FABA QUARTERLY
Florida Association for Behavior Analysis
Vol. 3 No. 3 Co-Editors: Bob Wehr and Gary M. Jackson May 1983

Call For Papers For '83 Annual Meeting and News of Key Speakers Including Gordon Paul, Ph.D. and David Pingree, Sec. of HRS

See Details on Pages 4, 5 & Insert.

FABA Spotlights Florida State Hospital's "New Directions" - A Model Geriatric Residential Discharge Program

By Bob Wehr
Florida State Hospital

As part of a continuing series of articles on Florida programs that have adopted a strong behavioral orientation, this quarter's issue takes us to the rolling hills of the "Panhandle" of Florida where the oldest and largest State mental health facility is located in Chattahoochee, Florida. This writer has just recently had the opportunity to join the staff of a specialized geriatric residential treatment program, called "New Directions" or Unit 15.

New Directions had its beginning in 1977 when Dr. Helen Williams, Service Director of Medical Services at Florida State Hospital, identified a large number of long term geriatric age patients who appeared to no longer be in need of psychiatric services, but who did need special assistance in relearning independent living skills. It was also noted that most of these clients presented very difficult placement problems because of legal barriers and loss of contact with relatives.

A brief historical recap of Unit 15 can best be summarized as a series of good ideas and talented personnel coming together at the right time and place. The State hospital system was looking for creative ways of better utilizing newly trained psychiatric aides being promoted into mental health technician types of positions known as Unit Treatment and Rehabilitative (UTR) Specialists. The Florida Mental Health Institute (FMHI) in Tampa, Florida, particularly Dr. Roger Patterson, Director of the Gerontology Program, was looking for a place to replicate the modular and behavior approaches being developed at the Institute. And Nell Melzer was looking for a new program to develop and shape with a sound educational approach and a normalization philosophy.

New Directions opened in February of 1978 with Nell Melzer as the Unit Director and an energetic staff of UTR, rehabilitation therapy, nursing, and social work personnel. During its first two years of operation, it served approximately 187 clients, discharged 83 clients to less restrictive community placements (some of them to total independent living), and experienced a recidivism rate of only eight percent.

The three primary areas of emphasis which have been designed into the treatment program of Unit 15 are: (1) Discharge Planning from "day-one" by a multidisciplinary team and highly trained social workers; (2) A Modular Teaching Approach wherein all UTR staff serve as instructors under the functional supervision of rehabilitation therapy supervisors; and (3) A Social Learning Theory approach towards dealing with more individualized behavior problems and skill deficits.

Today, as in 1978, New Directions is still a very homelike unit that is unlocked, furnished as normally as possible within State budget constraints, and wherein the residents are truly treated as "clients" rather than "patients". And, as might be expected,

many of the elderly population that are left at Florida State Hospital are truly more handicapped than the initial population for which the program was designed. Nevertheless, today's clients on this unit are very actively involved in modular programming designed to teach skills that will prepare them for discharge to less restrictive community settings. The average client attends five to seven classes on a daily basis in such areas as Activities of Daily Living (three levels), Personal Information Training, Memory Development, Social Leisure, Music, Self-Esteem, Remotivation, Communication, Discharge Motivation, and Current Events. When the clients begin to show progress in making up skill deficits, they are frequently taken on Community Orientation trips by staff to look at various alternative community living facilities such as Adult Congregate Living Facilities (ACLF's), boarding homes, Geriatric Residential Treatment Systems (GRTS facilities), and, occasionally, homes of relatives.

According to New Directions present Unit Director, Jim Warren, the skill deficits of current clients referred from other units have become more pronounced and it has also been noticed that many of the clients have more behavior problems than the group that was initially served. Because of these considerations, the treatment program has found it necessary to become increasingly more data-based and to more frequently use single case behavior treatment strategies and procedures.

Some statistics drawn from a recent quarterly report (July 1, 1982 to March 31, 1983) underscore Mr. Warren's observations. During this period, there was a total of 41 admissions (the unit serves an average of 50 to 54 clients), 20 clients were discharged to less restrictive community settings, and 9 were transferred back to other Florida State Hospital treatment units. The average length of hospitalization of the discharged clients prior to coming to Unit 15 was 25 years. Their average length of stay on Unit 15 was 14 months. Only one client out of this group had to be returned to Unit 15 and that was because of technical eligibility problems surrounding the State/Federal income maintenance program supporting her.

FABA readers may recall the book review in the last issue describing the Gerontology Program at FMHI. New Directions continues to be a major replication site for the modular and single case behavior treatment approaches that have been pioneered in that program. Future plans for Unit 15 call for continued active consultation with FMHI's Department of Aging staff.

Anyone desiring further information on New Directions should contact Mr. Jim Warren, Unit Director, New Directions (Unit 15), Florida State Hospital, Chattahoochee, Florida 32324 (Phone: (904) 663-7548).

(Editor's Note: We would like to acknowledge the continuing support of several other personnel who were most instrumental in the early days of developing New Directions and who continue to be involved in maintaining its continuing improvement: Mr. Bob Williams, FSH Hospital Administrator, Mr. Dave Zimpfer, Quality Assurance Director; Mrs. Annette Maleszewski, Clinical Social Worker & former Acting Director; Ms. Vivian Johnson, Rehabilitation Therapy Program Supervisor; Wes Griffin, Rehabilitation Therapist; Mrs. Charlotte Bailey, Unit Manager Coordinator; Mrs. Ethel Rogers, Psychiatric Nurse Specialist Supervisor and Mr. David Eberly and Mr. Michael O'Sullivan of the Florida Mental Health Institute, and all the current UTR personnel of Unit 15. FABA

Practical Parent Training: Teaching Parents New Skills and Problem Solving Techniques

By Cynthia S. Archer
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The Florida Mental Health Institute's Child/Adolescent Department (CAD) serves severely emotionally disturbed children, ages two through eighteen, and their families. Since its inception, the Child/Adolescent Department has supported the premise that parental involvement in the treatment of severely emotionally disturbed children and adolescents is vital and necessary to treatment gains, and to their generalization and maintenance in more natural settings. With this in mind, a parent training program has been developed over the years that effectively and efficiently meets these requirements for parents of children aged two through twelve. (An adolescent parent training model is currently in development.)

This parent training model was developed using guidelines established by Dr. L. Adlai Boyd, director of the Child/ Adolescent Department. These guidelines include the following requirements:

The model must be:

1. *Data-based*, through reliable and valid observation techniques;
2. *Consistent* within itself, theoretically and programmatically, for replication purposes;
3. *Flexible* enough to allow for small differences in theory or practice;
4. *Practical* enough so that parent trainers can do the job;
5. *Effective*, as demonstrated by continuous data taken before, during, and after the services are delivered;
6. *Cost effective* enough to be adopted by agencies with limited resources;
7. *Trainable*, in a week's workshop, to other professionals;
8. *Supervisable*, through direct observation, data checklists, individual feedback, etc.;
9. *Simple* enough for the slowest parent, challenging enough for the brightest;
10. As *short* as possible, and still be effective;
11. *Responsive* to other confounding parental needs and problems;
12. *Comprehensive* and *applicable* (through adaptation) to most residential or day treatment (including public schools) programs for parents of mentally or behaviorally handicapped children.

Currently, the FMHI/CAD parent training model consists of three phases. Phase I consists of a fourteen week parent training class. Phase II, which may begin concurrently with Phase I and continue until the child is discharged from FMHI, is a set of structured one-to-one treatment sessions with a parent trainer. These sessions often involve the child with the parent, as well. Phase III is begun at the child's discharge from FMHI and continues for two years, delivering maintenance and generalization services, as well as long term program evaluation of effects. Phase I and II can be implemented independently of one another, depending upon the needs and resources of the service providing agency. Phase III, though desirable, could be optional for replicating agen-

cies. Phase I, the parent training class, is divided into three sets of activities. Each class meeting consists of a one hour group training session, which is immediately followed by one hour small group meetings. Parents in the class are introduced to seven "How To's." These include the following topics:

1. How to increase appropriate behavior;
2. How to decrease inappropriate behavior;
3. How to teach new skills;
4. How to motivate greater efforts;
5. How to measure problems and progress;
6. How to negotiate and contract;
7. How to maintain and generalize behavioral gains.

The large group sessions introduce each topic to the parents. One of the parent training staff presents specific behavioral principles, procedures, and techniques. Each presentation is followed by videotaped examples of the procedure(s) described. Then, the parent training staff give "slow-motion" demonstrations, breaking skills down into their component parts (a task analysis approach to parenting skills). It is critical to keep these large group sessions informal, low key, and non-threatening.

Parents are assigned to small group sessions by their parent trainers. These parent trainers are the therapists who will work directly with these families throughout all Phase I and II activities. The small group sessions begin with a brief review of the lecture material, offering parents additional opportunities for clarification and question asking. Then, under the supervision of the parent trainer, participants role-play the skills demonstrated until data-based mastery levels are achieved. The small group sessions close with each parent defining how he/she can use the new technique at home in the following week. The small group sessions provide parents with peer support, lessen the burdens of guilt, focus the parents' attention on remediation rather than causes, and generate a team spirit with a "we'll figure out how to fix it" flavor.

At several identified points in the course of the parent training class, individual data-based training sessions are set up for hands-on guided practice with each parent/child dyad. Each practice session focuses on a specific skill. Some of these skills include how to praise, how to give directions, how to use extinction, and how to use time-out from positive reinforcement. A "bug-in-the-ear" procedure has been developed for use in these parent/child training sessions. The parent trainer, standing behind a one-way mirror, transmits information to the parent (who wears a small earpiece), without the child hearing the parent training instructions. The parent trainer may initially need to tell the parent exactly what to do and when to do it. But through a gradual fading process, the parent trainer leads the parent to independent implementation of the techniques. This hands-on practice is one of the most powerful training techniques offered at FMHI.

Phase II of the FMHI parent training program focuses on using the skills learned in Phase I to solve the home problems specific to an individual family. Parent trainers meet weekly to biweekly with each set of parents. The parent trainer's long term goal is to ensure that each parent is proficient in problem solving methodologies that will generate solutions to current home problems, and continue to generate solutions to new problems after the child's discharge. Very briefly, this problem-solving methodology includes problem selection and definition, measurement of problems, an antecedent/behavior/consequence analysis, specification of objective, selection and implementation of a modification plan, monitoring and modification of the plan, and maintenance of desired goal behavior. Over time, the parent trainer begins to fade his/her participation in the structuring of behavior change plans, and the parents increasingly become the planners as well as the implementors of behavior change strategies.

Phase III, or community adjustment, initially functions as a transition program upon the child's discharge from FMHI. The parents may need support in dealing with their child's limit testing after discharge, with novel problems in new settings, and with developing relationships and joint strategies with new school personnel. Parent contact is frequent immediately following discharge and fades over time. Direct observation data are collected at several points during the community adjustment phase, which provides information about the effectiveness of the parent training program, about the resistance to erosion of effective parenting techniques, over time, and about what kinds of families and problems are most effectively helped.

Development of the parent training program in future years will focus on those parents whose personal problems interfere with the acquisition and application of parent training skills. These are the parents who exhibit difficulties in managing their own lives, who have marital problems, who lack self control or have poor self sufficiency skills, high stress, and anxiety.

Workshops on any component of the FMHI/CAD parent training model can be provided. For further information, please write or call:

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FABA

Behavior Management Procedures: A Perspective and Commentary

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The purpose of this paper is to describe a trend in the field of psychology which, depending on its regional focus, may ground client treatment in the bureaucratic jungle of euphemism, social bias, cookbook behavior modification, and non-scientific myth. This trend to classify therapeutic intervention according to restrictiveness grew out of litigation as well as the need to control the activity of psychologists and other therapists who utilized "cruel and unusual" methods of treatment, yet the intent was not to compromise an individual's "need" for effective, immediate treatment.

The trend to which I refer is the method by which program restrictiveness is established or determined. Typically, when reviewing "behavioral treatment hierarchies", many times one finds that they are developed based on the social values of a group of psychologists, administrators, and other professionals. This basis typically is influenced by the lack of

Continued on page 6.

FABA
Florida Association for Behavior Analysis

Third Annual Conference
September 15-16, 1983 - Orlando
Hilton Inn, Florida Center on International Drive

Call For Presentations
Deadline July 8, 1983

CALL FOR PRESENTATION PROPOSALS

The Florida Association for Behavior Analysis (FABA) invites all persons engaged in research, training and/or the practice of behavior analysis and modification to submit proposals for presentation during the Third Annual Conference in Orlando, September 15 and 16, 1983. Applied, experimental, and theoretical analyses in the specialty areas indicated below are desired including program descriptions, case studies, and technical presentations. Reviews and commentaries on legal, ethical, social, philosophical or historical perspectives are also welcome. Significant works in the fields of behavioral medicine, pharmacology, physiology, and biology are also appropriate, in addition to psychology and education.

TYPES OF PRESENTATIONS:

The conference program will be arranged in "tracks". To the greatest extent possible, a "track" will allow a participant to attend many presentations on the subject area(s) in which he/she has most interest. The "tracks" will prevent the accidental scheduling of all presentations in a specialty area in several different rooms at the same time.

The program will consist of these presentation types:

WORKSHOPS

A "workshop" is presented by an individual or team of persons to an audience for from three (3) to six (6) consecutive hours in the morning and afternoon. The audience is expected to gain skills or knowledge which can be applied upon return to research or service sites. This is accomplished by extensive audience involvement and participation to maximize individual attention. Your proposal should indicate the prerequisite skill or knowledge level necessary for participants, i.e.:

Introductory: little incoming knowledge
Intermediate: some knowledge about area
Advanced: extensive incoming knowledge

It is assumed that workshop presenters will compose appropriate handouts to reduce note-taking requirements and encourage subsequent application of skills.

PAPERS

A "paper" is an oral and/or audio-visual presentation or demonstration by one individual to an audience for fifteen (15 to thirty (30) minutes. Papers are usually grouped together to form a symposium. A symposium is a presentation of several papers by individuals from various (or the same) research, service, or academic institutions. The presentations are usually organized around a central or special issue or theme. Typically, a designated chairperson (often a presenter at that symposium) will introduce the presenters and make a summary evaluative statement at the end of the symposium. The session usually lasts one (1) hour and may consist of two to four papers. Some symposia may last for two hours with a number of papers. You may indicate your preference to present your paper in a symposium with your colleagues (if you do so, please indicate who will be the chairperson). Otherwise, the program committee will assign your paper to a particular session. Papers which are primarily data oriented are often most suited for "poster-sessions" (see below). The program committee may assign certain "paper" proposals to poster-sessions where it deems appropriate.

POSTER SESSIONS

A poster-session is a room arranged with multiple booths along the perimeter. Each presenter erects a poster-board-type arrangement on a table. The poster is a visual representation by an individual or team of persons and consists primarily of data-oriented information to attract and engage onlookers in direct discussion with the author(s). Ample walking and standing room is provided so the audience can leisurely study the presentation. Poster sessions will be one to two hours in length. Presenters will be given *only* 10 minutes just prior to the session to set up the poster and handout materials. At the end of the session the

presentation materials must be dismantled in *five* minutes, therefore essentially all preparation of the presentation *must* be accomplished prior to the conference.

Posters will be grouped together to form a session which represents the works of individuals from various or the same research, service, or academic institutions. Posters are usually organized around a central theme. You may indicate your preference to present your poster with your colleagues. Otherwise, the program committee will assign you to a session.

Poster sessions will be visited by accomplished behavior analysts and each session will be hosted by a chairperson appointed by FABA. This chairperson may (together with designates) bestow an award for the poster which best incorporates clarity, attractiveness, creativeness, and content value.

The Poster Table

Each presenter will be given space on a table (approx. 5 ft. long and 2 ft. wide) to display their poster. Generally, posters should be designed so that they will be free standing on the table or will sit at the back of the table and rest against the wall. Presenters must provide all materials (including poster board, pins, tape, markers, etc.) to construct support their poster. In addition, each poster should be accompanied at all times by one or more of the assigned presenters. No electrical outlets or other audiovisual equipment will be provided.

Poster Content & Design

A poster is a visual presentation and all parts should be clear and legible from 6 feet away. It should be pleasing and professional in appearance. Do not hesitate to use colors, photographs and diagrams. Strive for a clear and pleasing layout. Refrain from using hand lettering unless you are sure it will look professional. Stencils and pressure sensitive letters (available at most art supply stores) are highly recommended. Be creative and remember part of your job is to make your poster so attractive that people passing by will want to stop and talk to you about your work.

Presenting a poster is not just a matter of preparing visually attractive materials. The format also requires an approach to the presentation of research which is different from the usual or written presentation. The poster should provide a short, clear, non-technical description of what you did, why you did it, and what you found. Generally, you should not emphasize subjects, apparatus or details of procedure in the main part of the poster unless these are critical aspects of the research. Most people will assume that these aspects were competently handled, and those who need more information can request a complete copy of the paper. You should have some copies available at the poster session, so interested persons can discuss it with you. The poster should not include much of the normal introduction and discussion materials, and keep reference and reviews of the literature to a minimum. Include a concise statement of the procedure, the results, and an interpretation of the data. The data, in graphic or tabular form, should be large and attractively presented with clear labels. The format requires you to be somewhat bolder in your style and to condense complicated events into a few short sentences. Above all, a poster is *not* just a regular paper in large type, stuck on a board. A poster is intended as a discussion-oriented visual format. The poster should communicate the essential issues and the conclusion, and the actual discussion with convention participants should provide the details.

PAPERS OR POSTER-SESSIONS:

You have the option of submitting your presentation proposal and allowing the program committee to determine whether it should be a "paper" or a "poster" presentation. Simply check the correct box on the submission form.

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SOME SUGGESTED RECOMMENDATIONS FOR POSTER SESSIONS

... Title, authors and affiliations in three letters, placed across the top of the poster. Use commercially available re-usable letters (from your local office supply or art supply house) against a background which you supply, e.g. black letters on white poster board.

... Abstract in at least one inch letters and located at the left of the display board.

... Method in one inch letters or very large type (i.g., IBM Orator or Primary typewriter).

... For figures, use over-sized graphs (e.g., 10 x 20 inches) with more detailed than usual figure captions located at the bottom and in large type.

... Use color where possible. This may be in the use of color letters or color backgrounds for lettering. Color photographs (8 x 10 inch size) of subjects, setting, etc., add life to a poster.

... Arrange the poster so that it can be read from top to bottom and from left to right.

... Have a one or two page handout giving a brief description of the study and perhaps one primary graph. Indicate on the handout where the reader may request a more detailed description and the cost, if any, of duplication and postage or

... Have a sign up sheet where interested persons may list their name and address to receive a copy of the paper.

... Bring plenty of map or push pins to attach the poster to the display board.

(Editor's Note: This information is reprinted with the permission of Jon S. Bailey and Darrel E. Bostow. It was extracted from their book, entitled *Research Methods in Applied Behavior Analysis,* 1979.)

BEHAVIOR MANAGEMENT

Continued from page 3.

knowledge and technical inaccuracy of individuals in the group, as well as current euphemistic trends which, depending on time and place, outlaw words such as "behavior modification" in the early 70's, "punishment" in the mid-70's, and "restraint" in the late 70's. Typically, one finds that the rank order of behavioral procedures which are based on social values may not be ordered in degrees of restrictiveness when risk to client is considered. Example: Extinction may appear in a level not requiring Human Rights approval, even though when utilized with aggression or self injurious behavior, this procedure might restrict by inflicting massive injury and/or death, whereas a program such as exclusion time-out might appear at a higher level and may not present as much risk to staff and/or clients. Through time, many of these attempts to rank order procedures evolve into cookbook behavior modification formula. When this results, the client may be subjected to a series of procedures so that he can "earn the needed therapy" which might be at a higher level.

This trend tends to ignore the objective of applied behavior analysis, which is individualized treatment and, as a result, clients and therapists are in a bureaucratic gauntlet. Typically, treatment teams and bureaucracy will confront each other based on "what the client needs as an individual" versus "dictum of a New False God, the procedure hierarchy". Few of these hierarchies would withstand the test of scientific validation, as well as social validation as the methods and procedures ranked, included, and/or excluded vary from facility to facility.

In conclusion, this author proposes that each method or procedure be evaluated (1) on the risk to client; (2) on the risk to staff; and (3) prior to application, on risk based on the individual case under consideration. (Killebrew, Harris and Kruckeberg, 1982)

Restrictiveness can be defined by (1) possible injury to the client due to self or application of procedure (Spreat and Baker-Potts, 1983); (2) severity of behavior in terms of injury to self or other persons. Example: ignoring and not preventing or interacting with a client who screams or paces would be less restrictive than ignoring and not interacting with or preventing a client from biting his arm. The restrictiveness is based on injury and possible damage which may impair the arm.

Ultimately, any rank or order of behavioral procedures should be scientifically validated, possibly by surveys as conducted by Killebrew.

References

Killebrew, J., Harris, L., Kruckeberg, K., A Conceptual Model for Determining the Least Restrictive Training Modality Within A Residential Setting for the Developmentally Disabled Person; *Journal of Hospital and Community Psychiatry*, 1982.

Spreat, S., Baker-Potts, C.J., Patterns of Injury in Institutionalized Mentally Retarded Residents; *Mental Retardation, 21*, 1, 23-29, 1983.

FABA

From the Editors

The next issue of the *FABA Quarterly* will be published in August, 1983. Please submit articles, ideas, and news by July 20, 1983 by writing or phoning either editor as follows:

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Also, please be advised that publication of items in the *FABA Quarterly* does not imply endorsement by FABA. We also reserve the right to edit all copy.

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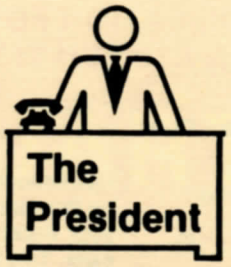
Complete the form on the back cover and mail by August 1, 1983 to get a member discount registration rate for the September conference.

Message From The President



Hopefully, all 1982 FABA members have received their Membership Directories by now. I know that I will have occasion to use the Directory on a regular basis. Darrel Bostow is to be commended for his hard work in producing it. The Directory should prompt those of you who have not paid your 1983 dues to do so. If you want to be included in the next FABA Membership Directory, you must pay your 1983 FABA dues. I would encourage all of you to take a hard look at the names included in our new Directory. What should be obvious to you are some of the names which are missing. We have a large number of individuals in Florida who are in "behavioral-type" jobs or who identify with behavior analysis or therapy, but who do not belong to FABA. Please tell these people about FABA. Encourage them to join and support behavior analysis in Florida. Our organization will only be as strong as its membership.

The big news in this issue of *FABA Quarterly* is the information about our third annual conference scheduled for September 15 and 16, 1983 in Orlando at the Hilton Inn at Florida Center. The Hilton provides excellent accommodations for the conference and is ideally located in the heart of Orlando's many attractions. FABA officials have contracted specially reduced room rates for the conference dates. Room rates will be $38 for both singles and doubles. That's right! As many as four persons can stay in a room at the $38 rate. I can safely assure you that this conference will even surpass the excellent conferences we have had in the past. We will have major sessions on a broad range of topics including mental health, developmental disabilities, the experimental analysis of behavior, behavioral medicine, child abuse, behavioral community psychology, drug treatment, and applications of behavior analysis to business, industry, and human service systems. I know that you will be pleasantly surprised when you discover the number of statewide and nationally prominent practitioners and researchers who have agreed to participate in our conference. Here's a list of just a *few* of the speakers who have agreed to participate: Steven Breunig; Gordon Paul; John Lutzker; Denny Reid; Brian Iwata; Pete Christian; Judy Favell; Jim Favell and David Pingree. And that's only a Partial List!! There is no doubt in my mind that this will be the most outstanding state-level behavior analysis conference ever held.

To make our conference even better, we need your help. Please respond to the "Call for Papers" included in this issue. We would like to have as many FABA members as possible participate in the program. This is your opportunity to be involved in a significant event in the history of behavior analysis in Florida. If you do not wish to be a part of the formal program, *do set aside September 15-16, 1983 and plan to attend the FABA Conference in Orlando.* Spread the word among your colleagues. We should have well over 500 people in attendance at such a conference. Do your part and support FABA!

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Sunland Center at Orlando

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