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PSYCHOLOGY IN INTELLECTUAL AND DEVELOPMENTAL DISABILITIES/ AUTISM SPECTRUM DISORDERS

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From the President's Desk

Sharon J. Krinsky-McHale, PhD

New York State Institute for Basic Research in Developmental Disabilities & Gertrude H. Sergievsky Center, Columbia University Medical Center

I am so excited and honored to serve as the President of Division 33 with its very dedicated and involved membership. I promise to do my best to keep you all engaged this year in the important work of our Division. Ultimately, we hope that our work will help enrich the lives of individuals with intellectual and developmental disabilities (IDD) including those with autism spectrum disorder (ASD).

In this edition of the newsletter, I would like to review some of the program highlights from the annual convention. The 2016 APA Convention in Denver was truly a stellar event. As in previous years, we had a full program which emphasized research, clinical practice, and current policies in IDD with presentations across the lifespan. I hope you were all stimulated and inspired by our member's presentations. Though, not surprising, given our recent name change, autism research was a major focus of many of them. I was impressed by every one of the presentations and struck by how much talent there is in this Division, not just by the seasoned professionals but by our early career professionals and graduate students.

The APA Convention also provides us with an opportunity to recognize scientists for their outstanding contributions to the field of IDD. The Edgar A. Doll Award, the highest honor of Division 33 was awarded to Dr. Michael F. Cataldo, the Director of the Department of Behavioral Psychology at the Kennedy Krieger Institute. Unfortunately, Mike could not be with us to receive his award in person, but, he promises to attend this year's convention in Washington, D.C. to deliver his address, *"Change."* The Sara S. Sparrow Early Career Research Award was presented to Dr. Abbey Eisenhower, Associate Professor of Psychology at University of Massachusetts, Boston who has made substantial contributions to the understanding of IDD even at this early stage of her career. We also recognized the outstanding submissions of two student members with our Student Research Excellence Award. These were awarded to Elina Veytsman, from UCLA PEERS Clinic and Jessica Scherr, from the University of South Carolina. We are anxious to see what they do in the future. We are very grateful to Pearson Clinical Assessments, Wiley Blackwell and Springer Publishers for continuing to sponsor these awards.

In addition to the excellent sessions, other exciting activities that were not in our "official" Division Program included an off-site mentoring session for the second year in a row and an Early Career Professional Cross-Divisional Social Hour (with Divisions 16 and 25). These activities explored career mentorship but maybe more importantly they fostered opportunities for building social connections, which are an essential element to our careers. Both events were well-attended and enjoyed by all involved. Thank you goes out to Drs. Rachel Fenning, Abbey Eisenhower, and Katy Mezher for their hard work in organizing these events.

In This Issue

From the President's Desk

Sharon J. Krinksy-McHale, PhD

Division 33—Continued

I'd like to thank Dr. Cameron Neece McDowell in her role as Division treasurer, though Camie could not join us at this year's convention because of advanced pregnancy (welcome to the world little Millie Grace), she still made sure that all awardees received their checks and reimbursements. Dr. David Michalec served as our official Division photographer documenting, for posterity, this convention's events.

I would like to take this opportunity to thank Past-President, Dr. Anna Esbensen. She proved to be an active and inclusive leader who did not shy away from discussing the important issues of concern. Anna was very generous with her time and advice in seeing me through my year as President-Elect and all that that job entails. She promptly answered my many emails with expert advice, showed a tremendous amount of patience with my continual questions and concerns, and did it all with her trademark rip-roaring sense of humor. Thanks Anna!

Division 33 welcomes Dr. Diana Bianchi, a geneticist and neonatologist as the new Director of NICHD. We were recently asked to contribute to a briefing document regarding psychological science priorities at NIHCD. We were asked to answer questions pertaining to our division's priorities that intersect with those of NICHD. Myself, along with the Division 33 Executive Committee listed the following:

- expanding and exchanging knowledge and information related to IDD/ASD through research, education, and professional communication;
- enhancing professional development and the quality of professional services;
- developing partnerships with persons with IDD/ASD and with organizations such as the NICHD that represent them in order to incorporate their perspectives;
- informing legislative and administrative bodies of the importance of psychological, behavioral, and social factors in developmental disabilities services and the value of psychology in contributing to the solution of problems in this service sector;
- strengthening the practice of psychology in developmental disabilities as a distinct professional and scientific entity and finally,
- pursuing the creation of standards for training, practice, and research for psychologists in developmental disabilities.

In the coming year, our Division and the field, in general, will continue to grapple with many important issues. In a recent NPR broadcast, legal affairs correspondent Nina Totenberg presented a case that is before the Supreme Court on the definition of ID and how the court decides whether a defendant with ID can be sentenced to death (http://www.npr.org/2016/11/22/503073510/texas-death-case-tests-standards-for-defining-retardation). No doubt psychologists will be compelled to weigh in on the use of torture for prisoner detainees that the new Trump Administration promises to revisit. As a Division, our members need to think about the important ways that psychology of IDD/ASD can impact these discussions.

I would also like to take this opportunity to encourage members to email me at Sharon.Krinsky-McHale@opwdd.ny.gov if you have any ideas about the ways that Division 33 can further promote our mission to improve the lives of individuals with intellectual and developmental disabilities including those with autism spectrum disorder through research, education, and dissemination of empirically supported best practices.

Our website, http://www.division33.org/ the product of Dr. Jason Baker's dedication is enabling our membership to keep abreast of what is happening in Division 33. Please visit our website often.

Our program chair for the 2017 Convention to be held in Washington, D.C. is Dr. Gael Orsmond from Boston University. I hope many of you submitted abstracts to present your work at this year's convention. We look forward to another stimulating conference in 2017.

Division 33 Student Interview

By: Elizabeth Will and Barbara Caplan
Division 33 Student Representatives

An interview with Jane Roberts, Ph. D.
Professor of Psychology, University of South Carolina

Interview with Jane Roberts, PhD

Dr. Jane Roberts is a Professor of Psychology at the University of South Carolina. She is a leading expert in fragile X syndrome, and her research program focuses on understanding early developmental trajectories associated with fragile x syndrome and comorbidities, including autism and anxiety.

Q: *You are well known for your work on fragile X syndrome. How did you first become interested in the field?*

I have always been interested in the biological bases for behavior including genetics so when I first inquired about the doctoral program at the University of North Carolina and met with Don Bailey, he told me about his fragile X project. I was fascinated with the notion of studying a single gene disorder and focusing on early development. The fact that fragile X has a number of co-morbid conditions was very appealing to me because I am very interested in co-morbidities and how they emerge and interact over time. This is how I came to initially focus on fragile X syndrome, and the more I have studied this disorder, the more fascinated I continue to become with the next set of questions.

Q: *Your current research program includes studying the early emergence and longitudinal stability of several comorbidities within fragile x syndrome, including autism and anxiety. What factors have contributed to the development of your research program and your overall career trajectory to shape where your current program of research is now?*

I have always been interested in infant development, and I think that is because studying infants allows you to characterize development in a somewhat "pure" sense. By that I mean that infants have limited environmental experience so your focus can more cleanly be on biological mechanisms that drive behavior, which is what I am really keen to learn more about. I have been interested in autism for a long time, since I was a graduate student, but it has evolved more into examining autism through fragile X syndrome which has become a real niche area for me. My interest in anxiety is more recent and evolved over the past 5 years through my focus on young children and autism. I kept seeing responses by children in my studies that appeared to reflect anxiety and not autism but trying to disentangle that, particularly in infants and toddlers, is a daunting task. However, I am now convinced that we can detect signs of anxiety and autism as early as the first year of life in infants with fragile X syndrome, and we have just launched a 5-year study that will let us characterize early signs of anxiety and autism in infants as young as 6 months through 5 years of age. I anticipate that I will have far more questions at the end of this study than answers, but that is what keeps me intrigued and vested in the process.

Q: *Much of your research focuses on physiological measurement. What advantages do physiological measures have in the field of developmental disabilities? How can these methods reveal novel insights into the development of children with neurodevelopmental disorders?*

As a graduate student, I used to think that studying physiology would let me detect underlying mechanisms in a stronger and less biased way than just studying behavior in

Division 33 Student Interview

An interview with Jane Roberts, Ph. D.

isolation. However, 20 years later, I know this was a naïve perspective because physiological data should not be reified and they are prone to error and interpretative bias just as behavior is. In my opinion, physiological measures in the absence of solid behavioral data are limited. Given the advance of technology, which allows us to integrate physiological signals with less expense and more ease, there can be a tendency to include physiology in the absence of a solid theoretical basis. So, I think the inclusion of physiological markers integrated with behavior and implemented with a sound theoretical rationale is the soundest of all approaches. This approach has a number of benefits to behavior alone including the ability to identify physiological markers in the absence of clear overt symptoms, to document biological vulnerability that could serve as a marker for later emerging behavioral disorders, and to identify individual differences that could impact treatment or inform the course of an impairing condition. For example, elevated cortisol could index stress in a child who is either too young or unable to communicate such affective states. Likewise, reduced vagal tone could be a marker for later emerging cognitive or behavioral impairments.

Q: *Research, and in turn, our understanding of fragile x syndrome has greatly increased over the past decade. Where do you see fragile X and IDD/ASD research moving within the next few years?*

Research in fragile X has, indeed, exploded over the past 20 years. I remember as a doctoral student that I was able to keep up with most of the literature, and it was a novelty when studies on early development or behavior were published whereas these studies are now being published at a rate that is hard for me to keep abreast of. It seems to be that the primary foci of future research in fragile X are on impact and treatment.

I think in many ways that autism research is in its "second generation" much as early intervention was described as entering a second-generation of research over 20 years ago when I was a doctoral student. By this I mean that many of the core features of autism have been characterized along with a refined set of diagnostic procedures. What I now see in the field of autism is a budding interest in what I might call the periphery of autism with a focus on individual differences and mechanistic factors. Ten years ago, studies of autism in fragile X syndrome were not as well received as they are now. I think this reflects an increasing interesting on cross-syndrome studies in autism as well as investigations into non-core features such as anxiety.

Q: *What was the most influential moment in your career thus far?*

If I had to pick an influential moment in my career, it would likely be getting my doctoral dissertation funded by the Department of Education. I will never forget my doctoral advisor tracking me down when I was on vacation with my family to tell me that I got funded. That was a turning point in my career because my research interests and efforts were validated in a very public and impactful way. That was the first time I had considered a career in research, and I have never looked back.

Q: *You have been quite successful in sustaining a productive research program. How can early investigators in the field of developmental disabilities stay competitive in applying for research funding?*

I think the most central factor in my career is that I have pursued questions that I was passionate about asking and answering. For example, I have been interested in infant development since the onset of my doctoral training but it was not until over 10 years after graduating that I got a grant that allowed me to focus on infants and the emergence of impairment. However, in the 10 years leading up to that first large grant, I took advantage of every opportunity to design studies and collect data on infants with the resources and opportunities I had available to me. Also, I have also been very fortunate to work with some wonderful colleagues who have mentored me over the years and who are still a part of my life. Finally, you cannot underestimate the impact of being hard working and resourceful.

Division 33 Student Interview

An interview with Jane Roberts, Ph. D.

For me, this meant pursuing small and moderate grants before targeting the large ones and also focusing on publishing as my top priority. So, I guess following your passion, soliciting mentorship from successful and supportive colleagues, and being doggedly determined to succeed are the key principles that have helped me succeed. That being said, I never set out to have a high-powered research career, and it surprises me at times when I stop and think about some of the successes I have had the fortune to experience..

Q: *What other advice would you give to junior faculty or post-docs who are in the early stages of their careers in the field of intellectual and developmental disabilities?*

I would encourage early career scholars to pursue the work they think is important and to do so in a way that makes them love their job. So often junior faculty focus on getting grants and publications as the primary marks of success, and I think they sometimes need a reminder that the focus really should be on strong science. In other words, getting a grant is not the focus, it is the fact that getting a grant will help you address your aims in a more powerful way than could be done without the grant. Also, publications are incredibly important, but a focus on the impact of your publications and developing a programmatic line of work is more important than counting publications or counting grants. I do not think "counting" is a good focus, and it can lead to burnout, stress or failed careers. Instead, I would encourage emerging academics to be reflective of what is most important to them personally and professionally and to pursue that unapologetically. For me, my family has always been my top priority, and I strive to have a strong work-life balance.

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Denver Memories!
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IDD/ASD Training Highlights

A new feature that asks those involved in training to share their ideas, programs, and philosophies about teaching the next generation of IDD/ASD psychologists. Each newsletter will "highlight" a different IDD/ASD training program.

Our Second Highlighted Program is:

UCLA Psychology Internship Program
Autism and Developmental Disabilities Track

Elizabeth Laugeson, PsyD

UCLA has an outstanding record of advanced training in behavioral, clinical and health services research relevant to autism spectrum disorder (ASD). From its inception as an NIH Center for Excellence in 2003, the UCLA Center for Autism Research and Treatment (CART) has taken the lead to design and develop training and education as key components of the Center. With an emphasis on interdisciplinary training and mentorship, the pre-doctoral psychology clinical internship, housed within the UCLA Semel Institute for Neuroscience and Human Behavior, has recently revised its training program to create an educational pathway to train the next generation of autism researchers.

The ultimate goal of the newly established pre-doctoral psychology internship in *Autism and Neurodevelopmental Disabilities* at UCLA is to train psychologists to enter careers in the field of neurodevelopmental disabilities. While emphasis on autism and neurodevelopmental disabilities are the focus of most internship activities, with growing awareness in the field about the profound clinical and genetic heterogeneity in ASD, broad training is also provided in the assessment and treatment of other psychiatric conditions that will serve to inform and strengthen differential diagnosis and treatment planning skills for this population. Under this training program, interns have the unique opportunity to work with individuals with autism and other neurodevelopmental disabilities in diverse treatment settings (outpatient, inpatient, partial hospitalization, and medical) within the context of a multidisciplinary treatment team.

In order to enhance professional development, which can sometimes fall by the wayside during the busy internship year, each trainee is assigned a faculty mentor within their discipline to help guide and refine their training. In an effort to further promote clinical and research development, trainees are also allowed to select a mentor from among CART research faculty across multiple disciplines who will serve as a secondary mentor throughout internship. Building upon our already strong interdisciplinary training base, the development of new interdisciplinary didactic and mentoring programs have been initiated in concert with several departments at UCLA, including the Departments of Psychiatry and Biobehavioral Sciences, Psychology, Pediatrics, Neurology, Psychological Studies in Education and Health Services.

The philosophy behind this newly enhanced training program is to provide interdisciplinary mentorship and professional development within the field of autism and neurodevelopmental disabilities, while going beyond the scope of developmental disorders. By providing both depth and breadth, within a specialized training program, we hope to prepare the next generation of psychologists in the field of autism and neurodevelopmental disabilities to take on the complexities of this evolving field in both multidisciplinary clinical and research settings.

For more information about the UCLA Autism and Neurodevelopmental Disabilities Psychology Internship, please contact Dr. Elizabeth Laugeson at elaugeson@mednet.ucla.edu

The Committee on Women in Psychology

A report by the Division 33 representative

Elizabeth Laugeson, PsyD, UCLA

As part of our commitment to gender equality and the advancement of women in the field of psychology, Division 33 provides representation at the APA Committee on Women in Psychology. The mission of this committee is to advance psychology as a science and a profession and as a means of promoting health, education and human welfare by ensuring that women in all their diversity achieve equality within the psychological community and in the larger society. More specifically, the Committee on Women in Psychology functions as a catalyst for equality by interacting with and making recommendations to the various parts of the APA's governing structure, to the APA's membership, and particularly to the Society for the Psychology of Women, Association for Women in Psychology and other relevant organizations, including groups whose missions address the status of women.

Under the leadership of committee chair, Dr. Earlise C. Ward, the priority tasks of the committee include:

- Collection of information and documentation concerning the status of women.
- Development of recommendations relevant to women.
- Monitoring the implementation of guidelines and recommendations from reports issued by APA that are relevant to women.
- Development of mechanisms to increase the participation of women in roles and functions both within and outside the profession.
- Ongoing communications with other agencies and institutions regarding the status of women.
- Monitoring current issues relevant to the lives of women in order to inform policy.

In an effort to uphold these priorities, the Committee held its annual meeting at the 2016 APA Convention in Denver, Colorado this past August. Over 30 members were in attendance, including representatives from Division 33. Several topics were covered, including:

- Changing the gender composition of the APA Psychology Report.
- The development of a resolution to address sexual assault and sexual harassment on college campuses.
- Addressing the issue of trafficking of girls and women.
- Highlighting the contributions of women of color in psychology during Women's History Month.
- A lively discussion about the pros and cons of being an editor for a scientific journal.

If you would like to attend the next annual meeting of the Committee on Women in Psychology at the 2017 APA Convention, or if you would like more information about the activities of the Committee, please visit: http://www.apa.org/pi/women/committee/

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Division 33 Student Research Excellence Award

Patterns of Physiological Arousal in Infants At-Risk for Autism Spectrum Disorder

Jessica Scherr, M.A., *Debra Reisinger, M.A., Tristan Yates, & Jane E. Roberts, PhD*
University of South Carolina

Autism Spectrum Disorder (ASD) is a chronic neurodevelopmental disorder classified by impairments in social communication and restricted and repetitive behaviors (American Psychiatric Association [APA], 2013). Fragile X syndrome (FXS) is a single-gene disorder and the most common genetic cause of ASD (Hagerman, 2008; Crawford et al., 2002). Given the pervasiveness of ASD, it is important to identify biomarkers in populations at-risk for ASD to inform differential diagnosis and early intervention. Atypical physiological arousal patterns are present in individuals with ASD (Goodwin et al., 2006) and have been found to predict the severity of symptoms of ASD in the first year of infancy in infants with FXS (Roberts, Tonnsen, Robinson, & Shinkareva, 2012). Respiratory sinus arrhythmia (RSA) is linked to a complex neurological feedback system involved with regulating parasympathetic activity and has been studied as a biomarker for stress and arousal patterns (Lewis, 2004). The present study examined patterns of physiological arousal in infants at-risk for ASD and typically developing infants during a frustration task.

Methods: The present study included a total of 53 infants (Mean Age = 12 months), which was comprised 13 infants with FXS (7 males), 17 infants that had an older sibling diagnosed with ASD (ASIB; 11 males), and 24 typically developing infants (TD; 18 males).The arm restraint epoch from the *Laboratory Temperament Assessment Battery* (Lab-TAB; Goldsmith & Rothbart, 1993) was used to elicit frustration from the infants. During the arm restraint epoch, the infant's mother lightly restrained the infant's arms once they demonstrated interest to a novel toy. The arm restraint epoch was divided into three consecutive conditions and consisted of 30 seconds of baseline prior to arm restraint, 30 seconds during arm restraint, and 30 seconds of recovery. Measures of physiological arousal included RSA and heart rate (HR) collected during baseline, arm restraint, and recovery conditions.

Results: Findings indicate that the FXS group had the highest baseline RSA (M = 4.02) compared to the ASIB (M = 3.94) and TD groups (M = 3.87). Additionally, the FXS group's RSA decreased from baseline to the arm restraint condition (M = 3.96), while the ASIB (M = 4.19) and TD (M = 4.14) group's RSA increased. All groups demonstrated decreases in RSA during the recovery condition. The TD group demonstrated the highest average heart rate (139.02) during the arm restraint task compared to the ASIB (134.38) and FXS (131.46) groups.

Discussion: This is the first study to compare physiological patterns of arousal in response to stress across infants with FXS, infants at-risk for ASD, and typically developing infants. These unique patterns of physiological arousal provide rationale for examining early biomarkers associated infants at-risk for ASD to help aid in understanding the dynamic relationship of neurophysiological processes and behavioral outcomes. Future directions include examining the relationship of physiological responses and behavioral indicators (e.g., facial expression, escape behavior, gaze patterns) during a frustration task, as well as later ASD symptom severity and diagnostic outcomes.

See the graphs on the next page for more information.

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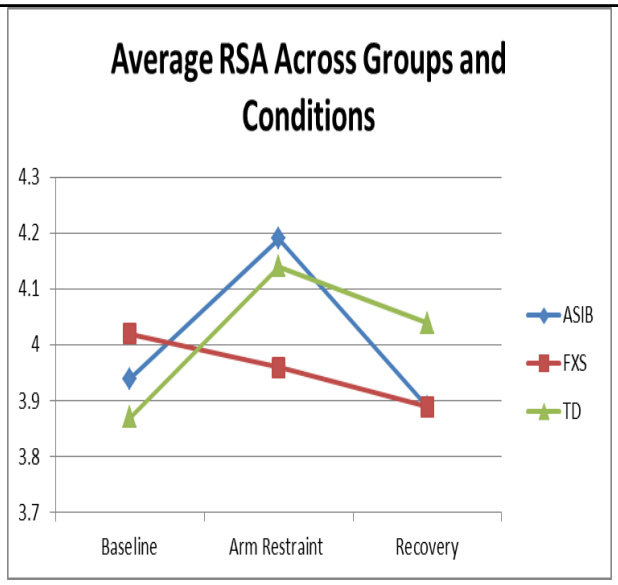
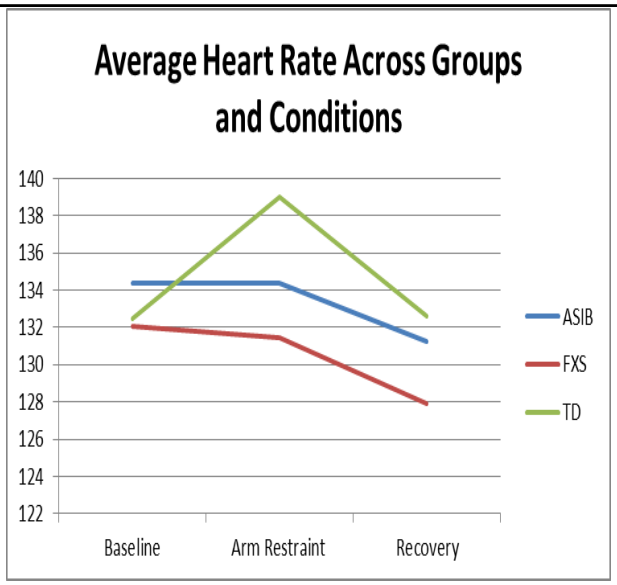
Division 33 Student Research Excellence Award





Division 33 Student Research Excellence Award

Selecting Informants to Assess Social Functioning and Treatment Outcome for Adolescents with ASD

Elina Veytsman, Crystal Ferrendelli, James Yang, Courtney Bolton, Elizabeth Laugeson

UCLA PEERS Clinic

Background: Assessment of social functioning of youth with social challenges consistent with Autism Spectrum Disorder (ASD) is complicated by conflicting informant perceptions. For youth with ASD, self report of symptoms of psychiatric diagnoses should be interpreted with caution (Mazefsky et al. 2011), as this population has shown poor diagnostic agreement with parents (Storch et al. 2012), underscoring the need for multiple informants, including teachers and therapists. Research shows concordance rates between parent and adolescent report are widely heterogeneous, dependent upon the instrument, the disorders under investigation, and the informant characteristics (Mazefsky et al. 2011). Understanding the discrepancy between parent, teacher, and self-report of social functioning and treatment outcome among youth with social challenges is critical for determining the most reliable informants.

Objectives: The current study examines perspectives from multiple informants following a 14 -week evidence-based social skills intervention for adolescents with ASD in order to investigate perceptual differences of social skills functioning and changes over time.

Methods: Participants included 239 adolescents with ASD referred for social skills training in outpatient and school settings. Among the clinic sample, participants included 133 adolescents (males=110; females=23) 11-18 years of age (*M*=14.02, *SD*=1.79) with ASD who attended 14 sessions of a weekly 90-minute social skills group with their parents using the Program for the Education and Enrichment of Relational Skills (PEERS®; Laugeson & Frankel 2010). Within the school sample, participants included106 adolescents (males=86; females=20) 11-18 years of age (*M*=15.08, *SD*=1.82) with ASD

Division 33 Student Research Excellence Award

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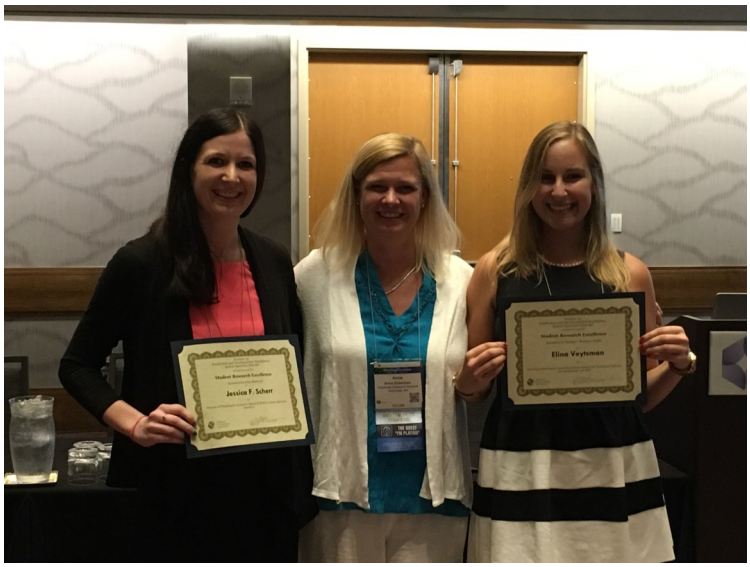
UCLA PEERS Clinic

who received daily teacher-facilitated social skills instruction in the classroom using the PEERS® school-based curriculum (Laugeson 2014). In order to assess perceptual differences of social functioning, adolescents and parents completed the Social Anxiety Scale (SAS; La Greca 1999), Quality of Socialization Questionnaire (QSQ; Frankel & Mintz 2008), and Empathy Quotient (EQ; Baron-Cohen 2004) at pre and post-test. Parents and teachers also completed the Social Skills Improvement System (SSIS; Gresham & Elliott 2008) and Social Responsiveness Scale (SRS; Constantino 2005) pre and post-treatment. Paired sample T-tests and Pearson product-moment correlations were conducted to examine informant perceptions of adolescent social functioning across settings, and Bonferroni adjustments were made.

Results: Results reveal moderate and significant correlations between parent, adolescent and teacher report for measures of social functioning. However, there were significant differences ($p < .001$) between parent and adolescent report of social anxiety and engagement, and parent and teacher report of social skills and autism symptoms at baseline and post-treatment. These differences decrease at post-treatment across measures in both samples, signifying increased agreement between informants following intervention. Conversely, differences in adolescent and parent report of social engagement measured by the QSQ significantly ($p < .001$) increase at post-treatment in the school-based sample.

Conclusion: This study highlights the complexity of using multiple informants in the assessment of social skills across settings. Although significant differences between reporters decreased over time in the outpatient sample following treatment, the increase in differences in the school-based sample may be explained by less parent involvement in this setting. The results demonstrate the need for multiple informants in social skills assessments.



**Jessica Scherr and Elina Veytsman—
our Student Award Winners!**

Looking for a fun Spring trip?

Join Division 33 members and other professionals at the

2017 Gatlinburg Conference

March 8th—10th, 2017
San Antonio, TX

http://www.ucdmc.ucdavis.edu/mindinstitute/

Early Career Psychologist Column

"Dissemination of Best Practices in ASD: Researcher Perspectives"

Katy Mezher, Ph.D.
Miami University, Ohio

In addition to identifying evidence-based practices for serving youth and adults with autism spectrum disorder (ASD), *dissemination* of these practices requires significant planning and attention. Thoughtful consideration of the packaging, transmission, adoption, implementation, and sustainability of best practices is warranted. For example, partnering with community providers to offer innovative training and coaching can address issues surrounding implementation fidelity (Vismara, Young, & Rogers, 2013). An implementation science approach, used across many disciplines, may continue to provide meaningful guidance in translating research to practice (see Odom, Cox, & Brock, 2013). As we begin a new year, it seems appropriate to reflect on dissemination of best practices at the present time, as well as dissemination priorities moving forward.

This column contains the perspectives of some esteemed researchers, all with different areas of expertise in the ASD field, including a student researcher. Specifically, six ASD researchers briefly share their views of:

1. *The current state* of dissemination of best practices in the ASD field

2. *Future directions* for dissemination of ASD best practices

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Topic: Early Intervention

Dr. Geraldine Dawson
Duke University Medical Center

Although it is possible to reliably diagnose autism in toddlerhood and despite the availability of efficacious early interventions, diagnosis often lags behind. The CDC reported that the average age at diagnosis for autism in the US is ~48 months. Without a diagnosis, children are not able to access the early interventions in a timely manner. Several factors contribute to diagnostic delay, including lower socioeconomic status, racial/ethnic minority background and presence of comorbid ADHD. Even with a diagnosis, many children with autism do not have access to high quality, intensive, early behavioral interventions. Many states in the US do not mandate insurance coverage for behavioral health interventions. A global perspective accentuates the scale of the challenge we face in disseminating and implementing best practices across the globe, especially in low-resource countries. There is an urgent need to scale up services for developmental disorders both in the US and abroad.

Looking toward the future, two strategies for scaling up services in remote and low-resource communities have received recent attention. First, clinical services that can be delivered by persons who are not trained professionals, including both caregivers and paraprofessionals, will allow communities greater access to screening and some forms of treatment. There is emerging evidence that such services can have short and long term benefit in enhancing caregiver-child interaction. Second, the use of eLearning and telehealth programs that can provide both professionals and caregivers training from remote locations promises to expand access to expertise and support. In order for such strategies to be effective, sustained collaboration and dedication of a variety of stakeholders, including government, professionals, caregivers, philanthropists, and nongovernment organizations, will be necessary.

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Early Career Psychologist Column

Topic: Social Communication Intervention

Dr. Brooke Ingersoll
Michigan State University

Best practices in social communication intervention for young children with ASD involve the use of a combination of developmental and behavioral intervention strategies that are child-centered and conducted in natural environments, and the active involvement of parents or other caregivers in intervention delivery. Despite positive views of parent-mediated social communication interventions held by parents, providers, and administrators, they are highly underutilized in community settings. There are a number of barriers that may impede the successful dissemination and implementation of best practices. At the family level, these include concrete barriers such as cost, transportation, and time commitments, as well as cultural barriers that can impact treatment acceptability. At the provider level, barriers include providers' attitudes regarding the role of parents in their child's intervention service, insufficient preparation in adult learning strategies to support parent coaching, and a lack of proactive facilitation strategies, such as accessible trainer and parent manuals and data monitoring and collection strategies. At the system level, barriers can include a lack of fit between the structure of the parent-mediated intervention program and the structure of existing service delivery models and provider training models that are incompatible with the organizational training structures of many community programs.

There are several ways forward that could enhance dissemination and implementation of best practices. One approach would be to change existing community practices to better support the use of evidence based social communication interventions. This could include the active dissemination of best practice guidelines through professional organizations, as well as developing organizational policies that can encourage the use of best practices. However, guidelines may not be sufficient to produce practice change. Thus, active pre-service and in-service training of community providers in common elements of evidence-based social communication interactions and effective adult learning strategies is also necessary. A number of effective strategies for increasing provider implementation of evidence-based strategies have been identified, including consultation and coaching. Another approach would be to develop and/or modify interventions to ensure that they can be easily adopted and implemented in community settings. To this end, intervention developers and researchers need to partner with community stakeholders to ensure that their models are compatible with needs, values, and constraints of community practice. This approach can identify and address likely barriers to community implementation early in the development process and ensure that the models which undergo rigorous testing have the greatest chance of success in our existing service delivery systems. In this process, it is important to consider family-, provider-, organization-, and system-level barriers. A third approach would be to develop new systems of care that surmount many of the barriers in current systems. For example, both self-directed and therapist-assisted telehealth-based programs are being developed that aim to teach parents effective strategies to support their child's social communication development. These programs have the potential to surmount many family-level barriers to access, including cost, transportation, and time.

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Topic: Supporting Transition to Adulthood in ASD

Sara R. Jeglum, School Psychology Doctoral Student
University of Wisconsin-Madison

Dr. Leann Smith DaWalt
University of Wisconsin-Madison

Youth and young adults with ASD are at risk for poor outcomes in multiple areas including employment, independence, and social connections (Howlin et al., 2004). However, there is an emerging literature on evidence-based practices (EBPs) with promising ways to improve outcomes for individuals with ASD during the transition to adulthood. Three key EBPs for transition-aged youth include (1) inclusive educational experiences with high expectations; (2) work-based learning opportunities; and (3) supportive family, peer, and community relationships (Test, Smith, & Carter, 2014). These practices challenge
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Early Career Psychologist Column

students to realize their potential and facilitate achievement of post-secondary goals.

Project SEARCH and Think College are two innovative programs that are currently translating research into practice. Project SEARCH (http://www.projectsearch.us), an international program model, matches students with ASD to integrated, competitive, and long-term employment settings. Project SEARCH interns are immersed in a workplace, developing relevant skills that are sought after by employers. The program mirrors the regulations of IDEA (2004), including quality Individualized Education Plan goals and the family-school partnership. Upon graduation, Project SEARCH follows graduates to help them retain employment. Think College is a national organization focused on innovating and disseminating post-secondary education options for individuals with intellectual disability, including those with ASD. Many resources are accessible on their website (http://www.thinkcollege.net), delineating EBPs, issues surrounding public policy, and available higher education programs nationwide. The distribution of transition research is expanding, giving rise to programs such as Project SEARCH and Think College. Future research should focus on evaluating factors that both facilitate and impede implementation of transition-related EBPs for adolescents with ASD in real world settings.

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Topic: ASD Social Skills Intervention

Dr. Elizabeth Laugeson
UCLA

Social skills training has been utilized for decades and is not a particularly novel treatment for individuals with autism spectrum disorder (ASD). Yet, historically the research suggests that these approaches, which have commonly focused on younger children, have not been tremendously effective in improving the social functioning of individuals on the spectrum (Reichow & Volkmar, 2010). In recent years, certain empirically-supported methods of treatment delivery have been identified (i.e., didactic instruction, role-play demonstrations, behavioral rehearsal exercises, homework assignments), with the emergence of a few evidence-based interventions (Miller, Vernon, Wu & Russo, 2014). Targeting interventions across the lifespan to focus on common social deficits shared among individuals with ASD, while using evidence-based methods of instruction, may make social skills interventions more effective with this population.

While social skills training has increasingly become a popular method for helping individuals with ASD adapt to their social environment, with a slowly growing body of evidence highlighting the effectiveness of social skills interventions, there is still considerable work to be done. As the field moves forward, recommendations for future research include:

- An emphasis on older populations (including adolescents and adults).

- Use of randomized controlled trials as the standard for examining the efficacy and effectiveness of social skills interventions.

- Assessment of treatment outcome using a combination of standardized outcomes measures and behavioral observations with multiple independent raters.

- Group research designs with large sample sizes and well-characterized populations.

- Long-term follow-up assessment to examine the maintenance of treatment gains over time.

- Dissemination of evidence-based practices to the community and school settings.

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Topic: Assessment

Dr. Catherine Lord
NewYork-Presbyterian Hospital/
Weill Cornell Medical College

First, I'm repeatedly surprised that academic reviews of best practices often focus on treatments and not on diagnosis and assessment. I worry that this has negative consequences because standards then tend to remain low. This seems important also because, for both assessment and treatment, practices extend across multiple disciplines which makes expectations even more complicated within service sys-

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tems. Second, for both treatment and assessment, we have had major steps forward in the coming together of natural behavioral developmental treatments and the potential to do so with different assessment strategies.

I think dissemination remains far behind knowledge. This is the case both for methods of treatment and assessment and diagnosis. It pertains to techniques and theory. I feel that we need to know much more about how best to implement (and get others to implement) what we know, both across systems and also for individual children. These issues are quite separate and will require very different kinds of research beyond the scope of what most of us do.

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Topic: School-based Intervention

Dr. Samuel L. Odom
University of North Carolina at Chapel Hill

Evidence-based practices identified for use in schools and by practitioners are generally the same practices used in other settings (community, home, clinic). The two main sources of information about evidence-based focused intervention practices for students with ASD are the National Professional Development Center on ASD (NPDC, http://autismpdc.fpg.unc.edu/) and the National Standards Project (NSP, http://www.nationalautismcenter.org/national-standards-project/). Although using different evaluation methodologies, they actually found similar intervention practices to have an evidence-base. The NPDC has, in turn, developed online modules that "translate" the EBPs into practical strategies that teachers and school personnel can use in classroom and school settings (http://afirm.fpg.unc.edu/afirm-modules).

Focused intervention evidence-based practices for students with ASD will continue to evolve because of the active research literature. A primary challenge today is that evidence-based reviews take so long to conduct, which creates a lag between when articles are published and when they enter a review. For example, the NPDC review identified 27 practices, but the literature review only went through 2011 (Wong et al., 2015). One future direction will be to establish a quicker cycle for reviewing the research literature and disseminating EBP findings to practitioners. A second future direction will be to use advances in instructional design and online capabilities to effectively communicate the most current information in a format that consumers (teachers and other service providers) easily access and use.

References

Howlin, P., Goode, S., Hutton, J., & Rutter, M. (2004). Adult outcome for children with autism. *Journal of Child Psychology and Psychiatry 45*(2), 212–229.

Individuals With Disabilities Education Act, 20 U.S.C. §§ 1400 *et seq.* (2004).

Miller, A., Vernon, T., Wu, V., & Russo, K. (2014). Social skill group intervention for adolescents with autism spectrum disorder: A systematic review. *Review Journal of Autism and Developmental Disorders, 1,* 254-265.

Odom, S. L., Cox, A., & Brock, M. (2013). Implementation science, professional development, and autism spectrum disorders: National Professional Development Center on ASD. *Exceptional Children, 79*, 233–251.

Reichow, B., & Volkmar, F. R. (2010). Social skills interventions for individuals with autism: Evaluation for evidence-based practices within a best evidence synthesis framework. *Journal of Autism and Developmental Disorders, 40*, 149-166.

Test, D. W., Smith, L. E., & Carter, E. W. (2014). Equipping youth with autism spectrum disorders for adulthood: Promoting rigor, relevance, and relationships. *Remedial and Special Education, 35,* 80–90.

Vismara, L. A., Young, G. S., & Rogers, S. J. (2013). Community dissemination of the Early Start Denver Model: Implications for science and practice. *Topics in Early Childhood Special Education, 32*, 223-233.

Wong, C., Odom, S. L., Hume, K. A., Cox, A. W., Fettig, A., Kucharczyk, S.... & Schultz, T. R. (2015). Evidence-based practices for children, youth, and young adults with autism spectrum disorders: A comprehensive review. *Journal of Autism and Developmental Disorders, 49,* 1951-1966.

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Sara S. Sparrow Early Career Research Award

"From Screening to Schooling: Maximizing the Benefit for Children with ASD"

Abbey Eisenhower, Ph.D
University of Massachusetts, Boston

It was an honor to receive the Sara Sparrow Early Career Award from Division 33 at this summer's APA Convention. During my Sparrow award talk at APA, I spoke about the early childhood experiences of children with autism spectrum disorders (ASD), focusing on two research areas I have been involved with: screening and early detection of ASD and the early school experiences of children with ASD. In this article, I highlight some key take-home messages from these two fields of research.

Screening and Early Detection of ASD

Children with ASD who are identified early stand to benefit from additional months and years of interventions, which in turn are linked to improved long-term functioning and optimal outcomes. Unfortunately, health disparities are present in access to a timely diagnosis of ASD. Children who are racial minorities, English language learners, or from low-income households experience lower rates of detection of ASD relative to their White, English-speaking, middle- and upper-income peers; when they do receive ASD diagnoses, they are 1-2 years older, on average, than these peers. This constitutes an important health disparity. Indeed, access to screening, to diagnostic evaluation services, and to early treatment, is not distributed evenly. The timeliness, quality, and appropriateness are also not equitable across race, income, and English proficiency.

In our research, through the ABCD Early Screening Project (PIs: Alice Carter, myself, Angel Fettig, and Chris Sheldrick; funded by HRSA and NIMH), we have implemented a multi-stage ASD screening and assessment protocol for toddlers who are participating in Early Intervention (EI) services. Figure 1 shows the 3-stage screening model. In the ABCD Project model, two screening stages (a paper-and-pencil screener and a subsequent play-based screening measure) are delivered by service providers at our partner EI agencies within the existing Part C Early Intervention system. In the third stage, a diagnostic assessment is offered by our clinical team to those screening positive. The process enables access to a timely diagnosis and, in turn, access to ASD-specific early intervention services.

In this work, we have identified several important messages that can guide our subsequent efforts to improve early detection and reduce disparities.

Lessons Learned

- Early screening that builds on existing family-provider relationships is a promising route toward earlier detection and earlier access to services for ASD.

Embedding a screening process within the Part C Early Intervention services (also known as birth-to-three services) may be one way of enabling better, more equitable access to screening, especially for children from groups that are currently under-identified. Relative to pediatricians, EI professionals have frequent (often weekly) contact with families. By embedding the screening process within families' already-occurring Early Intervention services, we capitalize on the positive relationships already in place between EI service providers and families. These existing alliances make difficult conversations around ASD concerns easier.

- HOWEVER, EI specialists and pediatricians feel underprepared to have difficult conversations around ASD with families.

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The health care providers we work with report a lack of readiness to initiate conversations with parents about social communication concerns, and express fears of rupturing their relationship with families or distressing already-stressed families. This lack of readiness leads to avoidance of these conversations, especially for children whose symptoms are less clear-cut. Psychologists are well-positioned to play a key role in supporting and training pediatricians, EI specialists, and other service providers to feel prepared to have conversations with families around their ASD concerns.

- Within the Early Intervention context, we should NOT wait to screen until parents express concerns.

To date, we have screened 1259 families (1259 at Stage 1, 316 at Stage 2), conducted diagnostic assessments with 207, and diagnosed 172 children with ASD. However, only 65% of the parents whose children were eventually diagnosed expressed concern about ASD at the time of the initial screening. This suggests that it is crucial to screen all children -- especially all children who are already presenting at Early Intervention -- for ASD, rather than only screening in case of parent concern. Relying on parental concern to trigger the screening process may result in missing ≥ 35% of children. This finding is relevant to the recent US Preventive Services Task Force recommendations (2016). The USPSTF guidelines asserted that there was insufficient evidence to recommend screening children for ASD except in cases where parents or providers were already concerned; our findings would suggest that a concern-based approach to screening would result in many delayed or missed diagnoses.

- The screening process is not only a means of identifying at-risk children; it is also an intervention tool in and of itself.

By the time families come in for a diagnostic evaluation, they have already had multiple conversations about autism with their EI service providers, at each earlier point of the multi-stage screening process. With each conversation, they have had multiple opportunities to reflect on their child's behaviors and symptoms with their EI providers. They are better positioned to consider an autism diagnosis for their child and are better prepared to advocate for their child.

Once children are identified, the hope is that early detection will lead to improved outcomes and greater readiness to learn in school. In the next section, I discuss our research on promoting school adaptation for children with ASD in the early school years.

The Early School Experiences of Children with ASD

Early schooling places new demands on children's academic & social skills, behavior, and self-regulation. The quality of relationships with teachers in the early school years is a vital aspect of school adjustment, one that has implications for long-term outcomes. We know from the research on typically developing children that student-teacher relationships are powerful drivers, or at least predictors, of long-term adjustment. The quality of relationships with teachers predicts academic performance, social acceptance and social skills, loneliness, anxiety, and behavior problems in subsequent grades.

We can understand this impact through the lens of attachment theory; children who are able to develop a secure attachment with their teachers will be comfortable and confident to explore their classroom environment and try new tasks or skills, with the teacher as a secure base. They will see school as a safe place where they can learn to take risks.

However, we know very little about the nature of these relationships for children with ASD. With Jan Blacher at UC-Riverside, we recently conducted a two-site, longitudinal study of about 180 children with ASD during their early years of school (the Smooth Sailing Study, funded by IES, PI: Blacher). Children were ages 4-7 and entering Pre-K, or K or 1st grade at the time of enrollment; they were assessed three more times over two school years, usually spanning two teachers and two classrooms. Roughly half of participants were attending gen-

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eral education or integrated classrooms for at least 50% of the school day, whereas half were enrolled in special education classrooms.

In this study, we have identified some key lessons that can guide our future efforts to improve the school adjustment of young children with ASD:

- Teachers, especially general education teachers, report a lack of preparedness to teach students with ASD.
- Of the roughly 150 teachers we surveyed, all of whom had students with ASD who were participating in our longitudinal study, only 25% report having any professional training in autism. This includes 46% of special education teachers and 9% of general education teachers.
- Less than half of general education teachers feel prepared to teach students with ASD.
- Of the teachers we surveyed, all of whom were teaching at least one student with ASD, 94% of special education teachers reported feeling "pretty prepared" or "very prepared" to teach students with autism (vs. "somewhat" or "not at all prepared"), but only 42% of general education teachers felt very or pretty prepared.
- Children with ASD have poorer relationships with teachers, with lower student-teacher closeness and higher conflict, relative to normative samples.
- These problems may interfere with academic growth, including development of reading skills. As a result, interventions that target student-teacher relationships may be beneficial in indirectly improving academic outcomes.
- On the positive side, nearly one-third of children with ASD do achieve positive relationships with teachers, laying a foundation for school adjustment. Future research should examine the teacher, child, and classroom qualities that promote such positive connections.

I am grateful to Division 33 for the opportunity to share these research interests at APA, and for the support and encouragement provided by Division 33 mentors for the research endeavors of students and early career professionals. In light of Sara Sparrow's own legacy of mentoring and collaboration, I want to thank several mentors who are foundational to my research. Jan Blacher and Alice Carter, collaborators on these two projects, and Bruce Baker, my grad school advisor, exemplify what it means to be a mentor.

The research described here is funded by HRSA (R40MC26195, PIs: Carter & Eisenhower), NIMH (R01 MH104400, PIs: Carter & Sheldrick), and IES (R324A110086, PI: Blacher, site PI: Eisenhower). Thank you to the teachers, EI providers, parents, and children who participated, and to the UMB, UCR and UCLA students and staff who contributed to this work.

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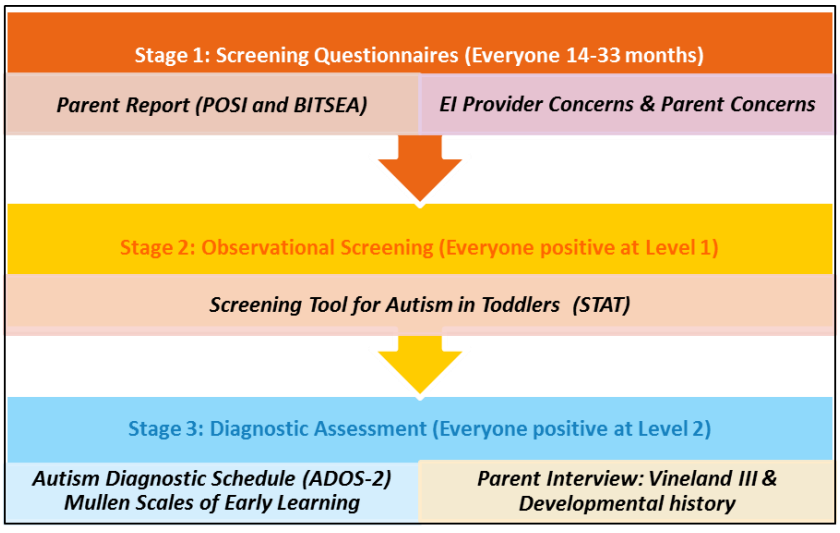

Carter, A., Eisenhower, A., Martinez-Pedraza, F.**, & Fettig, A. (2015, July). *Addressing Health Disparities in Early Diagnosis and Service Receipt: Implementing Two-Stage Screening in Early intervention*. Poster presented at the ASD CARES Convention for HRSA Grantees, Bethesda, MD.
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DSM-5: Diagnosis of intellectual disability and the "relatedness" phrase

A special contribution:

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Part 1: DSM-5: Development of the IDD criteria
For Adaptive Functioning

James C. Harris, MD, Professor of Psychiatry and Behavioral Sciences. Mental Health, Pediatrics and History of Medicine. The Johns Hopkins University School of Medicine and The Bloomberg School of Public Health.

Part 2: Capturing the Cognitive Essence of IDD: Explaining the "Relatedness" Clause in DSM-5

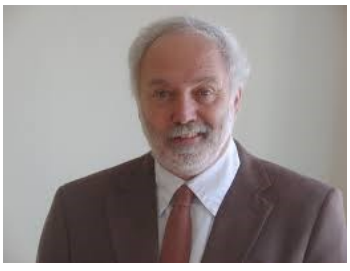
Stephen Greenspan, PhD, Professor Emeritus of Educational Psychology, University of Connecticut

Part 3: Intellectual Disability, Adaptive Behavior, and the DSM-5

Marc J. Tassé, PhD

The Ohio State University Professor, Departments of Psychology and Psychiatry , Director, Nisonger Center—UCEDD

Dr. Harris



Dr. Greenspan

Dr. Tassé
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DSM-5: Diagnosis of intellectual disability and the "relatedness" phrase

Marc J. Tassé, PhD, James C. Harris, MD, & Stephan Greenspan, PhD

Introduction

DSM-5: Diagnosis of intellectual disability and the "relatedness" phrase

Marc J. Tassé, PhD

This three-part series examines the 5th edition of the Diagnostic and Statistical Manual's (DSM-5; American Association, 2013) definition of intellectual disability and a phrase that asserts that in order to make a diagnosis of intellectual disability, the person's deficits in adaptive functioning must be related to their deficits in intellectual functioning. James C. Harris, a member of the DSM-5 neurodevelopmental disorders work group that wrote the diagnostic criteria for intellectual disability, authored the first segment of this series and presents the rationale behind the work of the DSM-5 work group and insights into their decisions made regarding intellectual disability. In the second article of this section, Stephen Greenspan presents a brief history and overview of the ideas behind the formulation of the DSM-5 "relatedness phrase". In the third and final section of this three-part series, I present a short review of the history of adaptive behavior and the definition of intellectual disability along with the research on the relationship between adaptive behavior and intelligence and argue that the relatedness phrase is problematic especially in forensic cases.

We hope this three-part series on the DSM-5 definition of intellectual disability and the newly inserted "relatedness" phrase will provide a helpful overview and shed light on the rationale for the insertion of this statement as well as offer a discussion of the possible implications.

Marc J. Tassé, PhD, Professor of Psychology and Psychiatry, Director of Nisonger Center - UCEDD, The Ohio State University. Marc is co-chair of the American Psychological Association Division 33 *ad hoc* Committee on *Developmental Disabilities and the Criminal Justice System*. Email: Marc.Tasse@osumc.edu.

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Part 1

DSM-5: Development of the IDD criteria For Adaptive Functioning

James C. Harris

Preamble

As a developmental neuropsychiatrist, I have always viewed adaptive functioning as the key feature in the definition of intellectual development disorders. In the chapter on mental retardation in my two-volume textbook, *Developmental Neuropsychiatry*, published in 1995, I deliberately reversed the order of criteria when describing DSM III-R, DSM IV, and the current AAMR definitions (see table 5-2 on diagnostic criteria) placing adaptive functioning first. Earlier as a medical student I spent one summer with NIH support seeking to replicate Piaget's genetic epistemology conservation experiments with severely psychosocially deprived children in Washington DC. I found that these children followed the same sequence but averaged one year behind in task mastery. Thus, from early in my career I have been interested in how children and adolescents reason in problem solving and brought this interest with me to DSM-5.

During my combined child psychiatry/ neurodevelopmental pediatrics fellowship training I read Barbel Inhelder's *Diagnoses of reasoning in the mental retarded* and began to reflect about the prospect that
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there may be failures in cognitive progression that define the levels we describe as profound, severe, moderate and mild deficits. If so, then children who were performing optimally within the constraints of their cognitive capacity could not be considered "retarded." I often point out to medical students that a young woman in the profound range meeting challenges by functioning at the peak of her cognitive capacity was higher functioning than many of them. Were they using their full cognitive potential as she was?

Thus, my interest in the progression of the neurobiological development of cognition emerged and led me to focus on neurodevelopmental disorders in DSM-5 when I joined the Neurodevelopmental committee. When I wrote my textbook on Intellectual disability (2010) I was intrigued by a *Monograph of the Society for Research in Child Development* issue by Demetriou et al (2002) who reframed Inhelder's earlier proposal into a study of the development of mental processing that combined information processing and differential psychological approaches. Like Inhelder they emphasized the importance of cognitive efficacy in problem solving. They provide a modern framework by discussing the emergence and maturation of working memory, executive function and thinking. They emphasize how these capacities improve with age. Finally, since a developmental approach to cognition recognizes how emergent new cognitive capacities encompass earlier ones and are qualitatively different I wondered about IQ testing in regard to developmental cognitive progression. I realized that IQ tests are normed by age group. One of our neuropsychologists pointed out to me that if raw scores were considered we might be better able to discern qualitative changes in reasoning during development.

On the DSM-5 committee I questioned continuing with the DSM-IV definition criterion 1 that specified an "*IQ of approximately 70 or below*" in the definition. This focus on a test score as the criteria for a psychiatric diagnosis was not in keeping with other criteria in DSM-5 that were based on psychiatric interviews and the phenomenology of the disorder being considered. Moreover, mental retardation in DSM-IV was an axis two diagnosis, a remnant of the 1969 triaxial classification that had morphed into the multiaxial classification. Essentially axis II, along with the other axes, was used for prognosis estimates by psychiatrists. But in DSM-5, to the chagrin of child psychiatrists who used the multiaxial classification, it was to be abandoned. If this cognitive disorder diagnosis was to be maintained in the classification DSM system, it would have to be redefined in keeping with the DSM-5 disorder diagnosis focus on the previous axis I.

Another issue to be considered in regard to DSM-5 was the legal requirement that it be linked to the World Health Organization (WHO) International Classification of Disease (ICD-11). Moreover, the term intellectual disability had been adopted in the US in Federal Law for provision of benefits and the AAIDD was using this term for its definition. The WHO had approved and promulgated the International Classification of Functioning (ICF). However, the US has not formally adopted the ICF. Still the AAIDD makes clear that its focus is on the disability construct as defined in ICF and states this in the introduction to its manual.

Because of the requirement for harmonization between ICD-11 and DSM-5 the APA asked me to serve as liaison to the ICD-11 committee in the revision of the criteria for mental retardation. Unlike DSM-5, ICD-11 had a separate committee to revise the definition. Ruth Luckasson represented the AAIDD on the ICD-11 committee and was a co-author of the ICD-11 committee's official position on naming that was published in the journal *World Psychiatry* (see: Salvador-Carulla et al., 2011). ICD-11 debated about whether to keep this intellectual disorder in their classification of diseases (ICD) because WHO had a separate classification for disability, the ICF. The ICD-11 committee eventually decided that disorders of intellectual development are health conditions and

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should be included in ICD-11 based on their conclusion that intellectual developmental disorder is "*a syndromic grouping or metasyndrome analogous to the construct of dementia, which is characterized by a deficit in cognitive functioning prior to the acquisition of skills through learning*." The naming for ICD-11 is now finalized as *Disorders of Intellectual Development*. For harmonization, a compromise was reached in DSM-5 with the use of the term. *Intellectual Disability (Intellectual Developmental Disorder).*

DSM-5 and Adaptive Functioning

The DSM-5 IDD committee was made up of official delegates chosen by the APA and advisors that included representatives from the American Psychological Association, AAIDD, pediatric neurology and other stakeholders. All of the DSM-5 committees had forensic psychiatric representation so the issue of eligibility of the death penalty was actively discussed in our deliberations.

IDD was included in the new category, neurodevelopmental disorders, consistent with ICD-11 plans. The first challenge for our committee was the elimination of the multiaxial classification. This required a new definition of IDD as a psychiatric disorder. To make this transition the first step was to incorporate a definition of intelligence in the first criterion. My recommendation that we include the consensus definition of intelligence referenced in the AAIDD manual was accepted. This recommendation was accepted and incorporated into the first criterion. Thus, the DSM-5 definition focuses on reasoning, problem solving and planning, etc. in the definition. The term "standardized testing" in criteria 1 refers to testing these capacities and refers to tests to measure all the constructs entailed in the definition not only using standardized IQ tests. Thus, for completeness in assessment for the eligibility for the death penalty this means that neuropsychological testing, particularly executive function testing, is required. We make clear in the text that IQ testing is not sufficient for assessment, especially, in regard to the death penalty issues. Clinical components of testing include verbal comprehension, working memory, perceptual reasoning, quantitative reasoning, abstract thought, and cognitive efficacy are mentioned in both DSM-5 and the ICD-11 draft. Each of these components are measured by standardized intelligence testing and neuropsychological testing. Psychiatrists also must render a clinical judgment based on the diagnostic criteria from their individual interview with the patient and review of testing. We assume that psychological and psychiatric testimony will address how deficits in verbal comprehension, working memory, perceptual reasoning, quantitative reasoning, abstract thought, and cognitive efficacy impact adaptive reasoning in death penalty cases. The DSM-5 emphasis is on fluid intelligence and cognitive flexibility--the capacity to shift cognitive set when stressed--as aspects of adaptive reasoning. In a recent chapter in Nirhbay Singh's book on evidence based treatments in intellectually disability neuroimaging correlates of these deficits are discussed but neuroimaging is not at this time recommended in forensic testimony.

The DSM-5 second criterion on adaptive functioning also has a cognitive component. Both criterion 1 and criterion 2 refer to reasoning. We point out that criteria one and two are related in the DSM-5 text but we do not state causation. However, we do propose that deficits in executive functions are correlated with behavior in cognitively demanding situations. The focus on everyday life experience in criterion 2 is specially focused on adaptive functioning in 3 domains: conceptual (academic), social and practical. By focusing on adaptive reasoning in criterion 2 our intention was to make clear that both criterion 1 and 2 involve reasoning. This is expressed in the table of severity levels where we specifically do not reference an IQ score range for levels of severity but instead give examples of adaptive functioning in the 3 domains. In forensic assessment, our construct is "adaptive reasoning" and for the death penalty we expect the focus of assessment refer to adaptive reasoning

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in socially demanding circumstances. When we refer to the first and second criteria being linked we are referring to cognitive reasoning being essential to both.

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Part 2

Capturing the Cognitive Essence of IDD: Explaining the "Relatedness" Clause in DSM-5

Stephen Greenspan

The intellectual developmental disorder (IDD) section in DSM-5 contains a sentence which states a need for deficits in Criterion B (adaptive functioning in DSM, adaptive behavior in AAIDD) to be related to deficits in Criterion A (intellectual impairments). This has posed some confusion, especially in Atkins (death penalty) cases, as some forensic psychologists and prosecutors have disputed a diagnosis of IDD by asserting that the accused person has mental illness or behavior issues (very frequently present in homicide defendants) and, thus, one cannot definitively know for sure whether his adaptive functioning (AF) deficits are attributable to low intelligence. I believe this is a mistaken interpretation, which distorts the reason underlying the sentence. As I am the person generally credited (or blamed) for the idea behind this sentence (if not for the wording, which came mainly from the pen of James C. Harris), it is appropriate that I attempt to clarify the reasons for this idea. As this paper mainly discusses DSM, I shall refer to prong two as adaptive functioning, or AF, as that is the term used there instead of the equivalent term adaptive behavior, or AB, found in the AAIDD manuals. See Greenspan (2015) for a fuller account of the history underlying this issue.

A problem is that AF is an invented construct, borrowed (before 1960) from the animal ecology literature, and it initially lacked an adequate (or any) constitutive definition. As with many other psychological constructs, including intelligence, what happened is that a first instrument was developed (the AAMD Adaptive Behavior Scale, or ABS) and then a definition of the construct was derived from analyses of that measure. A better approach, in my view, would have been to devise an adequate definition of the AF construct and then develop measures based on the predefined construct. One problem with grounding a definition of AF on the ABS (different from the much later-developed ABAS) is that it was developed at an institution in Kansas (the Parsons State School), and consequently the items were devised with lower-functioning individuals in mind. Thus, the items tended to focus on behaviors that are problems for lower-functioning individuals, such as basic self-help and acting out-difficulties. An additional problem is that the developers were psychologists with a behaviorist orientation (true of most psychologists in the 1960's who worked in the IDD field), and thus lacked sufficient appreciation of the need to emphasize cognitive aspects of AF. This is important, in that the commonsense phenomenology of IDD is behaving in the world in a manner indicating poor cognitive functioning. For AF to capture the IDD phenotype or taxon, therefore, it stands to reason that its items should emphasize cognitive challenges and approaches to everyday life. It should be noted, however, that the first AF instruments were mainly used programmatically rather than diagnostically, which explains in part the focus on overt behaviors. With a shift to using instruments diagnostically, however, a cognitive wording of items is desirable. This makes the recent decision by developers of the (long-stalled) Diagnostic Adaptive Behavior Scale (DABS) to drop any cognitive items—justified on the grounds that they require subjectivity and are likely less reliable (Tassé, 2016)--a mistake, in my opinion.

In several publications beginning nearly four decades ago (Greenspan, 1979), I argued
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for the advantages of basing the definition of IDD (and of AF) on a tripartite model of intelligence first proposed by E.L. Thorndike in 1920. The three components of the model I (re)named Conceptual Intelligence, Practical Intelligence, and Social Intelligence. This tripartite model (with different domain names) was used by various intelligence scholars, such as Carroll (1986). Although the tripartite model was mentioned prominently in the 1992 "blue book" manual of AAIDD (at that time, AAMD, but I shall use the current name), it was not fully implemented until the 2002 "red book" AAIDD manual, where it became the basis for the current model of AF, which continues to be used in both the 2010 AAIDD "green book" as well as in DSM-5. It is also the basis for rating measures of AF, including the ABAS-3 and the recent Adaptive Behavior Diagnostic System (ABDS; Pearson, Patton & Mruzek, 2016). However, while the inspiration for my suggesting a tripartite model of intelligence as the basis for AF (and of IDD) was to bring a heavy emphasis on cognition into the AF construct, that aspect of my proposal was not adopted.

When the tripartite model was implemented in the 2002 AAIDD manual, it morphed from a tripartite model of intelligence into a tripartite model of AF, with "intelligence" continuing to be found only on the Criterion A side of the equation. Thus, IQ continued to be the only indicator of intelligence, and AF continued to be peripheral (kind of a separate, even if correlated, personality domain) to the definition of IDD. My original idea had been that IDD would be redefined as a disorder characterized by deficits (not necessarily minus 2 standard deviations) in all three areas of intelligence: social intelligence (understanding of the social world), practical intelligence (understanding of the physical world) and conceptual intelligence (understanding of the academic world). This would have kept the historical understanding of IDD as a disorder of intelligence, but would have broadened intelligence to include more than Conceptual intelligence (traditionally captured by IQ, which from the Binet on, has been based on items from academic curricula). In what was termed a "Hegelian synthesis" **(**Schalock, 1999), the tripartite model of intelligence morphed into a tripartite model of AF, leaving intelligence (captured by IQ and related measures such as executive functioning) alone on the Criterion A side of the equation.

To me, this shift was unfortunate, for the simple reason that the phenomenology of IDD is best understood as lack of intelligence in these three domains. This can be demonstrated empirically (McGrew, Bruininks, & Johnson, 1996), but more importantly by the experience of caregivers and others who know children and adults with IDD well. As my colleagues and I demonstrated years ago in our research on supported employment (Greenspan & Shoultz, 1981), when adults with relatively high-functioning IDD get fired from jobs, it is typically not because they cannot master the job, and not because they act out emotionally. Rather it is mainly because of foolish" (i.e., risk-unaware) inability to follow unwritten social work rules, such as a hotel chambermaid not understanding that it is unwise to tell a guest to "get your ass out of bed" or a copy machine operator not recognizing when a work meeting is too important to interrupt with information about what he had seen on TV the night before.

The failure of the AAIDD T&C committee and test developers to fully appreciate the (diagnostically critical) cognitive aspect of AF can also be found in the way the "social" items are worded in AF rating instruments. Although the committee followed my recommendation from around 1980 to change the "social" domain from maladaptive behavior (which continues only as a supplemental scale, for example on the Vineland) to social competence, the social aspect on AF rating instruments contains many personality

(niceness/ nastiness) items and few if any social judgment items (except for a small number of gullibility items suggested by me). This niceness rather than clueless emphasis explains why individuals with possible IDD (as in Atkins assessments) almost always receive their highest scores in the social domain (as family members and other informants often see them as nice), even though their histories are replete with failures in work and elsewhere demonstrating an absence of social judgment.

To preliminarily test the advantages of a cognitively-worded AF scale, I took the small (but still substantial) number of cognitive items (Greenspan, 2016) on the social domain of the ABDS and created pro-rated standard scores. The result was that individuals slightly above the mild IDD range on the non-cognitive social items on the ABDS scored in the moderately IDD range on the cognitively worded social items. Furthermore, informants who had poor interrater agreement on the non-cognitive social items, had much stronger interrater agreement on the cognitive social items. In other words, raters who might disagree as to a person's niceness were likely to agree strongly on his lack of social judgment. This suggests that the decision to drop or change cognitively worded items on the (not yet published) DABS may have been based on a mistaken assumption. Contrary to the (underlying belief) of test developers that cognitively-worded items on an AF instrument could not be reliable, I found evidence that the opposite may in fact be true.

By implementing AF in the 2002 AAIDD manual as a broad model of everyday behavior rather than (as I had suggested) a broad model of everyday intelligence, AF continued to play a peripheral role in the definition of IDD. This is reflected in such things as the decision to make the definitional criterion for Criterion B involve significant deficits in just one out of three domains. The stated rationale for this was the (to me, questionable) argument that as the three domains are correlated, then deficiency in one domain should be interpreted as global AF deficiency. The main reason for the requirement of only one (out of three) domain deficits is, in my opinion, a continued reflection of a statement from as far back as the 1992 AAIDD manual (where the AF criterion was only 2 out of 10 skill deficits) indicating a desire to keep Criterion B an easy hurdle to meet, thus avoiding too many false negatives. (This is but one of several instances in the history of IDD definitions, where statistical reasons have been used to justify what were more likely policy-driven decisions).

Basically, as the phenotype for IDD has always been low intelligence, and as IQ continues to be the *sina qua non* of intelligence, then making a non-cognitively worded criterion B (as in low global composite AF scores) too difficult was seen as something to be avoided, in that the person's true "IDD-ness" could best be seen in his or her low IQ. If, on the other hand, AF were to be dropped as a separate construct, and IDD was defined as deficits across three domains of intelligence, then maintaining the one-out-of-three criterion would no longer make much sense, as the cognitive aspect of IDD would be continued. In this way, seeing the cognitive aspect of IDD primarily as low IQ would have been ended.

While the AAIDD manuals have never articulated a behavioral phenotype for IDD (which opened the door for idiosyncratic efforts, such as the Texas Briseño factors), in 2013 the DSM-5 came close, when it asserted that the best way of approaching Criterion B (adaptive functioning) is to think of it as poor "adaptive reasoning." Such things as gullibility and risk-unawareness (both constructs I have written much about recently) and executive functioning (especially consequential thinking) deficits were noted as central aspects of this legal prong, and by extension, of IDD. In the majority decision in the seminal 2002 *Atkins v Virginia*, Justice Stevens argued that "rationality" is a core aspect of IDD, an aspect with special importance for granting relief from execution, as a limiter of moral culpability. Rationality, a much written-about

(but still, poorly defined) construct, can be best conceptualized I believe as a failure to understand consequences of actions. This clearly does provide a justification for execution exemption, as poor risk-awareness limits *mens rea* (criminal intent), the key ingredient in Anglo-American criminal culpability theory.

If one thinks of IDD as a disorder characterized by limited reasoning about everyday actions and phenomena, then the "relatedness" clause in DSM-5 begins to make a lot of sense. The key mistake made by prosecutors and their experts (few knowledgeable about IDD) in recent cases—including in the recent US Supreme Court oral arguments in *Moore v Texas* (which centered on the *Briseño* factors, but also involved a discussion of the relatedness clause)--is to think that the clause requires that deficits in IQ "cause" deficits in adaptive functioning. A proper way to view the relatedness clause, in my opinion, is that it says that both Criteria A and Criterion B reflect deficits in reasoning ability. People with IDD lack reasoning ability in all activities and spheres of functioning, although these deficits do not show up equally in all settings (some problems obviously pose greater cognitive challenges than others). The relatedness clause points to the need for IDD experts to understand that Criterion B is central to a disorder characterized definitionally almost entirely by limitations in everyday thinking.

The fact is that IDD, like other psychiatric categories, is a construct that continues to evolve. Two aspects of this evolution are (a) recognizing the limitations of full-scale IQ, and bringing other aspects of cognitive inefficiency into the definition; and (b) better capturing the real-world behavioral phenotype of IDD as a disorder of impaired judgment and vulnerable decision-making. The IDD section in DSM-5 is a step towards realizing these related objectives, and should be viewed as a refinement, and not a repudiation, of existing practice.

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This paper is based on a Division 33 presentation at the Denver APA convention in August 2016.

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Part 3

Intellectual Disability, Adaptive Behavior, and the DSM-5

Marc J. Tassé

Adaptive behavior has long been part of our conceptualization of intellectual disability even before we had standardized scales to assess the construct (see: Doll, 1936; Tredgold, 1937). Edgar Doll, the forefather of the *Vineland Adaptive Behavior Scales*, used the term "social competence" to define the individual's personal competence and social responsibility that were the product of educational, physical, intellectual, emotional, volitional, and vocational aspects of personal growth, adjustment, and attainment (Doll, 1936). Doll developed the *Vineland Social Maturity Scale* as an alternative to intelligence tests and thought of it as a better measure of human behavior.

Adaptive behavior first became part of the definition of intellectual disability in 1959 when Heber proposed adding deficits in learning, social adjustment and maturation to the diagnostic criteria along with deficits in intellectual functioning and age of onset during the developmental period. Later, learning, social adjustment, and maturation got folded into "adaptive behavior" and became henceforth an essential component of the American Association on Intellectual and Developmental Disabilities (AAIDD) diagnostic criteria for intellectual disability (Heber, 1959, 1961). The second edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-II; American Psychiatric Association, 1968) adopted Heber's (1959) three adaptive behavior domains (learning, social adjustment, and maturation) into its diagnostic criteria for intellectual disability, along with significant deficits in intellectual functioning and age of onset during the developmental period.
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The DSM-III (APA, 1980) replaced the three behavioral domains of learning, social adjustment, and maturation with the term "adaptive behavior".

Back to the future

Adaptive behavior is defined as the skills that we learn and perform (across conceptual, social, and practical domains) to meet our needs as well as the societal expectations which will vary across chronological age, contexts, and culture (Schalock et al., 2010). Adaptive behavior has been an integral part of defining intellectual disability for more than 50 years. The last several decades of psychometric work and research in this area has solidified the conceptualization of the construct of adaptive behavior (Luckasson et al., 2002; Tassé et al., 2012; Schalock, 1999; Thompson, McGrew, & Bruininks, 1999). In somewhat of a "return to the future" both the AAIDD manual (Luckasson et al., 2002; Schalock et al., 2010) and the DSM-5 (APA, 2013) adopted a more refined conceptualization of adaptive behavior that very much resembles the conceptual model originally proposed by Heber in 1959, including: conceptual (or learning), social (or social adjustment), and practical (or maturation) domains. In essence, the definition and diagnostic criteria of intellectual disability used today are virtually the same as those proposed by AAIDD more than 50 years ago (see: Heber, 1959, 1961).

DSM-5 and AAIDD: Similarities and differences

The definition and diagnostic criteria of intellectual disability in the DSM-5 (APA, 2013) and AAIDD manual (Schalock et al., 2010) are essentially identical, with a few nagging differences.

Let's start with what is the same. DSM-5 and AAIDD agree that the condition is characterized by significant deficits in both intellectual functioning and adaptive behavior. AAIDD and DSM-5 present the exact same definition of the psychological construct of "intellectual functioning" and both have the same operational definition of "significant deficits" defined as a performance that is approximately two standard deviations below the population average with consideration of all sources of measurement error when interpreting test results. Although the DSM-5 uses the terminology adaptive "functioning" and AAIDD uses adaptive "behavior" both define adaptive behavior/functioning as consisting of conceptual, social, and practical domains and deficits in adaptive behavior/functioning are met if the person has significant deficits in one or more of these three domains. Lastly, both agree that the condition has a developmental onset. AAIDD defines the developmental period somewhat arbitrarily as ending with the person's 18th birthday, whereas the DSM-5 does not operationally define when the developmental period ends, leaving it up to the clinician's judgment. The DSM-5 (as does AAIDD) recommends that clinicians use a combination of standardized tests and clinical assessments to inform their clinical judgment in making the determination of intellectual disability.

There are a few differences between the DSM-5 and the current AAIDD manual. First, the choice of terminology used by the DSM-5 is somewhat confusing because it uses both "intellectual disability" and "intellectual developmental disorder". The term "intellectual developmental disorder" is a new term never before used. The rationale provided by the DSM-5 for including "intellectual developmental disorder" in a parenthetical is their goal to align the DSM-5 with the World Health Organization's (WHO) draft publication of the 11th edition of the International Classification of Diseases (ICD). The WHO, however, appears to have moved away from using "intellectual developmental disorders" in favor of "disorders of intellectual development". Anyhow, in the US, the preferred term for the condition remains "intellectual disability" (Rose's Law, 2010; Schalock et al., 2010; Schalock, Luckasson, & Shogren, 2007).

Second, perhaps the biggest difference (and concern) is the insertion in the DSM-5 of the following phrase: "*To meet diagnostic criteria for intellectual*

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disability, the deficits in adaptive functioning must be directly related to the intellectual impairments described in Criterion A'' (APA, 2013; p. 28). Although benign in appearance, this phrase can result pose an insurmountable hurdle to making a diagnosis of intellectual disability. To assert that intelligence and adaptive behavior are related is to state the obvious. However, as discussed in Tassé, Luckasson, and Schalock (2016), the inserted phrase can be easily misinterpreted (and has been in the criminal justice system with potentially serious consequences) to signify that there is some sort of causal link between the two constructs. In any event, the DSM-5 may have inadvertently inserted a fourth diagnostic criterion to meet a diagnosis of intellectual disability: (1) significant deficits in intellectual functioning; (2) significant deficits in adaptive behavior (conceptual, social, or practical); (3) these deficits much originate during the developmental period; and (4) the deficits in adaptive behavior must be directly related to the deficits in intellectual functioning (Tassé et al., 2016).

A review of the research examining the relationship between intelligence and adaptive behavior measures concluded that although the two constructs (intelligence and adaptive behavior) correlate modestly (Kamphaus, 1987), they remain two distinct and separate constructs (Harrison, 1987; Keith, Fehrmann, Harrison, & Pottebaum, 1987). The authors of this manuscript have yet to find a published study that has empirically demonstrated a causal link between intellectual functioning and adaptive behavior. Although one could simply assert it, it would be quite challenging for a clinician to empirically demonstrate the "direct relatedness" of the deficits in adaptive behavior to the deficits in intellectual disability. Additionally, an analysis of the definitions of ID proposed over the past 5 decades by both the American Psychiatric Association and AAIDD indicates a consistent use of the terms "associated with" or "existing concurrently" or "deficits in both" when referring to deficits in intellectual functioning and adaptive behavior (Tassé et al., 2016).

If the goal of this phrase was meant to rule-out individuals who present adaptive behavior deficits that are related to conditions other than intellectual disability – why is that necessary? Is that not captured by requiring significant deficits in both intellectual functioning and adaptive behavior with an onset during the developmental period? If a person does present with significant deficits in both intellectual functioning and adaptive behavior and these deficits originated during the developmental period – why would it be necessary for the clinician to establish the "relatedness" between the two to diagnose intellectual disability? We know that people can also present with any number of mental illnesses and still have intellectual disability (Fletcher, Barnhill, & Cooper, 2017). Also, the etiology of intellectual disability can be any number of factors or combination of factors and its determination has never been required to establish a diagnosis of intellectual disability, as long as the three aforementioned criteria are met.

Conclusion

The newly added "relatedness" phrase in the DSM-5 will probably be ignored by the vast majority of clinicians making everyday determinations of intellectual disability. However, it will be and has been, cited by some as a bar to establishing a diagnosis of intellectual disability. And this will most likely happen in high stakes cases and in adversarial contexts such as the criminal justice system. In fact, the DSM-5 "relatedness" phrase was cited by the state of Texas in *Moore v. Texas* (a death penalty case) as one reason for denying Mr. Moore his claim that he had intellectual disability. The state of Texas asserted: "*Even if petitioner had met his burden to prove significantly subaverage intellectual functioning and significant limitations in adaptive functioning, he was still required to show further that the adaptive deficits are "related" to limited intellectual functioning*" (Attorney General of Texas, 2016). Thus, having potentially having life and death consequences.

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Thank you Dr. Harris, Dr. Greenspan, and Dr. Tassé for this thoughtful analysis.

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Part 1: References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Barbey, A. K., Colom, R., Paul, E. J., & Grafman, J. (2014). Architecture of fluid intelligence and working memory revealed by lesion mapping. *Brain Structure and Function, 219*, 485–494.

Barbey, A. K., Colom, R., Solomon, J., Krueger, F., Forbes, C., & Grafman, J. (2012). An integrative architecture for general intelligence and executive function revealed by lesion mapping. *Brain, 135* (Pt. 4), 1154–1164.

Barbey, A. K., Colom, R., & Grafman, J. (2013). Architecture of cognitive flexibility revealed by lesion mapping. *NeuroImage, 82*, 547–554.

Barbey, A. K., Colom, R., & Grafman, J. (2014). Distributed neural system for emotional intelligence revealed by lesion mapping. *Social Cognitive and Affective Neuroscience, 9* (3), 265–272.

Bertelli, M. O., Harris, J. C., & Salvador-Carulla, L. (2016). Classification and diagnosis of intellectual developmental disorders. In C. Hemmings & N. Bouras (Eds.), *Psychiatric and behavioural disorders in intellectual and developmental disabilities*. Cambridge: Cambridge University Press.

Demetriou, A., Christou, C., Spanoudis, G., & Platsidou, M. (2002). The development of mental processing: Efficiency, working memory, and thinking. *Monographs of the Society for Research in Child Development, 67*, 1–156.

Harris, J. C. (1995) *Developmental Neuropsychiatry: The Fundament*als (vol 1)*. Developmental Neuropsychiatry: Assessment Diagnosis and Treatment.* (vol 2) New York: Oxford University Press.

Harris, J. C. (2006). *Intellectual disability: Understanding its development, causes, classification, evaluation and treatment*. New York: Oxford University Press.

Harris, J. C. (2009). Legal aspects of intellectual disability. In E. Benedek, P. Ash, & C. Scott (Eds.), *Principles of child and adolescent forensic mental health* . Washington, DC: American Psychiatric Publishing.

Harris, J. C. & Greenspan, S. (2016). Definition and Nature of Intellectual Disability. In N. Singh, *Handbook of Evidence-Based Practices in Intellectual and Developmental Disabilities*. Switzerland: Springer International Publishing.

Rutter, M., Lebovici, S., Eisenberg, L., Sneznevskij, A. V., Sadoun, R., Brooke, E., & Lin, T. Y. (1969) A tri-axial classification of mental disorders in childhood. An international study. *Journal of Child Psychology and Psychiatry, 10(1),* 41-61.

Salvador-Carulla, L., Reed, G. M., Vaez-Azizi, L. M., Cooper, S. A., Martinez-Leal, R., Bertelli, M., …, Saxena, S. (2011). Intellectual developmental disorders: Towards a new name, defi nition and framework for "mental retardation/intellectual disability" in ICD -11. *World Psychiatry*, *10*, 175–180.
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Part 2: References

Carroll, J.B. (1986). What is intelligence? In R.J. Sternberg & K. Detterman (Eds.), *What is intelligence*? *Contemporary viewpoints on its nature and definition* (pp. 51-54). Norwood, NJ: Ablex.

Greenspan, S. (1979). Social intelligence in the retarded. In N.R. Ellis (Ed.), *Handbook of mental deficiency: Psychological theory and research.* Second edition (pp. 483-531). Hillsdale, N.J.: Erlbaum.

Greenspan, S. (2015). Evolving conceptions of adaptive behavior. In E. Polloway (Ed.), *The death penalty and intellectual disability: A guide* (pp. 173-185). Washington, DC: American Association on Intellectual and Developmental Disabilities.

Greenspan, S, (2016, Aug. 5). *Why DSM-5 suggested a switch from adaptive functioning to adaptive reasoning*. Paper presented at the American Psychological Association, Denver, CO.

Greenspan, S. & Shoultz, B. (1981). Why mentally retarded adults lose their jobs: Social competence as a factor in work. adjustment. *Applied Research in Mental Retardation, 2,* 23-38.

McGrew, K. S., Bruininks, R.H., & Johnson, D.R. (1996). A confirmatory factor analysis investigation of Greenspan's model of personal competence. *American Journal on Mental Retardation*, *100*, 533-545.

Pearson, N. A., Patton, J. R., & Mruzek, D.W. (2016) *ABDS: Adaptive Behavior Diagnostic Scale*. Austin, TX: PRO-ED Inc.

Schalock, R.L. (1999). Adaptive behavior and its measurement: Setting the future agenda. In R.L. Schalock (Ed.), *Adaptive behavior and its measurement: Implications for the field of mental retardation*. (pp. 209-222). Washington, DC: American Association on Mental Retardation.

Tassé, M. J. (2016, Nov. 28). *Personal communication*. Columbus, OH: The Ohio State University.

Part 3 References

American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders (2nd ed.)*. Washington, DC: Author.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders (3rd ed.)*. Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.)*. Washington, DC: Author.

Attorney General of Texas (2016). *Brief for the Respondent Texas in Bobby James Moore v. State of Texas*. The Supreme Court of the United States. No. 15-797.

Doll, E. A. (1936). *The Vineland Social Maturity Scale: Revised Condensed Manual of Directions*. Vineland, NJ: Publication of the Training School, Department of Research.

Fletcher, R. J., Barnhill, J., & Cooper, S.-A. (2017). *Diagnostic Manual-Intellectual Disability (DM-ID) 2: A Textbook of Diagnosis*. Kingston, NY: NADD Publishing.

Harrison, P. L. (1987). Research with adaptive behavior scales. *The Journal of Special Education, 21,* 37- 68.

Heber, R. (1959). A manual on terminology and classification in mental retardation. *American Journal of Mental Deficiency [A monograph supplement], 64*, 1–111.

Heber, R. (1961). A manual on terminology and classification in mental retardation (2nd ed.). *American Journal of Mental Deficiency [A monograph supplement], 66*, 1–109.

Kamphaus, R. W. (1987). Conceptual and psychometric issues in the assessment of adaptive behavior. *The Special Education Journal, 21,* 27-35.

Keith, T. Z., Fehrmann, P. G., Harrison, P. L., & Pottebaum, S. M. (1987). The relation between adaptive behavior and intelligence: Testing alternative explanations. *Journal of School Psychology, 25,* 31-43.

Luckasson, R., Borthwick-Duffy, S., Buntinx, W. H. E., Coulter, D. L., Craig, E. M., Reeve, A., Schalock, R. L., Snell, M. E., Spitalnik, D. M., Spreat, S., & Tassé, M. J. (2002). *Mental retardation: Definition, classification, and system of supports*. Washington, DC: American Association on Mental Retardation.

Rose's Law (2010). *S. 2781 (111th Congress)*.

Schalock, R. L., Buntinx, W. H. E., Borthwick-Duffy, S., Bradley, V., Craig, E. M., Coulter, D. L., … Yeager, M. H. (2010). *Intellectual disability: Definition, classification, and system of supports (11e)*. Washington, DC: American Association on Intellectual and Developmental Disabilities.

Schalock R. L., Luckasson, R., & Shogren, K. A. (2007). The renaming of mental retardation: Understanding the change to the

DSM-5: Diagnosis of intellectual disability and the "relatedness" phrase

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term intellectual disability. *Intellectual and Developmental Disabilities, 45*, 116–124.

Tassé, M. J., Luckasson, R., & Schalock, R. L. (2016). The Relation between intellectual functioning and adaptive behavior in the diagnosis of intellectual disability. *Intellectual Developmental Disabilities, 54,* 381-390.

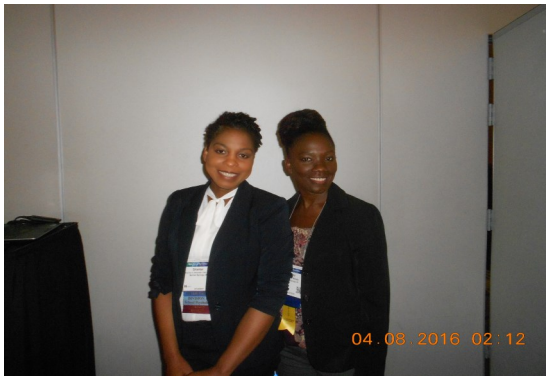
Tassé, M. J., Schalock, R. L., Balboni, G., Bersani, H., Borthwick-Duffy, S. A., Spreat, S., Thissen, D. T., Widaman, K. F., & Zhang, D. (2012). The Construct of Adaptive Behavior: Its Conceptualization, Measurement, and Use in the Field of Intellectual Disability. *American Journal on Intellectual and Developmental Disabilities, 117,* 291-303.

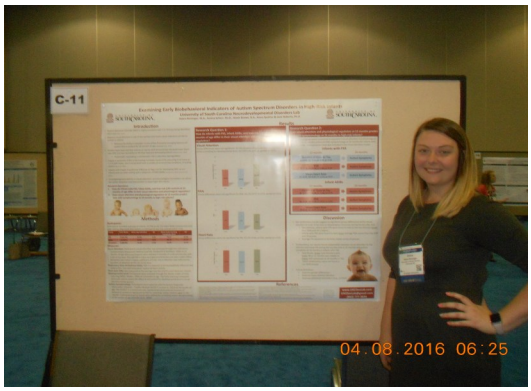
Thompson, J. T., McGrew, K., & Bruininks, R. H. (1999). Adaptive behavior and maladaptive behavior: Functional and structural characteristics. In R. L. Schalock (Ed.), *Adaptive behavior and its measurement: Implications for the field of mental retardation* (pp. 15–42). Washington, DC: American Association on Mental Retardation.

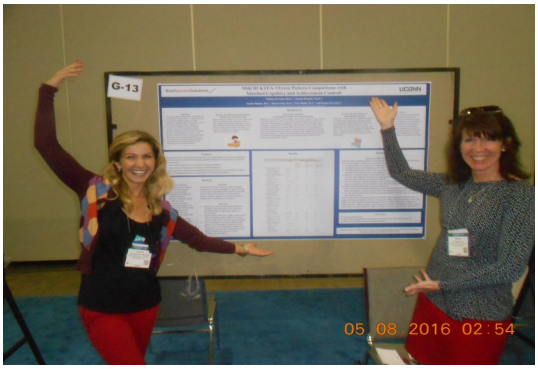
Tredgold, A. F. (1937). *Mental deficiency*. Baltimore: Williams and Wilkins.*Education, 21,* 37- 68.

APA Denver Memories!!

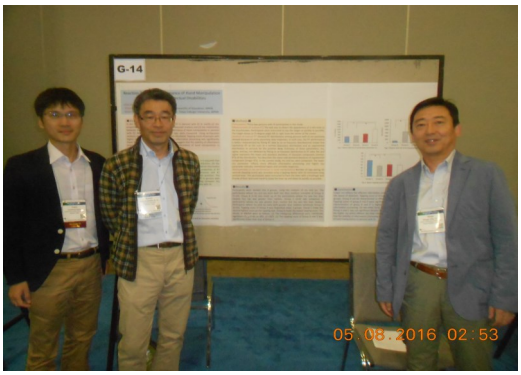
APA Pictures from Denver — Good Times and Great Memories

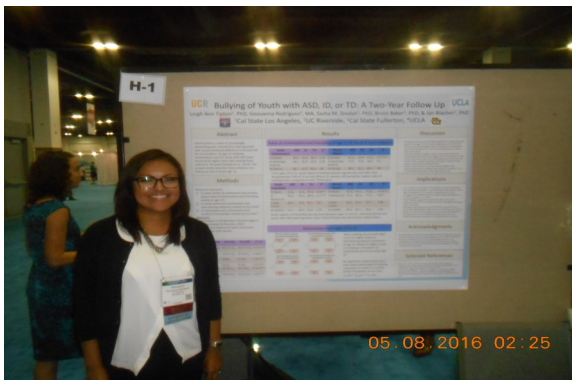


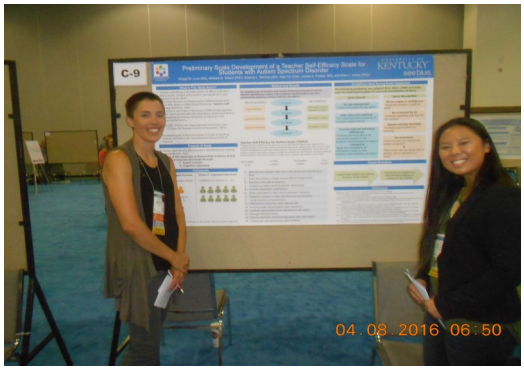




APA Pictures from Denver — Good Times and Great Memories







APA "Council Conversations"

Eric Butter, PhD—Division 33 Council Representative
August 3rd & 5th, Denver, Colorado

This is a column from your representative to APA's Council of Representatives focused on providing context to the issues and movements in the governance of the Association.

You may recall, the Winter 2016 meeting last February was plagued by significant discord and distress. And, by the shadows of the great Rocky Mountains in August 2016, the Association still had some heavy lifting to do. One year since the release of the Independent Review (IR) report related to APA's involvement in national security activities, APA Governance remains largely consumed by the after effects. Much Council business revolves around responding to the cultural and procedural deficits identified in APA's leadership structure and practices. However, new business was also engaged. Serious financial matters about the health and future of the Association were discussed.

In sum, it felt like we were getting unstuck and moving forward, and not just moving on. I can say that Council is, if not reinvigorated, at least focused on the future of psychology and the Association. Below, I summarize some of the new business from the Convention 2016 meeting of the Council of Representatives.

Directly relevant to our work in Division 33, the **Resolution on the Maltreatment of Children with Disabilities** passed by Council in 2003 was approved for archiving and a new version of the resolution was adopted. The full resolution is too long to be included here, but the highlights of the resolution include the following recommendations:

- A national strategy to accurately count the number of children with disabilities who are maltreated. The federal government needs to standardize definitions of disability and child maltreatment, data collection methodologies, and recordkeeping across all the states and territories;
- Encourage national and international researchers to clarify the current state of knowledge regarding maltreatment of children with disabilities. Such research should add disability status to all studies of child maltreatment and to evaluation studies of child maltreatment interventions, utilize consistent definitions of disability and child maltreatment, identify multifactorial risk factors for child maltreatment, assess the impact of multiple types of maltreatment on children with disabilities, and identify the multiple-service needs of children with disabilities and their families;
- Encourage the further development and provision of effective evidence-based family-focused prevention and interventions such as early childhood services, home visiting programs, the medical home model, parent and grandparent support groups, and respite care that build on the strengths of the child and family. Such programs should address family quality of life, such as reducing stress, isolation, depression, and anger, teaching caregivers positive behavior management techniques and coping strategies, and providing families practical support such as transportation, identification of service providers, and financial support.
- Services as described above should be appropriate to child characteristics such as developmental level, physical and sensory ability, gender, and intersecting identities and to caregiver characteristics such as physical and mental health to prevent and address the sequelae of child maltreatment;

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- All programs for maltreated children and their families need to be disability accessible and embedded in communities with high rates of child protective services involvement and low rates of geographical access, whether urban, rural, or suburban, and also offered alternatively through telephone and computer when feasible for both providers and family members;
- Encourage the consistent inclusion of students with disabilities in bullying intervention programs, given their elevated level of risk of victimization;
- Encourage the development of enhanced, disability-relevant training for CPS workers and all mandated reporters of suspected child abuse or neglect regarding crisis response, specifically, the identification and treatment of maltreated children with disabilities, and the utilization of investigation teams and foster care services that include disability specialists;
- Strongly encourage collaboration between professionals in the child maltreatment and disability communities (e.g., lawyers, law enforcement personnel, child advocates, mental health professionals), and dissemination of research on the special needs of maltreated children with disabilities to both of these groups and to education and training programs in psychology.

For a copy of the complete resolution, go to this link: http://www2.apa.org/about/policy/maltreatment-children.aspx

Council also approved other important resolutions that our Division Membership may be interested in knowing more about. Council debated and then approved an amendment to the composition of **Committee of Teachers of Psychology in Secondary Schools**. A **Resolution on Data about Sexual Orientation and Gender Identity** was amended and amendments approved. The amended resolution makes recommendations designed to protect confidentiality, privacy, anonymity, and privilege of gender identity data. This resolution also amended cited literature and provided for broader inclusion of gender identity issues. Additionally, a **Resolution on the Free and Responsible Practice of Science, Freedom of Movement of Scientists, and APA International Engagement** was adopted as APA policy. The policy adheres to the Universality of Science as stated in the statutes of the International Science for Council (ICSU) and the International Union of Psychological Science (IUPsyS). From the resolution, and in these new times, you may be inspired to read the following:

> *"This principle embodies free and responsible practice of science, freedom of movement, association, expression and communication for scientists, as well as equitable opportunities for access to science and its benefits, access to data, information and research material. It also upholds the responsibilities of scientists to society, and the responsibilities for scientists to promote the potential benefits of their work and to protect from potential harms of their work."*

One other resolution that was approved is especially noteworthy. Council approved the **Resolution on Psychologists in Integrated Primary Care and Specialty Health Settings.** The principles of training, working, and providing care in integrated primary care and specialty healthcare settings is now APA policy. It has been a focused aspect of APA President Susan McDaniel to promote Psychology in Healthcare. Her observations in a recent farewell communication to Council Representatives was that, though it may be hard to know where we are going in healthcare right now, "putting primary care and behavioral health closer to the center of healthcare" can still be a part of our future. During her time as APA President, Dr. McDaniel has started the Integrated Primary Care (IPC) Alliance. This initiative brings together an alliance among primary care and behavioral health professional associations involved in developing and promoting integrated primary care as a strategy for improving

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healthcare in general and access to mental health services in particular. Also, APA is nearly done with creating a curriculum for an Interprofessional Seminar on Integrated Primary Care. Relevant to many members of Division 33, APA has also developed a Work Group on Integrated Specialty Care and as Dr. McDaniel commented, "My own experience in Rochester is that I have more requests for psychologists than I have psychologists trained to do this work." You can view the full resolution on Integrated Care yourself at http://www.apa.org/about/policy/integrated-primary-care.aspx .

It is also worth noting that APA has also focused on Interprofessional Team Science and the Science of Teams during Dr. McDaniel's time as President. "Psychological science has and will contribute so much to our understanding of health and healthcare." She will be co-editing a Special Issue of the American Psychologist on team effectiveness in a variety of contexts—"from primary care to surgery, from schools to corporations, from disaster recovery work to astronauts." It will be published sometime in the next year. Additionally, the Board of Scientific Affairs is initiating an Interdisciplinary Team Research Prize to recognize the value of interdisciplinary collaboration involving psychologists. Given the scope of our Division member's involvement in interdisciplinary research, it seems the Association's attention to team science is welcomed!

IN OTHER NEWS . . . .

We created a new membership category called "Friends of Psychology." The creation of a new membership category is not an automatic action but require a process. The first step was that Council voted to approve a bylaws amendment that will now be sent to the full membership to create a new membership. These members would be individuals who are interested in the mission of APA as a science and profession but who are not otherwise eligible for any other APA membership categories. This struck me as an opportunity for IDD/ASD Psychology given the interdisciplinary nature of our work as well as the multiple levels of training and experience of the work force in IDD/ASD helping professionals.

We revised the Ethics Code. The Ethics Committee recommended that Council approve a change to **Standard 3.04 Avoiding Harm.** There was a lengthy discussion and review. The deliberation ended with Council approving the following addition as part b" of the standard:

> *Psychologists do not participate in, facilitate, assist or otherwise engage in torture, defined as any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person, or in any other cruel, inhuman or degrading behavior that violates.*

In the same spirit, Council continued to grapple with an APA that is still learning the lessons from the IR report. Council participated in structured and semi-structured deliberation of a business item titled **"Resolution in Favor of Providing Support and Assistance to Military and National Security Psychologists Striving to Abide by the APA Ethics Code and APA Policy."** The resolution has many implications for provision of services by military psychologists, and some of those implications could be unintended. Council decided to postpone the item to our next meeting. There was agreement that greater clarity around implications and meanings of various aspects of the item was required before we can vote this up or down.

There were other matters discussed in Executive Session, and for the good of the Association, these matters cannot be publicly discussed. This session was confidential and privileged. As information becomes available for dissemination, I am committed to keeping all of our Division members "in the know."

I am honored to be your Representative in APA Governance. In an effort to heighten the influence of Division 33 on Council's business and to build more awareness of issues and matters important to IDD/ASD Psychology, I've increased my **Caucus Participation.** The Council Caucus struc-

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ture is the vehicle that helps to move new business in front of the Council of Representatives for consideration.

At the Denver Meeting, I was elected as Secretary of the **Child Adolescent and Family Caucus**. My hope is that I can work to advance issues important to our membership. I also attend other caucus sessions. Most notably, the discussion related to supporting the scientific foundation of APA at the Science, Research, and Academic Psychology Caucus could be associated with interests of our Division. Please reach out to me if you have ideas or issues you wish for me to move forward. (Eric.Butter@nationwidechildrens.org)

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AMERICAN PSYCHOLOGICAL ASSOCIATION

ECP news!!!

Interested in being a Mentor at APA in 2017??

The Early Career Psychologist Committee will host the third annual "Mix and Mingle" mentoring session. Building on the successful event the last two years, this session will provide an opportunity for students and early career psychologists to engage with established members of our Division on a variety of topics regarding career development and related experiences.

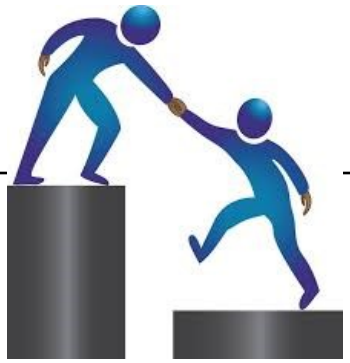
The APA 2017 Convention takes place in Washington, DC from August 3-6. Those interested in serving as a mentor, please fill out our online form:

https://goo.gl/forms/aqGfMDFTTt5Ti8YM2

Expressing interest does not commit you to participation. The ECP committee will follow up with you individually. THANK YOU!

Sincerely,

The Division 33 ECP committee.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Division 33 has a new and improved on-line presence

Come visit the Division 33 Website!

www.division33.org

With special thanks to **Jason Baker** who spearheaded the effort to design the website!!

Check out the Division 33 Facebook Page!

https://www.facebook.com/APADiv33

The page has updates, information from APA, job/training opportunities, and more up-to-date news about the Division. Check it out!

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
2014 Wayne Silverman	James McPartland	
2015 Laraine Masters Glidden		V. Mark Durand
2016 Michael F. Cataldo	Abby Eisenhower	

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PSYCHOLOGY IN INTELLECTUAL AND DEVELOPMENTAL DISABILITIES/ AUTISM SPECTRUM DISORDERS
Editorial Policy

Psychology in Intellectual and Developmental Disabilities/Autism Spectrum Disorders 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/ASD. Brief articles about policy issues in psychology and IDD/ASD, 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 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.

AMERICAN PSYCHOLOGICAL ASSOCIATION - DIVISION 33

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AMERICAN PSYCHOLOGICAL ASSOCIATION -Division 33

Psychology in Intellectual and Developmental Disabilities/Autism Spectrum Disorders

Applications for Membership

APA members & Non-Students

Name: _____

Address: _____

_____

Phone (___) _____

Email: _____

Interest Area (s): _____

_____

APA Membership Statius:

( ) Affiliate
( ) Associate
( ) Member
( ) Fellow

Current Fees:
$30.00 = APA Associates, Members, & Fellows
$30.00 = Non-APA psychologists
$30.00 = Other interested individuals
*APA charges $2.00 for renewals for members

Student Memberships

Name: _____

Address: _____

_____

Phone (___) _____

Email: _____

Affiliation: _____
Student Member of APA: ( ) Yes ( ) No
Faculty Endorsement: This student is enrolled as a student in a course of study which is primarily psychological in nature.

Signature: _____

Affiliation: _____

Current Fees:
$15.00 = APA Student Affiliate
$15.00 = Non-APA Student Affiliate

Please return your form to:
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Nationwide Children's Hospital, Child Development Center
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Westerville, OH 43081
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Checks are payable to :
"APA Division 33"

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The page has updates, information from APA, job/training opportunities, and more up-to-date news about the Division. Check it out!