



AMERICAN
PSYCHOLOGICAL
ASSOCIATION

Division of Clinical Neuropsychology Newsletter 40

Volume 18, Number 2

Summer/Fall 2000

DIVISION 40 OFFICERS AND COMMITTEE CHAIRS

PRESIDENT:

Gordon J. Chelune, Ph.D.

PRESIDENT-ELECT:

Jason Brandt, Ph.D.

PAST-PRESIDENT:

Cecil R. Reynolds, PhD

SECRETARY:

Ann C. Marcotte, PhD

TREASURER:

Wilfred G. Van Gorp, PhD

MEMBERS-AT-LARGE:

Lloyd Cripe, Ph.D. C. Munro Cullum, PhD

Keith O. Yeates, Ph. D.

COUNCIL REPRESENTATIVES:

Theodore Blau, PhD. Kerry Hamsher, PhD

Thomas J. Boll, PhD, Antonio Puente, PhD

COMMITTEE CHAIRS (STANDING COMMITTEES)

FELLOWS: Stan Berent, PhD

MEMBERSHIP: William B. Meneese, PhD

ELECTIONS: Cecil R. Reynolds, PhD

PROGRAM: Joseph H. Ricker, PhD

Paula Shear, Ph.D.

COMMITTEE HEADS (AD HOC

COMMITTEES/TASK FORCES):

SCIENCE ADVISORY:

Russell Bauer, PhD

EDUCATION ADVISORY:

Kerry Hamsher, PhD

PRACTICE ADVISORY:

Christopher Grote, PhD

PUBLIC INTEREST ADVISORY:

Barbara C. Wilson, PhD

ETHICS:

Richard Naugle, PhD

MINORITY AFFAIRS:

Duane E. Dede, PhD

NEWSLETTER:

John DeLuca, PhD

TRAINING PROGRAMS DATA BANK:

Lloyd Cripe, PhD

AWARDS COMMITTEE:

Ida Sue Baron, PhD

CPT CODE: Antonio Puente, PhD

ASHA/DIV. 40 TASK FORCE LIAISON:

Jill Fischer, PhD

“INCIDENT TO” TASK FORCE:

Linas Bieliauskas, Ph.D.

POLICY/PROCEDURES MANUAL COMMITTEE:

Darlene G. Nemeth, Ph.D.

LIAISONS TO APA COMM. ON GAY, LESBIAN & BISEXUAL

CONCERNS:

Kristine M. Herfkens, PhD

Robert L. Mapou, PhD

LIAISON TO APA COMM. ON WOMEN IN PSYCHOLOGY:

Paula Shear, PhD

REP. TO THE INTERDIVISIONAL COUNCIL:

Ann C. Marcotte, PhD

Eileen Fennell, PhD

DIVISION 40 ARCHIVIST:

Darlyne Nemeth, PhD

www.div40 Webmaster:

Lloyd Cripe, Ph.D.

Memorial Tribute To Laird Cermak, PhD

With the untimely passing of Laird Cermak, neuropsychology has lost one of its most energetic and dedicated advocates. Cermak influenced the field in numerous ways. He conducted groundbreaking studies of encoding and retrieval processes in the amnesic syndrome; founded the Memory Disorders Research Society, whose annual meeting has become a forum for cutting-edge research on memory and the brain; and edited *Neuropsychology*, a leading voice for experimental research on neuropsychological disorders. Perhaps most important, Cermak was one of a small group of early pioneers who attempted to join together a neuropsychological perspective on memory with the techniques and approaches of experimental cognitive psychology.



When Cermak began his career as a memory researcher in the early 1970s, there was little or no cross-talk between neuropsychologists and experimental cognitive psychologists who studied human memory. Trained as an experimentalist, and intrigued by the possible insights into normal memory that could be gleaned by studying memory pathology, Cermak began an influential collaboration with his close friend and colleague, the late Nelson Butters. By systematically applying the latest paradigms and theoretical constructs from cognitive psychology to neuropsychological populations, they helped to raise the methodological and theoretical standards of the field to a new level, and charted a course for the future.

Cermak's multiple skills as an organizer, editor, and researcher were nowhere better illustrated than in his realization of what was, to the best of my knowledge, the first conference ever to bring together experimental cognitive psychologists and neuropsychologists. Held in October 1979 at Lake Morey, Vermont, Cermak managed to attract many of the most illustrious researchers of the time to the task of exploring intersections between normal and abnormal memory, including Alan Baddeley, Robert Crowder, Larry Jacoby, Elizabeth

In This Issue

Memorial Tribute to Laird Cermak PhD	1
From The Editor:	2
Clinical Corner	3
Evaluation of Children with Extremely Low Birth Weight	
Ethics Code Task Force	8
Science Scene	9
Prevalence Rates for Neuropsychological Malingering Indexes in Traumatic Brain Injury	
APPCN's Role in Education and Training in Clinical Neuropsychology	14
Division 22 Program for the 2000 APA Annual Convention	17
Division 40 Program for the 2000 APA Annual Convention	19
Division 40 Contributes to APA Legal Action Fund	26
Forensic Assessments and Professional Relations	28
Division 40 Executive Committee Meeting Minutes	32

Back issues of the division 40 Newsletter are now available on line at the Division 40 Archives website at Louisiana State University.
 The URL address is:
<http://www.lib.lsu.edu/special/findaid/apa/print.html>

From The Editor

With this edition of *Newsletter 40* we pay a special tribute to the memory of Dr. Laird Cermack. I greatly appreciate all who contributed their personal thoughts and feelings to one of our most distinguished members, and especially to Dr. Margaret O'Connor for all of her help in coordinating this project. We have what we hope is interesting reading in our usual columns. Clinical Corner features an interesting article by Dr. Gerry Taylor on the evaluation of children with low birth weight. Drs. Curtis and Vanderploeg present a thought-provoking piece on prevalence rates for malingering in Science Scene, and we have a timely paper by Drs. McCartney-Filgate and Snow on forensic assessments and professional ethics. Of course we also have the Division 40 and 22 Programs for APA, which look really outstanding, as well as other columns and announcements. I want to personally thank all of our authors and contributors. We hope you will enjoy this issue of your Newsletter. See you at APA in Washington.

Joel E. Morgan, Ph.D.
 Associate Editor

Announcement

It is with considerable sadness that we report on the recent death of Dr. Oscar Parsons, who passed away in February, 2000. Dr. Parsons had a distinguished career as a neuropsychologist and among his numerous awards, he won the Division 40 Distinguished Benton Lectureship several years ago. It was our distinct honor to have interviewed Dr. Parsons for *Newsletter 40*. He was a kind, generous, and gracious man who will be long remembered and sorely missed.

Clinical Corner

Evaluation of Children with Extremely Low Birth Weight

H. Gerry Taylor, Ph.D., ABPP-CN
Department of Pediatrics,
Case Western Reserve University and
Rainbow Babies & Children's Hospital
Cleveland, Ohio

Author Note:

Research on low birthweight outcomes by the author and his colleagues is supported by Grant HD26554 from the National Institute of Child Health and Human Development. Correspondence concerning this article can be addressed to H. Gerry Taylor, Ph.D., Department of Pediatrics, Rainbow Babies & Children's Hospital, 11100 Euclid Avenue, Cleveland, OH 44106-6038.

Recent developments in neonatal intensive care have resulted in increased survival of extremely low birthweight (ELBW) children, most frequently defined as those with birth weight <1000 g (2 lbs., 3 oz.) (Taylor, Klein, & Hack, in press). Children at the lower end of this range, with birth weights <750 g (1 lb., 3 oz.), rarely survived prior to the 1980s. Unfortunately, increased survival has come at a cost. ELBW children are at substantially higher risk than their normal birthweight peers for cognitive and educational problems at school age. Despite the fact that ELBW infants comprise less than 1% of live births, these problems can be formidable and may well lead to increasing demand for neuropsychological services.

The major aim of this article is to illustrate the unique problems and needs of ELBW children via a case example. After reviewing presenting complaints and background information, I summarize evaluation findings and interpretations and describe intervention strategies. Demonstration of problems common to this population underscores the potential utility of neuropsychological assessment in defining children's strengths and weaknesses and identifying psychoeducational needs.

Case Illustration

Background. Jane (not real name) was referred at age 12 years by a pediatric neurologist to evaluate learning problems. She was a sixth grade regular education student who had largely succeeded in elementary school. However, she had received considerable individual assistance from her teachers, and she was having increasing difficulty keeping up with her peers with each advancing grade. Grades had recently declined in reading, math, and science, and she had not passed the state proficiency tests in math and science. Concerned that less support would be available to Jane in junior high school, her mother wanted to know if Jane had a learning problem or developmental disability, if she might qualify for special assistance in school, and what the future held for her.

According to comments from her teacher, Jane had difficulty following oral or written directions and understanding and recalling what she read. Her mother felt that Jane was skilled in word decoding, but that she was deficient in understanding story themes and solving math problems. Jane was not able to find her way around the neighborhood and was concrete in her thinking. For example, she would vocally answer a taped message on an answering machine as if someone were present on the other end of the line. She knew how to dial her mother's pager, but was clueless about what to do after the beep sounded and no one answered. Despite multiple attempts, she continued to be confused as to how to load the washer and dryer, often putting the liquid soap in the washer and the paper fabric softener in the washer. She also had

difficulty remembering the position of the phone book when it was moved to a new location in the house.

Jane's poor problem solving abilities and limited adaptive skills interfered with her ability to function independently and in social activities. She did well with routine and was compliant, but did not seem to know how to improvise if an activity did not go as planned or if a problem arose. She would become withdrawn or cry if children fought or argued in her presence, and her mother did not leave her alone in the house or trust her to care for younger children on her own. She had steady friendships, interacted well with others generally, and had interests in extracurricular activities such as sports and music. At the same time, her friends would sometimes leave her out of an activity or take advantage of her social naivete (e.g., advising her to say something to another child that was socially inappropriate). Despite these tendencies, her conversational skills were well developed and she had developed effective compensatory abilities. For example, she had a habit of asking for clarification when she was uncertain of directions, and she always took a friend when she went to unfamiliar places.

Jane was originally placed with her parents as a foster child at age 6 months and later adopted by them. Although her parents were not aware of all aspects of her early upbringing, they do know that her birth weight was less than 2 lbs., and that she remained in the hospital for the first 3 months of her life. Neonatal complications included bronchopulmonary dysplasia (underdeveloped lungs), grade III intraventricular hemorrhage (IVH), periventricular leukomalacia, and a surgically corrected patent ductus arteriosus. There were multiple episodes of respiratory distress during the first year, but no history of seizures or other frank neurologic disorders. Motor and speech milestones were delayed, with reports of tremors and choreoathetoid movements, and Jane's parents enrolled her in preschool programs for children with developmental disabilities. Her hearing and vision were normal, although she had had several prescription changes to correct vision problems.

Test findings. Parent ratings on the Child Behavior Checklist (Achenbach, 1991a) were well within the average range, although the Teacher's Report Form (Achenbach, 1991b) revealed borderline clinical ratings of internalizing behaviors (e.g., nervous, self-conscious, shy, stares) and externalizing behaviors (inattentive, demanding, moody, stubborn). Her teacher rated her on the ACTeRS (Ullman, Sleator, & Sprague, 1991) as rarely able to complete work or follow instructions. However, neither parent nor teacher ratings supported the diagnosis of attention-deficit hyperactivity disorder (ADHD). In interview and testing, Jane was pleasant, happy, and cooperative. She enjoyed conversing and was deliberate and focused during testing.

Table 1 summarizes results from tests of academic achievement and neuropsychological skills. Despite academic concerns, findings from the Wechsler Individual Achievement Test (Wechsler, 1991) suggested that Jane was maintaining age-appropriate progress in reading decoding, spelling, writing, and math computation. However, math problem solving was only low average, and the Gray Oral Reading Test, Third Edition (Wiederholt & Bryant, 1992) substantiated reports of difficulties in reading comprehension.

Jane was efficient on the Coding subtest of the Wechsler Intelligence Scale of Children—3rd Edition (WISC-III, Wechsler, 1991), but weak on Comprehension, Picture Completion, Picture Arrangement, and Object Assembly. WISC-III summary scores revealed low average overall abilities, with relative weaknesses in Perceptual Organization.

Additional neuropsychological testing documented weaknesses in language processing skills on both the NEPSY (Korkman, Kirk, & Kemp, 1998) and Clinical Evaluation of Language Fundamentals-3rd. Edition (CELF-III, Semel, Wiig, & Secord, 1995). In contrast to solid performance on NEPSY tests of memory, visual-motor, and sensorimotor skills, Jane also scored below age standards on tasks measuring naming speed and perceptual planning. Although motor dexterity was intact on the Grooved Pegboard Test (Spreen & Strauss, 1998), she did less well relative to norms with her nondominant hand than with her dominant hand. Further difficulties were noted in her reproductions of the Rey Osterrieth Complex Figure (Bernstein & Waber, 1996). Weaknesses in organization were most obvious on the delayed recall portion of this test.

Table 1. Test Results.

<u>Academic Achievement</u>			
WIAT standard scores (x = 100, SD = 15):			
Basic Reading	100	Written Expression	92
Reading Comprehension	103	Mathematics Reasoning	85
Spelling	102	Numerical Operations	101
GORT-3 standard scores (x = 10, SD = 3):			
Rate	16	Comprehension	5
Accuracy	11	Oral Reading Quotient	94
<u>IQ</u>			
WISC-III Subtest scaled scores:			
Information	8	Picture Completion	6
Similarities	7	Coding	13
Arithmetic	8	Picture Arrangement	4
Vocabulary	9	Block Design	7
Comprehension	6	Object Assembly	6
Digit Span	8		
WISC-III standard scores:			
Verbal Comprehension	87	Verbal IQ	87
Perceptual Organization	76	Performance IQ	82
Freedom from Distractibility	90	Full Scale IQ	83
<u>Language</u>			
NEPSY scaled scores (x = 10, SD = 3):		CELF-R standard scores (x = 10, SD = 3):	
Phonological Processing	8	Concepts and Directions	4
Speeded Naming	6	Formulated Sentences	6
Comprehension of Instructions	7	Recalling Sentences	4
<u>Visual-Motor and Sensorimotor</u>			
NEPSY scaled scores (x = 10, SD = 3):		Grooved Pegboard z scores (x = 10, SD = 1):	
Design Copying	13	Dominant Hand Time	-0.2
Arrows	8	Nondominant Hand Time	0.4 (slow)
Finger Tapping	14		
Visuomotor Precision	13		
<u>Attention of Executive Function</u>			
NEPSY scaled scores (x = 10, SD = 3):		Rey-Osterrieth Complex Figure z scores	
Tower of London	6	(x = 0, SD = 1):	
Auditory Attention & Response Set	9	Copy	-1.2
Visual Attention	12	30-Minute Recall	-2.1
<u>Memory</u>			
NEPSY scaled scores (x = 10, SD = 3):			
Memory for Faces	12	Narrative Memory	11
Memory for Names	13		

Note: WIAT = Wechsler Individual Achievement Tests; GORT-3 = Gray Oral Reading Tests, Third Edition; WISC-III = Wechsler Intelligence Scale for Children, Third Edition; CELF-III = Clinical Evaluation of Language Fundamentals—Third Edition; NEPSY = NEPSY: A Developmental Neuropsychological Test.

Summary and interpretation. Despite Jane's low average IQ, she scored in the average range on tests of reading decoding, spelling, writing, and math computation. She also scored age appropriately on tests of psychomotor skills, visual recognition memory, memory for face-name pairings, and story recall. Weaknesses were nevertheless evident in verbal and reading comprehension, math problem solving, working memory, naming speed, perceptual planning, and perceptual-organization and constructional ability. Although teacher ratings suggested performance difficulties in the classroom, these problems were likely related to Jane's processing limitations. Jane was highly motivated, interacted well with adults, and had developed effective strategies for compensating for her weaknesses.

The pattern of neuropsychological findings was similar to that seen in other ELBW children. As a group, ELBW children score within the low average range on tests of IQ, with relative strengths in verbal semantic skills and reading decoding and relative weaknesses in math and executive functions (Taylor, et al., in press). Jane's multiple neonatal complications, including a grade III IVH and lung disease, make it even more probable that her developmental problems were related to ELBW (Taylor, Klein, Schatschneider, & Hack, 1998). The type of neuropathology found in ELBW children, which includes damage to the periventricular and frontal-striatal regions, is consistent with Jane's weaknesses in executive functions.

Based on Jane's high-risk birth and the correspondence of her cognitive and learning difficulties with those found in other ELBW children, Jane was given the DSM-IV diagnosis of Cognitive Disorder Not Otherwise Specified. Jane's weaknesses in math, comprehension skills, and problem solving, together with parent report of deficits in spatial orientation and appreciation of social nuances, also suggested a Nonverbal Learning Disability (NVLD, Rourke, 1989). The latter syndrome has been observed in association with a number of early neurological disorders.

Recommendations.

Intervention strategies that have been suggested for children with NVLD are well suited for ELBW

children like Jane. These methods include emphasis on verbal rules and verbal explications, provision of a high degree of structure at home and school, assistance in developing study skills and organization strategies, efforts to make abstract concepts semantically meaningful, and opportunities for familiarization and review at times of transition and in learning new materials (Rourke, 1989; Thompson, 1999). Clinical work with ELBW children suggests that they are less likely than their normal birthweight peers to discover relationships on their own, make inferences, and engage in divergent thinking. Given the need for repetition and individual guidance in learning, a private tutor may be helpful as resources allow. Because ELBW children are less competent in some respects than their classmates, developmentally appropriate instruction (i.e., instruction that is geared to the child's skill level) is especially critical to learning. Strategies for managing attention deficits may also be applicable, although more so for those ELBW children who meet criteria for ADHD (Barkley, 1998).

An Individual Educational Plan would be useful in providing the additional structure and practice needed for the child to master classroom learning objectives. Unfortunately, there is no special educational classification for low birthweight children, or for any child with more subtle manifestations of early neurological disorder other than non-birth-related traumatic brain injuries. Eligibility for special education can nevertheless be considered under the "Other Health Impaired" or similar category. Given the adverse effects of low birth weight on learning, a Section 504 Plan (Rehabilitation Act) is another, though less intensive, option for formalizing intervention strategies.

Finally, weaknesses in social and academic skills suggest the need for children like Jane to develop nonacademic strengths and interests and to have opportunities for positive interactions with peers. Jane was fortunate to be involved in a number of extracurricular activities and to have some talents and strong friendships. Her teachers and parents had been willing to give her individual assistance with her school work, modify expectations in accordance

with her abilities, and teach her ways to compensate for her limitations. These advantages, along with Jane's high level of motivation and exuberant personality, had undoubtedly contributed to her academic and social progress and will continue to do so in the future. Results from longitudinal follow-up studies, however, indicate that ELBW sequelae do not abate over time (Taylor, et al., in press); hence ongoing guidance will likely be required to optimize longer-term outcomes.

Discussion

Although neuropsychological findings were compatible with Jane's birth history, she did not have several problems commonly found in ELBW children. She failed to meet criteria for ADHD, and her performances on tests of math ability, memory, motor, and visual-spatial skills were higher than expected based on the existing literature on ELBW outcomes (Taylor, Hack, & Klein, 1998; Taylor, et al., in press). One possible reason for these disparities is that Jane's early brain insults were relatively selective. Another possibility is that the enriched environment provided by Jane's parents, teachers, and therapists resulted in neural reorganization, or helped her learn methods to compensate for her limitations. Jane's good performance on NEPSY memory tests, for example, may have reflected use of semantic strategies for remembering faces, names, and story details. In hindsight, administration of a verbal list learning test would have been useful in further assessment of memory, and may well have revealed difficulties in acquisition rates not seen on the NEPSY tests (Taylor, Minich, Klein, & Hack, in press). Jane may also have had genetically based talents, partially offsetting the adverse consequence of early brain damage.

Jane's presentation is thus a variation of the profile frequently seen in ELBW children. Outcomes for other ELBW children also vary from the modal pattern, with some survivors having few if any disabilities (Taylor, Klein, Minich, & Hack, in press). The goals of neuropsychological assessment in these cases are to document and clarify strengths and weaknesses, determine the feasibility of brain-based interpretations of findings, consider other potential influences on outcomes, and formulate

interventions that follow from an understanding of the sources of the child's deficiencies. We now know enough about ELBW outcomes to assist parents and teachers in identifying and conceptualizing ELBW children's problems and needs. Further work is required to refine assessments methods, learn more about the nature the underlying neuropathology and how it limits development, and examine the influences of environmental factors and treatment methods on outcomes. Advancements in these areas will result in a better understanding of the sources of individual differences and enhance the utility of neuropsychological assessment.

References

- Achenbach, T. (1991a). Manual for the Child Behavior Checklist. Burlington, VT: University Associates in Psychiatry.
- Achenbach, T. (1991b). Manual for the Teacher's Report Form. Burlington, VT: University Associates in Psychiatry.
- Barkley, R.A. (1998). Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment (2nd Edition). New York, NY: Guilford.
- Bernstein, J.H., & Waber, D.P. (1996). Developmental scoring system for the Rey-Osterrieth Complex Figure: Professional manual. Odessa, FL: Psychological Assessment Resources.
- Korkman, M., Kirk, U., & Kemp, S. (1998). NEPSY: A Developmental Neuropsychological Assessment: Manual. Orlando, FL: The Psychological Corporation.
- Rourke, B.P. (1989). Nonverbal learning disabilities: The syndrome and the model. New York, NY: Guilford.
- Semel, E., Wiig, E.H., & Secord, W.A. (1995). CELF-3: Clinical Evaluation of Language Fundamentals Third Edition, Examiner's manual. San Antonio, TX: Psychological Corporation.
- Spreen, O., & Strauss, E. (1998). A compendium of neuropsychological tests: Administration, norms, and commentary (2nd Ed.). New York, NY: Oxford.

Taylor, H.G., Hack, M., & Klein, N. (1998). Attention deficits in children with <750 gm birth weight. Child Neuropsychology, 4, 21-34.

Taylor, H.G., Klein, N., Minich, N.M., & Hack, M. (in press). Middle school-age outcomes in children with <750 gm birth weight. Child Development.

Taylor, H.G., Klein, N., & Hack, M. (in press). School-age consequences of <750 g birth weight: A review and update. Developmental Neuropsychology.

Taylor, H.G., Klein, N., Schatschneider, C., & Hack, M. (1998). Predictors of early school age outcomes in very low birthweight children. Developmental and Behavioral Pediatrics, 19, 235-243.

Taylor, H.G., Minich, N.M., Klein, N., & Hack, M. (in press). Verbal memory deficits in children with <750 g birthweight. Child Neuropsychology.

The Psychological Corporation. (1992). WIAT: Wechsler Individual Achievement Test manual. San Antonio, TX: Author.

Thompson, S. (1999). The source for nonverbal learning disorders. East Moline, IL: LinguSystems.

Ullman, R.K., Sleator, E.K., & Sprague, R.L. (1991). ACTeRS (2nd Edition). Champaign, IL: MetriTech.

Wechsler, D. (1991). WISC-III: Wechsler Intelligence Scale for Children—3rd Edition manual. San Antonio, TX: Psychological Corporation.

Wiederholt, J.L., & Bryant, B.R. (1992). Gray Oral Reading Tests, Third Edition: Examiner's manual. Austin, TX: Pro-Ed.

Ethics Code Task Force

The Ethics Code Task Force is in the process of revising the *Ethical Principles for Psychologists and Code of Conduct*. Since the publication of an earlier draft of the revised code in the *Monitor* last summer, two sections have received considerable attention among neuropsychologists. Those sections pertain to the need to obtain informed consent to perform assessments and the release of raw test data to attorneys. Those parts of the most recent draft of the revised code, which was produced on 20 March, follow:

9.03 Informed Consent in Assessments

(a) Psychologists obtain informed consent for assessments, evaluations, or diagnostic services, as described in Standard 3.11, except when testing is mandated by law or governmental regulation or when testing is conducted as a routine educational activity.

(b) Psychologists inform persons for whom testing is mandated by law or governmental regulations about the nature and purpose of the proposed assessment services, using language that is reasonably understandable to the person being assessed.

9.04 Release of test data

(a) Psychologists may release test data, including raw responses and raw scores, to another qualified professional based on a client release. Psychologists refrain from releasing test data to persons who are not qualified to use such information, except (1) as required by statute or court order or (2) to an attorney or court based on a client release or (3) to the patient or client as appropriate. (See also Standards 1.03, Relationship of Ethics and Law, and 2.01, Boundaries of Competence.)

The Ethics Committee is in the process of preparing a response to these suggested revisions. Members of Division 40 are encouraged to communicate their reactions to me so that I can incorporate those comments in our response.

Richard Naugle, PhD, ABPP
Chair, Division 40 Ethics Committee
Cleveland Clinic Foundation
9500 Euclid Avenue (P57)
Cleveland, Ohio 44195

Science Scene

Prevalence Rates for Neuropsychological Malingering Indexes in Traumatic Brain Injury

Glenn Curtiss, Ph.D.^{1,2,3}
Rodney D. Vanderploeg, Ph. D.^{1,2,3}

¹Defense and Veterans Head Injury Program

²J. A. Haley VAMC, Tampa, FL

³University of South Florida

Portions of this article were presented at the annual meeting of the National Academy of Neuropsychology, San Antonio, TX, November, 1999.

An aspect of neuropsychological interpretation involves trying to determine whether poor performance on tests is indicative of underlying neurological dysfunction, psychological disturbance (e.g., severe depression or psychotic disorder), instrument error (test administration problems, scoring errors, or error variance), less than maximal effort on the client's part, exaggeration of genuine problems, or actual malingering of non-existent cognitive deficits. The determination of exaggeration or malingering is of particular importance in assessment of alleged mild head trauma. Complicating that determination is the forensic setting where such examinations typically occur. Clients who were involved in accidents and who have experienced subjective symptoms are required to attend numerous medical and legal appointments and complete multiple evaluations. In such a context, the development of resentment, anger, and hostility to what appear to be unnecessary and unwanted evaluations is almost inevitable. In turn, such anger and hostility can only undermine a client's maximal effort and full participation during lengthy and unwanted examinations, which in turn may be misinterpreted as exaggeration of deficits or overt malingering.

While tests have been developed specifically to help identify malingering with some success (e.g., forced-choice testing), more recent efforts have attempted to detect feigning by identifying patterns of performance within and across standard neuropsychological instruments that are inconsistent and that do not make "neuropsychological sense" (Larrabee, 1991). These efforts include patterns of performance and cut scores using the Wechsler Memory Scale-Revised (WMS-R; Wechsler, 1987; e.g., Mittenberg, Azrin, Millsaps, & Heilbronner, 1993), the Wechsler Adult Intelligence Scales-Revised (WAIS-R; Wechsler, 1981; e.g., Trueblood, 1994; Mittenberg, Theroux-Fichera, Zielinski, & Heilbronner, 1995), the California Verbal Learning Test (CVLT; Delis, Kramer, Kaplan, & Ober, 1987; e.g., Millis, Putnam, Adams, & Ricker, 1995; Trueblood, 1994), and the Wisconsin Card Sorting Test (WCST; Heaton, Chelune, Talley, Kay, & Curtiss, 1993; e.g., Bernard, McGrath, & Houston, 1996). The patterns of performance that have been identified typically involve relatively poorer performance on easier aspects of a test compared to relatively better performance on harder aspects. Alternatively, level of performance cut scores on such clinical instruments are identified by particularly poor performances on some easier task (e.g., Digit Span forward or recognition memory). With such an approach, patterns are identified that potentially discriminate between someone with a genuine brain injury versus someone feigning a brain injury.

Mittenberg et al. (1993) using the WMS-R found that individuals with actual head trauma had a pattern of higher Attention/Concentration index scores compared with the General Memory index score while simulated malingerers showed the opposite pattern. Using a difference score of General Memory minus Attention/Concentration greater than 33, these authors found an accurate classification rate of greater than 80%. Trueblood (1994) evaluated the ability of the WAIS-R to detect putative malingered performance and

Continued on page 10

performance of questionable validity from that of mild traumatic brain injury. Results indicated that low overall level of performance, rather than differential pattern, distinguished the groups in this study. However, Mittenberg et al. (1995) found that a performance pattern of age-corrected Vocabulary scores two points or more greater than that of Digit Span discriminated simulated malingerers from a group of individuals who had sustained mild to severe head injuries.

Using discriminant analysis on CVLT scores, Millis et al. (1995) found that a combination of List A Trials 1-5 Total Score, Recognition Discriminability, and Long-Delay Cued Recall distinguished severe from questionable mild head-injured patients. Finally, Bernard et al. (1996) examined the ability of performance patterns on the WCST to detect simulated malingering. They found that a combination of subtle and obvious WCST scores best discriminated simulated malingering subjects from those with closed head injuries. Number of Categories Completed was used as the obvious measure while Perseverative Responses and Perseverative Errors were the subtle measures. Simulated malingerers produced approximately twice as many Perseverative Error responses but completed only one-seventh as many categories compared with the closed head injury group.

There is some evidence to support the pattern of performance approach in detecting malingered performance on neuropsychological tests. However, base rate information for positive scores on these indexes in a broad spectrum of traumatically brain injured population (TBI) is not known. Without such base rate information, clinicians may overinterpret the significance of positive findings. Here we report on the base rates of “malingering” in questionable TBI, mild TBI, and moderate to severe TBI subgroups for the indices described above involving the WMS-R, WAIS-R, CVLT, and WCST.

Data were available from 244 (90% males) active military duty personnel or military veterans with minimal to severe TBI. All individuals were enrolled in the Defense and Veterans Head Injury Program (DVHIP), a multi-site treatment and research program. All individuals underwent standard comprehensive medical and

neuropsychological evaluations as part of their routine clinical care. The average age was 30.7 (SD = 11.7); 70 percent were Caucasians, 16 percent African-American, 7 percent Hispanic, and 7 percent from other racial backgrounds. The average level of education was about 13 years.

Fifteen individuals experienced neither loss of consciousness (LOC) nor post-traumatic amnesia (PTA), yet were reported as having experienced a traumatic brain injury. This subgroup was therefore seen as only questionably having sustained a TBI and as being possible dissimulators, although no data were available to document malingering. All other participants had documented alterations in consciousness. The other participants were classified into either mild TBI (length of LOC plus PTA < 24 hours; N = 44) or moderate to very severe TBI (length of LOC plus PTA > 24 hours; N = 185) in a manner similar to that proposed by Bond (1983).

The base rate question of interest was: Do the questionable TBI participants have a higher rate of being classified as malingering than the mild TBI group? Typically, there is not a question of whether individuals with moderate to severe TBIs are malingering, although they may also exaggerate existing deficits. Therefore, the base rates of being identified as malingering in the moderate to severe TBIs were also examined. Because no data were available to definitively identify malingers, the sensitivity of these indices could not be examined. Therefore, for the present analyses the false positive malingering rate in mild TBI cases was of most interest.

Malingering indexes were derived for the WCST, WAIS-R, WMS-R, and CVLT. With one exception, indexes were derived based on the cutoff scores or classification data presented in the literature. Table 1 presents these formulae. Because the DVHIP research protocol does not administer the complete WMS-R, a variant of the malingering index derived by Mittenberg et al. (1993) was calculated and used in the present study.

Table 1 presents the classification rates for being identified as malingering. Only two indexes, the WCST index and the WMS-R index, had acceptably low base rates for subjects with documented TBIs (less than 10%). For the other indices the rate of

Table 1. Base rates of being Classified as Malingering

Index Classification	Brain Injury Severity		
	Questionable	Mild	Moderate - Very Severe
<u>WAIS-R Related</u> ^a			
Digit Span < 7 (Trueblood & Schmidt, 1993)			
Malingering	2 (20%)	12 (38%)	25 (18%)
Nonmalingering	8 (80%)	20 (63%)	113 (82%)
Vocabulary < 7 (Trueblood, 1994)			
Malingering	1 (7%)	0 (0%)	36 (20%)
Nonmalingering	13 (93%)	43 (100%)	142 (80%)
(Vocabulary - Digit Span) ≥ 2 (Mittenberg et al., 1995)			
Malingering	4 (40%)	16 (50%)	31 (23%)
Nonmalingering	6 (60%)	16 (50%)	105 (77%)
<u>CVLT Related</u>			
Total of Trials 1-5 < 48 (Trueblood, 1994)			
Malingering	8 (57%)	21 (60%)	133 (78%)
Nonmalingering	6 (43%)	14 (40%)	38 (22%)
Recognition Hits < 13 (Trueblood, 1994)			
Malingering	1 (7%)	12 (34%)	71 (42%)
Nonmalingering	13 (93%)	23 (66%)	100 (58%)
Discriminant function equation of: Total of Trials 1-5, Discriminability, and Long-Delay Cued Recall (Millis et al., 1995)			
Malingering	2 (14%)	7 (20%)	68 (40%)
Nonmalingering	12 (86%)	28 (80%)	103 (60%)
<u>WMS-R Related</u>			
*(General Memory Quotient - Attention/ Concentration Quotient) > 34 (Mittenberg et al., 1993)			
Malingering	1 (10%)	2 (7%)	0 (0%)
Nonmalingering	9 (90%)	25 (93%)	127 (100%)
<u>WCST Related</u> (Bernard et al., 1996)			
Categories Completed ≤ 1 and Perseverative Errors ≤ 36			
Malingering	5 (33%)	4 (9%)	7 (4%)
Nonmalingering	10 (67%)	40 (91%)	178 (96%)

^aScores are age-corrected scaled scores. Not all neuropsychological variables were available on all subjects.

*Modified as: (General Memory Quotient based only on average MQ equivalent from Logical Memory I and Visual Reproduction I; and Attention Concentration Quotient based on the standard score equivalent from only Digit Span).

Table 2

Percentage of Participants

Number of Indices Identifying Malingering	Brain Injury Severity		
	Questionable	Mild	Moderate - Very Severe
0	27%	32%	23%
1	27%	25%	23%
2	20%	14%	20%
3	20%	14%	24%
4	7%	7%	7%
5	0%	7%	4%
6	0%	2%	0%

Columns do not add up to 100% because of rounding error.

being classified as malingering was high in subjects with documented TBIs and, even more problematic, was essentially comparable across the questionable, mild, and moderate to severe groups.

We further examined those mild TBI cases that were classified as malingering by the WMS-R and the WCST indices. Medical, observational, other clinical data were available on 1 of the 2 mild cases identified as malingering by the WMS-R index, and on 3 of the 4 mild cases identified as malingering by the WCST index. All of these cases were clearly not malingerers. Thus, assuming perfect prediction of all other questionable and mild TBI cases, these data indicate a minimum false positive malingering prediction rate of 33% in mild TBI. For the other indices reported in Table 1, the false positive rates are even higher.

Finally, we examined whether the frequency of meeting criteria on more than one malingering index differed across questionable TBI, mild TBI, and moderate to severe TBI subgroups. These data are presented in Table 2. There is no difference among groups in rates of being classified as malingering ($\chi^2(12, N = 244) = 9.8, p = .63$). That is, requiring

subjects to meet criteria on more than one index before identifying them as malingering does not reduce the false positive rate.

Taken together, these findings indicate that significant caution should be used when attributing malingering based on these patterns of performance on various clinical neuropsychological test measures. We believe that the risk of falsely labeling someone as malingering is unacceptably high with all of the proposed indices, whether used individually or in combination. These cautions echo those of Rosenfeld, Sands, and van Gorp (2000) who state: “given the obvious interdependence of base rates and classification accuracy statistics, clinicians should be particularly cautious when offering estimates of the likelihood of malingering” (p. 358). With actual data on false positive rates, clinicians are in a better position to understand and appreciate the limitations of their diagnostic statements. Finally, this article cannot address the issue of the sensitivity of these clinical malingering indices to the detection of actual malingering in questionable or mild TBI cases. Further research will be necessary to address sensitivity issues.

References

- Bernard, L. C., McGrath, M. J., & Houston, W. (1996). The differential effects of simulating malingering, closed head injury, and other CNS pathology on the Wisconsin Card Sorting Test: Support for the "Pattern of Performance" hypothesis. Archives of Clinical Neuropsychology, 11, 231-245.
- Bond, M. R. (1983). Standardized methods of assessing and predicting outcomes. In M. Rosenthal, E. Griffith, M. Bond, & J. Miller (Eds.), Rehabilitation of the head injured adult, (pp. 97-113). Philadelphia: Davis.
- Delis, D. C., Kramer, J. H., Kaplan, E., & Ober, B. A. (1987). The California Verbal Learning Test: Research Edition. San Antonio, TX: The Psychological Corporation.
- Heaton, R. K., Chelune, G. L., Talley, J. L., Kay, G. G., & Curtiss, G. (1993). Wisconsin Card Sorting Test Manual: Revised and Expanded. Odessa, FL: Psychological Assessment Resources.
- Larrabee, G. J. (1991). Cautions in the use of neuropsychological evaluation in legal settings: Neuropsychological tests can be failed for reasons other than brain damage. Neuropsychology, 4, 239-249.
- Millis, S. R., Putnam, S. H., Adams, K. M., & Ricker, J. H. (1995). The California Verbal Learning Test in the detection of incomplete effort in neuropsychological evaluation. Psychological Assessment, 7, 463-471.
- Mittenberg, W., Azrin, R., Millsaps, C., & Heilbronner, R. (1993). Identification of malingered head injury on the Wechsler Memory Scale - Revised. Psychological Assessment, 5, 34-40.
- Mittenberg, W., Theroux-Fichera, S., Zielinski, R. E., & Heilbronner, R. L. (1995). Identification of malingered head injury on the Wechsler Adult Intelligence Scale - Revised. Professional Psychology: Research and Practice, 26, 491-498.
- Rosenfeld, B., Sands, S. A., & van Gorp, W. G. (2000). Have we forgotten the base rate problem? Methodological issues in the detection of distortion. Archives of Clinical Neuropsychology, 15, 349-359.
- Trueblood, W. (1994). Qualitative and quantitative characteristics of malingered and other invalid WAIS-R and clinical memory data. Journal of Clinical and Experimental Neuropsychology, 16, 597-607.
- Trueblood, W., & Schmidt, M. (1993). Malingering and other validity considerations in the neuropsychological evaluation of mild head injury. Journal of Clinical and Experimental Neuropsychology, 15, 578-590.
- Wechsler, D. (1981). Wechsler Adult Intelligence Scale - Revised. San Antonio, TX: The Psychological Corporation.
- Wechsler, D. (1987). Wechsler Memory Scale - Revised. San Antonio, TX: The Psychological Corporation.

APPCN's Role in Education and Training in Clinical Neuropsychology

Thomas A. Hammeke and James F. Malec

There are now three national organizations whose principal concern is the education and training of new clinical neuropsychologists. Each is devoted to a different stage in the education and training sequence. These are the Association of Doctoral Education in Clinical Neuropsychology (ADECN, pronounced “add/ a sin”), the Association of Internship Programs in Clinical Neuropsychology (AITCN; pronounced “ate/ sin”), and the Association of Postdoctoral Programs in Clinical Neuropsychology (APPCN; pronounced “ap/ sin”). APPCN is the oldest and most developed of the three organizations. The cumulative goal of these three organizations is to produce graduates who are competent to independently practice in the specialty. Maintenance of that competence is subsequently achieved through continuing educational opportunities, which are provided in a variety of forums including coursework and workshops sponsored by numerous organizations in professional psychology.

The **organization and development of APPCN** owes a great debt to the publication of education and training guidelines for clinical neuropsychology by a task force sponsored jointly by the International Neuropsychological Society and Division 40 of APA¹. These guidelines, referred to as the “INS/Division 40 Guidelines,” served to coalesce a group of postdoctoral programs in the Midwest who formed a consortium in 1988 to implement the guidelines and facilitate development of program evaluation and accreditation procedures. At the encouragement of the Midwest Neuropsychology Consortium, the American Board of Professional Psychology sponsored a conference in Minneapolis in September 1991 on the accreditation of postdoctoral programs in professional psychology. Representatives of many national organizations with interests in postdoctoral accreditation attended this conference. The Minneapolis conference called for the development of national organizations of postdoctoral program directors in each of the postdoctoral specialties. In response, the Midwest Neuropsychology Consortium hosted the inaugural national meeting of postdoctoral clinical neuropsychology training programs in San Diego in February 1992. APPCN grew out of this meeting of program directors. APPCN adopted bylaws and was formally incorporated in 1994. In 1997, APPCN was a sponsor and participated in the further development of guidelines for education and training in clinical neuropsychology at the Houston Conference. Currently there are about 40 APPCN member programs and several with applications under review.

APPCN's mission is to foster the development of postdoctoral (now referred to as residency) education and training programs in clinical neuropsychology and to establish standards for residency programs in clinical neuropsychology which should lead to the development of competency in this area of specialty practice. APPCN initially endorsed the INS/Division 40 guidelines for education and training at the postdoctoral level and subsequently has endorsed the revised residency guidelines generated by the Houston Conference². The organization has attempted to objectify the education and training standards embodied by these guidelines, and continues to work at curriculum development. APPCN supports board certification in clinical neuropsychology by ABPP as the criterion of competency in clinical neuropsychology. Programs affiliated with APPCN seek to train residents in clinical competencies that will qualify them for this certification. All member directors of APPCN are board certified by ABPP. APPCN endorses the scientist-practitioner model of training. Thus APPCN programs provide research and academic experiences in addition to clinical training. The organization has developed specific ethical standards and a code of conduct for residency programs. APPCN disseminates information about affiliated programs. APPCN remains active and vigilant in confronting other issues relevant to the development of training and practice in clinical neuropsychology.

APPCN is working to implement **accreditation of postdoctoral programs**. APPCN is not an accrediting body, but instead supports the APA's Committee on Accreditation (CoA). APPCN maintains a liaison with the CoA and sends a representative to the Clinical Neuropsychology Synarchy (CNS), an organization with representation from all major professional organization in clinical neuropsychology. The CNS in turn sends a representative to the Council of Specialties, an organization endorsed by APA to oversee the development of accreditation standards for new specialties in psychology. APPCN has developed a document that merges the CoA's standards for generic residency programs (known and the "Guidelines and Principles") with specialty standards as defined by the Houston Conference Guidelines. From this document of merged generic and specialty standards, a self-study form was developed for individual program evaluation. The purpose of developing these documents was to simplify the process of specialty programs making application for accreditation in the specialty. Otherwise, a residency program wishing for specialty accreditation would have had to complete two self-studies, one to demonstrate compliance with generic standards and another to show compliance with specialty standards. These documents have now been approved for use by the CNS, the CoS, and the CoA. The documents can be reviewed and downloaded from the APPCN website (www.appcn.org).

While APPCN's forms were approved for use with the CoA in 1998, APPCN asked its member programs not to apply to the CoA for specialty accreditation until two issues were better resolved, one having to do with a CoA program requirement of a two-resident minimum and the other having to do with fees for accreditation. The CoA, in developing generic standards for residency programs, adopted the same residency number requirement that was in place at the internship level, i.e., a minimum of two residents. The principal purpose of this requirement was to ensure adequate socialization of the intern into the profession of psychology. Since a large portion of APPCN programs are single-resident programs, APPCN petitioned the CoA to relax this

requirement in the case of clinical neuropsychology residency programs. APPCN argued that, while socialization into the profession of psychology was important at the internship level, the proper focus of professional socialization at the residency level should be the professional environment in which the specialist will practice. In clinical neuropsychology the professional environment is typically multidisciplinary, and it is this milieu that should be the proper concern of professional socialization in neuropsychology. The CoA has subsequently relaxed this requirement, stating that the residency number requirement should be in compliance with the model of education and training endorsed by the program making application. In the case of clinical neuropsychology, the Houston Conference model does not require more than one resident.

The second concern about proceeding with accreditation has been the fees charged by the CoA for making application (\$2,000), completing a site visit (\$3,000, i.e., \$1,500 per site visitor), and annual maintenance of accredited status (\$2,000). While these fees are the same as those currently charged to doctoral and internship programs, they are nonetheless of a magnitude that prohibits many APPCN programs from seeking accreditation. Again APPCN has petitioned the CoA, this time to reconsider the fee structure at the residency level where, compared to doctoral and internship programs, there typically are fewer institutional resources and the program size is smaller. The CoA is currently considering this petition.

During the past year APPCN decided to pursue implementation of a **Matching Program** for recruitment of residency applicants into APPCN programs similar to that currently used for internship programs in psychology. Prior to this year APPCN simply maintained a uniform notification date and standard statements of feedback that could be given to applicants prior to the notification date. APPCN has chosen to work with the National Matching Service Inc. (NMS) to develop the neuropsychology residency match. NMS is the leader in the field, having developed the medical residency matching program as well as the Matching Program for clinical psychology internships, dental residencies, and others. The preparatory work to implement the neuropsychology residency match for next year has already started. Informational materials about the

Match will be distributed to APPCN program directors late this summer, and to applicants in fall and winter. A match date is tentatively planned for mid-April of 2001. Follow-up procedures will be available for programs and applicants who did not match on the first round. Procedures and fees for both applicants and programs involved in the match will be very similar to those used in the internship program.

A Matching Program allows program directors and residency applicants an opportunity to evaluate each other fully before offers are made. It is an effective and fair means of implementing a standardized acceptance date. All offers and acceptances or rejections occur simultaneously on the designated date. By using a Matching Program, decisions regarding making offers and accepting or rejecting offers can be based solely on the directors' and applicants' preferences for each other, without the need to speculate on the likelihood of subsequent offers being made or accepted. Common problems with recruitment, such as applicants accepting an offer prematurely, applicants renegeing on a prior acceptance in order to accept a more preferred subsequent offer, and directors attempting to "game" the system, are eliminated.

The basic requirement in a matching system is that each program rank all its acceptable candidates from most preferred to least preferred. Similarly, each applicant ranks all acceptable programs in the same manner. The computer then uses these rankings to match each applicant to the most preferred program available to the applicant, while at the same time matching each program with the most preferred applicant(s) available to the program.

For more information about APPCN, its programs, and the Match Program, see APPCN's website at www.appcn.org and its formal announcement³.

Reports of the INS - Division 40 Task Force on Education, Accreditation, and Credentialing (1987). *The Clinical Neuropsychologist*, 1, 29-34.

The Houston Conference on Specialty Education and Training in Clinical Neuropsychology: Policy Statement. (1998). *Archives of Clinical Neuropsychology*, 13, 160-166.

Hammeke, T.A. (1993). The Association of Postdoctoral Programs in Clinical Neuropsychology. *The Clinical Neuropsychologist*, 7, 197-204.

Daryl Bohac, Ph.D.
University of Nebraska Medical Center

John Lucas, Ph.D.
Mayo Clinic Jacksonville, Jacksonville, FL

Janet Grace, Ph.D.
Brown University, Providence, RI

Helene Yurk, Ph.D.
Independent Practice, Advance, NC

Robert Elliot, Ph.D.
Independent Practice, Manhattan Beach, CA

Catherine Stern, Ph.D.
Brown University, Providence, RI

Michael Basso, Ph.D.
University of Tulsa, Tulsa, OK

Jane Paulsen, Ph.D.
University of Iowa, Iowa City, IA

Rod Vanderploeg, Ph.D.
VAMC, Tampa, FL

Jeffrey Allen, Ph.D.
Wright State University, Dayton, OH

Joel Morgan, Ph.D.
VAMC, East Orange, NJ

Robin Hanks, Ph.D.
Wayne State University, Detroit, MI

Robert L. Mapou, Ph.D.
Independent Practice, Silver Spring, MD

Thomas Bennett, Ph.D.
Brain Injury Recovery Program, Colorado Springs, CO

**Division 22 Program for the
2000 APA Annual Convention**

Friday, August 4, 2000

- 8:00 - 9:50 International Experiences of Psychologists in Rehabilitation: Lessons Learned and Opportunities. Chair: Dale F. Thomas, PhD
- 10:00 - 11:50 Federally-Funded Research Opportunities for Rehabilitation Psychologists During the New Millennium. Chair: Denise G. Tate, PhD,
- 1:00 - 1:50 Work Incentives Improvement Act: Rehabilitating Social Security Beneficiaries. Chair: Stephanie Hanson, PhD
- 2:00 - 5:00 Business Meeting

Saturday, August 5, 2000

- 8:00 - 9:50 The Psychologist's Role in the Social Security Disability Process. Chair: Vito J. Dongiovanni, PsyD
- 10:00 - 11:50 Substance Abuse and Disability: Outcomes Research and Policy Implications. Chair: Allen W. Heinemann, PhD
- 1:00 - 1:50 Psychology's Understanding of Disability: An Exploration of Independent Living Philosophy. Chair: Linda R. Mona, PhD
- 2:00 - 2:50 Invited Speaker: Susan Daniels, Ph.D., Deputy Commissioner, Disability and Income Security Programs. Chair: Don Kewman, PhD
- 3:00 - 4:50 Presidential and Fellows Addresses
- 5:00 - 7:00 Division 22 Social Hour

Sunday, August 6, 2000

- 8:00 - 8:50 Long-term Neuropsychological Services in Rehabilitation Following Pediatric Brain Tumor. Chair: Peter L. Stavinoha, PhD
- 9:00 - 10:50 Employment and Disability Policy: The Role of the Psychologist. Chair: Susanne M. Bruyere, PhD
- 11:00 - 11:50 Len Diller Honorary Lecture: Denise Tate, PhD. Chair: Bruce Caplan, PhD
- 1:00 - 1:50 Enhancing Quality of Life Through Community-Based Interventions. Chair: Janet E. Farmer, PhD

Newsletter

- 2:00 - 2:50 Integrative Medicine and Psychology: Partnership for New Healthcare. Chair: Marie DiCowden, PhD. Invited Speaker: William Benda, MD
- 3:00 - 4:50 GME: Psychology's Greatest Training Opportunity. Chair: Robert Frank, PhD
- 5:00 - 7:00 Divisions 22 and 40 Social Hour

Monday, August 7, 2000

- 8:00 - 9:50 Low Functioning Deaf Adults: Status of Research and Service Provision. Chair: Cynthia J. Nickless, PhD
- 10:00 - 11:50 Global Psychological Practice: The Opportunities and Challenges of Internet Technology. Chair: Stephanie L. Hanson, PhD
- 1:00 - 2:50 Understanding Federal Reimbursement, Medicare, and CPT Coding. Chair: Diane M. Pedulla, JD
- 3:00 - 3:50 Recent Supreme Court Decisions and Disability. Chair: Alan Goldberg, PhD, JD
- 4:00 - 4:50 Poster session. Chair: Kristofer Hagglund, PhD

Sunday, August 6, 2000 - "Breaking Convention - - Changing Practice and Research"

- Practice Exhibition Assessment of Deaf Persons: Innovative Directions. Chair: Irene Leigh, PhD
- Telerehabilitation Initiatives: Leading Edge Programs for People with Disabilities. Chair: Laura Schopp, PhD
- Research Innovations in TBI. Chair: Bruce Caplan, PhD
- Workshop Challenging Traditional Views in Dealing with Diverse Populations. Speakers: Monica Pedemonte, PhD and TBA

2000 APA Convention
Division 40 Program

Session contents are listed by title (or first few words of title) of presentation/poster and name of first author

Friday 8/4/00

- 8-8:50 Education Advisory Committee Chair Kerry Hamsher.
Renaissance Washington DC Hotel, Meeting Room 2
- 8-8:50 Ethics Committee Meeting. Chair: Rick Naugle.
Renaissance Washington DC Hotel, Meeting Room 6
- 8-9:50 Poster Session I: Neuropsychological Assessment, Chair: Joseph Ricker.
Washington Convention Center, Hall A
- 9-10:50 Symposium: The Assessment of Driving Ability: Past and Future Directions
Chair: Maria Schultheis.
Renaissance Washington DC Hotel, Congressional Hall A
- 11-11:50 Paper Session I: WAIS and WASI session. Chair: Rod Vanderploeg.
Grand Hyatt, Franklin Square & McPherson Square Rooms
- 1-1:50 Paper Session: Cross-cultural, Language, and Ethnicity Issues in
Neuropsychological Assessment. Chair: Robb Mapou.
Grand Hyatt, Constitution Ballroom C
- 2-2:50 Invited Symposium: Division 40 Science Advisory.
Renaissance Washington DC Hotel, Renaissance Ballroom West B
Mesial temporal vs basal forebrain amnesia: Single vs multiple memory system(s)? Chair:
John DeLuca.
- 3-3:50 Paper Session: Assessing feigned impairment in head injury. Chair: Robin Hanks.
Renaissance Washington DC Hotel, Meeting Room 15
- 3-5:50 Division 40 Executive Committee Meeting.
Renaissance Washington DC Hotel, Meeting Room 2

Saturday 8/5/00

- 8-9:50 Poster Session II: Pediatric Neuropsychology. Chair: Paula Shear.
Washington Convention Center, Hall A
- 10-10:50 Outcomes Research I. Chair Mark Aloia.
Renaissance Washington DC Hotel, Renaissance Ballroom West A
- 11-11:50 Outcomes Research II . Chair Jeff Allen.
Renaissance Washington DC Hotel, Renaissance Ballroom West A
- 12-12:50 Div 40 Ethics Committee Discussion Hour. Chair: Rick Naugle.
Washington Convention Center, Meeting Room 25/26
- 1-2:50 Symposium: Neuropsychology, Face Recognition, and Race: Is There a Connection? Chair:
Melanie Talley
Washington Convention Center, Meeting Room 33
- 3-4:50 Symposium: New Approaches to Clinical Interpretation Using the WAISIII and WMSIII.
Chair: David Tulsky.
Washington Convention Center, Meeting Room 31

Newsletter

6-7:50 Education Advisory Committee Social Hour for Students.
Grand Hyatt, Arlington & Cabin John rooms

Sunday 8/6/00

8-8:50 Pediatric Neuropsychology Interest Group Chair: Keith Yeates.
Renaissance Washington DC Hotel, Meeting Room 16

8-8:50 Division 40 Science Advisory Chair: Russell Bauer.
Renaissance Washington DC Hotel, Meeting Room 5

8-8:50 Division 40 Practice Advisory Committee; Chair: Chris Grote.
Renaissance Washington DC Hotel, Meeting Room 4

11-11:50 Paper Session: Div 40 and Science Advisory Award Student Award Winners. Chairs:
Russell Bauer and Joseph Ricker
Grand Hyatt, Constitution Ballroom C & D

2:-2:50 Paper Session: Pediatric Neuropsychology. Chair Bob Elliott.
Grand Hyatt, Constitution Ballroom E

3-3:50 Presidential Address: Gordon Chelune; Chair: Cecil Reynolds
Grand Hyatt, Constitution Ballroom A

4-4:50 Division 40 Business Meeting. Chair Gordon Chelune.
Grand Hyatt, Constitution Ballroom A

5-6:50 Div 40 and Div22 Collaborative Social Hour; Sponsored by AGS, The Psychological
Corporation, and Psychological Assessment Resources Inc.
Grand Hyatt, Constitution Ballroom B

Monday 8/07/00

8:-9:50 Poster Session: Aging And Dementia; Chair John Lucas.
Washington Convention Center, Hall A

9:-9:50 Paper Session: Neuropsychology of Substance Abuse. Chair: Joel Morgan.
Washington Convention Center, Meeting Room 21

10-11:50 Paper Session: Neuropsychological Assessment. Chair: Joseph Ricker.
Grand Hyatt, Franklin Square & McPherson Square Rooms

1:-2:50 Paper Session: Geriatric Neuropsychology. Chair: Daryl Bohac.
Grand Hyatt, Constitution Ballroom C & D

APA Division 40 Program Committee 2000

Joseph Ricker, Ph.D., Chair
Kessler Medical Rehabilitation / UMDNJ, West Orange, NJ

Paula Shear, Ph.D., Co-Chair
University of Cincinnati, Cincinnati, OH

Mark Aloia, Ph.D.
VAMC/Brown University, Providence, RI

Continued on page 16

Tribute to Laird Cermak
Continued from page 1

Loftus, Morris Moscovitch, Malcolm Piercy, Larry Squire, and Endel Tulving. The conference holds a special personal resonance, because Laird graciously allowed me - then a graduate student at the University of Toronto working with Tulving - to participate in the entire meeting. I will never forget the experience: the discussions were consistently animated and sometimes contentious, but always filled with a sense of excitement that a new approach to studying and understanding memory and amnesia was beginning to emerge that would capitalize on the complementary strengths of cognitive psychology and neuropsychology. Cermak skillfully structured the meeting, gently guided the discussion, and carefully edited the resulting volume, entitled *Human Memory and Amnesia*, published by Lawrence Erlbaum Associates in 1982. There is no doubt in my mind that the Lake Morey conference and volume had a major influence on what followed in the 1980s and 1990s: sustained and productive interactions between cognitive psychology and neuropsychology that have contributed greatly to the impressive recent progress in research on human memory.

Laird Cermak made fundamental contributions to this new approach to memory in his usual modest style, taking quiet satisfaction in the field's success and generating new ways to promote it, such as the Memory Disorders Research Society. We all owe him a debt of gratitude that we can repay by honoring his work and his memory

Daniel Schacter
Department of Psychology
Harvard University
William James Hall
Cambridge, MA 02138

dls@wjh.harvard.edu
<http://wjh-www.harvard.edu/~dls>
Phone: (617) 495-3855
FAX: (617) 496-3122

How strange to be writing tributes for Laird Cermak. His death has been so premature, for he still had so much to offer, and was active in so many areas of our field. It still seems odd that we are talking about him in the past tense.

I was fortunate to have known Laird since the mid 70's, and it was always a treat to be in touch, whether by phone, e-mail, or hanging around at conferences. Laird could sometimes present in a somewhat shy manner, but that hid an underlying great wit and a real mensch. For one not trained as a formal 'clinician', he sure had the gift of observation and skill of reading all the pragmatics in an exchange, and, he knew to drop anything for a good joke.

He could seem like a deceptively regular guy. But as we know, Laird wasn't. I, like many, knew that he could resolve a bunch of jumbled issues into the one salient thread. That was part of his brilliance. He knew how to hierarchize what was relevant and what was not. He knew this about people and he knew it about content. And therefore, his contribution to the field reached far, both in the area of memory, as well as in his personal influence. He would always be there to help, by being a sounding board on career issues, or by providing guiding or running commentary about a paper's perspective not yet considered. He was the kind of person who was there to help, because it was just what one did. He never expected anything in return, perhaps with the exception of the obscure baseball or golf trivia. His kind of generosity was rare, but one that we can emulate. Laird, the researcher, made sure that the human perspective wasn't lost in his own work either. He and I had conversations about the treatment of subjects and the information that we had gathered (as researchers or as clinicians): data was to be considered a privilege. His amnesics were people first, then subjects; they deserved the same privacy, rights and consideration as anyone. Laird was, indeed, a very special type of person to have had working as a research psychologist.

With Laird's death, we've lost a great contributor and representative of this field. But, we've also lost one of the souls of neuropsychology. I, like so many of you, miss him as a colleague and wonderful friend.

Nancy S. Foldi, Ph.D.
Queens College, NY

A Tribute to Laird Cermak

Laird Cermak and his collaborator Nelson Butters were among the pioneers that helped shape and promote the field of neuropsychology and cognitive neuroscience. More than any of the other leading investigators of the neuropsychology of memory, Laird seemed more interested in promoting the field than in gaining acceptance for his own ideas. In this he succeeded admirably, and though he was modest about his own achievements, he made some important, lasting contributions.

I first met Laird briefly when he presented a paper on release from proactive inhibition in amnesia at the APA conference in Montreal in 1973 where I had just arrived to begin a post-doctoral fellowship with Brenda Milner. That paper was the inspiration for some of the research I conducted in Montreal, which served as the centerpiece of a paper I presented at a conference that Laird organized at Lake Moray in 1979. Those who attended that conference saw it as a watershed in research on memory; re-reading the proceedings of that conference today only reinforces that opinion (Cermak, 1982). Drawing on his own experience, Laird believed strongly that neuropsychologists and cognitive psychologists would benefit from having close ties with each other and, if possible, collaborating. The Lake Moray conference not only set the agenda for human memory research for the next 20 years, but created a bridge between cognitive psychology and neuropsychology that set us all on the road of cognitive neuroscience, the amalgam that the two fields have become today. That cognitive neuroscience has come to dominate the field of human memory research vindicated Laird's beliefs and repaid his efforts.

It was at that conference that I got to know Laird. His manner and even appearance changed little in the intervening years. I picture his hair, which remained enviably thick even as it turned gray, atop a twinkly, pudgy face. He was casual, friendly, gracious and generous, both as a host and as a scientist. He had a light touch in running the scientific meetings, letting discussions proceed with a minimum of guidance. To promote a sense of camaraderie and facilitate discussions, Laird made

sure that we had as much fun outside the meetings as in them. I remember jogging along country roads, having coffee and light meals on a porch overlooking the lake, and a round of golf with Dan Schacter, Endel Tulving, and Laird, in which I dropped out after the first few holes to let those who knew what they were doing proceed unencumbered. All this took place in a New England resplendent in its fall foliage.

Though not controlling, Laird never lost his sense of purpose which he conveyed unmistakably to the rest of us. One could say that the conference was such a success because it occurred at the right time, but I believe that most of its success was owed to Laird's organizational skills, good judgement, and exemplary character. He had a quiet, but tough, integrity that tolerated diversity without compromising excellence. I also learned that he had a strong sense of loyalty to his field and to his colleagues, which was returned in kind.

Laird continued to promote the field in other ways – by making the patients and facilities at the Memory Research Unit at the Boston V.A. readily available to other investigators (I know of no other memory researcher who was as generous and open with his or her laboratory), by organizing other conferences and workshops, by serving as Editor of Neuropsychology, and by establishing the Memory Disorders Research Society. In many ways, that Society was Laird's attempt to perpetuate the Lake Moray conference. Once a year, cognitive neuroscientists with different theoretical and empirical orientations meet to present papers and exchange ideas. It is the scientific meeting to which I and many others look forward to most, and it is one of Laird's enduring legacies.

Laird's own scientific achievements were many but two are especially noteworthy. He was among the first to advance the idea that memory depends on the level to which incoming stimuli are processed – the deeper the processing, the better the memory. The influence that the levels of processing framework had on memory research cannot be overstated, and although it is associated more with Craik and Lockhart (1979), Laird's publications preceded theirs (Cermak, 1971). In Laird's typical fashion, he and Craik later convened a conference on levels of processing (Craik and Cermak, 1979). The

second was Laird's proposal of a distinction between true autobiographical memory and personal semantics (what Laird termed personal folklore), those facts and stories that we know about ourselves that are similar in kind to facts and stories we know about the world. That distinction helped explain why some amnesic patients have remote, episodic memories that appear to be well-preserved whereas on closer examination, it is only personal semantics that are spared. The distinction also has become part of the Autobiographical Memory Inventory, which is the most widely-used test of remote memory (Kopelman, Baddeley, and Wilson, 1989).

The last time I corresponded with Laird was just before he entered the hospital for a bone marrow transplant. I apologized for not completing a book chapter, and asked if there is anything I could do to make up for it. He wrote back, "Shout out my name in a crowded conference room." There was never any need for that because everyone in our field knew Laird but to honor his memory, and his last request to me, I did just that at the most recent meeting of the MDRS. And I'll do it again now. "Laird Cermak, I wish you were here!"

Morris Moscovitch

Perspective: "the capacity to view things in their true relations or relative importance". Perspective was one of Laird's most important and admired qualities and was something that kept his very busy family life and work life in balance. As a mentor, Laird not only passed on to his students the technical aspects of being a top-notch research psychologist, he also, by example, passed on his sense of the things in life that are most important and that should be held most dear. He taught perspective. His intense dedication to all aspects of his life continues to be an inspiration to me. I am forever thankful that I was able to know and learn from such a remarkable man.

Regina McGlinchey-Berroth, PhD

I am very pleased to be able to join in paying tribute to Professor Laird Cermak, a colleague at the Boston VA Hospital for nearly 30 years.

I met Laird in 1970, while he still was a young assistant professor at Tufts University, Medford, MA. I already had been lured by Nelson Butters to work at the Boston VA, and it was Nelson who encouraged me to visit Laird to find out about their collaborative work (which had been ongoing for a few years). I remember our first meeting: Laird was young looking, with a full head of dark brown hair; he was low keyed; and he was clearly committed to a career in memory research. About a year later, Laird left Tufts to join the exciting group of scientists at the Boston VA Hospital.

Laird worked at the Boston VA for more than 25 years, and it is there that he wrote most of his seminal papers and books. During his Boston VA years, he made important contributions to research and practice related to memory disorders. Much of his early work with Nelson focused on amnesia from alcoholic Korsakoff's syndrome and herpes encephalopathy. However, Laird also studied patients with head injuries, stroke, and varieties of dementia.

His many honors include his being the recipient of the VA's Career Scientist Award for Excellence in Research; his election to the office of President of the Division of Clinical Neuropsychology of the American Psychological Association (APA), and President of the International Neuropsychology Society; his founding of the Memory Disorders Research Society; his leadership role in the NIH supported Memory Disorders Research Center; and his membership in numerous societies and editorial boards of professional journals. In his job as Editor-in-Chief of APA's publication, *Neuropsychology*, he helped to craft the journal into an internationally respected and scholarly reference.

Laird also was actively involved in many non-scientific activities. At the Boston VA, for example, when he and Sharon began having children, Laird created "Small World," the child care center that, to this time, still cares for the offspring of VA employees. Laird - a man so devoted to understanding the underpinnings of Memory - has left an indelible legacy.

Marlene Oscar Berman, Ph.D.
 Professor of Psychiatry, and Professor of Neurology
 Boston University School of Medicine
 Research Scientist, Boston VA Healthcare System

Laird Cermak was, above all else, a caring and gracious man. To be sure, he had a personal agenda for neuropsychology, and clearly harbored a closely-held set of values and viewpoints about the current and future of our field. By the time I got to know him personally, he had made seminal contributions to the study of memory disorders and represented, at least to me, one of the clearest examples of a scientist who was comfortable in working the borderland between cognitive psychology and neuropsychology. Laird practiced cognitive neuroscience before the term was broadly popular, but he seemed never really concerned with the political ramifications of his contributions. He simply did excellent work, over and over again, since his critical contribution, with Nelson Butters, on Korsakoff's syndrome in 1980.

I, like most contemporary neuropsychologists, am grateful for his empirical contributions to memory research, including incisive analyses of encoding deficits in certain forms of amnesia, his information-processing analysis of memory failures, and his pursuit of the processes underlying priming effects. This work continues within the Memory Disorders Research Center (MDRC) at Boston University/Boston VA, an interdisciplinary Center that his vision made possible. It also lives within the Memory Disorders Research Society, a collection of prominent memory researchers he initially assembled for purposes of advancing the field through mutual accountability, collaboration, and fellowship.

However, I think Laird's most important legacy is as a facilitator. He keenly understood the value of collaboration and nurturance in science, and played a critical role in developing the talents of other investigators who were drawn to him. He played a key role in the emotional development of many contemporary memory researchers, and thus advanced the field in unspeakable ways that are not reflected in CV's, grant portfolios, or other observable measures of productivity.

My personal contact with Laird came in the context of this facilitative role. At the time, I had published some work showing that psychophysiological responses could be used as indices of "implicit" memory and perceptual

processing, and he thought that this line of research would provide a useful supplement to the behavioral studies of priming that were then occurring at MDRC. I served as MDRC Visiting Scientist from June – November 1990, where I was given freedom to develop a research program, contribute to the renewal of the NIH MDRC grant, and, in my spare time, devise schemes to get Laird to accompany me for standing-room-only seats at evening Red Sox games. I succeeded in all of these tasks in proportion to Laird's generosity, forward-thinking, and fun-loving character. Some 10 years later, the residue of this experience remains on my skin, as I seek to facilitate others' growth through my own activities as the Director of Clinical Training at UF's Graduate program in Clinical and Health Psychology.

Thus, although I have almost reverent respect for Laird's literature contributions, his legacy, for me, is as a mentor. I believe that a dedication to research involves conceptual, physical, and spiritual commitments. Laird was good on 2 of 3, and good for him! Conceptually, Laird was a giant, a pioneer, and, although he may have been wrong on certain points, he certainly got others to think, produce important research products, and to react to his assertions. Physically, he was remarkably unimpressive, leaving work at 4:30 most days (lest the VA security guards ask him what he was doing in his office). His family also needed him, and he was there. Spiritually, he was a masterful leader, a visionary, and a true inspiration for those of us who knew him. I, for one, will miss his spirit the most of all.

Russell M. Bauer, Ph.D.,
University of Florida

Laird Cermak lived life with grace and humor. He was was, first and foremost, a dedicated husband and father. He had immense respect for his wife Sharon, his intellectual partner and “soul mate”. His children - Kendra, Michael, Bethany and Amanda- are his legacy. Some of us in the Boston area had the privilege of attending the bat mitzvah of his daughter Amanda which took place two days after Laird’s memorial service. Laird’s family and the whole congregation were in the initial stages of mourning and many of us could barely talk. Amanda, his 12 year old, was remarkably composed throughout the ceremony. Laird’s calm and gentle presence was there supporting her on the bima.

Laird also had a research family of which I am a proud member. The esprit de corps at the Memory Disorders Research Center, which he established in 1989, continues to reflect his integrity and his generosity. In his role as Director of the Center, Laird emphasized the importance of pursuing interesting research questions in thoughtfully. In an era when technology threatens to eclipse the theoretical underpinnings of many studies, I find myself yearning for the concept-driven question that Laird asked. When lecturing he often spoke without slides. The ideas mattered, not the display. Laird encouraged collaborative efforts between the many researchers in his group. He was the glue. He was a brother to many of us and a father figure to a good number of young research assistants who also mourn his loss. The pain that I feel at losing this wonderful man is compounded by my vicarious experience of the pain of many of my colleagues at the Memory Disorders Research Center. We will miss him for a very long time.

At the Memory Center, I have specialized in single case studies and, in that capacity, I can truly say that Laird was an N of 1: he was an independent thinker, a maverick, compassionate, irreverent, and very funny. Laird embodied many paradoxes. He was highly intellectual but derived a great deal of pleasure from pop culture. He was extremely busy but always had time to talk. He held a number of very public positions but was very private. He was held in high regard by everyone but was totally devoid of pretense. In light of Laird’s paradoxical nature it only seems fitting that I experience an unusual blend of emotions when I think of him. I feel a deep sense of sorrow but, at the same time, I find myself smiling.

Margaret O’Connor, Ph.D.

In January of 1984, I came to work for Psychology Research at the Boston VA Medical Center. When Dr. Harold Goodglass retired from the VAMC in 1986, Laird Cermak became the Director of Psychology Research. At that time I became Laird’s administrative assistant. Laird immediately made me feel comfortable in my new position. He was very respectful and was a great deal of fun to work with. He granted me a great deal of autonomy in carrying out my administrative duties at the Memory Disorders Research Center and as editorial assistant for Neuropsychology. I always felt that I was a valued member of his team. I was truly his assistant, rather than a secretary. I always felt engaged in my work with Laird. Every year I organized the annual Memory Disorders Research Society meeting. When deciding on locations for the meeting, Laird would come into my office and say “let’s go on a field trip and check out some of these places.” We had a great deal of fun on these adventures.

Laird often liked to talk about his family. He was so proud of them. He was always eager to tell a funny story about each one of them. He was also very interested in hearing about my family. Laird made coming to work such a pleasure. He was always so easy to work with. I worked for Laird for 17 years. He was a big part of my life and I will miss him.

Mary Fitzgerald

**Division 40 Contributes to
APA Legal Action Fund**

Keith Owen Yeates, Ph.D., Member-at-Large,
Division 40 Executive Committee
Deborah C. Koltai, Ph.D., Chair, Division 40 Public
Interest Advisory Committee

On March 24, Division 40 contributed \$10,000 to the Legal Action Fund of the American Psychological Association. Accepting the contribution were Ron Fox, Ph.D., Chair of the Committee for the Advancement of Professional Practice (CAPP), and Russ Newman, Ph.D., J.D., Executive Director of the Practice Directorate. The contribution was presented by Ida Sue Baron, Ph.D., on behalf of the Division 40 Executive Committee, at the spring consolidated meetings of the APA held in Chantilly, Virginia. Dr. Baron is one of two official CAPP observers recently appointed by Division 40.

The APA Legal Action Fund was established to provide financial assistance in legal test cases directed against selected managed care companies. The cases selected thus far have a direct bearing on the practice of professional psychology and also have broad public policy implications. The Legal Action Fund helps to defray litigation costs that are not included in the budgets of CAPP or the Practice Directorate. APA is currently pursuing four law suits, in partnership with state psychological associations:

In Florida, a suit was filed by Robert Brown, Ph.D., against Magellan CBHS Holdings, Inc., and Merit Behavioral Care of Florida. He alleges that Magellan arbitrarily terminated mental health services to his patients in retaliation for his efforts to enforce his agreement with the company. The amended lawsuit alleges interference with the doctor/patient relationship, fraudulent representation, and breach of contract.

In New Jersey, the New Jersey Psychological Association and seven individual psychologists filed suit against MCC Behavioral Care. They allege that MCC frequently terminates psychologists from its provider networks by

invoking the “no cause” termination clauses in its contracts in a manner that is against public policy, breaches agreements with its providers, is fraudulent, and harms both patients and providers.

In Virginia, the Virginia Academy of Clinical Psychologists, six psychologists, a patient, and a subscriber brought suit against Blue Cross/Blue Shield and its behavioral health subcontractors. They allege that Blue Cross/Blue Shield unilaterally and arbitrarily reduced provider fees in an attempt to pare down its network after first representing to purchasers and patients that the network contained a large, stable panel of psychologists.

In California, the California Psychological Association, along with two psychologists and two patients, filed suit against Aetna U.S. Healthcare and two of its subcontractors. The suit focuses on decisions made by the company that affect patient care and treatment (i.e., replacing psychotherapy with a limited crisis intervention). The complaint alleges that Aetna engaged in false advertising and other unlawful practices.

Division 40 is the first APA division to make a contribution to the Legal Action Fund. All previous contributions had been made by individual psychologists. The Division 40 Executive Committee voted overwhelmingly in favor of the contribution, following extended discussion regarding the import of the cases both for the practice of clinical neuropsychology and for professional psychology more generally.

In a letter to Gordon Chelune, Ph.D., President of Division 40, Dr. Newman thanked Division 40 on behalf of CAPP and the Practice Directorate, stating that they “could not have been more pleased and appreciative.” In expressing his gratitude, Dr. Newman said, “The Practice Directorate would have little hope of achieving its objectives in the health care arena without the effort of constituent groups like Division 40.”

Dr. Newman’s sentiments were echoed by Randy

Phelps, Ph.D., Administrative Director of the Practice Directorate, in a telephone interview. Dr. Phelps said that partnerships within the practice community are crucial for advancing psychology's efforts on the legal front and elsewhere. He stated that Division 40 had established a "very significant and important precedent" by making its contribution to the APA Legal Action Fund. Dr. Phelps added that the contribution was a hallmark of the growing relationship between Division 40 and the Practice Directorate.

More information about the APA Legal Action Fund is available in recent publications by the Practice Directorate and on the APA web site (www.apa.org). Any member of Division 40 wishing to make an individual contribution to the Legal Action Fund should send a check payable to "APA Legal Action Fund" to APA, Attn: Cash Receipts, 750 First St., NE, Washington, DC 20002-4242.



Russ Newman, Ida Sue Baron, Ron Fox

Executive Committee Meeting Minutes

continued from page 31

The EC was informed at the end of the meeting of the death of former Division 40 President Dr. Oscar Parsons. The EC extends its condolences to the Parsons family, and we mourn the loss of one of our field's leaders.

30. The EC will next meet in August, 2000 in conjunction with the APA Annual Convention in Washington, DC. There being no other business, the meeting was adjourned at 4:10pm.

Respectfully Submitted,
Ann C. Marcotte, Ph.D.
Secretary, Division 40

One of the responsibilities of the Ethics Committee of Division 40 is increasing members' awareness of the content of the *Ethical Principles of Psychologists and Code of Conduct*. In the spirit of serving that function, the following case study has been prepared by current and past members of the Committee to illustrate how aspects of the *Ethical Principles of Psychologists and Code of Conduct* might be used to guide decision-making

Forensic Assessments and Professional Relations

M.S. Macartney-Filgate¹ and W.G. Snow²

Neuropsychologists who conduct medicolegal assessments may encounter reports from other psychologists as well other health professionals which raise troubling ethical questions. While critiquing the methods and conclusions of other practitioners is a standard part of forensic practice, the situation is more challenging when review prompts concerns about professional practice and conduct. Does the neuropsychologist have an obligation to call attention to ethical violations encountered during the course of forensic evaluation and, if so, in what manner?

The following case scenario is a composite, based on situations encountered by the authors. It embodies several different types of ethical issues, but our principal aim is to promote discussion of how to appropriately respond to perceived ethical violations, a topic which is not explicitly discussed within existing ethical guidelines. The proposed solutions represent the opinions of the authors. We recognize that other resolutions may also be appropriate, depending on local regulations and standards.

Case Scenario

Ms. Smith was involved in a car accident, sustaining a right rib and right wrist fracture. Her GCS on ambulance arrival was 15, remaining 15 on transport and admission to hospital, where she was retained overnight in Emergency. She did not recall the actual impact, or events for 5-10 minutes thereafter, but there was no retrograde amnesia. There was no observation of cognitive or behavioral disturbance during her hospital stay, but she did report a headache. No CT scan or neurological consultation was obtained. She was discharged with a diagnosis of concussion, to be followed by her family physician.

Ms. Smith was 42 years old at the time of the accident. She had completed a Grade 9 education at age 15, with below average marks. She had been employed in factory assembly, and was raising three children as a single parent. Medical history was unremarkable except for one episode of depression 10 years previously, in relation to the marital breakup. The family physician's records noted occasional preaccident sleep disturbance, anxiety, fatigue and low back discomfort. There were also concerns raised about alcohol and prescription medication use.

Two months following the accident Ms. Smith was seen for psychological consultation by a clinical psychologist, Dr. First, on referral from her lawyer. Dr. First did not have any background or accident records, and did not request any, rather relying on a summary from the lawyer and Ms. Smith's report that she had been 'unconscious' for over 30 minutes after the accident. On the basis of an interview and without any formal assessment Dr. First concluded that Ms. Smith had sustained a 'significant' brain injury. He commenced therapy for treatment of the emotional effects of this and to assist in coping with ongoing pain. After four months of treatment with Dr. First, Ms. Smith showed little change. She had continuing complaints of attention and memory problems, word-finding difficulty, irritability, depression, sleep disturbance, fatigue, back and neck pain and headache. Characterizing the symptoms as typical long term effects of traumatic brain injury, Dr. First recommended referral to a neuropsychiatrist, Dr. Green, and to Dr. Cook for neuropsychological evaluation. The referrals were then made by Ms. Smith's lawyer. Dr. First continued treating Ms. Smith, as well as her daughter, who had also been involved in the accident.

Dr. Green saw Ms. Smith at six months post injury, and on the basis of a subjective symptom checklist, mental status exam and interview concluded that she had sustained diffuse axonal injury resulting in

permanent brain damage rendering her unemployable and posing an increased risk of early onset Alzheimer's disease. He also concluded that she had a severe depression, chronic pain syndrome and migraines. Dr. Green commenced treatment, including medication for pain consisting of large doses of Dilaudid and MS Contin. At 12 months post injury Dr. Green stated that Ms. Smith was severely depressed in response to her cognitive symptoms, and at times suicidal. He continued his treatment, with the addition of an antidepressant.

Dr. Cook trained as a clinical psychologist, but attended a couple of workshops in neuropsychology, subsequently offering neuropsychological evaluation and treatment services. Dr. Cook saw Ms. Smith for neuropsychological evaluation nine months post-accident, when the lawyer requested evaluation. Dr. Cook relied largely on the history as provided by the lawyer, Ms. Smith, Dr. First and Dr. Green. No preaccident records were reviewed or requested. Only very brief screening of emotional function was undertaken, no measures of effort or motivation were administered, and abbreviated versions of standard measures of memory and intellectual function were employed. Dr. Cook concluded that Ms. Smith had persisting neuropsychological deficits from traumatic brain injury and needed cognitive rehabilitation, basing his conclusions on below average scores on measures of attention, memory, rate of information processing and executive function. Dr. Cook then referred Ms. Smith on to his own clinic, where she received intensive cognitive remediation. After several months treatment she was described as performing better on computer based remediation programs, but with increased difficulty managing at home. Dr. Cook recommended more treatment and increased support services in the home. Following neuropsychological reassessment at 15 months post-injury Dr. Cook issued a report to the lawyer stating that Ms. Smith had serious neuropsychological deficits arising from brain injury incurred in the accident. He also stated that these were likely to be permanent, that it was unlikely she would be able to return to work, and that she needed ongoing assistance in the home. Dr. Cook never made any comment about the medication issues.

Dr. Ethics is asked to see Ms. Smith for assessment at 18 months post-injury. There has been little or no change in Ms. Smith's reported symptoms, despite continued treatment. She has not returned to work and continues to receive assistance with home making activities. Ms. Smith now believes that her situation is hopeless as she has irreversible brain damage, and at least on one occasion she has taken a medication overdose. Ms. Smith's lawyer objects to the proposed assessment as his experts all state that Ms. Smith is simply too fragile to undergo the stress of another evaluation, that it would disrupt treatment, and that her condition would likely deteriorate. Dr. Ethics is eventually able to conduct an assessment, but finds Ms. Smith to be virtually untestable because of complaints of fatigue, pain, and headache as well as marked psychomotor retardation.

Discussion

This case illustrates multiple ethical problems, among them dual and conflicting roles, rendering a diagnosis without adequate information and evaluation, practice outside the boundaries of competence, and inappropriate and potentially harmful treatment. However, for the purposes of this article our focus is on how Dr. Ethics should respond to the behavior of the other practitioners involved in the case. The following remarks provide an overview of what we see as the central issues, as space does not permit a detailed analysis of each point.

Dr. Ethics has strong feelings about the behavior of the other professionals involved with Ms. Smith. At the same time, Dr. Ethics realizes that strong feelings are no basis for ethical decision making, and that her course must be grounded in a system of ethics.

Dr. Ethics begins her deliberations about her own ethical obligations and how far they extend by analyzing her role in light of existing standards, including those of all professional organizations in which she is a member. Existing standards (APA, 1992) state that one provides services only within the context of a defined professional role. In this case her immediate role is to provide advice to the defense lawyer. Dr. Ethics understands that in acting

as an expert witness she serves not as a health practitioner whose function is to provide advice directly to Ms. Smith, but rather as an independent professional who provides advice to another party about Ms. Smith. Her primary client is thus the retaining lawyer, although her ultimate duty is to render an objective, unbiased opinion to the court. In her role as expert witness she needs to abide by legal standards and procedures in her jurisdiction. Courses of action that would be appropriate if she was providing health care services could be deemed as unethical or unprofessional in the forensic arena. Although the APA Standard concerning avoidance or minimization of harm to clients is typically interpreted within the context of a treating relationship, Dr. Ethics is functioning as a forensic expert and ill-considered decisions on her part could affect the interests of her primary client, the retaining lawyer, and impair her ability to advise the trier of fact. The Specialty Guidelines for Forensic Psychologists state that not only does she have a duty to understand the civil rights of parties in legal proceedings, but that she must also *...manage her professional conduct in a manner that does not diminish or threaten those rights* (Committee on Ethical Guidelines for Forensic Psychologists, 1991).

On the other hand, Dr. Ethics recognizes that she has ongoing professional obligations as a psychologist irrespective of her expert witness role. One of these obligations is to minimize harm to Ms. Smith, in view of her concerns about the treatments being provided. The APA standards also mandate duties to both the profession and the public, which must be taken into account in formulating her course of action. Dr. Ethics is aware that simply remaining silent on the issues risks discredit to the profession, and also potential harm to the public, in this case other individuals who may currently or in the future be treated by the other professionals.

As part of her analysis of the issues and attempts to reach a resolution Dr. Ethics secures a formal consultation with an experienced and respected colleague. In the course of this dialogue both Dr. Ethics and Dr. Consultant keep a formal, detailed record of the issues, the relevant standards, and their interpretation of these standards in Ms. Smith's

case. They note in particular that psychologists are concerned about their colleagues' ethical conduct and compliance, and that psychologists have a personal commitment to act ethically and to encourage ethical behavior by colleagues. As well, they are aware that forensic practitioners have a special responsibility for fairness and accuracy in public statements (such as reports).

The consultation adds weight to Dr. Ethics' concerns about the behavior of the other professionals. Dr. Ethics and Dr. Consultant agree she has a professional duty to in some form address her concerns, even though she is not in a treating or patient/practitioner relationship. This includes a duty to convey her concerns about Dr. Green's prescriptions. They then consider the manner in which Dr. Ethics can best address her concerns.

There are several parties who could be informed of the problems, among them Ms. Smith, Ms. Smith's lawyer, Ms. Smith's family physician, the retaining lawyer, the other professionals, and the professional regulatory bodies. Dr. Ethics and Dr. Consultant agree that although Ms. Smith is at risk for harm, it does not appear to be so imminent or severe that a direct report to her or her family physician is justified. Direct contact with Ms. Smith's own lawyer is clearly not appropriate. Although some standards of practice recommend informal resolution through contacting the errant psychologist directly and discussing the concerns, Dr. Ethics and Dr. Consultant conclude that, given the legal context, this would also be inappropriate. Dr. Ethics and Dr. Consultant consider whether the situations should be reported directly to the licensing bodies. Although existing standards suggest this course of action, Dr. Ethics and Dr. Consultant agree that it is inappropriate for her to personally do so, again in view of the outstanding legal issues. She is mindful of not jeopardizing the rights of any party, but especially her lawyer client, and the need to maintain impartiality in her role as expert, not taking on a new and potentially conflicting role as complainant to the licensing body. In their discussions on this point Dr. Ethics and Dr. Consultant have also noted that the situation is not one which is reportable by law (such as child abuse), and the risk of harm is not of such proportions to

warrant an immediate report. However, Dr. Ethics knows that a report to the licensing body remains an option for her after Ms. Smith's case is resolved.

Dr. Ethics and Dr. Consultant believe that Dr. Ethics' obligations would not be met by just discussing her concerns with the referring lawyer, although this would be an appropriate initial step. They are in agreement that she should document her concerns in her report. They do not believe that simply pointing out the weaknesses of the other reports, including the lack of evidence for the diagnoses and prognoses that have been rendered, constitutes an adequate response, particularly in view of the potential further exacerbation of Ms. Smith's symptoms by the treatment she is receiving.

Dr. Ethics then calls the referring lawyer, outlining the issues, her concerns and her understanding of her professional ethical obligations. In this discussion Dr. Ethics emphasizes that although she has a basis for believing that the other psychologists are in contravention of practice standards, Dr. Ethics herself must be careful not to enter into a dual or conflicting role, or become overly involved in the case by prejudging the issues and acting in lieu of the appropriate regulatory body. Dr. Ethics suggests that in view of the concerns the lawyer may wish to discuss the issues with the licensing boards, leaving this determination up to him (though from experience she knows the lawyer is unlikely to follow through until the case is resolved). Dr. Ethics does inform the lawyer that she feels obligated to comment on the issues in her report, but that the discussion is framed in terms of her individual opinion and concern about specific practice issues, and not as a final judgment about failure to meet accepted practice standards and ethical guidelines, such as might be rendered by a regulatory body.

In her written report Dr. Ethics explains why she believes it is likely that Ms. Smith's ongoing difficulties are in large part caused by the treatment she has received. She writes her report so that all potential readers, including Ms. Smith and her lawyer, will have a clear understanding of the issues at hand. She takes care to make her comments in an unbiased and dispassionate manner, so as not to slip into the role of advocate rather than expert.

Although she identifies the practices that raise concerns, she does not render an absolute judgment. Since she is not a physician, Dr. Ethics does not state that the medication is provided by Dr. Green is inappropriate but stays within her area of practice, discussing the issue in terms of the confounding effects of the medication on cognitive function, the potential for its use in a suicide attempt, and potential substance dependence issues. She recommends that the medication regimen be reviewed by an appropriately qualified physician, and that the family physician be made aware of the concerns.

As she sends off her report Dr. Ethics knows that while the ethical violations will not immediately cease, she has crafted a reasonable approach to a difficult problem, balancing her obligations as expert witness and as psychologist, and fully and carefully documenting her concerns and her actions. Her report will at least focus attention on the issues, and perhaps even prompt the other professionals to revise their practices.

References

American Psychological Association. Ethical principles of psychologists and code of conduct (1992). *American Psychologist*, 47, 1597-1611.

Committee on Ethical Guidelines for Forensic Psychologists (1991). Specialty guidelines for forensic psychologists. *Law and Human Behavior*, 15, 655-665.

DIVISION 40 EXECUTIVE COMMITTEE MEETING MINUTES

Wednesday, February 9, 2000

Adam's Mark Hotel

Denver, Colorado

Present: Artiola Baron, Bauer, Brandt, Chelune, Cullum, DeLuca, Fischer, Grote, Heaton, Mapou, Marcotte, Morgan, Naugle, Puente, Ricker, Shear, Van Gorp, Wilson, Yeates.

Absent: Berent, Blau, Boll, Cripe, Dede, Fennell, Hamsher, Meneese, Nemeth, Reynolds.

Invited Guest: Koltai

1. The meeting was called to order by Dr. Chelune at 1:02 pm.

2. Dr. Marcotte extended her thanks in advance to Dr. Keith Yeates for his invaluable assistance in recording notes during the meeting. Minutes of the Executive Committee (EC) meeting held in August, 1999 were reviewed and amended as follows. Item 23 (ASHA/Div 40 Task Force), delete last line. Typographical errors noted in item 30, change "sent" to "send", and item 7, change "as" to "was". With these modifications, the Minutes were approved.

3. Dr. Marcotte reminded all EC members that the Spring Mailing would be sent to Division 40 members in early April, and she encouraged anyone with announcements to forward them to her. The mailing will include an update to the membership from Dr. Chelune, a request for new committee members, nomination statements, highlights of the Division 40 Program at APA, and announcements. Dr. Marcotte also report that the Division 40 Annual Report was submitted to APA on January 26, 2000. Copies of the Report were circulated to the EC members for review.

4. Treasurer's Report: Dr. Van Gorp presented the Treasurer's Report for the fiscal year 1999. Dr. Van Gorp reported that Division 40 continues to be in excellent financial state. As of December 31, 1999, Division 40 had total assets of \$215,514.56 (\$175,413.20 cash on deposit at APA; \$40,101.36 in a Certificate of Deposit at Southern Pacific Thrift and Loan). Preliminary expenses for 1999 (some December, 1999 expenses were still pending) totaled \$44,615.25, well within the fiscal budget of \$62,315.00.

Dr. Van Gorp reviewed the Fiscal Budget for 2000

approved by the EC in August, 1999. A proposal was made to provide a one-time amount of money to aid in the training of the incoming Secretary (the person to be decided in the spring elections) and to assist in the transfer of Divisional materials. Dr. Marcotte was asked to present a budget to Drs. Van Gorp and Chelune for review. Additional line items were proposed to fund the travel expenses of the two Division 40 Observers to the Committee for the Advancement of Professional Psychology (Drs. Baron and Craig to prepare a budget), and the representatives to the Interdivisional Health Care Committee (Dr. Marcotte to prepare a budget). Dr. Bauer requested the monies allocated to the Science Advisory Committee be raised from \$2500.00 to \$3000.00. An increase was also proposed for the Membership Committee given rising costs associated with mailings (Dr. Meneese will be asked to submit a revised budget to Drs. Van Gorp and Chelune). Dr. Fischer indicated that the ASHA/Division 40 Task Force may seek to disseminate their report upon completion and may require funds to do so; she will keep the EC informed. The Awards Committee needs to have \$1000.00 allocated for the Division 40 Early Career Award on an annual basis. The Education Committee budget of \$4,000 was approved by the EC approved in August, 1999. A motion was made to approve the modifications of the 2000 Fiscal Budget as discussed, and the motion carried.

5. Dr. Chelune prepared a summary of Divisional activities since August, 1999. He has appointed several new Committee Chairs (Dr. Deborah Koltai for Public Affairs, Dr. Richard Naugle for Ethics, and Dr. Christopher Grote for Practice) and two observers (Drs. Ida Sue Baron and Paul Craig) to the APA Committee for the Advancement of Professional Psychology (CAPP). Drs. Chelune and Baron attended the Fall meeting of CAPP to present the Division's concerns regarding GME funding via allied health care, and the exclusion of fellows. The Division has also made formal response to a number of APA requests for feedback on proposed documents (BPA Test User Qualifications Standards, HHS regulatory proposal concerning medical record privacy, and BPA and BSA Criteria for Evaluating Treatment Guidelines), and responded to the APA Publications and Communications Committee

seeking a new Editor for *Neuropsychology*. The Division has also assisted members in Maine on issues pertaining to the use of technicians. Drs. Chelune and Grote attended an Executive Workshop held at NAN regarding HCFA and CPT codes. Ongoing projects highlighted included: a practice survey to be conducted jointly by Division 40 and NAN, a Medicare Carriers listing to be posted on the Division's website, and the outcomes theme for the Division's Scientific Program for the APA 2000 Convention.

6. Council Representatives' Report: Drs. Puente made the following report, noting that Council will meet toward the end of February. States have been gaining increasing power within Council. Dr. Puente reviewed materials for the upcoming meeting. Dr. Puente offered suggestions as to how Division 40 might bring forward motions for future Council action on important issues, such as the use of technicians in neuropsychological and psychological practice. Dr. Chelune requested that the Division Council Representatives prepare a report after the February meeting for review.

7. Newsletter: Drs. DeLuca and Morgan reported that the Winter/Spring edition of the *Newsletter 40* is now available for members to review on the Division's webpage (www.div40.org). Drs. DeLuca and Morgan were thanked for their efforts in achieving this important goal. The Newsletter is also now being mailed directly to the Division 40 Archives. The deadline for submissions for the Summer/Fall edition is May 1, 2000. A tribute to honor the memory of Dr. Laird Cermak is planned for the upcoming edition.

8. Membership: Dr. Marcotte presented a written report prepared by Dr. Meneese who was unable to attend the meeting. Dr. Meneese presented the names of 70 applicants to the EC for membership in Division 40 (30 Members, 40 Student Affiliates). Dr. Meneese reported the small pool was due to delays by APA in providing him with names due to computer problems. He received over 400 new names for processing the week prior to the EC meeting, which will be presented in August, 2000. The EC voted to accept all of the applicants. The newly elected members will bring the Division 40 membership to 4362 Fellows, Members and Associate Members, and 213 student affiliates.

9. Nominations: Dr. Marcotte reported for Dr. Reynolds, who was unable to attend but who submitted the following report. In the upcoming elections, the following positions will be open:

President-Elect, Secretary, Treasurer, Member-at-Large and one Council Representative. The Division maintained its four Council Representatives in the Fall apportionment vote. A Call for Nominations was sent to all voting members in December, 1999. Five members received enough votes from the membership to have their names placed on the ballot. The Nominations Committee, Chaired by Dr. Reynolds and including former Presidents, Drs. Robert Heaton and Carl Dodrill, solicited additional members for candidacy to positions so that two names appear for each position as mandated by Division Bylaws. Ballots will be mailed to members directly from APA on or around April 17, 2000.

10. Fellows: Dr. Marcotte presented the following report for Dr. Berent who was unable to attend. The Fellowship Committee received completed applications for Fellowship status from 9 members (7 men, 2 women; two applicants already are Fellows in other Divisions). The Committee is currently reviewing the applications and will send on their recommendations to APA by the February deadline. Dr. Berent also reported that certificates will be made to honor Fellows within the Division.

11 Program: Drs. Ricker and Shear presented the tentative 2000 Division 40 Program to be held in Washington, DC in conjunction with the Annual Convention of the APA, August 4 - 7, 2000. A total of 104 submissions were received for review; the acceptance rate was 70%. Submissions were down from previously years, and this trend was noted in most all Divisions. A special call had been made for research on outcomes, and there will be two paper sessions devoted to this topic in the program. The committee used a new rating system in reviewing submissions. This year's Student Award recipient is Timothy Crowell, whose award winning submission, "Consolidation versus retrieval deficits in traumatic brain injury" was co-authored by colleagues at the Tampa VAMC. Blue Ribbon awards for top submissions will be awarded to Erin Holker and colleagues (Mayo Clinic), Malcolm Dick and colleagues (UC Irvine) and Courtney Peters and colleagues (Brown University). A Social Hour will be held with Division 22 on Sunday of the Convention, and is being sponsored in part by Psychological Assessment Resources, The Psychological Corporation and American Guidance Services.

12. Awards Committee: Dr. Baron reported that the 2000 Benton Lectureship will be delivered at the Convention by Dr. Muriel Lezak. This fall, the Division was notified of the discontinuation of

funding for the Levitt Early Career Award, and the Division EC voted to maintain the award as the Division 40 Early Career Award, using the same criteria used in the past. Dr. Baron reported that there were no submissions for this year's award. The EC discussed ways of increasing applications for next year, including soliciting nominations from the membership and contacting those nominated to apply versus the current mechanism of self-nomination. The Awards Committee will work this spring with the American Psychological Foundation to select the student recipients of the awards in honor of Henri Hécaen and Manfred Meier. An announcement seeking nominations will appear in the Spring Division 40 mailing.

13. Ethics: Dr. Naugle reported that the Committee has provided feedback to the APA Task Force on the Ethical Code, and Dr. Naugle will act as a Monitor to this APA Committee. The Ethics Committee is sponsoring a Discussion Hour at the APA Convention. They will also be contributing a column to appear in *Newsletter 40*.

14. Science Advisory: Dr. Bauer reported that the Science Advisory Committee in collaboration with the Program Committee has organized an invited symposium for this year's Annual Convention, entitled, "Basal Forebrain vs. Medial Temporal Lobe". Dr. Bauer also announced this year's recipients of the two Science Advisory Committee's Awards for student submissions to the convention, Kathryn Lockwood (Clinical Neuropsychology) and Paul Newman (Cognitive Neuroscience). The Committee has begun work on organizing information pertaining to funding for research, which it hopes to have available on the Division's webpage.

15. Education Advisory: No report.

16. Public Interest Advisory: Dr. Wilson circulated copies of a new brochure prepared by the Public Interest Committee on Clinical Neuropsychology. The EC discussed possible dissemination plans, and Dr. Van Gorp suggested it might be a good investment for the Division to invest revenue in making copies of the brochure available to the membership. Dr. Wilson introduced Dr. Deborah Koltai who will be replacing her as Chair of the Public Advisory Committee at the end of this EC meeting. Dr. Chelune thanked Dr. Wilson on behalf of the Division for her service for the past three years as Chair of this Committee.

17. Practice Advisory: Dr. Grote presented a

summary prepared by Dr. Bieliauskas pertaining to the work of the ad hoc Task Force on "Incident To", which reports to the Practice Advisory Committee (PAC). The PAC provided feedback to Dr. Chelune on two APA documents, "Test User Qualifications" and "Criteria for Evaluating Treatment Guidelines". PAC members have also created a document summarizing the websites and mailing addresses for each of the 22 Medicare Carriers, which will be posted on the Division's webpage. The PAC plans to meet during INS to discuss possible restructuring of this important committee. Dr. Grote also reported for the Division's Federal Advocacy Coordinator (FAC) with the APA Practice Directorate, Dr. Dan Eubanks. He has alerted Dr. Grote of two APA Action Alerts, but they have not yet been received. The importance of receiving these Action Alerts in a timely manner was discussed. Dr. Chelune thanked Dr. Grote on behalf of the Division for the committee's work these past few months.

Dr. Baron reported on her observations of the recent meeting of the APA Committee on the Advancement of Professional Psychology (CAPP), highlighting many issues of importance for the Division. Dr. Paul Craig will be joining her in March, 2000 for the next meeting as the Division's other Observer. She will work with Dr. Chelune in identifying roles the Division should be pursuing.

18. Interdivisional Health Care Committee: Dr. Marcotte attended the IHC meeting in January, 2000. The IHC has continued to work to move the CPT codes developed for the delivery of psychological/behavioral medicine services in health care settings toward approval by the American Medical Association. These codes are to be presented for possible passage to the AMA in the next few weeks. The IHC member Divisions' representatives also reviewed the "Criteria for Evaluating Treatment Guidelines" for APA, and wrote a joint summary letter of commentary. The IHC discussed the Work Incentives Improvement Act and "Ticket to Work" legislation recently enacted by Congress. A request was made by the IHC to have CAPP take up this important matter in March, and that APA Practice Directorate Staff be assigned to monitoring and interfacing if possible with the Social Security Agency, which will be implementing this program. Those interested in learning more about this legislation can review materials on the following website:
http://www.house.gov/ways_means/fullcomm/106cong/fc-16act.htm

19. CPT Code Task Force: Dr. Puente commented

on Dr. Marcotte's update on the CPT codes proposed by the IHC for Behavioral Health Evaluation and Treatment, and on behalf of APA. He will be presenting them for approval to the AMA in the next few weeks. Limitations of the current CPT system were discussed, including a need for unbundling technical versus professional services in neuropsychology. The need to document activities was highlighted, as Dr. Puente reported that more audits may be occurring in the future. Dr. Puente's presentation at NAN on CPT codes is now available for review on the NAN webpage.

20. Division 40 Archivist: Dr. Marcotte presented a report for Dr. Nemeth who was unable to attend the meeting. She has met with the LSU Curator of our archives, Ms. Elaine Smith, who reports that prior problems with digitizing materials have been resolved. Approval was received by Dr. Cecil Reynolds, Editor of *Archives of Clinical Neuropsychology* to place The Houston Conference documents in the collection. Another appeal for past Presidents of the Division to donate their papers was made.

21. ASHA/Division 40 Task Force: Dr. Fischer reported the Task Force has continued to work on a document pertaining to collaborations and referrals between speech language pathologists and clinical neuropsychologists. A draft of the document, written by Drs. Diane Paul-Brown and Joseph Ricker was circulated. The Committee hopes to finalize this draft in the very near future and will then look to disseminate it appropriately.

22. Minority Affairs: Dr. Dede was unable to attend the meeting but submitted a written report for review, that included a listing of the committee's current members. The Committee met in August, 1999 and communicate via e-mail on matters. There is interest in developing a bibliography of articles on issues in assessment of ethnic minorities. This could be placed on the Division's website. The committee is also pursuing the development of a student award to be presented to an ethnic minority student member. The committee has been discussing this possibility with Dr. Baron, Chair of the Awards Committee and Dr. Stuss, a member of the Awards Committee. The goal is to have the first award presented at the 2001 Convention.

23. Committee on Empirically Supported Practice: Dr. Heaton submitted a preliminary draft of a document under review by the COESP outlining projects this committee seeks to sponsor. He has been exploring with various journals their interest in

possibly publishing these papers. The EC was asked to provide Dr. Heaton with any feedback and suggestions. He hopes to have this information distributed to the Division membership in the next few weeks.

24. Division 40 Representative to the APA Committee on Gay, Lesbian and Bisexual Concerns (CGLBC): Dr. Mapou reported that there was no CGLBC meeting this cycle. He has reviewed the committee's work and reports there are few issues germane to neuropsychology under discussion at this time. He suggested that this Liaison might best be subsumed under the Minority Affairs Committee; this idea was tabled for future discussion.

25. Division 40 Representative to the APA Committee on Women: Dr. Shear continues to monitor this APA Committee, and reported few if any items of interest to clinical neuropsychology are under current discussion. Dr. Shear presented some information pertaining to women in neuropsychology. According to 1997 APA data, women comprise 50% of students earning doctorates in the neurosciences, and 71% of those earning clinical degrees are women. However, within Division 40, only 35% of the total membership are women. Within the Division's leadership, women comprise only 18%, which ranks the Division 40 as the 5th lowest within all of APA for this statistic. She also reviewed the gender distributions of editorial board membership for many neuropsychology-related journals, and found women to be disproportionately represented. Ways of increasing the presence of women in leadership positions within the Division and within the field were briefly discussed.

26. International Liaison: Dr. Lidia Artiola presented a proposal to join the Division's efforts on international issues with those undertaken by the INS International Liaison Committee. The EC voted to approve this proposal.

27. Other Business: Dr. Chelune will be considering reconstituting the Division's Planning Committee, and this matter will be discussed and voted on via e-mail by the EC. He is proposing holding a Planning meeting this Spring, possibly at APA Headquarters. The EC will also discuss via E-mail an appeal made by the Practice Directorate seeking donations to support its litigation efforts directed to preventing abuses of psychology by managed care and securing a patient's bill of rights. Dr. Keith Yeates has been nominated by the Division for consideration to serve on APA's CODAPAR Committee.

Newsletter 40 is the official publication of Division 40. The Editor is John DeLuca, and the Associate Editor is Joel Morgan.

Dr. DeLuca's address is
Neuropsychology and Neuroscience Laboratory,
Kessler Medical Rehabilitation Research and Education
Corporation,
1199 Pleasant Valley Way, West Orange, NJ 07052.

Dr. Morgan's address is
Neuropsychology Service,
VA Medical Center, 385 Tremont Ave.,
East Orange, NJ 07019.

Division 40's Website is: www.div40.org.

Webmaster is Dr. Lloyd Cripe.