

PSYCHOLOGY IN INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

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Message from the President

Leonard Abbeduto

University of Wisconsin - Madison



It is an honor to represent you as President of Division 33. I would like to take this opportunity to make a few comments about the past and future of the Division and to offer

some congratulations and thank yous.

The 2010 APA Convention in San Diego was, from my perspective, a well-organized and exciting event. The Division 33 program was a nice mix of invited and submitted presentations. Not surprisingly, the topic of autism was a major focus of the program. Indeed, one of the Divisions' two poster sessions was devoted exclusively to autism. Two invited talks by Connie Kasari and Ralph Axel Mueller focused on social interventions and the neural signature of individuals on the autism spectrum, respectively. Their presentations were thought-provoking and data rich and I thank each of them for the important contributions to the success of the program. I also thank Warren Zigman for organizing at my request a simply outstanding symposium on research into the nature, causes and consequences of aging and dementia in adults with Down syndrome. Warren and his colleagues shared some of the findings of their path-breaking biobehavioral program of research. Thank you to all of the other presenters on the Division program for taking the time to share their work with us. It was exhilarating.

The APA Convention is also a time for recognizing those in our field who have made particularly noteworthy contributions. The Edgar A. Doll Award,

the highest honor of Division 33, was presented to Bruce Baker. Bruce presented a wonderful retrospective of his research and our field, highlighting both the societal changes that have impacted the lives of people with intellectual and developmental disabilities and the factors that affect the emergence of behavior problems which are a continuing barrier to full and meaningful inclusion. The Division 33 Award for Early Career Contributions to the field was re-named the Sara Sparrow Award in honor of our late colleague. Laura Lee McIntyre was the recipient of this award and she delivered a wonderful presentation focusing on her research into interventions for children with intellectual and developmental disabilities. I have no doubt that Sara would have been particularly pleased with Laura Lee as the recipient of this award.

Each year, the Division honors outstanding students for their submissions. This year we asked our award recipients to make oral presentations in a special session of the program. Paula McCall presented the findings from her study of the perceptions of school psychologists regarding students with intellectual disabilities and depression and Sarah Kuriakose presented results of her longitudinal analysis of language in young children on the autism spectrum. Both presentations were superb and reinforced the selection committee's decision to honor these outstanding promising students.

In keeping with the Division 33 goal of supporting the development of early career scholars, the Division hosted a breakfast and panel discussion focused on issues around training and career paths. Thank you to Laura Lee McIntyre for organizing this event. It was well-attended and the discussion was lively despite the early hour.

A few final convention-related thank

yous. I am indebted to Audra Sterling and Rachel Fenning for all their help in planning the Division 33 Program and to John Lutzker, Laura Lee McIntyre, Cameron Neece and Ashley Dillon for their thoughtful and thorough reviews of submissions. And a big thank you to Susan Heimlich. In her role as Division treasurer Susan made sure that all awardees received their checks and that all speakers received their reimbursements. Susan also served as unofficial Division photographer, timekeeper and cheerleader at every session. Her hard work, no-nonsense attitude and keen sense of humor were very much appreciated.

In This Issue...

Message From the President

by Leonard Abbeduto 1

President's Address - The Death Penalty, the Court, and What We Have Learned about Intellectual Disability

..... 2

Award Nomination Information

..... 6

Dual Cognitive and Behavioral Risk in

Young Children: Beyond Implications for Intervention

by Laura Lee McIntyre 7

Call for Proposals

..... 7

Memories from San Diego - 2010 APA Convention

..... 10

Save the Date


..... 11



In the coming year, the Division and the field will continue to face important issues. Many of these issues are likely to revolve around the application of the definition of intellectual disability to important social decisions from eligibility for social services to death penalty cases. I encourage all members of the Division to participate in the discussion of such issues. Do not feel that only Division

officers are entitled to have a voice. Get involved!

In concluding my remarks, I want to take this opportunity to thank Past-President Greg Olley. He has been an active and inclusive leader who has not shied away from tackling tough issues. His presidential address at the San Diego Conference was an informative and impassioned examination of death penalty

cases involving people with intellectual disabilities. I want to thank Greg for his efforts on behalf of the Division 33 membership and our field and for his generosity in seeing me through my year as President-elect. He answered every frantic email and phone call with patience and good humor. Thanks, Greg! 

Division 33
President's Address
Presented at the Annual Meeting of the American Psychological Association
August, 2010

The Death Penalty, the Courts, and What We Have Learned about Intellectual Disability

University of North Carolina at Chapel Hill
J. Gregory Olley

In 2002, the United States Supreme Court in its *Atkins v. Virginia* decision found in a 5-4 decision that the execution of people with intellectual disability (ID, known at that time as mental retardation) violates the 8th Amendment's prohibition of cruel and unusual punishment. Although this decision was widely praised in the disability community and widely debated in the legal community, the courts of the 37 states that have capital punishment faced a need to clarify the standards by which the decision would be implemented. In 2005, then President of Division 33, Sara Sparrow created an *ad hoc* Committee on Mental Retardation and the Death Penalty. That initial committee of three has grown to eight¹. Since 2005 our committee has worked as individuals and in collaboration with other individuals and organizations to clarify the scientific and clinical basis on which expert witnesses could testify to the diagnosis of mental retardation in *Atkins* hearings. I would like to share with you my view of the progress that we have made and that the field of psychology and related disciplines have made in this effort.

In the *Atkins* decision, Justice Stevens wrote for the majority, and I think that his statement of the basis of the majority decision is a good summary of the characteristics of intellectual disability that led the court to decide that such individuals should be less culpable for capital crimes than individuals without the disability.

"...they have diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, and engage in logical reasoning, to control impulses, and to understand the reactions of

others." (*Atkins v. Virginia*, 2002)

I should emphasize that this decision simply removed the death penalty from consideration, and people with intellectual disabilities are still responsible for their actions. If convicted of a capital crime, most individuals will serve life in prison. Our committee and other expert witnesses responded to *Atkins* in several ways. We wrote articles and presented at meetings of attorneys, forensic psychologists and colleagues specializing in developmental disabilities. We also conducted evaluations of individual defendants, which led to testifying in court regarding their diagnosis. The testimony and the resulting court decisions have contributed to progress in clarifying the most valid procedures for making this diagnosis in capital cases. But there is much to be done.

I want to summarize our progress in three categories. First, psychologists have a large body of research and clinical findings on ID that go back far before the *Atkins* decision. In other words, we knew a lot before *Atkins*. Second, *Atkins* hearings have pushed some issues into the spotlight that might otherwise have received less attention. I want to discuss what we have learned so far from *Atkins*. Third, there is much that we need to learn, and I want to emphasize the challenges that remain.

Why are *Atkins* Cases so Challenging?

Although there are decades of psychological research on the nature of mild intellectual disability, established clinical procedures for diagnosis, and a definition of intellectual disability that is widely accepted, translating what we know in the customary research and

clinical settings to the adversarial setting of the courtroom can be very difficult. Most clinical assessment procedures are used to help determine the best services for the individual. They examine strengths, weaknesses and preferences and present complex findings. Clinicians and researchers work collaboratively and openly. Science shares objective information and usually progresses in small increments. Researchers acknowledge positive and negative findings and live comfortably with shades of gray.

Courtroom testimony, however, is presented in the adversarial context of defense and prosecution, and the court must produce a decision. It is a world of black and white with little tolerance for gray. On the positive side, the court does welcome scientific evidence. Different states embrace either the *Daubert* (*Daubert v. Merrell Dow Pharmaceuticals*, 1993) or *Frye* (*Frye v. United States*, 1923) standard for evidence presented by experts. Under either standard, the expert must back up his or her testimony with scientific evidence that is accepted in the appropriate field.

Things We Already Know

Whether the expert is hired by the prosecution or the defense, it is his or her ethical responsibility to present objective information (Committee on the Revision of the Specialty Guidelines for Forensic Psychology, 2008). Thus, it is essential that we rely upon the established research on intellectual disability. The list of established findings that are relevant to *Atkins* is long, but a few examples may make the point.

First, psychological research over many years has identified numerous

¹ thanks to Committee members Steve Greenspan, Harvey Switzky, Caroline Everington, Karen Salekin, Gary Siperstein, Sol Fulero and Keith Widaman



characteristics that are common, although not universal, in individuals with mild intellectual disability (Snell & Luckasson, 2009). I emphasize this group, because they are the people who are most vulnerable to engaging in criminal activities. They are the most likely to be receiving no supports or services or to have never received a diagnosis of intellectual disability. Nevertheless, they are likely to have the characteristics of impulsiveness, responsiveness to immediate rather than long-term consequences, naïveté, gullibility, poor problem-solving, and, of course, low intelligence. In addition, they are likely to come from backgrounds of social and economic deprivation and families with generations of similar problems.

Second, we know from the work of one of our committee members, Gary Siperstein, and his colleagues (Siperstein, Norins, Corbin, & Shriver, 2003) that in many countries, including the United States, the public generally misunderstands mild intellectual disability and expects that such individuals are easy to identify by their physical appearance, their speech or other readily apparent characteristics. This misunderstanding is common in court, and the expert witness must clarify for the court the fact that mild intellectual disability typically presents no obvious physical signs and that such individuals have many areas of competence to accompany areas of impairment (American Association on Intellectual and Developmental Disabilities, 2010).

Third, the most widely accepted definitions of intellectual disability are quite similar. The American Association on Intellectual and Developmental Disabilities (2010) and the American Psychiatric Association (2000) definitions require the same three elements for a diagnosis: significant impairment in intelligence and adaptive functioning, both of which originate in childhood. Although there are differences in their descriptions of areas of adaptive behavior, they are conceptually similar.

Fourth, there are well established standards for the administration and interpretation of intelligence tests and related measures (American Educational Research Association, American Psychological Association, & National Council on Measurement in Education, 1999). These standards help to establish the reliability and validity of tests that may be relied upon for diagnosis and guide us in interpretation by taking into consideration factors such as the standard error of measurement of the test and the possible influence of the practice effect. Reliance on such standards is important, because the states affected by the *Atkins* decision often do not have

statutes that specify standards for test administration in sufficient detail.

Fifth, clinicians and others who have personal experience with people with mild ID readily find that these individuals eschew the label of mental retardation. This phenomenon of attempting to hide one's limitations has been called the "cloak of competence" by Robert Edgerton (1967, 1993). This point is very important in *Atkins* cases, because those not familiar with it may assume that people will eagerly try to fake the condition of mental retardation in order to avoid the death penalty. In fact, I have found that even with their lives at stake, many defendants will try to do their best in order to avoid the stigma of mental retardation.

Sixth and related to the point above, research has identified many pitfalls in interviewing people with ID (Finlay & Lyons, 2001, 2002; Perry, 2004). Although an interview of the defendant is a customary part of an *Atkins* evaluation or any evaluation related to the diagnosis of ID, one must be aware of many ways in which the self-report of the defendant may be inaccurate. Interviews may be influenced by the communication limitations of the defendant (e.g., difficulty understanding the questions, particularly those of a conceptual nature, or difficulty responding to open-ended questions) or the tendency to try to hide one's limitations (i.e., the cloak of competence).

Seventh, the relationship between the conditions of poverty and mild ID are well established (Hurley, 1969), especially when such conditions are experienced in early childhood (Center for the Developing Child, 2008). Investigation of the background and history of *Atkins* defendants can be tragically sad as one documents the environmental deprivation and family history of limited education, unemployment, criminal activity, neglect, and abuse. These conditions contribute to intellectual disability. A failure to understand this relationship sometimes leads to misguided court testimony in which it is argued that these conditions are the cause of the defendant's limitations and thus the diagnosis of mental retardation cannot be made. In fact, these conditions are such a familiar pattern that mild ID has historically been referred to as "cultural familial mental retardation."

Eighth, intellectual disability can co-exist with mental health problems. Awareness of these "dual diagnoses" has increased in recent years leading to the publication of a diagnostic manual (Fletcher, Loschen, Stavrakaki & First, 2007) and the *Journal of Mental Health Research in Intellectual Disabilities*, edited by Johannes Rojahn, a Past President and Fellow in Division 33.

An understanding of dual diagnoses is important, because it may be mistakenly argued in court that the defendant has a mental illness diagnosis that rules out mental retardation.

Ninth, Steve Greenspan, an original member of our committee, has argued for many years that a central characteristic of intellectual disability is naïveté or gullibility (Greenspan, Loughlin & Black, 2001). Thus, people with mild ID are easily led into criminal activities and are very limited in their ability to deal with the criminal justice system. It is shocking to learn how poorly the general public understands their *Miranda* rights (Rogers, 2008) and how readily police interrogation techniques can induce innocent people to confess to murder (Kassin, 2005). These vulnerabilities are even greater for people with ID (Perske, 2008).

Finally, it is important to note that a clinical evaluation emphasizes strengths in order to plan services that capitalize upon those strengths to promote success. An evaluation for the court is focused on deficits because its purpose is to determine a diagnosis, and an intellectual disability is, by definition, a condition characterized by deficits. As noted earlier, people with mild ID have an individual profile of relative strengths and weaknesses. One cannot argue that the presence of a particular strength rules out ID, particularly if it is a strength shared with others with ID. In fact, the DSM-IV-TR (2000) definition of mental retardation specifically stated that there is no exclusion criterion for the diagnosis. Thus, neither having a mental illness nor a learning disability nor driving a car, nor various other circumstances excludes a diagnosis of intellectual disability.

Things we Have Learned from *Atkins* Hearings

Atkins hearings have brought considerable attention to some issues that had seldom been considered previously. A few examples follow.

The Flynn Effect

The best example of this increased attention is the Flynn effect. Flynn (1984, 2007) pointed out the rise of IQ scores over many years in countries around the world. The existence of this phenomenon is not particularly controversial. After all, norms do become out of date, and IQ tests are re-normed every 10 or 15 years to make current scores more reflective of the general population. The issue that is often argued in court is whether the Flynn effect should be taken into consideration when interpreting the scores of individuals. The literature on this topic indicates that on average scores rise about .3 points per year. Therefore, for an IQ test normed 10 years ago, the



mean score for the population is now 103, rather than 100. Many courts have accepted Flynn's (2009) argument that inferring from the general population to an individual is something that psychological testing does regularly and that, although it is an approximation, applying the Flynn effect to the score of an individual leads to a more accurate understanding of the person's general intelligence. Division 33 member, Kevin McGrew, has created a blog that is a remarkable resource for information on *Atkins* cases and the associated literature. Among other topics, he has compiled a nearly complete bibliography of articles on the Flynn effect and has written several blog posts on this topic (www.atkinsmrdeathpenalty.com).

Malingering

Justice Scalia, in his dissenting opinion in *Atkins*, expressed concern "that the symptoms of this condition can readily be feigned" (*Atkins v. Virginia*, 2002) and that the decision would result in a flood of appeals by death row inmates. With regard to his first concern, research by one of our Division 33 Committee members, Karen Salekin, (Salekin & Doan, 2009) has shown that the few instruments used to identify malingered intellectual disability lack acceptable validity. Considering this limitation and the general reluctance of people with low intelligence to embrace the label "mental retardation," the prevalence of malingering in *Atkins* cases is unknown. Fortunately, the requirement that the characteristics of ID be present in childhood serves to identify people who feign ID in adulthood but lack a history of impaired functioning.

With regard to Justice Scalia's second concern, Blume, Johnson, & Seeds (2009) reviewed the *Atkins* cases that had been ruled on in the 6 years following the 2002 decision. They found that only about 7% of death row inmates filed *Atkins* claims, and nearly 40% resulted in a decision supporting those claims (although the success rate varied widely among states). Thus, contrary to Justice Scalia's prediction, *Atkins* has not resulted in a flood of frivolous claims.

Retrospective Evaluation

Atkins evaluations are, by their nature, retrospective. We are being asked to determine intellectual functioning in childhood, at the time of the crime, and, in some cases, currently. The customary instruments used for diagnosis of intellectual disability are designed to assess current functioning. Thus, in looking back in time, we must rely on as many sources as possible in order to achieve consensual validity. Many *Atkins* evaluations in the first years after the decision relied on the available records and an interview of the defendant and

little else. More recent evaluations have been, in my experience, much more comprehensive. This is a good trend, but it raises a question of which sources of information are most valid. For instance, is information gathered in prison valid for a diagnosis of current or past functioning? The definition of adaptive behavior (AAIDD, 2010) is functioning in one's community, so functioning in the restricted circumstances of prison would appear to have limited value. Is the self-report of defendants with known low intelligence a valid source? Substantial research on interviewing people with low intelligence should make us very cautious in our interpretation of this information (Finlay & Lyons, 2001, 2002; Perry, 2004).

Parents are the most common source of adaptive behavior information. Are parents automatically biased and assumed to provide false information indicating low functioning, or do parents show bias toward exaggerated accomplishments and want their children and their family to appear in the best light? Or is every case different, and is the clinical experience of the expert an essential component of a valid evaluation? I vote for the latter.

Although the best source of information is not always clear, sometimes the worst source is. It is inappropriate and clearly invalid to ask a family member, friend, or other lay witness, "Do you think he has mental retardation?"

Interpreting Multiple Scores

Atkins cases typically offer mixed evidence for a diagnosis of ID, including a history of several IQ tests at different periods and with somewhat variable scores. Looking at this information from its black-or-white viewpoint, the court wants to know, which is the "true IQ?" The gray world of science acknowledges that there are many reasons that scores vary. Whitaker (2008) provided a clear discussion of the many factors influencing score variability and noted that variability is greater in low IQ ranges than in the average range. In an analysis of score variability, Whitaker (2010) concluded that "for low Full Scale IQs the WAIS-III can only be considered accurate to within 18 points above the measured IQ and 28 points below, and the WISC-IV to 16 points below the measured IQ and 25 points above it" (p. 517). We may not be able to know the exact reason(s) for score variability in any single case, but we do know that averaging several IQ scores is statistically inaccurate, although it has been done and accepted by courts in several *Atkins* cases.

Evaluating Non-English Speaking Defendants

The evaluation of non-English speaking defendants presents several

challenges with regard to both IQ and adaptive functioning. For a person who lived most of his life in another country and culture, what norm group should be used to judge an adaptive functioning deficit? For IQ measurement, it is clear that an IQ test should be administered in the defendant's native language and not in English or with an interpreter. However, what is the appropriate test and norm group? Most non-English speaking defendants in *Atkins* cases have been Spanish speaking, and there are several IQ tests in Spanish. Steve Greenspan, a member of our Division 33 Committee, pointed out problems with the use of the Mexican WAIS (Suen & Greenspan, 2009). Kevin McGrew, mentioned earlier, is one of the authors of a more appropriate test, the Bateria III Woodcock- Muñoz, (Woodcock, Muñoz-Sandoval, McGrew, & Mather, 2010).

We Need to Learn More

Although members of Division 33 and other experts in intellectual disability have successfully translated some of the extensive research and clinical base to the unfamiliar territory of the courtroom and have used the timely circumstances of *Atkins* to clarify new issues, much work remains. For instance, virtually no research exists on the effect of incarceration on IQ scores of people of low intelligence. Is it possible that the environment of prison with healthy meals, access to exercise, social interaction, and the absence of street drugs and alcohol is actually an intellectually beneficial setting?

This discussion has only touched on a sample of the challenging issues that the *Atkins* decision has raised for the field of intellectual disability. The challenges will continue, but I am confident that Division 33 members will continue to provide leadership to assist the courts in the best application of science and clinical practice in their *Atkins* decisions.

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Dear Division 33 Member:

The Awards Committee of Division 33, Intellectual and Developmental Disabilities, welcomes nominations for the 2010 Doll Award and the Jacobson Award for Critical Thinking.

Award Criteria

The **Edgar A. Doll Award** honors an individual for his or her substantial contributions to the understanding of intellectual or developmental disabilities throughout their career. The award is presented annually.

Every other year the **Jacobson Award for Critical Thinking** is presented to an individual who has made meritorious contributions to the field of intellectual and developmental disabilities in an area related to behavioral psychology, evidence-based practice, dual diagnosis or public policy. The recipient must be a member of Division 33.

Nominations for these awards will be sought from the full membership of the division. The Division Awards Committee will select the honoree. A list of the previous award winners is presented below.

Application Procedure

- Nominations should include the following: a) a letter of nomination; b) complete vita; c) two letters of recommendation. One of these letters must be from a Division 33 member and should address the contributions of the nominee relevant to intellectual and developmental disabilities.
- Nominations should be sent directly to Steven F. Warren via email at sfwarren@ku.edu. Dr. Warren serves as chair of the Division Awards Committee.
- Nominations can be made anytime, but must be received no later than **February 1, 2011**.
- Nominees will be notified of the award committee's decision by on or about March 1st.
- The award winners will receive a \$1,000 honorarium.
- Any questions about the award or application procedure should be sent via email to Dr. Warren.

	Edgar A. Doll Award (est. 1980)	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 MacMilan	
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	
2009	Sara Sparrow	James Mulick
2010	Bruce Baker	

PSYCHOLOGY IN INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

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Editorial Policy

Psychology in Intellectual and Developmental Disabilities is an official publication of Division 33 of the **American Psychological Association**. It is devoted to keeping members informed about the activities of Division 33 and to news and comment concerning all aspects of service, research, dissemination, and teaching in psychology and intellectual and developmental disabilities. Brief articles about policy issues in psychology and intellectual and developmental disabilities,

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: maclea@uwyo.edu. Address hardcopy correspondence to: William E. MacLean, Jr., Ph.D., Editor, *Psychology in Intellectual*

and Developmental Disabilities, University of Wyoming, Dept. 4298, 1000 E. University Ave., Laramie, WY 82071. 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.

Issue Deadlines are September 15, Fall; March 1, Spring; June 1, Summer.



Division 33
Sara S. Sparrow Award
Address
 Presented at the Annual Meeting of the American Psychological Association
 August, 2010

Dual Cognitive and Behavioral Risk in Young Children: Beyond Implications for Intervention

Laura Lee McIntyre
 University of Oregon

It is an honor to receive the 2010 Sara S. Sparrow Early Career Research Award from Division 33 of APA. Sara Sparrow was a true leader in the field of intellectual and developmental disabilities. Sara had a tremendous impact on the careers of countless trainees and early career professionals through her leadership and mentorship at the Yale Child Study Center. It is special to receive an award named after such a prominent figure in the field and a dear friend and colleague to me and others in Division 33.

My paper addresses the dual cognitive and behavioral risk in children with developmental disabilities and their families, as well as advances in intervention to ameliorate behavioral risk.

The population of children with developmental delays and disabilities (DD) is estimated to be more than 1.5 million in the United States and growing (Batshaw, Shapiro, & Farber, 2007). Because of cognitive, social, and/or language deficits, children with DD are at risk for emotional and behavioral problems in early childhood and throughout development. Early intervention and prevention are clearly needed to reduce problems in this high-risk sample of children. Multifaceted interventions that support child outcomes and family adaptation, including parenting skills and parent mental health, are especially important, given the array of child and family risks associated with developmental disabilities.

Young Children At Risk

Research suggests that children as young as 3 years old with DD already exhibit increased behavior problems that negatively affect their families (Baker, Blacher, Crnic, & Edelbrock, 2002; Baker et al., 2003). In the absence of targeted

interventions, these behavior problems appear to persist over the preschool period and into the early school years (Baker et al., 2003; Eisenhower, Baker, & Blacher, 2007; McIntyre, Blacher, & Baker, 2006). Recent estimates suggest that as many as 50% of children and adolescents with DD have diagnosable psychopathology (Baker, Neece, Fenning, Crnic, & Blacher, 2010; Einfeld & Tonge, 1996; Einfeld et al., 2006; Emerson, 2003), resulting in a dual diagnosis and a major public health concern (Einfeld et al., 2006). Although less is known about the emergence of behavior problems in young children with DD, it is likely a combination of biological, environmental, and social factors that contribute to risk (Sameroff & Fiese, 2000).

Early School Adjustment

As a graduate student, I had the good fortune of working as a research assistant on the newly funded Collaborative Family Study, a multisite longitudinal study investigating family processes and child adjustment in families who had a young child with or without a developmental delay (PI, Crnic; Co-I, Edelbrock; UCLA PI, Baker, UC-Riverside PI, Blacher). My dissertation research addressed early school adjustment in children with ($n = 24$) and without ($n = 43$) DD (McIntyre et al., 2006). Results suggested that children with disabilities were at heightened risk for school adjustment difficulties, in part because of their deficits in adaptive behavior, including social and self-regulatory skills. Specifically, child social skills (per parent and teacher report) and self-regulation (per delay of gratification laboratory tasks) were predicted to affect adaptive transition experiences for young children. Data from self-regulation tasks at child age 3 and 5 years were used in

a partial mediational model of transition outcomes. Adaptive behavior, including social and self-regulatory skills, was more predictive of adaptation to school than was IQ for young children. Furthermore, in comparison with typically developing children in the control group, young children with DD experienced 3 times the number of adjustment difficulties in school (maladaptive behavior, poor student-teacher relationships), according to teacher assessments (McIntyre et al., 2006).

Not only do children with DD experience increased difficulties upon school entry, but parents also report more concerns regarding kindergarten transition. In a later study, we examined the transition to kindergarten in a sample of 132 students in a diverse sample of families from an urban school district (McIntyre, Eckert, Fiese, DiGennaro & Wildenger, 2007). In particular, family experiences and involvement in preparation for kindergarten were examined. The majority of parents in the sample reported that they wanted to do more to help their children become ready for school; however, they indicated that they did know how to best support their children. Furthermore, most families did not know what the academic and behavioral expectations were for kindergarten, an important prerequisite to providing appropriate support to promote school readiness. A follow up study suggested that parents of children with special needs expressed more concerns about kindergarten transition than did parents of typically developing children (McIntyre, Eckert, Fiese, DiGennaro & Wildenger, 2010), not surprising given the very real skill deficits in children with DD.

Given the early presentation of child adjustment problems (Baker et al., 2003), stability over the preschool period (Baker

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et al., 2002; McIntyre et al., 2006), and impact across both home and school settings (McIntyre et al., 2006), early intervention and prevention of behavioral problems emerge as an important research priority. Interventions that are family-based and involve strategies for reducing child behavior problems are especially important given that behavior problems, more so than cognitive problems, contribute to caregiver stress and burden (Baker et al., 2003; Eisenhower et al., 2005; Lecavalier et al., 2006).

Figure 1 describes the current model that guides my conceptualization of child developmental risk, child adaptive and maladaptive behavior outcomes, and the role of parenting practices, including positive and negative interactions. My work is guided by the hypothesis that primary and secondary preventions aimed at altering parenting practices will impact child outcomes through changes in parenting. I will next discuss some of my preliminary work that has led to my current conceptual framework.

Parent Training, Education, and Support

Rather than develop a new primary or secondary prevention program to address behavior problems in children with DD, I adapted Webster-Stratton's Incredible Years Parent Training (Webster-Stratton, 2001) intervention to target families with young children with DD. The Incredible Years Parent Training series (IYPT) is an empirically supported intervention for use with typically developing children with or at-risk for conduct problems. It has been demonstrated to be more effective than control treatments in more than six randomized trials and in five independent replication studies (Webster-Stratton, 1984, 1994, 2000) for reducing children's maladaptive behavior and increasing parents' adaptive parenting skills. IYPT uses videotape modeling using generic parent/child models, role playing, rehearsal, and weekly homework activities in small groups of 8–14 parents (see Webster-Stratton, 2000, for a review). Thus, the IYPT model provided a solid empirical basis from which to adapt to a DD sample. The core content of the IYPT (developmentally appropriate play, praise and rewards,

effective limit setting, and handling misbehavior) remained the same; however, several adaptations were made to tailor to families with children with DD. Adaptations to the IYPT protocol include the addition of a section about the blessings and challenges of raising a child with a DD, a section about advocacy and community resources, and a section about descriptive functional behavioral assessments (FBA) and implementation of interventions based on FBAs (see McIntyre, 2008a). Paper-and-pencil measures of child impact on the family, child behavior problems, and maternal depression were collected pre- and posttreatment. In addition, videotaped parent-child interactions were collected in the family home. Results suggest the feasibility of adaptations and show preliminary evidence of efficacy of the intervention for reducing negative parent and child behavior and increasing parental perceptions of child positive impact. In addition, several correlates of change were explored. For example, children's adaptive behavior (Vineland; Sparrow, Balla, & Cicchetti, 1984) was significantly correlated with change in Child Behavior Checklist (CBCL; Achenbach, 2000) scores ($r = -.48, p = .032$), observed parental inappropriate behavior ($r = -.58, p = .007$), and observed parental appropriate praise ($r = .59, p = .006$). Higher maternal education was significantly correlated to increases in child positive impact ($r = .50, p = .014$). Maternal employment status was significantly correlated with changes in observed parental inappropriate behavior ($r = .42, p = .040$), as were baseline levels of observed parental inappropriate behavior. Maternal employment outside of the home was related to a reduction in observed parental inappropriate behavior, as was having higher preintervention levels of inappropriate behavior. Child sex and baseline levels of child inappropriate behavior were significantly correlated with decreases in observed child inappropriate behavior ($r = .62, p = .003$ and $r = .69, p = .001$, respectively). That is, there was a significant relation between child female sex with reduction in child observed inappropriate behavior. Higher baseline levels of inappropriate behavior were related to reduction in observed child inappropriate behavior. This study provided evidence for the feasibility of the DD modifications

applied to the IYPT and provided preliminary data for exploring variables related to treatment effects. However, because of the small sample size and treatment group-only design, inferences based on study findings and implications for treatment effects were limited.

A second study, based on the results of a completed NICHD-funded R03 grant (PI, McIntyre) reported the results of a small RCT that evaluated IYPT-DD with a usual-care control group for caregivers with preschool-age children with or at risk for DD. Families in the experimental group ($n = 24$) received usual care plus the 12-week IYPT-DD. Families in the control group ($n = 25$) received usual care, including early childhood education and related services. Forty-four participants completed the study ($n = 21$ experimental; $n = 23$ control). Results suggested that the parent training intervention, IYPT-DD, was superior to usual care for young children with or at risk for DD in terms of reducing observed negative parent-child interactions and child behavior problems as delineated on the CBCL. Figures 2 and 3 depict changes from pre- to posttreatment relevant to negative parent-child interactions and

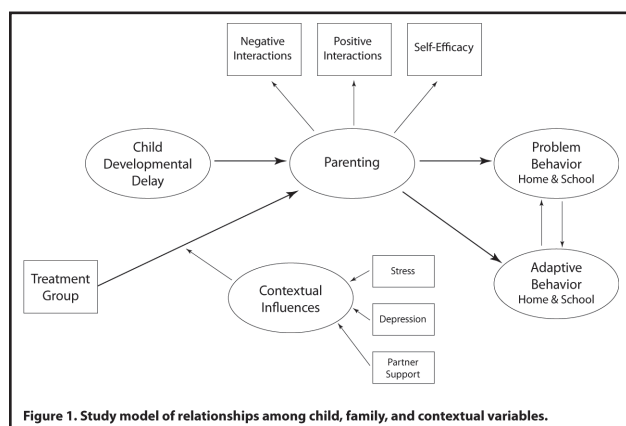
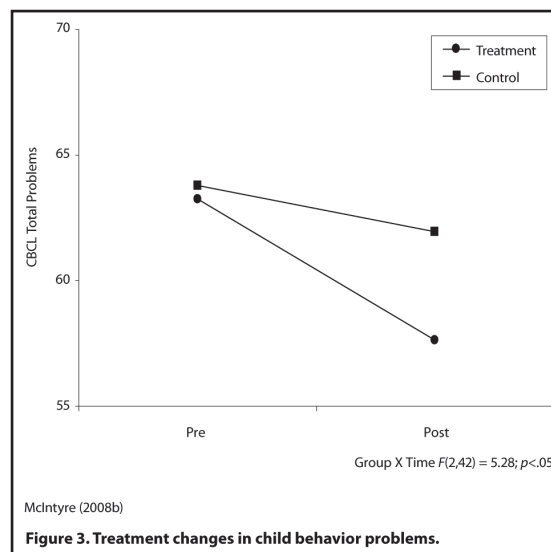
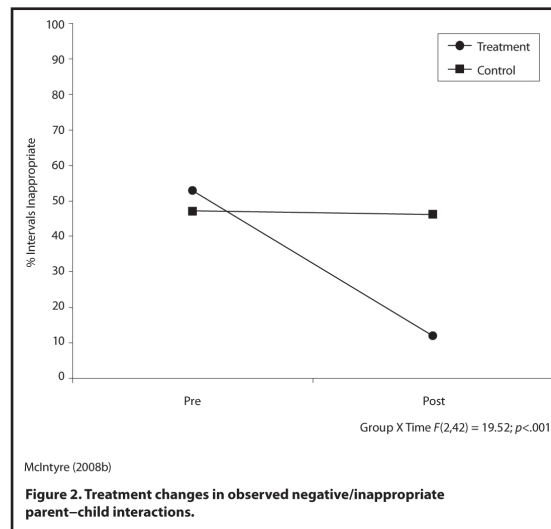


Figure 1. Study model of relationships among child, family, and contextual variables.



child problem behavior. Participants in the experimental group indicated high satisfaction with treatment.

We conducted an additional study, published in the *Journal of Applied Behavior Analysis* (Phaneuf & McIntyre, 2007) that used single-case experimental methodology to examine the effects of adding individualized video feedback (IVF) to IYPT-DD. IVF sessions consisted of parents viewing their own videotaped parent-child interaction and receiving positive and corrective feedback regarding their interactions with their child from the therapist/researcher. Results of this study suggested that IYPT-DD + IVF reduced maternal inappropriate behavior to levels below those of IYPT-DD alone. Thus, it may be necessary to consider enhancing traditional parent management interventions with individualized, tailored components for parents and children who require more intensive intervention.

On the basis of this work, we can conclude that there is evidence of high treatment completion, satisfaction, and preliminary evidence of treatment effects. For example, of the total number of families (91) recruited to participate in these preliminary studies, 81 (89%) completed the studies, indicating an 11% attrition rate. Attendance was high, with an average attendance rate of 87% (range 58%–100%). Approximately 85% of participants attended at least 10 of the 12 sessions. Weekly evaluations and overall consumer satisfaction ratings suggest that participants viewed the intervention as helpful. In addition, there is a growing body of evidence suggesting moderate to large treatment effects.

Future Research

Although this initial work is promising, these studies are far from conclusive. My current work (see Figure 1) is attempting to address some of the methodological limitations of my previous studies. I hope to be able to present these data at a later APA Division 33 meeting. For now, I offer several important future directions for intervention research. First, we need larger scale randomized controlled trial studies that include longitudinal follow up assessments across early childhood settings (e.g., home, school). Second, we need to examine mechanisms of change, as well as contextual influences (e.g., partner support, maternal mental health) that support or interfere with positive outcomes. Third, we need to focus our intervention efforts on preventing behavior disorders in children with DD, rather than providing costly, tertiary supports in schools and community placements. Fourth, we need to combine multiple systems of care to support families, including early intervention community supports, education, and health care. Finally, we need interventions that are flexible and meet the changing needs of children and families over time. Our work in this area has just begun.

I wish to acknowledge the

wonderful mentors I have had who have been instrumental in my career development—Jan Blacher and Frank Gresham at UC Riverside and Bruce Baker at UCLA. Thank you. I have also been blessed with wonderful students at Syracuse University and the University of Oregon who have contributed to this work and have shared their joy, passion, and energy. And finally, thank you to the scores of families who have shared their struggles and triumphs with me and who have graciously participated in this research.

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Experience of Early Adolescents with and without IDD
Becky Fraynt, Lisa Christensen & Gazi Belgum



Neurological and Cognitive Phenotypes and Dementia in Adults with Down Syndrome
Sharon Krinsky-McHale, Wayne Silverman, Matt Janicki, Athea Baumann, Warren Zigman & Ira Lott



Parenting Children with Early Developmental Risk
Shulamite Green, Natalie Wieland & Rachel Fenning



Research on Aberrant Behavior
Andrea Courtemanche, Jill Fodstad, Nicole Turygin, Johannes Rojahn & Steve Schroeder

AWARDS



President Greg Olley presents the Edgar A. Doll Award to Bruce Baker



Treatment of Social and Disruptive Behaviors in Autism
Mi Park, Anna Krasno, Sarah Kuriakose & Anjileen Singh



President Elect Len Abbeduto presents a Student Research Excellence Award to Paula McCall



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President Elect Len Abbeduto presents a Student Research Excellence Award to Sarah Kurjakose

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IDD – Policy Issues and Services
Stacy Bliss Fudge, Dan Reschley, Eric Butter, and David Michalec

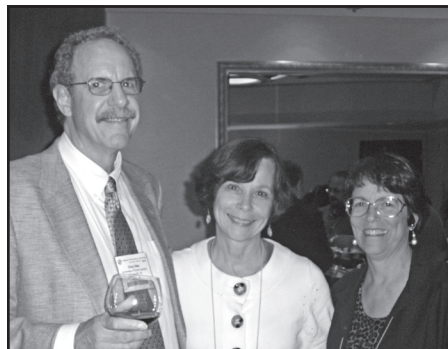


IDD – Attitudes, Behavior & Education
Sharon Robbins, Jill Stinson, Shari Jorissen, Kimberly Belmonte, and Carol Vasquez



ASD – Symptoms, Impacts & Treatments
Elizabeth Laugeson, Jamie McPartland, and Grace Gengoux

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