of children with autism (Siller & Sigman, 2002, 2008). Parent-implemented interventions that fit inside daily routines have the potential to provide a greater level of intensity, consistency, and generalization than professionally delivered interventions.

Several studies of parent-implemented interventions for

## Rogers (continued)

these youngest children with autism have recently been published.

These tend to be short-term studies of low-intensity, brief interventions focused on coaching parents to follow children's leads, establish shared activities, respond to children's communicative intents, and join them in the activities that they are already engaged in, rather than directing them to new activities. These are the interactive techniques that best scaffold language development in typically developing children, and data from Siller and others demonstrate that language progress in children with autism is enhanced by these techniques as well (Siller & Sigman, 2002, 2008). A number of controlled studies have demonstrated that parents successfully learn the techniques in relatively short periods of time (e.g., Vismara et al., 2013; Kasari et al., 2010; Carter et al., 2010; Green et al., 2010), and some studies that directly assess behavioral changes in children have also found positive effects on child communicative behavior (e.g. Vismara et al, 2008; Schertz et al., 2012). However, not all studies demonstrate differential effects of experimental interventions over community interventions (Rogers et al, 2012; Green et al, 2010). And in very few studies is there evidence of child effects from standardized measures of IQ, language development, or autism symptoms.

Efforts to interpret the rather modest outcomes reported from these parent-implemented intervention studies open up a number of questions involving methodology and interpretation and underline the difficulty of conducting efficacy trials of this type of treatment in environments in which similar services are legally mandated. One methodological difficulty is the timing of these short-term studies. It is often the case that throughout the 3-6 months

between child enrollment and the end of the experimental intervention period, the parent is actively learning the techniques. This means that by definition the children cannot be receiving the full "dose" of the intervention, because the parent is not completely trained in the method. Thus in many studies, child outcome data are being gathered just at the point that the parent is mastering the techniques (see Rogers et al., 2012, for an example), rather than after a period of time in which the parent is actually fluent in the methods. Lack of significant effects may reflect an ineffective treatment approach, or an inadequate dosage of an effective treatment. One cannot discriminate between these choices when the treatment period is also the parent learning period.

A second difficulty is the use of a group of children and families who are receiving community-based intervention services as a contrast group. Since several hours a week of intervention is the public norm, and the service is a public mandate, children in comparison groups, and their parents, are receiving early intervention from infant-toddler intervention services, and these parents are also well informed about early ASD, given that they have enrolled in the research study. It is clear from the outcome data in some of these studies that children in the community benefit from community services (see Carter et al., 2002; Rogers et al., 2012, for examples). In some studies, the comparison group children are receiving far more hours of service than the experimental group is receiving. Since community infant-toddler intervention services generally apply developmental models and teach parents to follow children's leads, engage in reciprocal play, and focus on child language learning, true differences between

the experimental and the community conditions may be minimal. Unlike drug studies, early intervention studies cannot have no-treatment or placebo-treatment groups. Intervention is a legal right and cannot be ethically withheld. This methodological problem could be addressed by using designs in which experimental children act as their own controls, like nonsequential multiple baseline designs (see Vismara et al. 2013 for a very convincing example).

A final difficulty is knowing what "dosage" of intervention is actually being delivered to children in parent-implemented treatment studies. Parents are taught certain techniques, and they demonstrate their learning during lab probes or videotaped home sessions. However, what parents implement at home, in their daily routines, day after day, is unknown, and we currently lack any objective means of measuring actual treatment delivery at home during parent-implemented interventions without the presence of experimenters or other stimuli that would serve as cues for parents to interact with their children in certain ways. Without knowing what and how much intervention has actually been delivered to children in the experimental groups, we cannot determine whether small or null effects indicate an ineffective treatment approach, or an under-delivered intervention. This is an enormous methodological problem, because it means we have no way of assessing the independent variable in the experimental paradigm.

The response of young children with autism, as a group, to intensive, systematic interventions like the ESDM or Lovaas's intervention approach, and the ability of parents to master these treatment techniques, suggest that parent-implemented interventions built on these effective practices and implemented throughout children's waking hours should have at least as strong an effect as therapist-

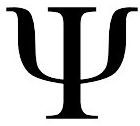
delivered interventions. We are not suggesting that parents need to become full-time therapists for their children. Parents already provide children's most powerful learning experiences. Furthermore, interventions that are synchronous with parent values and preferences and are built to fit into existing parent daily routines with their children do not have to place an undue burden on parents. Finally, whatever parental burden ensues may replace the heavy burden that exists for too many parents who are raising a challenging child with autism without appropriate resources or needed help. Thus, the potential seems to be real that well-designed parent-implemented interventions could have large positive effects on the development of infants and toddlers with ASD.

However, even if we are successful in designing effective parent-implemented interventions, we need to guard against an "inoculation" way of thinking about these treatments. Parents who are delivering interventions at home need ongoing support from their families, their social networks, and their communities, as well as from autism specialists, in order to foster positive development of the child and the family, a viewpoint clearly articulated in Bronfenbrenner's ecological systems model (1992). In our efforts to spread limited autism resources to families and children with autism around the globe, we cannot depend only on relatively brief parent training to provide the ongoing intervention needed for children to thrive. Just as we provide ongoing supervision, inservice training, and support to our clinical and university teams of autism therapists to maintain and advance their skills and motivation, so we have to plan long-term community supports for parents into our short-term parent-implemented intervention models. When we develop effective

models for parent-implementation that also provide long-term parent supports, then we will have a chance of providing the benefits of intensive early autism intervention to many more of the world's children.

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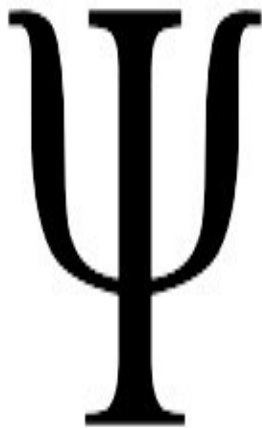


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## Early Career Psychologist Corner

Abbey Eisenhower, Ph.D.,

Assistant Professor, University of Massachusetts Boston

### *An interview with Dr. Daniel Bagner Florida International University*

As the new Early Career Representative to Division 33's Executive Committee, I am excited to bring you a column in the newsletter focused on issues of relevance to Early Career Psychologists (ECPs). Division 33 has many ECP members, and these ECPs are doing important and impressive work in their scholarship, clinical service, and other pursuits. In this issue, we highlight one such Early Career Psychologist, whose ground-breaking work has great relevance for children with intellectual and developmental disabilities and their families.

Dr. Daniel Bagner is an Assistant Professor at Florida International University. Dr. Bagner is an accomplished researcher, clinical psychologist, and instructor whose work has revealed important lessons about how Parent-Child Interaction Therapy and other treatments can be applied successfully to young children with developmental delays, children born premature, and children from low income and underserved and underrepresented racial and ethnic backgrounds. I recently caught up with Dr. Bagner for an interview, in which he shared his research interests, his experiences as an Early Career Psychologist, and his advice for student members of Division 33.

#### ***Tell us about your career path so far. What was your route to graduate school?***

As an undergraduate student looking to go to graduate

school, I was primarily interested in pursuing treatment outcome research with children. I had taken an undergraduate class with Saul Garfield, a professor at Washington University St. Louis, who was a pioneer in the adult psychotherapy outcome world. Dr. Garfield was one of the first in the field to talk about measuring the effects of psychotherapy, and his work had a major impact on me. Dr. Garfield's course led to my interest in treatment outcome research. In addition to this interest, I also knew I wanted to work with children. I was fortunate to be accepted to work with Sheila Eyberg at the University of Florida for graduate school, where I received my Ph.D. in Clinical Psychology in 2007.

#### ***Tell us about your graduate school research.***

During my first three years in graduate school I was involved in Dr. Eyberg's NIMH-funded study of maintenance treatment with Parent-Child Interaction Therapy (PCIT). In this study--in which all participants received PCIT and half were randomized to receive monthly maintenance booster sessions--we aimed to address the fact that a third of children who receive such treatments do not maintain their behavioral gains over time.

For my master's thesis, I examined the role of father involvement in contributing to treatment outcomes.



### **Eisenhower (continued)**

We found that, for children who received PCIT, fathers' involvement in sessions helped maintain the behavioral gains they made in treatment in the long term.

For my dissertation, I conducted a randomized, controlled trial to determine whether PCIT would be effective for children with developmental delays (DD). This was supported by an NRSA and funding from Division 53. I found that PCIT was just as effective for children with DD as it is for children without DD.

### ***Tell us about your career path since graduate school.***

After graduate school, I went to Brown for my internship and then did a post-doc there, where I worked with Drs. Steve Sheinkopf and Barry Lester at the Brown Center for the Study of Children at Risk. I received an F-32 NRSA post-doctoral fellowship from NICHD to examine the effectiveness of PCIT for children who were born premature. This is a high-risk group of children, with elevated rates of both DD and behavior problems. Similar to a DD sample, this group of parents often reports feeling more protective of their children and having a hard time with discipline strategies, making PCIT a good fit. In doing this work, we learned that PCIT could be effective at a younger age than previously tested, including with children as young as 18 months.

For the last 4.5 years, I have been at Florida International University as an Assistant Professor. I am in my final year of a K Award, which has allowed me to do research applying the first phase of PCIT (i.e., Child-Directed Interaction) with very young children (ages 12-15 months) from underserved backgrounds.

### ***Parent-Child Interaction Therapy***

### ***has been a central focus of your research. Can you describe the basic tenets of this treatment approach?***

PCIT is a behavioral parent-training intervention to treat disruptive behavior in preschool-age children and was developed by Dr. Sheila Eyberg in the 1970s. It includes two distinct phases. The Child-Directed Interaction phase focuses on strengthening the parent-child relationship in the context of play. Therapists teach parents to use positive attention for appropriate child behavior and ignoring in response to inappropriate child behavior. In the Parent-Directed Interaction phase, parents are taught to use specific discipline strategies to increase child compliance and reduce negative child disruptive behaviors (e.g., hitting). PCIT is unique for a number of reasons, including active coaching of parents through a one-way mirror, where the parent wears a wireless headset and practices the newly learned skills with the child while receiving direct, second-by-second feedback from the therapist.

### ***You have pioneered the application of PCIT to families with children DD. What have you learned from this work?***

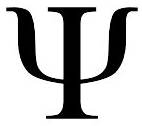
When I first decided to apply PCIT to children with DD for my dissertation, I was really interested in the fact that there are numerous evidence-based treatments available for addressing early childhood behavior problems, yet all of these programs (at the time) screened out children with DD. Furthermore, the rates of externalizing problems among children with DD are much higher than among children without DD, sometimes 3 or 4 times higher, suggesting the urgent need to examine these interventions with these children. In the RCT I conducted for my dissertation, I found that PCIT was effective for children with DD relative to a waitlist condition, and that it was just as effective for chil-

dren with DD as it had been shown to be for children without DD; these findings were published in the *Journal of Clinical Child and Adolescent Psychology*.

In my experience, PCIT did not need major modifications in order to work with families of children with DD. In PCIT, the program is always tailored to the specific needs of the child and family and would apply with a family with a child with DD. For instance, in the Parent-Directed Interaction phase of PCIT, we teach the parent to give clear, effective commands and follow through with praise for compliance and timeout for noncompliance. A common issue for children with DD is to know whether they understand receptively what they are being told to do. As with parents of typically developing children, we would help the parents ensure that the child understands the command, otherwise it would be unfair to follow-through with time out for noncompliance. Similarly, we worked with the parents of children with DD to give simple commands and ensure children's understanding.

Another example of tailoring occurred in the first Child-Directed Interaction phase of PCIT, when parents are taught to reflect the child's speech. If a child is not using much spoken language, we may tailor the number of reflections we expect parents make. So instead of requiring parents to use at least 10 reflections per 5-minute play session, we would ensure that the parent repeated or reflected at least 75% of what their children say during play, including sounds (e.g., "Moo" when playing with a cow).

### ***What else has your research taught you about treatment outcomes for children with DD?***



I recently studied the impact of father involvement in treatment for children with DD, similar to my earlier study of father involvement in PCIT for children without DD. In this sample of children with DD, we found that a subset of them had father who lived in the same home but were not involved in treatment. Among two-parent families, those with involved fathers (i.e. fathers who attended treatment sessions) showed greater improvements in externalizing problems than those with either uninvolved fathers or single mothers. Additionally, children from two-parent families were significantly more compliant after treatment than children from single-mother families. Furthermore, we found that dropout rates were higher among single mothers than two-parent families. These findings highlight the importance of including fathers in treatment when working with children with DD and recognizing and addressing the higher risk for dropout among single mothers.

***Tell us about the research you're currently working on.***

We are currently examining an adaptation of the Child-Directed Interaction phase of PCIT with infants ages 12-15 months old. PCIT has been empirically supported from children as young as age 18 months (described above), but we think the Child-Directed Interaction is applicable for children much younger. There has been little empirical support for interventions that target behavior problems in infants, with some notable exceptions such as David Olds' nurse home-visiting program and the Family Check-Up work of Danny Shaw and colleagues. Yet, infancy may be a particularly good time to intervene in order to help those families in highest need.

Implementing the Child-Directed Interaction phase of PCIT earlier may help overcome barriers to

engagement, including barriers facing families from underrepresented racial and ethnic minorities. While programs such as PCIT are effective, they are only effective if parents come to treatment sessions and complete treatment. As many as 30% to 50% of families drop out of PCIT and other parenting interventions, and those who drop out are more often from underserved communities, including racial and ethnic minorities. Among those who do complete treatment, children from low-income and underserved groups have poorer response to treatment compared to children from middle and upper socioeconomic backgrounds. This is on top of the fact that many of these families don't even come in the door to receive treatment in the first place. Overcoming these barriers to treatment access is a major challenge. If we can identify behavior problems at the earliest point possible, we may be able to apply a briefer intervention that is more effective at engaging and retaining families before barriers arise and before problems become more entrenched. We recently completed an open trial (published in *Cognitive and Behavioral Practice*) and are in the process of completing a small RCT of a brief, 5-6 session version of the Child-Directed Interaction phase of PCIT among 54 young, 12-15-month-old children, with preliminary results yielding promising findings. These children were about 95% ethnic minorities and about half were Spanish-speaking. We think this briefer, earlier model will improve our ability to engage underserved families.

***What is next for your research?***

Next, I would like to continue examining the Child-Directed Interaction phase of PCIT with infants. It seems like an ideal opportunity to work with families just as children are beginning to walk and talk and test limits with their par-

ents. We are currently preparing to submit an R01 grant application to conduct a larger RCT of this approach, with a longer follow-up period of two years, continuing to follow the children after treatment until they are 3 years old.

We are interested not only in behavioral outcomes but in pre-academic outcomes as well. A lot of PCIT is about encouraging parents to talk to their children, which can potentially influence pre-academic outcomes as well. We are also interested in how such early treatment may be mediated or moderated by infants' regulation. We're planning to examine how observed self-regulation, including physiological markers such as heart rate variability, may mediate the intervention's impact on child behavior.

***As an academic and researcher, you have obtained numerous grants to support your work. What advice do you have for students and new ECPs as they apply for grants?***

Be persistent. I submitted an F-31 pre-doctoral NRSA application to support my dissertation, during a time when the funding prospects were bleak. I had to submit three times, so something I learned from this was the importance of persistence.

I also learned to stay the course about aspects of the study design I felt strongly about when revising a grant application. For instance, a primary criticism I received from grant reviewers for my dissertation study--in which I proposed to examine the effectiveness of PCIT for children with DD--was that I was not proposing any major modifications to PCIT in order to be suitable for children with DD. I felt strongly that the existing strategies and PCIT were a very good fit for families with children with DD and would be effective for these families without major adaptations. In addition to respectfully raising responses to this criticism by reviewers, I provided PCIT to a family with a child with delays (in between grant submissions) to provide some pilot data in support of my



argument. In the end, the grant was funded and we found that the treatment was just as effective for children with DD as it has been for children without DD.

***What advice do you have for students dealing with unexpected results in their research?***

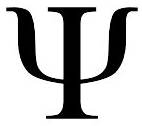
Look for the interesting story behind your results, even if the results are different than you expected to find. Even unexpected findings are informative. In the clinic where I worked as a graduate student, our model was to see families whenever they could come in (evenings, weekends) and whichever family members could come. Sometimes this meant that, in two-parent families, only one parent (usually a mother) could attend sessions. This flexible approach helped make it convenient and feasible for families, but I began to wonder? Does it matter who comes to sessions? How important is it that fathers participate? In my master's thesis, I looked at the role of father involvement in children's treatment outcomes.

I had expected different results, thinking that those families where fathers did not regularly participate in sessions would do worse. However, what we actually found is that, when families had dads living in the home, we were actually really good at getting dads to come in for treatment. So in contrast to my expectations, we did not have many fathers who were not attending sessions at our clinic. Another interesting finding was that, at post-treatment, single mothers actually reported greater improvements in child behavior than mothers from two-parent households, but at later follow-up assessments, the two-parent families maintained these gains better over time. These findings told us something interesting but unexpected about the way treatment works for families with one and two parents, and I went on to publish my

master's thesis findings in the Journal of Clinical Child and Adolescent Psychology.

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## Meaningful Change

### Steven F. Warren, PhD

University of Kansas

### 2013 Doll Award Winner



My career has been spent at the University of Kansas and at Vanderbilt University, two fine institutions with long traditions of groundbreaking research in intellectual and developmental disabilities. A large number of Doll Award winners have been associated with one and in several instances both of these institutions. Though each has its unique strengths, together faculty associated with the Institute of Life Span Studies at Kansas and the John F. Kennedy Center at Vanderbilt have been responsible for a great deal of groundbreaking IDD related research over the past five decades.

It is the common observation that a significant program of research is typically the outgrowth of the long term pursuit of a big important question. My question for the past 35 years has been “how can you meaningfully improve the communication and language development of young children with developmental delays?” Like most big questions, it sounds almost trite. But just below the surface lie lots of big, messy, complex issues. The impact I’ve had on the answer to this question have been mostly the result of lots of very fruitful collaborations combined with a strong adherence to the rules of science, but a weak adherence to any given theory of development or behavior.

The first part of my career, up until the early 1990’s, was focused mostly on developing and refining communication interventions. Most of these studies used single subject designs as these are well suited for

creating a treatment or intervention and determining its initial effects (e.g. Warren & Kaiser, 1986). Since the early 90’s there has been very little new produced in terms of basic approaches to communication intervention in my view, although there has and continues to be a certain degree of repackaging and rebranding that may include minor innovations. Consequently, early in the 1990s I turned my attention away from developing and testing intervention techniques and focused primarily on determining the actual impact of these interventions by conducting randomized clinical trials (RCTs). Much of this work has and continues to be done in collaboration with Paul Yoder of Vanderbilt and Marc Fey at KU (e.g. Fey et al, 2006).

In the process of designing and conducting RCT’s of the effects of early milieu communication interventions, Paul, Marc and I developed a deep appreciation for the weaknesses in much of what passed as the comparative intervention literature. For example, it was readily apparent that there was no widely accepted definition of treatment intensity in the broadly defined behavioral intervention literature. Instead most studies that purported to compare the different interventions were deeply flawed despite their use of some type of comparative design. To “outsiders”, such as those who control federal research

budgets, these weaknesses leave the broad field of behavioral and educational interventions (which encompasses the communication intervention research) at significant risk. Fortunately, this is clearly changing and just in the nick of time because in the world of BIG DIGITAL DATA, it is becoming increasingly easy for just about any determined group to find out “what really makes a meaningful difference”. And in fact these efforts are now well underway with a big push from the Obama administration.

So back to our field – just as we had no widely accepted definitions of treatment intensity, we noted the complete lack of a precise terminology to measure what might make up “different levels of intensity”. Consequently, Marc, and Paul and I borrowed and modified some terms from the best examples we could find – the terminology used to evaluate the effects of different drug dosages. We began using this terminology in our grant applications and research and wrote a paper about it (Warren, Fey & Yoder, 2007). This paper apparently struck a cord and in a short time it became the basis of special issues in two journals in related fields. In the paper we proposed an approach to treatment intensity studies and introduced 5 terms borrowed and appropriately modified by the drug research literature.

## Warren (continued)

Dose – number of events per treatment session (the active ingredient).

Dose form – manner in which the dose is delivered (e.g. 1-to-1 play sessions).

Dose frequency – the number of treatment sessions per day, week, month or whatever.

Total intervention duration – the total length of the intervention (e.g. 9 months).

Cumulative intervention intensity – the product of “dose” X “dose frequency”, X “total intervention duration”.

As an example of this approach we recently we published the results of a comparison of two different treatment intensities of milieu communication intervention that use this precise terminology (Fey et al 2013). More importantly, we now see evidence of this terminology spreading to closely related fields.

## Final Observations

Since I began my research career our field has advanced from creating interventions to the point where we are now positioned to determine whether some of these really do make a “meaningful difference”. Yes, we’ve come a long way. Now, in the age in which government is increasingly playing “Moneyball” (i.e. looking for cheap but effective solutions to real problems) the future use and impact of these interventions will be determined by how they fare under the harsh light of RCTs. The results will often be “uncertain”, or “not as hoped”. But as others have pointed out – the definition of a successful clinical trial is that at the end of the day you’ve learned something (Clifton Leaf, NY Times, July 13, 2013). In other words, this is the next step in a long road to make meaningful difference for individuals with intellectual and developmental disabilities.

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Acknowledgments: Hundreds of children and families; the Schiefelbusch Institute of Life Span Studies at the University of Kansas; the John F. Kennedy Center for Research on Human Development at Vanderbilt University; the National Institutes of Health (NICHD and NIDCD), the US Department of Education, the LENA Foundation in Boulder, Colorado; and host of colleagues including but not limited to Paul Yoder, Marc Fey, Nancy Brady, Eva Horn, Don Baer, Joe Spradlin, Todd Risley, Betty Hart, Dick Schiefelbusch, Don Bailey, Marsha Malick, Frank Symons, John Borkowski, Travis Thompson, Bill MacLean, Steve Schroeder, Ann Kaiser, Mabel Rice, Jill Gilkerson, Audra Sterling, and many other colleagues and students.

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## Report from APA Council of Representatives

**James A. Mulick, PhD**

The Ohio State University/Nationwide Children's Hospital  
Division 33 Council Representative

The APA Council of Representatives had its second annual meeting immediately before and during the annual convention in Hawaii. It was a momentous meeting. The members of the Council of Representatives have been working with a select committee and outside consultants to develop a plan for improving the governance structure of the Association. This process has been ongoing during and between the last several meetings of Council. During past meetings time has been devoted to focus-groups and straw polls to select characteristics of a new structure for accomplishing the business of the association. The process acquired a life of its own and ploughed through any objections like a runaway train.

You ask why? The reasons given revolved around the need for agility in decision making in a world where electronic media and a 24-hour news and financial environment have resulted lost opportunities. What lost opportunities? Nobody could tell me despite my persistent questioning. Nobody did anything but scowl when I pointed out that the cautionary resolution by APA on Facilitated Communication and recognition by APA of the professional psychology Behavioral Specialty were each both accomplished in a single one-year cycle of Council, mainly as a result of coordinated lobbying and behind the scenes consultation efforts with the relevant staff leaders, divisions, boards and committees of APA by Division 33 past-presidents and others. That was pretty agile, but

still met high standards of vetting and deliberation. In contrast, and I pointed this out too whenever I could, the egregious policy on psychologists in settings that use torture during interrogation, a policy that I thought was passed to meet the needs of vested interests involved in work with the military and national security establishment rather than the humanitarian and ethical values of most psychologists, was developed too quickly and passed by a Council that was whipped up with the general war fever. It has taken us *years* of public embarrassment and membership pressure to backtrack on this policy and join with other health professions in clearly articulating our ethical standard of nonparticipation in torture. We don't need that kind of agility, or do you disagree?

Up to the present, APA policy initiatives and financial authorizations required approval by the very large (as such bodies go) Council of Representatives, which is legally the Board of Directors of APA, and this body meets only two times each year. The Council further selects a smaller body called the Board of Directors (BOD), but while this body makes recommendations to the Council, it is really only the executive committee of the Council and needs full Council approval for major actions like approving a budget or issuing a policy statement on behalf of the APA. Changes to this structure, require actions by vote of the full Council and sometimes a change in the bylaws that require a vote by

the entire APA membership. Most by-laws changes in the past have not been approved by the membership, especially when pro and con statements have been presented along with the ballot issue.

### **Democracy be Damned**

Why has Council grown so large? The short answer is that it is representative of the many constituencies in APA. These constituencies tend to increase. The Council has at least one representative for each division, and then additional Council members are allocated to a division based on how members allocate their 10 votes on the apportionment ballot. The more votes a division gets, the more seats on Council they get according to a formula. Larger divisions tend to have more representatives. Further, new divisions are forming and being approved all the time, and many divisions have overlapping memberships with nearly identical interests, and these factors tend to result in some degree of over-representation, especially with respect to practitioner interests. Next, each state and Canadian province is permitted at least one council representative, and those with more members obtain more Council seats according to a formula. Fortunately, new states and Canadian provinces are not as frequently created as new divisions. And, yes, State and Provincial representatives do tend to over-represent practitioner interests. The ever-growing membership of Council does increase its cost and make management of it more difficult. The result has been for policy to tend not to originate with Council,

but rather to come down (or is it up?) to it for ratification after the Board of Directors staff, and Boards and Committees have both formulated and vetted the policy or action proposed to Council.

Members of Council have been known to complain of being no more than a rubber stamp, despite the fact that Council votes on the members of the BOD and APA Boards and Committees and many members of Council serve on those same policy and idea originating bodies. Mind you, Division 33 representatives *have* successfully initiated policy changes for APA as a whole by doing the required homework and footwork, but apparently others have not had the same experience within the familiar governance structure. This restructuring is arguably the result of the widely shared sense of ineffectiveness among the majority of Council delegates. I am forced to reflect on the thought that organizational restructuring is not the same thing as promoting the interests of members, science and the practice of professional psychology.

### **I Got Your Change Right Here**

Council voted on many changes recommended by the body charged with designing a new structure, a body known as the *Good Governance Project*. In the interest of space, I will now list the changes approved by Council in Hawaii as reflected in the official minutes.

Council also voted to approve the following motions related to GGP:

1. In order to enhance governance effectiveness, efficiency and nimbleness in addressing the future of psychology and APA, Council supports the enhanced use of technology to engage members and provide increased opportunity to do the work of governance (as

well as the advisory bodies) in addition to face-to-face meetings.

Council directs the President to instruct the Implementation Work Group (IWG) to design the specific steps, including a determination of the fiscal implications, and to present these to Council for approval beginning in February 2014.

The plan will address what is needed to:

- Expand opportunities for communication with and learning by members of governance;
- Add general member's viewpoints into deliberations;
- Increase opportunity to do the work of governance between face to face meetings;
- Increase communication about the activities of governance.

2. Council supports developing a process for opening, and thus broadening opportunities for leadership participation and leadership development for governance service. Council directs the President to instruct the IWG to develop a transition and implementation plan for the development of a leadership program focused on training for governance leadership as well as leadership in the general APA community, including fiscal implications, and to present these to Council for approval beginning in February 2014.

3. Council supports the creation of an APA governance-wide triage system to ensure that the appropriate level of governance authority addresses new items and emergent situations in a timely and comprehensive fashion, without duplicative efforts.

Council directs the President to instruct IWG to bring back a triage implementation plan including fiscal

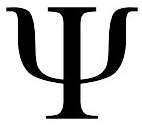
implications for review and approval beginning at Council's February 2014 meeting. The work group should examine ways to incorporate technology into this process and a method for tracking items as they move through the system.

4. Council will expand its scope to also focus on directing and informing policy and ensuring APA policies are aligned with APA's mission and strategic plan. The Council will review and revise the strategic plan and identify and prioritize the major issues facing psychology and APA's efforts to fulfill its mission.

To meet its purpose, the APA Council will need to:

- Develop a mechanism to select a Council Leadership Team to help manage the Council's workflow;
- Develop a process to identify and prioritize and address the major issues facing psychology;
- Develop a mechanism to articulate and prioritize APA's efforts to advance its mission;
- Develop a plan to use technology to advance the work of the Council;
- Participate in an APA wide triage system to enhance the work of the Association;
- Develop a strategy to employ APA boards and committees as Council resources of expertise and action.

The IWG will report on progress of the development of an implementation plan and present this to Council for approval beginning in February 2014.



5. Council supports delegating the authority for the following areas of fiduciary responsibility to the Board of Directors on a trial basis for a three-year period following implementation:

- Financial/budget matters
- Hiring, evaluation and support for the Chief Executive Officer
- Assuring alignment of the budget with the APA strategic plan
- Internally focused policy development

In addition, Council will receive regular reports from the Board on the delegated areas during the trial period and retains its responsibility as set forth in the Bylaws. In the interest of transparency, such reports to Council will also be made available to the entire membership. Council directs the President to instruct the IWG to develop an implementation plan that includes an evaluation process for the end of the three-year trial period and to present these to Council for approval beginning in February 2014.

6. Council approves the following composition for the Board of Directors:

- 6 members-at-large elected directly by membership, drawn from general membership
- 4 elected by the Council, including Secretary & Treasurer and two from Council leadership team
- 1 elected directly by APAGS membership, drawn from APAGS members (APAGS Past Chair)
- 3 in the Presidential cycle
- 1 appointed by Board

from the public (Public Member with needed expertise; non-voting.)

- CEO in *ex officio* role
- A commitment to have at least one ECP on the Board through the ANSD process

Council approves utilizing the Assessment of Needs and Slate Development (ANSD) process for those members-at-large elected by the APA membership.

The IWG is tasked with developing an implementation strategy and presenting this to Council for approval beginning in February 2014. The new Board structure will be evaluated 3 years following implementation of the new configuration.

Council believes a substantive change in Council structure is needed to be effective in the future.

*[Because the Council approved endorsing a substantive change in Council's structure (59% in favor), model 7A (current Council structure retained) was dropped from consideration. A straw poll was then conducted to see where Council stood on the remaining various models of change. Council members were asked to vote for their preferred model. The vote was as follows:*

- A constituent unit based model—38%
- A disciplinary/mission based model aka “the pillar model” - 19%
- A constituent based model with pillar elements—41%
- Abstain—4%

As a result of the above straw poll, an amendment was added to motion #8 to include a request for IWG to

further develop models 7B and 7D (the two models receiving the highest percentage of votes) and bring them back for Council's consideration. Council approved motion #8 as amended.]

7. Council directs the President to appoint an Implementation Work Group (IWG) made up of 15-20 individuals who are a broadly representative group of leaders from diverse backgrounds and organizational perspectives and who shall include members of Council, the Board of Directors and other members who have relevant expertise. For motions #4 and 7 that affect the structure or function of only Council, a subgroup of the IWG shall be created directly from Council including at least one member of the Committee on Structure and Function of Council. The IWG is tasked with developing the implementation and transition plans of the governance changes that Council adopted and to present these to Council for approval beginning in February 2014. The IWG is also asked to further develop model 7B – structural modification of the existing constituent based model, and 7D – the blended model that includes elements from 7B and 7C (the disciplinary/mission based model aka “the pillar model”) and bring them back for Council's consideration.

Council approves the addition of \$24,000 in the 2013 Budget for one meeting in 2013 of the IWG and the inclusion of \$48,000 in the 2014 Budget for two meetings in 2014 of the IWG.

#### **But wait there's more:**

A. Council voted to approve the recognition of Sleep Psychology as a specialty in professional psychology for a period of seven years.

B. Council voted to approve the recognition of Police & Public Safety Psychology as a specialty in professional psychology for a period of seven years.



C. Council voted to approve the continued recognition of Counseling Psychology as a specialty in professional psychology for a period of seven years.

## There you have it!

Ironically, at least to my way of thinking, Council voted itself out of the loop on budget approval, at least temporarily, after learning just prior to the Hawaii meeting of an unexpected budget deficit to six figures. Go figure.

The new structure is now in a 'try out' period even as the nuts and bolts of it are still being hashed out by the IWG (i.e., insiders). Thus, at this point, we don't really know how APA will work hereafter.

Oh yes, there was 'other business' completed at Council.

Council voted to approve the continued recognition of School Psychology as a specialty in professional psychology for a period of seven years.

Council voted to approve an extension of recognition of Biofeedback: Applied Psychophysiology as a proficiency in professional psychology for an additional period of one year to expire in August 2014.

Council voted to approve an extension of recognition of Clinical Psychology as a specialty in professional psychology for an additional period of one year, to expire in August 2014.

Council voted to adopt as APA policy the APA Guidelines for the Undergraduate Psychology Major and approve August 2023 as the expiration date for the Guidelines.

Council voted to adopt as APA policy the following Quality Professional Development and Continuing Edu-

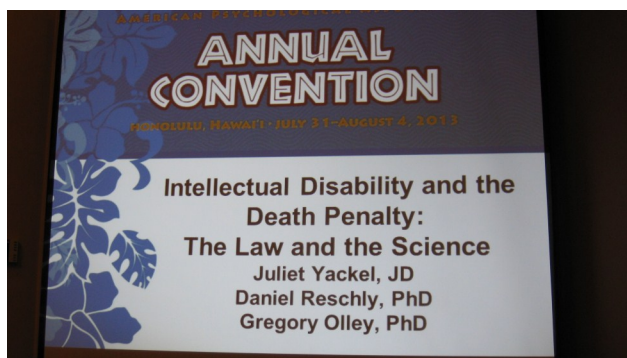
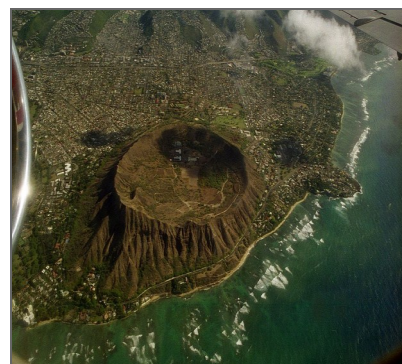
cation Resolution...(in part)... continuing education programs should be dedicated to an evidence-based approach...should serve the purpose of enhancing and improving psychologists' skills especially in term of service to the public, contributions to the profession, and the development of interdisciplinary and inter-professional collaboration... reflect current research on diversity... includes evaluation... include introductory to advanced course sequencing... accessible to all psychologists ... makes a clear connection between program content and the application of this content within the learner's professional environment...

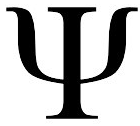
Council officially restated, in an attempt to attain greater clarity (?), the condemnation of torture.

A number of new members and Fellows were voted in.

Finally, Council approved what may have been among our last budgets as a Council serving as the legal Board of Directors for APA (although, ultimately the bylaws changes needed to make it permanent will be your decision to make).

*Note to Readers: We were still able to sit on the beach, look at the stars in a fairly unfamiliar sky, meet friends and colleagues, listen to papers, and occasionally learn something new about psychology.*





## Poster Award

Hillary Bush, MA & Abbey Eisenhower,  
PhD

### “Parent-Teacher and Student-Teacher Relationships Over time for Young Children with ASD”

Poster title: “Parent-Teacher and Student-Teacher Relationships Over Time for Young Children with ASD”  
Authors: Hillary Hurst Bush, M.A., & Abbey Eisenhower, Ph.D.

#### Introduction

Previous research has suggested that children with autism spectrum disorder (ASD) are at risk for poor school adjustment (Chamberlain, Kasari, & Rotheram-Fuller, 2007). Student-teacher relationship quality has been found to help children from other at-risk groups (e.g., children with disruptive behavior problems) to adjust to the school environment (Jerome, Hamre, & Pianta, 2009). However, the core features of ASD, including difficulties with verbal and non-verbal communication and reciprocal social interaction, may make it challenging for children with ASD to form strong bonds with their teachers. While parent-teacher relationship quality has been found to help children, particularly those at risk, to build relationships with their teachers (Rimm-Kaufman & Pianta, 2005), we know little about the roles of parent-teacher and student-teacher relationship quality for young students with ASD. The goal of this study was to address the following questions:

How do parents and teachers rate parent-teacher and student-teacher relationship quality at the beginning and end of the school year for

children with ASD?

Does parent-teacher relationship quality at the beginning of the school year predict student-teacher relationship quality at the end of the school year, and/or vice versa, for children with ASD?

To test these questions, we analyzed data collected for the Smooth Sailing Study (funded by the Institute of Education Sciences; PI: Blacher, R34A110086), a multi-site, longitudinal research study on the factors that contribute to early school adjustment for children between the ages of 4 and 7 with ASD. Please note that data collection for this study is currently in progress, and that the findings below reflect preliminary analyses.

#### Methods

To be eligible for the study, children had to have a previous ASD diagnosis, demonstrate an IQ of 50 or higher on a brief form of the *WPPSI-III*, and be enrolled in school. The analyses reported here are preliminary and reflect a subsample of the larger Smooth Sailing Study sample, based on the first enrolled waves of participants. These parent-child dyads were assessed during the fall of the school year (N=123) and again during the spring of the same school year (N=115). Teachers also completed mailed questionnaires at both time points. Our child sample

was predominately male (80%) and racially diverse: 70% White (including 15% Latino/as), 11% multiracial, 8% Asian-American, 5% Black, and 2% Native American. Child participants were, on average, 5 years, 8 months old ( $SD = 1$  year), and the vast majority (89%) received special education services in school. Most of our parent participants were the biological mothers (89%) or biological fathers (9%) of the participating children; they were, on average, 39 years old ( $SD = 5$  years, 6 months). The majority of families in our sample had dual-parent households (86%). Our teacher participants were predominately female (71%) and White (64%). The majority of teachers had earned a master's degree or higher (55%) and had, on average, 14 years of teaching experience ( $SD = 9$  years).

To assess parent-teacher and student-teacher relationship quality over time, we used the parent- and teacher-report versions of the Relationship scale of the *Parent-Teacher Involvement Scale* (Vickers & Minke, 1995) and the teacher-report *Student-Teacher Relationship Scale – Short Form* (Pianta, 2001), respectively. On each of these measures, both parents and teachers reported very consistent levels of parent-teacher and student-teacher relationship quality from the beginning of the school year to the end of the year. Of note, teachers reported average levels of student-teacher relationship quality (32<sup>nd</sup> percentile at the beginning of the school year; 34<sup>th</sup> percentile at the end), even on a questionnaire that was designed for and normed using a typically developing student sample.

#### Results

Cross-lagged panel models were used to test the larger question of how parent-teacher relationships at the beginning of the school year predicted student-teacher relationships at the end of the school year, and how student-teacher relationships at the beginning of the school year predicted parent-teacher relationships at the end (see figure below). Given that only a

subsample of participants was available for analysis at this time, all results are preliminary. Prior to running these analyses, parents' and teachers' responses on the Parent-Teacher Relationship scale items were parceled in order to create a latent parent-teacher relationship quality variable; student-teacher relationship quality was tested as an observed variable.

As the model shows, we ultimately did not find that parent-teacher relationship quality predicted later student-teacher relationship quality, or vice versa. However, we did observe relations between parent-teacher and student-teacher relationship quality within each time point: we observed a marginal positive correlation between these two variables at the beginning of the school year, and a significant positive correlation at the end of the school year.

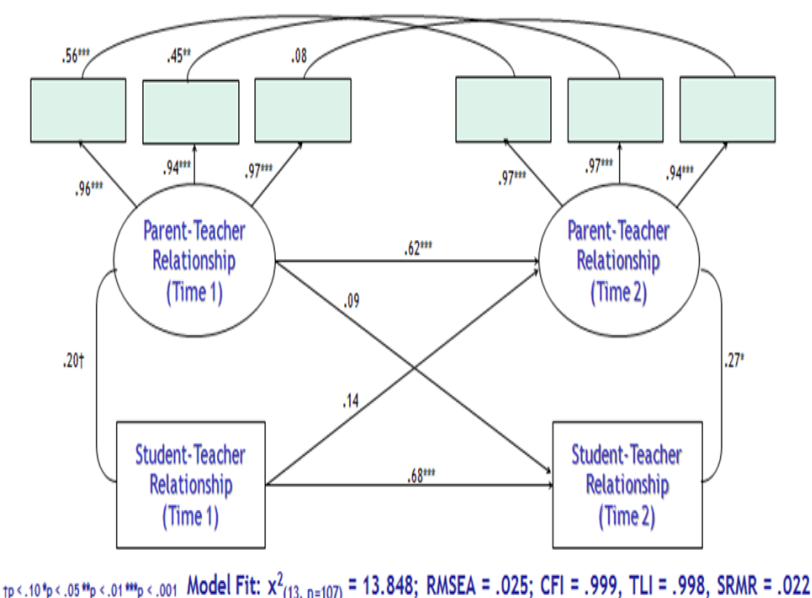
## Conclusions

Overall, our findings demonstrated a high level of consistency in parent-teacher and student-teacher relationship quality over time, from both parents' and teachers' perspectives. Teachers' reports also suggested that children with ASD may be at only somewhat elevated risk for poor student-teacher relationship quality, relative to typically developing children. Our next step is to replicate the analyses described above once data collection is complete; other steps include examining how these relationships change over time, across multiple school years and multiple teachers. We also plan to consider covariates (e.g., racial and ethnic identity, socioeconomic status) that may influence both parent-teacher relationship quality and student-teacher relationship quality, and including these in our preliminary model. Also, we plan to test child-level factors (e.g., level of internalizing and externalizing behavior problems) as

a potential moderator of the relation between parent-teacher and student-teacher relationships over time; in other words, we want to study whether these two types of relationships function differently for some children with ASD as opposed to others.

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Edgar A. Doll Award (est. 1980)	Sara Sparrow Early Career Research Award (est. 2008)	Jacobson Award (est. 2007)
1981 Sam Kirk		
1982 Gershon Berkson		
1983 Marie S. Crissey		
1984 Sidney Bijou		
1985 no award		
1986 Norman Ellis		
1987 Ed Zigler		
1988 H. Carl Haywood		
1989 Donald MacMillan		
1990 Henry Leland		
1991 Alfred Baumeister		
1992 Earl Butterfield		
1993 Brian Iwata		
1994 Ivar Lovaas		
1995 Stephen Schroeder		
1996 Donald Baer		
1997 Richard Eyman		
1998 Nancy Robinson		
1999 Murray Sidman		
2000 Todd Risley		
2001 Don Routh		
2002 Travis Thompson		
2003 John Borkowski		
2004 Gene P. "Jim" Sackett		
2005 Robert Sprague		
2006 Ann Streissguth		
2007 Douglas K. Detterman		Richard Foxx
2008 Michael Guralnick	Luc Lecavalier	
2009 Sara Sparrow		James Mulick
2010 Bruce Baker	Laura Lee McIntyre	
2011 Michael Aman		Stephen Greenspan
2012 Ann Kaiser	Anna Esbensen	
2013 Steve Warren		Sally Rogers

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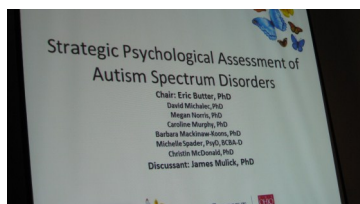
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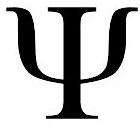
VOLUME 39, NUMBER 2

## PSYCHOLOGY IN INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

### Editorial Policy

*Psychology in Intellectual and Developmental Disabilities* is an official publication of Division 33 of the **American Psychological Association**. It is devoted to keeping members informed about the activities of Division 33 and to present news and comment concerning all aspects of service, research, dissemination, and teaching in psychology and IDD. Brief articles about policy issues in psychology and IDD, as well as descriptions of service programs and preliminary research summaries are invited. We are especially interested in articles inviting the reaction and comment of colleagues in future issues. Comments and letters will be published as space allows. Manuscripts must conform to APA style and should be submitted via an email attachment. Articles, comments, and announcements should be sent to the current Division 33 President until a new Newsletter Editor is selected. Books, films, videotapes, and other material also may be submitted to the Editor for possible review. Unless stated otherwise, opinions expressed are those of the author and do not necessarily represent official positions of Division 33.





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##### **Stanley E. Lunde, Chair**

Stanlunde@gmail.com

#### **Fellows**

##### **Laraine Glidden, Chair**

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#### **Membership**

##### **Eric Butter, Chair**

Child Development Center  
Nationwide Children's Hospital  
187 West Schrock Road  
Westerville, OH 43801  
Eric.Butter@nationwidechildrens.org

#### **Early Career Representative**

##### **Abbey Eisenhower**

Abbey.eisenhower@umb.edu

#### **Nominations and Elections**

##### **Alice Carter, Chair**

Alice.Carter@umb.edu

#### **Division 33 Student Representatives**

##### **Hillary Hurst Bush**

hjhurst@gmail.com

##### **Sasha Zeedyk**

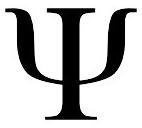
szeedyk@gmail.com



## Memories of Hawaii—APA, August, 2013 Social Hour, Awards, and Presentations!



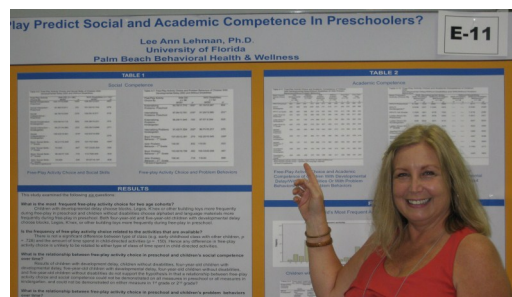
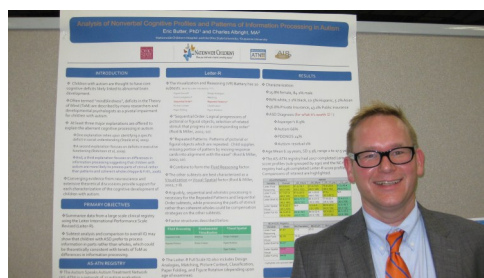
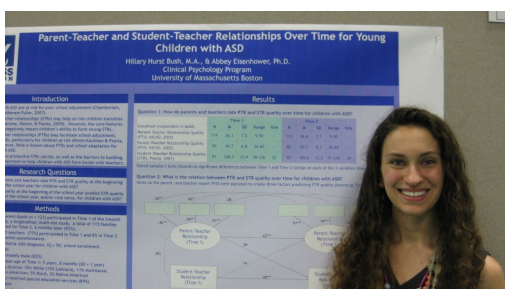
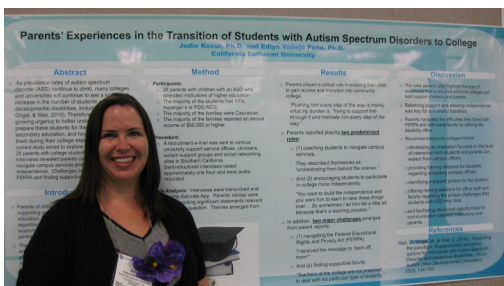




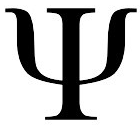
## Memories of Hawaii—APA, August, 2013 Social Hour, Awards, and Presentations!



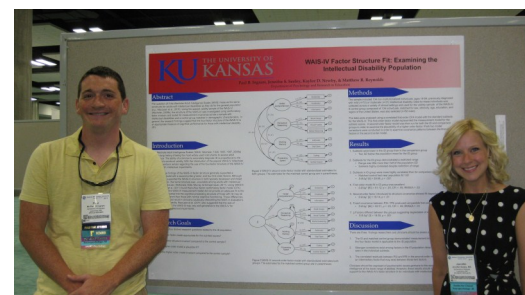
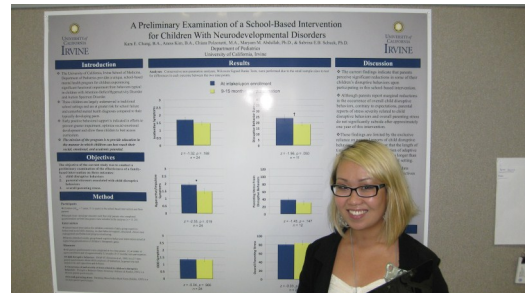
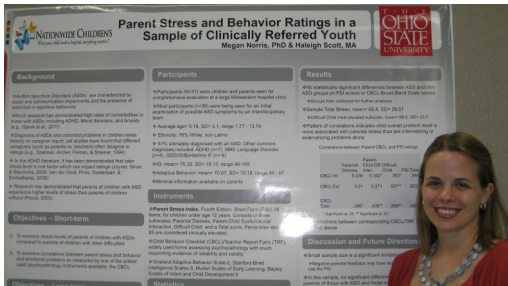
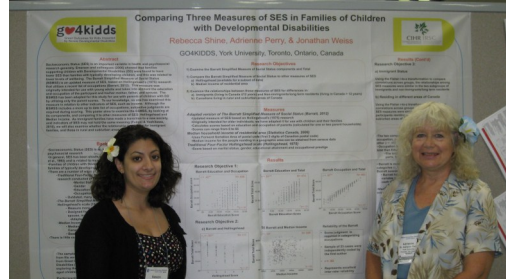
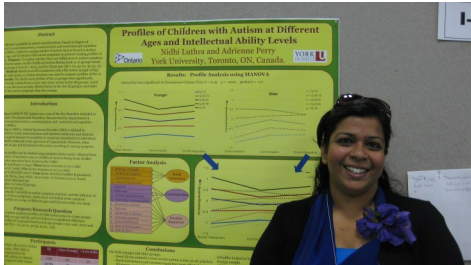
# Memories of Hawaii—APA, August, 2013 Some of our posters!







## Memories of Hawaii—APA, August, 2013 More Posters!





**AMERICAN PSYCHOLOGICAL  
ASSOCIATION**

**Division 33  
Psychology in Intellectual and  
Developmental Disabilities  
Application for Membership**

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Work Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Home ( \_\_\_\_\_ ) \_\_\_\_\_

Work ( \_\_\_\_\_ ) \_\_\_\_\_

APA Membership Status:

- ☐ Affiliate  
☐ Associate  
☐ Member  
☐ Fellow

Interest Area(s): \_\_\_\_\_

**Return to:**

Eric Butter  
Child Development Center  
Nationwide Children's Hospital  
187 West Schrock Road  
Westerville, OH 43801  
Eric.Butter@nationwidechildrens.org

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ASSOCIATION**

**Division 33  
Application for Student Membership  
Membership is open to Student Members of  
APA in good standing.**

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Affiliation: \_\_\_\_\_

Telephone: \_\_\_\_\_

Home ( \_\_\_\_\_ ) \_\_\_\_\_

Work ( \_\_\_\_\_ ) \_\_\_\_\_

Student Member of APA: ( ) Yes ( ) No

Faculty Endorsement: The student named  
above is enrolled as a student in a course of  
study which is primarily psychological in nature.

Signature: \_\_\_\_\_

Affiliation: \_\_\_\_\_

Please return the completed form with a check  
in the amount of \$15.00 made out to "**APA  
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**PSYCHOLOGY IN  
INTELLECTUAL AND  
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