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Division of Clinical Neuropsychology Newsletter 40

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Who Do They Think They're Kidding: A Review of the Use of Symptom Validity Tests with Children

Martin L. Rohling, Ph.D.
University of South Alabama

Introduction

The question arises: Why do we need to assess symptom validity in children? Clinical lore posits that children are unable to consistently and purposefully exaggerate or feign cognitive impairment because of their level of cognitive development. Specifically, neuropsychologists reason that most children are unaware of the complexities of a neuropsychological test battery and thus, they are unable to "outsmart" the examination or the examiner. Theoretically, then, children's attempts to feign impairment, in the unlikely event that they did occur, would be easy to detect because of their unsophisticated nature. Moreover, the skilled child examiner is expected to be able to intervene immediately, either through confrontation and/or improved rapport, to ensure valid and interpretable data is obtained.

However, more recently, Courtney, Dinkins, Allen, and Kuroski (2003) noted that children can and do engage in suboptimal performance during examinations (see also, Baron, Fennell, & Voeller, 1995, pp 157-159). Furthermore, some children have also been found to engage in frank malingering (Lu & Boone, 2002; Oldershaw & Bagby, 1997). These findings suggest that this phenomenon needs to be assessed routinely in children being examined by neuropsychologists.

Detecting Suboptimal Performance in Children

But, how good are neuropsychologists at determining when children are performing invalidly? In general, many researchers (Dawes, Faust, & Meehl; 1989; Garb & Schramke, 1996; Swet, Dawes, & Monahan, 2000; and Trueblood & Binder, 1997) have found that in a variety of contexts, clinicians are over confident of their clinical skills, believing themselves to be more capable than objective data supports. Specifically with regard to detecting malingering, Heaton, Smith, Lehman, and Vogt (1978) found that clinicians are relatively poor at detecting suboptimal performance in adults. Research on the degree to which clinicians are able to detect suboptimal performance in children has been sparse. However, Faust and colleagues (Faust, Hart, & Guilmette, 1988; Faust, Hart, Guilmette, & Arkes, 1988) have reported that clinicians are also relatively poor at detecting suboptimal

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<http://www.lib.lsu.edu/special/findaid/apa/print.html>

From The Editor

Dear Division 40 Members,

After nine years of involvement with Newsletter40 as associate editor and editor, it is now time to move forward. It has been a great pleasure and distinct honor to have served the division and the profession in this capacity and I feel most fortunate to have had the opportunity to do so.

I greatly appreciate the trust placed in me by the Division 40 Executive Committee(s) for whom I have served, and wish to thank every member of each of the nine EC's for affording me the freedom and privilege to change the Newsletter and try new formats, columns, and articles. I also cannot thank enough each of the authors who graciously agreed to provide a myriad of manuscripts on diverse topics of interest to our readers. I could not have done it without you. Literally.

Over the years many of you have been very kind with your comments about the shape that this publication has taken and I want all of you to know how appreciative I am concerning those kind words. Thank you all for your generosity and loyalty.

I leave the Newsletter in the able hands of Dr. Nancy Chiaravalloti, who served so well as Associate Editor, and will now take over the reigns as editor. I know she will do an absolutely outstanding job.

Thank you all so much.

Joel E. Morgan, Ph.D.
Editor

**Recovery from mild traumatic brain injury:
Lessons learned from the study of sports-concussion**

William B. Barr, Ph.D., ABPP
NYU Comprehensive Epilepsy Center
New York University School of Medicine

Michael McCrea, Ph.D., ABPP
Neuroscience Center, Waukesha Memorial Hospital,
Medical College of Wisconsin

How long should it take a person to recover from the effects of an uncomplicated mild traumatic brain injury (MTBI)? This is a question that is posed commonly to neuropsychologists working in a variety of clinical and forensic settings. Available evidence indicates that most individuals experiencing a MTBI will exhibit a full recovery within three-months of the injury, with a minority of individuals continuing to experience symptoms for a much longer period of time (Binder, 1997; Levin, Mattis, Ruff, Eisenberg, & Marshall, 1987). For this subgroup of MTBI patients with persistent symptoms, a major issue becomes, when do the "neurological" effects subside and other, more "psychological", effects begin to take over?

One approach to answering that question has been to divide the recovery from MTBI into two stages. Few will deny that, by definition, there must be an acute stage of injury resulting from some form of biomechanical trauma. This is often accompanied by headache, dizziness, and cognitive symptoms believed to be caused by the direct pathophysiological effects of the injury. An undetermined number of individuals passing through this acute stage will then progress into a subsequent stage of recovery, characterized by a profile of chronic symptoms that is emblematic of the post-concussion syndrome (PCS). There are many that believe that PCS is the primary result of psychological factors superimposed on the resolving physiological effects of the injury (Binder, 1997; Mittenberg, DiGuilio, Perrin, & Bass, 1992).

There is, of course, much significant debate regarding details of the nature and course of recovery from MTBI. Much of the controversy focuses on the expected length of symptoms and the likelihood of experiencing persistent "neurological" effects of an injury (several months or more after its occurrence) in patients without positive findings on neuroimaging. Progress in the field has been hindered by a lack of empirical evidence to guide clinical and forensic decision-making. The methodological difficulties inherent to performing controlled investigations of MTBI victims of motor vehicle accidents and work-related injuries are well known. There has been a need to study the effects of head injury longitudinally in a controlled sample with a high prevalence of brain injury and a lack of motivational influences (e.g., secondary gain) associated with the effects of impending litigation. For many of these reasons, the field of neuropsychology is now turning to studies of sports concussion.

While neuropsychological tests were used in studies of athletes in the 1960's and 1970's, the model used in most sports settings today can be traced to the pioneering work of Barth and colleagues with collegiate athletes in the 1980's (Barth et al., 1989; Macciocchi, Barth, Alves, Rimel, & Jane, 1996). In their development of the "Sports as a Laboratory Assessment Model" (SLAM), this group was the first to administer a baseline battery of neuropsychological tests to large numbers of athletes prior to competition and over the course of recovery after a sport-related concussion. Repeat testing was conducted on both injured athletes and matched controls. Results from their early studies provided evidence that neuropsychological testing is sensitive to the effects of sports concussion and that the length of symptoms

is time-limited, with significant recovery occurring within a period of ten days (Barth et al., 1989; Macciocchi et al., 1996). The SLAM has become the paradigm for neuropsychological applications in other settings, with similar programs in use with athletes ranging from youth to professional levels (Echemendia & Julian, 2001; Erlanger, 1999; Lovell & Collins, 1998).

Results from two studies recently published in JAMA using methodology consistent with the SLAM provide important empirical findings regarding the nature and course of recovery from concussion. McCrea and colleagues studied a sample of 1631 collegiate football players over three seasons of athletic competition (McCrea et al., 2003), Ninety-four of these athletes sustained a concussion during either practice or a game. All injured players underwent detailed assessment with standardized measures of symptoms, postural stability, and

experiencing a concussion exhibited impairments in cognitive processing speed and verbal fluency during the first week after concussion, but no sign of lingering neuropsychological impairment 3-months postinjury. An accompanying article indicates that athletes with a history of previous concussion from this same cohort are three times as likely to sustain a concussion than those with no history of concussion (Guskiewicz et al., 2003). Injured athletes were at greatest risk of sustaining a repeat concussion within 7-10 days of their initial concussion, suggesting a period of cerebral vulnerability (or lower threshold for concussion) during the acute postinjury recovery phase. The findings also indicate that these athletes with prior concussions also take longer to recover from their symptoms. (See Figure 1)

Findings from these articles are similar to previous findings regarding the presence and nature

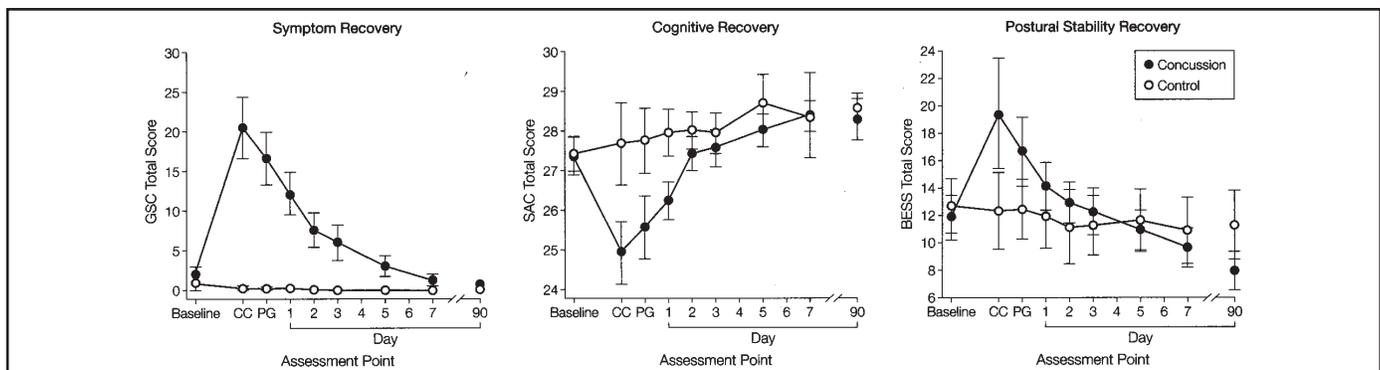


Figure 1
Symptom, cognitive, and postural stability recovery patterns in collegiate football players following concussion and matched controls (Reprinted with permission from JAMA, 290, 2556-2563, Copyrighted © 2003, American Medical Association. All Rights reserved).

cognitive functioning immediately after the injury, at 8 additional timepoints within the first seven days, and 90 days after concussion. Comparisons were made between data obtained from these athletes and those from a sample of matched controls, who were administered the identical protocol. The recovery curves in Figure 1 demonstrate a gradual improvement in all of these measures over a period of 5-7 days. By that time, 91% of the injured athletes reached a full symptom recovery and had no residual impairments on standardized tests of cognition and balance.

The study participants also were administered a battery of neuropsychological tests administered at 2, 7, and 90 days following the injury. Athletes

of symptoms of brain dysfunction in athletes within the first week following concussion (Collins et al., 1999; Echemendia, Putukian, Mackin, Julian, & Shoss, 2001; Macciocchi et al., 1996), and with those obtained from studies using animal models of concussion. In laboratory studies, a mild injury to the brain is thought to elicit a complex cascade of neuronal events including accelerated glycolysis that persists over a period of 7-10 days (Giza & Hovda, 2001). This sequence and time course is depicted in Figure 2. Many of the acute symptoms occurring during that time period are thought to result from a mismatch between the brain's increased energy demands and a reduction in cerebral blood flow. There is also evidence of other neurophysiological

factors, such as increased lactate production, that might be responsible for the increased susceptibility of athletes prone to the effects of an additional concussion. The time course of recovery and increased susceptibility described in the recent studies of collegiate football players is very similar in nature to the pattern described in the animal models, suggesting that similar mechanisms might underlie the expression of acute symptoms in humans. The findings from animal and athlete studies converge to indicate that the physiological effects of MTBI have a limited course, with a recovery of acute symptoms expected within a week to ten days. (See Figure 2)

There is clearly a lack of consensus regarding the origin and nature of symptoms occurring in those

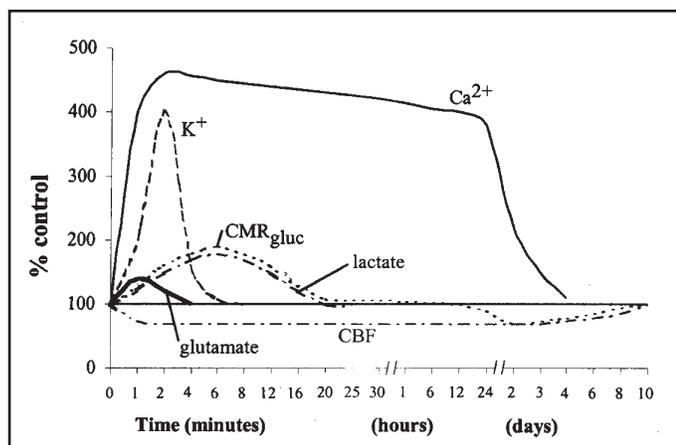


Figure 2
Neurometabolic cascade following experimental concussion. K⁺, potassium; Ca²⁺, calcium; CMR_{gluc}, oxidative glucose metabolism; CBF, cerebral blood flow. (Reprinted from *Neurologic Athletic and Spine Injuries*, Giza & Hovda, Ionic and metabolic consequences of concussion, pp. 80-100, Copyright 2000, with permission from National University Health Sciences.

individuals experiencing symptoms of PCS extending well beyond the acute stage of injury. Some argue that persisting symptoms are the result of the permanent neurological damage developing secondary to mechanisms such as diffuse axonal injury (Bigler, 2001, 2003). Others counter with the argument that much of the syndrome is influenced by conscious or underlying motivational factors related to financial incentives or other sources of secondary gain (Binder, 1997; Lees-Haley, Green, Rohling, Fox, & Allen, 2003). There are also those

that consider PCS as highly influenced by psychological factors related to somatization, mood disorder, or a tendency to misattribute commonly experienced symptoms to the effects of concussion (Mittenberg et al., 1992). Recent studies have examined the latter issue in studies of athlete samples.

Ferguson and colleagues examined ratings of PCS symptoms in a sample of 209 athletes, including 59 that had experienced a concussion within 6-months of the study (Ferguson, Mittenberg, Barone, & Schneider, 1999). All completed a 30-item symptom checklist. Injured athletes showed no difference in current symptom levels in comparison to the non-injured control group. However, they did, as a group, underestimate the level of baseline symptoms that were present before the injury. The findings indicate that injured athletes show a tendency to overestimate changes in symptom level after injuries in a manner that is consistent with symptom expectations. Another study found that athletes have a general expectation for a healthy recovery from concussion, which differs from the types of expectations observed in other groups (Gunstad & Suhr, 2001). Findings from these studies might explain some of the psychological factors that make an individual susceptible to experiencing symptoms of persistent post-concussion syndrome.

We are now seeing a number of exciting new findings from studies of concussion in athletes. Some of these may change the way that neuropsychologists conduct assessments and treatment of MTBI in the general population. Critics of sports concussion studies have suggested that athletes comprise a very select group of individuals that differ in many physical, psychological, and motivational characteristics from most other patient groups. They argue that results from studies of these highly conditioned individuals cannot be applied to individuals suffering injuries in other contexts. Counter arguments aside, it appears that at this point, the SLAM provides the best method we have to conduct controlled investigations of the effects and natural history of MTBI.

Findings from these recent studies provide good support for a two-stage model characterized by a relatively brief stage of acute physiological effects in

the order of several days, followed in some by longer lasting effects that are likely influenced by a range of psychological or motivational factors. One of the major challenges will be to adapt this methodology for use with non-athlete samples to provide critical information regarding the early effects of concussion secondary to other forms of injury. Many are eager to see what comes next in studies of MTBI in athletes and in other populations.

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Attending to APA: The 2004 Consolidated Meetings

Deborah Koltai Attix, Ph.D.
Chair, Public Interest Advisory Committee

Clinical Neuropsychology is an exciting, dynamic, energetic field. We are constantly evolving, defining ourselves, our practice, and moving forward in our clinical work and science. We hold, I believe, a distinguished seat amongst our peers in the psychology world. What we lack at times is an appreciation of how we fit into this world and why it is of the greatest importance for us to attend to it.

Division 40 (Div40; Clinical Neuropsychology) of the American Psychological Association (APA) boasts over 4,000 members and affiliates. APA as a whole currently has approximately 137,000 members and is the largest and most powerful group of organized psychologists in the world. The scope of the association is difficult to capture and describe, but its import to our profession is unequivocal. We benefit through its constant advocacy efforts and relationship with Capital Hill. Guidelines by which we practice and work are born and enforced within the association. The agenda of psychology is largely formed within APA, and influences our direction from funding to practice. The list could and does go on.

Yes, there are a plethora of acronyms, and how governance works within APA is not abundantly clear to the average member. But there really are no secrets, APA is transparent and can be understood by spending some time at www.apa.org or talking with those who are involved in APA governance. Further, in 2000 Div40 underwent a structural reorganization that sought to organize our committees and officer positions in parallel to the structure of APA, to facilitate communication and coordination of efforts.

Most of us consider ourselves content being a part of the neuropsychology tribe. We like and take pride in what we do, and work within our field enthusiastically. We attend to matters within our Specialty with great concern and energy. But too many of us forget to look at the bigger world about us, and protest when that world affects us as it shapes itself. But, if we do not participate in setting policy, it will be set for us. If we do not participate in solving problems, they will be solved for us. If we do not participate in shaping psychology, it will be shaped for us. If we opt not to play, we must abandon any insult, indignation, or protest of outcomes. Conversely, if we are invested in the outcome and want a voice in the process, we must proactively contribute.

You will see that various neuropsychologists contributed to this summary article to better inform the membership. I want to thank them for their summaries, but most importantly for their service on behalf of Div40 or neuropsychology as a whole. As you read the brief notes on the activities of various Div40 members at the Spring Consolidated meetings (CMs) below, consider how some of the key issues being reported on, and thus addressed by APA governance, are relevant to neuropsychology. Issues that are inextricably linked to our practice and science (ie, use of technicians, third-party observers, education of professionals, issues of diversity) are currently being addressed. Consider the full possible range of outcomes regarding these highlighted topics, and what the effect of a Div40 representative within the relevant governance bodies has on outcome. While this report attests that we are participating, the size and activity of APA governance suggests that more frequent, informed, and formal Div40 input would indeed be wise.

2004 Spring Consolidated Meetings

Dr. Norm Anderson, current APA CEO, shared his Points of Emphasis with a number of APA Boards and Committees during the Spring CMs. These include:

- 1) Increase non-dues revenue
- 2) Increase the influence of psychology in the world (eg, health care, education, business, law, policy, science)
- 3) Work to ensure that APA and psychology can meet the practice and science needs of a multicultural nation and world
- 4) Helping psychology expand its role and capitalize on new opportunities
- 5) Make APA an even better place to work.

Listening to this presentation inspired reflection on how the Div40s Public Interest Advisory Committee (PIAC) is doing in these areas, and the results were encouraging. In regards to increasing the influence of psychology in the world, we have distributed over 130,000 brochures educating the public and related health professionals about Clinical Neuropsychology or Pediatric Neuropsychology (now available online at www.div40.org/Resources_Pages/neuropsychology_brochures.htm). In terms of meeting the needs of a multicultural nation, the PIACs Ethnic Minority Affairs (EMA) committee has had a number of influential successes: EMA was awarded a grant by the APA Commission on Ethnic Minority Recruitment, Retention and Training in Psychology (CEMRRAT) to help fund their efforts to address the under-representation of ethnic minorities within neuropsychology training programs, researchers, and clinicians; EMA had a successful mentoring activity at the recent INS meeting; Dr. Jennifer Manly will be interviewed for an APA Monitor article addressing the mentoring initiatives of Div40s EMA.

The association is committed to these goals, and Dr. Anderson specifically requested that governance ask themselves what activities APA could undertake to achieve goals 2-4. As an extension, Div40 members should consider specific projects/goals related to these overarching initiatives that our own committees, liaisons, and monitors could consider working with APA as a whole to implement.

Dr. Deborah Koltai Attix, current chair of Division 40s PIAC, attended a variety of meetings at the Spring CMs. She visited the Committee on Disability Issues in Psychology (CDIP) with Dr. Johnson-Greene, which is detailed below. She also had the honor of joining the Committee on Aging (CONA) for specific discussions. First, she participated during discussion of an American Psychological Association/American Bar Association collaborative project on the Assessment of Capacity in Older Adults, which has many planned initiatives. Its first product is a near complete draft Guide for Attorney Practice with Older Adults with Diminished Capacity that offers attorneys (and psychologists!) specific guidelines to work through relevant legal and psychological capacity issues. Div40 is fortunate that Dr. Dan Marson, attorney and neuropsychologist, has been an active member of the group authoring this work. The result has been one of the finest examples of a clearly written, well-informed product that will be instrumental in shaping how attorneys approach this issue with elders. In addition to providing some limited input to CONA, Dr. Attix was present to hear how the Committee on Legal Issues (COLI) responded to CONA and this draft, which was just short of a standing ovation. COLI recognized the importance of this document for attorney practice and education. Dr. Attix also sat in as CONA met with Dr. Barry Lebowitz to discuss the recent changes within NIMH. Of interest to Div40, Dr. Lebowitz is now Director of the newly established NIMH Aging Treatment and Preventive Interventions Research Branch, and will also assume leadership of an NIMH-wide Aging Consortium (of note, Dr. Jovier Evans, neuropsychologist and former Chair of Div40s EMA, will be joining the Aging group at NIMH shortly!). Dr. Lebowitz discussed areas of interest currently at NIMH, interested readers can visit <http://www.nimh.nih.gov/aging/index.cfm> to learn more.

Dr. Tony Wong, Division 40 co-liaison to the APA Committee on Ethnic Minority Affairs (CEMA), also attended the CMs. CEMA was exceptionally open to Dr. Wong, welcoming him as an "extra member" during their deliberations.

Because CEMA is a "watchdog" committee, ensuring that ethnic-minority or diversity issues are properly considered in all Association agenda activities, their agenda spanned a wide range of topics. However, two agenda items had very clear relevance to the specific interests of Division 40. First, CEMA has been working with CPTA (Committee on Psychological Tests and Assessment) since Spring 2003 on a collaborative project that includes the development of a web page containing a bibliography on cross-cultural testing/assessment, with one section devoted to cross-cultural neuropsychological assessment. Dr. Wong was able to review and provide input to a draft on this. Second, CEMA met with the Membership Committee to discuss concerns and ideas regarding the recruitment and retention of ethnic-minority psychologists. Dr. Wong shared about the recent successful mentoring activity sponsored by Div40's EMA subcommittee that was held at INS, and how things learned from planning and conducting that activity are relevant to effective recruitment and retention of ethnic-minority neuropsychologists. Dr. Wong concluded that based on his experience at the CMs, he believes that our representation at these meetings to be very valuable as an avenue through which our neuropsychology community can participate in a meaningful way within APA, and to exert appropriate influence upon the psychological community as a whole. He stated that our participation within CEMA was valuable, given the free access and involvement afforded due to the "culture" of that committee.

Drs. Doug Johnson-Greene and Attix joined the Committee on Disability Issues in Psychology (CDIP) at the Spring CMs for a discussion on issues pertaining to barriers to training in psychometric testing for persons with disabilities. We were invited to join CDIP to discuss their progress and ways in which Division 40 may be of assistance in response to a letter sent by Dr. Johnson-Greene and current Div40 President Dr. Haaland expressing interest in working with the group on such matters. Though many attempts have been made to secure accessible test manuals for students with disabilities, these arrangements continue to be made on an individual basis. Focusing primarily on students with visual

impairments, CDIP would like to have available for purchase test manuals on CD so that it can be utilized with software and visual readers that make this information accessible to psychology students in training. Discussion focused on an interdivisional task force that could pursue this objective, though continued discussion is needed to determine specific tasks, interest from other divisions, and exact leadership roles. Div40s primary interest in this matter would be to work toward better instrument accessibility for students to support and enhance training with sensitivity to disability and diversity issues.

Dr. Bernice Marcopulos, Division 40 liaison to the APA Committee on Rural Health (CRH), attended some of the Spring CM CRH sessions. She reported that CRH was very welcoming and receptive to her comments, and also noted that fellow neuropsychologist, Dr. Laura Schopp, currently serves on the CRH. Topics of focus included Prescriptive Authority and methods of recruitment of psychologists to rural practice. A number of APA groups and outside agencies are working with CRH on policy or projects related to improve access and quality of health care to rural citizens (eg, APA Education Advocacy on National Health Services Corps and Mental Health Professional Shortage Areas projects; APA Practice Directorate has been working diligently to pass the Wellstone Mental Health Equitable Treatment Act; U.S. Health Resources and Services Administration Office of Rural Health Policy report; National Rural Health Association report). A number of CRH committee members also work on rural mental and behavioral health programs in their communities. Of particular interest to Div40, Dr. Schopp is working on a series of informatics-oriented initiatives at the University of MO-Columbia to bring neuropsychological and TBI rehabilitation services to rural communities. This involves telehealth video conferencing for neuropsychological assessment, one-on-one video teleconferencing training of rural behavioral health providers in the needs of persons with TBI, telehealth multimedia enhancements for patients or providers who are deaf or hard of hearing, rehabilitation information needs assessment, and a patient and family-driven network to share local

rehabilitation information, particularly in resource-scarce rural environments.

Dr. Joel Morgan attended the Board of Educational Affairs (BEA) as Ad Hoc liaison for Division 40. Relevant to the interests of neuropsychology was a report by the subcommittee/task force concerned with re-constitution of the Committee on Accreditation (COA). The proposal suggests: (1) enlarging the COA and changing its constituency to better reflect stake-holders; (2) enlarging the cadre of site visitors to better reflect the nature of programs; and (3) that individuals could "work their way up the ladder" to an eventual seat on the COA by first being a successful site visitor. There are other suggested changes which seem to make the COA somewhat more democratic, representative, and responsive to the diversity of psychologists within APA. Response to the proposal was mixed, breaking down along 'party lines', i.e., with more clinically-oriented participants registering approval and more experimental/academics participants registering disapproval. It will be studied further and raised again at the next BEA meeting. Issues more germane to Div 40 involve the establishment of standards for education and training in psychology. Further developments regarding specialty guidelines remain at a low simmer on the back burner at present.

Moreover, a number of neuropsychologists attended the Spring CMs in roles outside of Div40. However, we are indebted to them as their service benefits Div40 and neuropsychology as a whole.

Dr. Paul Craig is Member at Large on the APA Board of Directors. He has written an important piece discussing the structure and importance of APA governance in this newsletter. His service to APA on behalf of Div40 is invaluable. Please see his comments about his experience at the recent CMs.

Dr. Anotnio Puente is a member of the APA Policy and Planning Board (P&P). The P&P is charged with reviewing both recent and anticipated shifts in policies within APA and psychology. Numerous issues have been raised including some related to membership and marketplace. The APA membership continues to age, with a larger percentage of women and an exceedingly low number of ethnic minorities. In addition, a focus on

what are the issues of concern to the membership, governance, and staff of APA is at the forefront of this board. Finally, an analysis of all policies, procedures, and guidelines of APA (since their inception) is currently underway. Every five years a report outlining these reviews is compiled and published in the American Psychologist. Of interest to Division 40 at present is the ongoing involvement of a neuropsychologist with APA policy decision as the organization continues to be the largest and most important membership organization in psychology.

Dr. Jerry Sweet is Chair of the Psychological Tests and Assessment (CPTA). CPTA is the single place within APA that all testing and assessment issues that pertain to any part of organized psychology (e.g., education, industry and organizations, clinical services) will be addressed. Because of CPTA's broad mission, it is the only APA standing committee that reports to all four major APA Boards (BSA, BPA, BEA, BAPPI). At these Spring CMs of APA, CPTA worked on a several issues relevant to clinical neuropsychologists. For a number of years, CPTA has endeavored to complete a position statement regarding third party observers of testing, which would be similar in nature to those already published by the National Academy of Neuropsychology and the American Academy of Clinical Neuropsychology. Further plans were made to work toward crafting a statement that would address last minute concerns, so that the statement on observers can become official in the near future. On another relevant topic, CPTA discussed and decided to revise a 1996 official APA statement concerning disclosure of test data, which was created before HIPAA and before the revision of the APA Ethics Code. Finally, the recent controversy within certain states regarding constraints on use of psychological and neuropsychological testing assistants was discussed. CPTA decided to address this issue, and in this regard expects to work with other organizations, such as Div40 and AACN, to facilitate a solution, which could ultimately include development of an official APA position statement on this topic.

Dr. Joseph Ricker attended the Board of Scientific Affairs (BSA) in his role as Liaison and Science Committee Chair for Division 22. Of course,

Div40 benefits given that many of the activities of BSA are of interest to our members and ultimately to our consumers. BSA functions in an advisory role to the APA Science Directorate. Its primary mission is to reinforce the scientific basis and practice of all aspects of psychology. BSA addresses research and policy across APA divisions. The long-standing Committee on Psychological Tests and Assessment (CPTA) of BSA addresses all forms of psychological assessment and testing across the multiple venues and contexts in which psychologists practice. CPTA works collaboratively with other APA boards and committees to address such topics as evaluating the effects of standardized testing on minority populations, assessing individuals with disabilities, and providing consultation to test developers when establishing the qualifications necessary for appropriate use of tests. Please see Dr. Sweet's comments on current CPTA activities. Finally, the BSA has established an advisory group on conducting research and testing via the Internet, to explore emerging ethical and scientific issues related to the gathering of psychological data over the Internet, both for research and clinical purposes. The advisory group issued a report to BSA that examined the opportunities and challenges of conducting research and testing on the Internet, and that provides a set of suggestions for researchers and for Institutional Review Boards (IRBs). A condensed version of this report can be found in the March 2004 issue of the *American Psychologist*.

In summary, it is hoped that this synopsis of activities of neuropsychologists at the Spring APA Consolidated Meetings has kept the membership informed about our recent presence within APA. It is also hoped that perhaps the importance of this presence has been adequately highlighted. At the PIAC, we look forward to continuing to serve the membership both within the Division and within the association as a whole. Please contact us at koltai@duke.edu with thoughts and ideas to this end.

**American Psychological Association Convention
Wednesday, July 28 - Sunday, August 1, 2004
Division 40 Program Summary**

It has been my pleasure to chair the Division 40 Program Committee for the 2004 APA convention. In this edition of the Newsletter, the Division 40 final version of the convention program is summarized.

In a new format this year most of the individual paper and workshop presenters were invited. In addition, 144 posters, individual papers, symposia, discussion hours, and workshop proposals were submitted to Division 40 for consideration for the program. The overall acceptance rate for submitted proposals was 89%. The final program that was selected is truly outstanding and covers several different areas of strong interest in neuropsychology.

This year 21 of our presentations will be offered for APA approved continuing education credit. In all, we will be offering a total of 26 CE credits for our approved presentations. Few of the Division 40 programs overlap and on four of the five days of the convention program, the Division 40 presentations end in the early afternoon, providing you with ample time to engage in other activities in this beautiful resort setting!

Two exceptional keynote addresses are scheduled for Wednesday, July 28, 2004. At 11:00 A.M., Alex Martin, Ph.D. of NIH, known for his research on the neural structures associated with information acquisition, storage, and retrieval, will be presenting, "Objects, Concepts, and the Brain." At 12:00 P.M.,

Alex Martin, Ph.D. of Harvard University and the author of *Seven Sins of Memory*, will be presenting, "Remembering Imperfectly: The Cognitive Neuroscience of False Memories." On Saturday, July 31, at 12:00 P.M., we will be presenting an exciting, innovative and controversial mock trial program, in workshop format, including an acting judge, defense and plaintiff attorneys, and opposing expert neuropsychologists, dealing with a topic on neuropsychology.

We are co-sponsoring two outstanding programs with other divisions. Division 38 joined us in sponsoring the workshop, "Meet the NIH: Workshop on Funding Opportunities for New Researchers", chaired by Ronald Abeles, Ph.D., of NIH. We are co-sponsoring, with Division 22, the symposium, "Testing of Cognitive Abilities in Individuals from Different Cultural and Linguistic Backgrounds", chaired by David Tulskey, Ph.D.

Division 40, along with Division 22, will be hosting a Social Hour and Reception on Saturday, July 31, 5:00 to 6:50 P.M. The Social Hour and Reception is being sponsored by Harcourt Assessment/Psych Corp and Psychological Assessment Resources.

Finally, I would like to express my gratitude to all of our Program Committee members for your expertise and important contributions to our Division.

I extend special thanks to Kimberly Espy, Ph.D. for her outstanding contribution as the Co-Chair of the Program Committee and to Laura Julian, Ph.D., my Program Assistant, for her exceptional organization skills and diligence.

Dr. Thomas Bennett
Dr. Julie Bobholz
Dr. Jane Cerhan
Dr. Glenn Curtiss
Dr. Jacques Donders
Dr. Kimberly Espy
Dr. Philip Fastenau

Dr. Tanis Ferman
Dr. Joanne Hamilton
Dr. Greg Lee
Dr. Cheryl Luis
Dr. Karen Mason
Dr. Edward Peck
Dr. Lisa Ravdin

Dr. Tresa Roebuck
Dr. Sean Rourke
Dr. Bradley Sewick
Dr. Maria Schultheis
Dr. David Tulskey
Dr. Tony Wong
Dr. Lisa Barnes Young

Robert W. Elliott, Ph.D.
2004 Program Chair
Division 40, Clinical Neuropsychology

APA Division 40, Clinical Neuropsychology 2004 Program (Honolulu, Hawaii)

Chair(s)	Participants	Title	Date	CE Offered	Time	Room*
Semrud-Clinkeman/ Walkowiak	Walkowiak, Trapani, Reynolds, Wilkinson	Symposium: Social Competence in Children with NVLD, Aspergers, and PDD	Wed 7/28	Yes	8:00 AM - 9:50 AM	HCC 303A
Haaland		Executive Committee Meeting	Wed 7/28	No	8:00 AM - 10:50 AM	HHV Sea Pearl Suite IV
Hooper	Stephen Hooper	Paper: Early Onset Schizophrenia: Neuropsychological Functioning, Psychiatric Symptomatology, and Adaptive Behavior	Wed 7/28	Yes	10:00 AM- 10:50 AM	HCC 301A
Haaland	Alex Martin	Keynote Address: Objects, Concepts, and the Brain	Wed 7/28	Yes	11:00 PM- 11:50 AM	HCC 316A
Ivnik	Daniel Schacter	Keynote Address: Remembering Imperfectly: The cognitive Neuroscience of False Memories	Wed 7/28	Yes	12:00 PM- 12:50 PM	HCC 315
Curtiss	Arthur Shimamura	Invited Address: Cognitive, Memory, and Emotional Disorders Following Frontal Lobe Damage	Wed 7/28	Yes	1:00 PM - 1:50 PM	HCC 323C
Kubu		Roundtable Discussion: Women in Neuropsychology	Wed 7/28	No	2:00 PM - 2:50 PM	HHV Nautilus Suite 1
Fastenau	Ruben Echemendia	Invited Address: Sports Related Brain Injury: A Decade of neuropsychological Findings	Thurs 7/29	Yes	8:00 AM - 8:50 AM	HCC 302A
Lee	Agnes Chan	Invited Address (Early Career Award): Application of the Traditional Chinese Medicine for Cognitive Rehabilitation: A Hope or a Fantasy	Thurs 7/29	No	8:00 AM - 8:50 AM	HCC 307A
Bobholz	Jane Paulsen	Invited Address: Psychology's Role in Phenotyping the Genome: Example from Huntington's Disease	Thurs 7/29	Yes	9:00 AM - 9:50 AM	HCC 327
Donders	Linda Ewing-Cobbs	Invited Address: Young Children with Traumatic Brain Injury: Neuropsychological and Neuroimaging Outcomes	Thurs 7/29	Yes	10:00 AM- 10:50 AM	HCC 318B
Goldstein	Haas, Allen, Goldstein	Symposium: Problem of Dual Diagnosis in Schizophrenia	Thurs 7/29	Yes	11:00 AM- 11:50 AM	HCC 328

Chair(s)	Participants	Title	Date	CE Offered	Time	Room*
Espy	Raymond Mulhern	Invited Address: Neuroimaging Contributions to Understanding Cognitive Sequelae of Childhood Cancer	Thurs 7/29	Yes	11:00 AM- 11:50 AM	HCC 316B
Bobholz	Ola Selnes	Invited Address: Hearts and Minds: Cognition After Bypass Surgery	Fri 7/30	Yes	8:00 AM - 8:50 AM	HCC 313A
Abeles	Abeles, Kelty, Micklin	Workshop: Meet the NIH--Workshop on Funding Opportunities for New Researchers (Co-Sponsor: Division 38)	Fri 7/30	No	8:00 - 9:50 AM	HHV Coral Ballroom IV
Ferman	Poster	Pediatric and Aging Issues in Neuropsychology	Fri 7/30	No	12:00 PM- 12:50 PM	HCC Exhibit Hall
Manly	Yaakov Stern	Invited Address: Studying Cognitive Reserve	Fri 7/30	Yes	12:00 PM- 12:50 PM	HCC 323A
Wong/ Mindt		Conversation Hour: Ethnic Minority Affairs Committee	Fri 7/30	Yes	1:00 PM - 1:50 PM	HCC 303B
Haaland	Robert Knight	Invited Address: Prefrontal Cortex and Executive Control of Cognitive and Social Behavior	Fri 7/30	Yes	1:00 PM - 1:50 PM	HCC 315
Espy	Robert Heaton	Invited Address: Use of Norms in Neuropsychological Decision Making	Sat 7/31	No	8:00 AM - 8:50 AM	HCC 315
Curtiss	Poster	General Neuropsychological Assessment, Traumatic Brain Injury, and Rehabilitation	Sat 7/31	No	9:00 AM - 9:50 AM	HCC Exhibit Hall
Fastenau	Poster	Neuropsychological Assessment of Medical and Psychiatric Patients	Sat 7/31	No	12:00 PM- 12:50 PM	HCC Exhibit Hall
Elliott	Lensegrav-Benson, Kalinian, O'Shea, Strong	Invited Address (Blue Ribbon Awards): Lensegrav-Benson: Sedentary Lifestyle Increases Demential Risk-The Cache County Study. Kalinian: Assessing Deductive Reasoning, Hypothesis Testing, and Problem Solving in Female Psychopaths. O'Shea: Analysis of Source memory in Children with Autism Spectrum Disorders. Strong: Validity of Demographically Corrected Norms for the WAIS-III.	Sat 7/31	No	12:00 PM- 12:50 PM	HCC 322A
Espy/Dixon	Lambert, Sims, Russell, Van Gorp	Workshop: Neuropsychologist in Court-- Mock Civil Trial	Sat 7/31	Yes	12:00 PM - 1:50 PM	HCC 311

Chair(s)	Participants	Title	Date	CE Offered	Time	Room*
Mirsky	Fong-Ichimura Lebowitz, Nye, Johnson	Invited Addresses (Science Advisory Committee/Harcourt Assessment Student Awards)	Sat 7/31	No	1:00 PM - 1:50 PM	HCC 322A
Fennell	Fischer, Ricker, Rapport, Donders	Fellows Addresses: Fischer: Neuropsychological Contributions to Clinical Trials. Ricker: Novel Functional Imaging Technologies in Brain Injury. Rapport: Driving After Acquired Brain Injury. Donders: Assessment of Effort and Motivation in Children	Sat 7/31	Yes	2:00 PM - 2:50 PM	HHV Coral Ballroom V
Puente	Haaland	Presidential Address: Left Hemisphere Dominance for Movement	Sat 7/31	Yes	3:00 PM - 3:50 PM	HHV Coral Ballroom V
Haaland		Business Meeting	Sat 7/31	No	4:00 PM - 4:50 PM	HHV Coral Ballroom V
Espy		Social Hour: Reception	Sat 7/31	No	5:00 PM - 6:50 AM	HHV Coral Ballroom V
Stern/ White	Stern, White, Ledbetter, Stern	Symposium: Introduction to the Neuropsychological Assessment Battery (NAB)	Sun 8/1	Yes	8:00 AM - 9:50 AM	HCC 313B
Bush	Behnke, Chadda, Johnson-Greene, Stein, Sims	Discussion: Revised Ethics Code-- Release of Test Information	Sun 8/1	Yes	10:00 AM- 11:50 AM	HCC 318B
Arffa/ Goldstrohm	Arffa, Goldstrohm	Symposium: Traumatic Brain Injury in Preschoolers--Cognitive and Behavioral Sequelae	Sun 8/1	Yes	11:00 AM- 12:50 PM	HCC 305B
Elliott	Puente	Invited Address: Status of the Economics and Public Policy of Clinical Neuropsychology	Sun 8/1	Yes	12:00 PM- 12:50 PM	HCC 306B

Program Chair: Robert W. Elliott, Ph.D.

* Rooms are in the Hawai'i Convention Center (HCC) or the Hilton Hawaiian Village (HHV).

Hospitality Suite

Division 40 has scheduled a number of committee meetings and a reception in our Hospitality Suite in the Hilton Hawaiian Village. The exact room assignment will be posted in the Hilton Hawaiian Village lobby. The dates are Wednesday, July 28 through Friday, July 30. All are welcome to attend the several committee meetings and the reception scheduled in the suite, which are listed below. Flyers listing the Division 40 Hospitality Schedule will be distributed in the convention packet and on the Division 40 website at <http://www.div40.org>.

The following dates and times have been scheduled:

Wednesday July 28

- 3:00 - 3:50 PM Women In Neuropsychology; Chair: Cynthia Kubu, PhD
- 4:00 - 4:50 PM Fellows Committee; Chair: Eileen Fennell, PhD
- 7:00 - 8:15 PM Association of Neuropsychology Students in Training,
Hosts: Michael Cole and Chris Loftis

Thursday July 29

- 12:00 - 12:50 PM Division 40 Program Committee Meeting, Chair: Kim Espy, PhD
- 2:00 - 2:50 PM Ethnic Minority Advisory Committee, Chair: Tony Wong, PhD
- 3:00 - 3:50 PM Science Advisory Committee; Chair: Allan Mirsky, PhD
- 4:00 - 4:50 PM Practice Advisory Committee; Chair: Neil Pliskin, PhD

Friday July 30

- 2:00 - 2:50 PM Education Advisory Committee; Chair: Sandra Koffler, PhD
- 3:00 - 3:50 PM Publications Committee Meeting; Russell Bauer, PhD
- 4:00 - 4:50 PM Public Interest Advisory; Chair: Deborah Koltai Attix, PhD
- 6:00 - 8:00 PM Division 40 Reception; Host: Kathleen Haaland, PhD

2004 APA Division 22 Program

Wednesday, July 28, 2004

- 8:00 - 9:50 Symposium: Understanding the Emotional Experience of Patients in Rehabilitation
 Chair: Janet Niemeier, PhD
 Location: Hawai'i Convention Center, Meeting Room 302A
- 10:00-10:50 Invited Address: Leonard Dillar Award
 Participant: J. Scott Richards, PhD
 Location: Hawai'i Convention Center, Meeting Room 302A

Thursday, July 29, 2004

- 8:00 - 8:50 Symposium: International Classification of Functioning, Disability, and Health--
 Rehabilitation Psychology Implications
 Chair: Susanne Bruyere, PhD
 Location: Hawai'i Convention Center, Meeting Room 319B
- 10:00 - 11:50 Symposium: Testing of Cognitive Abilities in Individuals From Different
 Cultural and Linguistic Backgrounds
 Chair: David Tulskey, PhD
 Location: Hawai'i Convention Center, Meeting Room 316A
- 3:00 -3:50 Symposium: Social and Ethical Issues in Rehabilitation--Multicultural
 Issues and Decision Making
 Chair: Shane Bush, PhD
 Location: Hilton Hawaiian Village, Nautilus Suite II

Friday, July 30, 2004

- 8:00 - 9:50 Symposium: Future Directions in Determining Treatment Efficacy
 and Effectiveness in Rehabilitation
 Chairs: Timothy Elliott, PhD; Elisabeth Sherwin, PhD
 Location: Hawai'i Convention Center, Meeting Room 322A
- 12:00 - 1:50 Symposium: Emerging Best Treatment Practices for Children with
 Neurodevelopmental Disabilities
 Chair: Janet Farmer, PhD
 Location: Hawai'i Convention Center, Meeting Room 319B
- 3:00 - 3:50 Division 22 Presidential Address by Kristopher Hagglund, PhD
 Location: Hilton Hawaiian Village, South Pacific Ballroom II
- 4:00 - 4:50 Fellows Addresses
 Chair: Robert Frank, PhD
 Location: Hilton Hawaiian Village, South Pacific Ballroom II

Saturday, July 31, 2004

8:00 - 9:50 Symposium: Capacity Issues-From the Perspectives of Geropsychology and Rehabilitation Psychology

Chairs: Cheryl Shigaki, PhD; Barry Edelstein, PhD

Location: Hawai'i Convention Center, Meeting Room 304B

12:00 - 12:50 Poster Session: Current Topics in Rehabilitation

Chair: David Hess, PhD

Location: Hawai'i Convention Center, Exhibit Hall

1:00 - 1:50 Workshop: Implications of Ethnic Minority Status for Persons with SCI

Chairs: Michelle Meade, PhD; Njeri Jackson, PhD

Location: Hawai'i Convention Center, Meeting Room 307A

3:00 - 6:50 Division 22 Executive Committee Meeting

Chair: Kristopher Hagglund, PhD

Hilton Hawaiian Village, Iolani Suite Suite III

Sunday, August 1, 2004

10:00 - 11:50 Symposium: Online Interventions in Rehabilitation-Postcards From the Edge

Chair: Shari Wade, PhD

Location: Hawai'i Convention Center, Meeting Room 324

Second Year

Paul L. Craig, Ph.D., ABPP-CN
 Member at Large, APA Board of Directors
 Anchorage, Alaska

As I begin my second year of a three-year term as Member at Large on the APA Board of Directors, I am becoming increasingly aware of the complexity and importance of APA Governance to the future of psychology in general, and neuropsychology in particular. APA Governance is a conundrum, at best, to most members of the Association. Despite paying annual dues to the APA, the majority of members do not cast their votes in the two elections in which all members participate. Specifically, the entire membership votes for only one office within Governance -- the APA President. The other vote in which the entire membership participates is the Apportionment Ballot within which each member allocates ten votes to one or more Divisions and/or State Associations. The Apportionment Ballot is the basis upon which the seats on the Council of Representatives are allocated each year. Parenthetically, I should add that there is a third vote in which APA members participate. Specifically, the entire membership is asked to vote regarding changes proposed for the APA Bylaws whenever the Council of Representatives proposes any bylaw amendment.

Why is the allocation of seats on Council important to members of the APA who are not directly involved in Governance? What most members don't fully realize is that all elected positions within the APA Governance, beyond the President, are voted for by the Council of Representatives. The Recording Secretary, the Treasurer, Members at Large of the Board of Directors, Members of CAPP with oversight of the Practice Organization, Board of Professional Affairs, Committee on Accreditation, and the list goes on and on, are all elected directly by the Council of Representatives. The Council is an extraordinarily powerful entity within APA Governance holding much of the power and influence within the Association. From a purely legal perspective, the

Council is, in fact, the Board of Directors of the APA per corporate statutes within Washington, DC, and has fiduciary responsibility for the actions of the APA. What is called the APA Board of Directors is actually an executive committee of the Council at large.

Through the Committees and Boards of the APA, new items of business, budget proposals, policies, procedures, standards, and guidelines are vetted. Upon extensive review, these business items are eventually returned to Council for a vote with input from each Committee or Board that has reviewed the item. Although this process is tedious, it provides for a careful review and critique of each item moving through Governance. By the time a business item returns to the floor of Council from the Boards and Committees, it is usually abundantly clear which items are meritorious of support without further consideration, which items are controversial and worthy of debate on the floor of Council, and which items warrant dismissal without further consideration.

Division 40's involvement within Governance is extraordinarily important for purposes of defining the agenda for the future of our specialty within psychology. We have recently increased from three to four seats on the Council of Representatives suggesting that members of Division 40 are increasingly aware of the importance of casting their Apportionment Ballot votes for Division 40. Division 40 is also sending liaisons and observers to various Boards and Committees. However, during the recently Consolidated

Meeting, I noticed that Division 40 did not have an observer in the room at the Board of Professional Affairs (BPA) meeting. The BPA considered several items of interest and concern to neuropsychology (e.g., there was an extensive presentation on "guidelines" at the meeting that may eventually bear upon the controversy that has arisen in several States regarding the use of technicians in the practice of neuropsychology). From my vantage point, having Division 40 at the table with BPA is as important as being present at the Board of Scientific Affairs and several other Boards and Committees. I would applaud Division 40 for what it is already doing but must emphasize that even greater involvement is

needed.

Over the next decade, a goal within Division 40 should be to significantly increase the number of elected seats occupied by neuropsychologists on the various Boards and Committees within the APA Governance. Members of Division 40 should be mentored so that they understand the process whereby they can get their names on a ballot for election to a Board or Committee of interest to them. The process is actually quite simple. If you are an interested member, you should contact the current Chair of a Board or Committee and express your interest in serving. Expressing interest to other members of the Board or Committee in addition to the Chair can be quite helpful. Through these personal contacts and expressions of interest, it is very possible to end up on a ballot, although the competition is stiff for each slot on each ballot. The next step is to inform members of the Council of Representatives about your interest in serving on the Board or Committee. This can involve direct communication with individual members of Council. In addition, members of Council typically join informal associations of like-minded members of Council called a "Caucus." It should be noted that members of Council are not obligated to join a Caucus. At the same time, many members of Council join several Caucuses. Each Caucus typically reviews each ballot and endorses particular candidates for each ballot. Through Caucus endorsement, the likelihood of election to a Board or Committee can be enhanced. However, there is no obligation for any member of Council to vote consistent with the recommendations of a Caucus. At the end of the day, the key to being elected is to have each member of Council know about your talents and interest in serving the APA so that when a Council member casts his or her votes for the various Boards and Committees, they select you for the role in which you are interested. Flagrant campaigning is inappropriate. However, you must let members of Council know about your particular interest if you wish to be a successful candidate for a position within the Governance of the APA.

During the past 15 years, I have had the honor of serving within the APA Governance in various capacities. Initially, I was the Liaison-Observer to

Council from the Alaska Psychological Association. I then helped start the Rural Health Task Force that eventually became the Rural Health Committee. I have served as the elected member of Council from Alaska followed by serving as a member of Council from Division 40. From the Division 40 seat on Council I was elected to serve on the APA Finance Committee and more recently was elected to serve as a Member at Large on the APA Board of Directors. Although each of these roles can be time consuming and occasionally frustrating, the rewards I have enjoyed as a result of my involvement with Governance cannot be expressed in words. I have had the opportunity to spend time with the giants of our science and profession and have learned much from them. Furthermore, I have developed friendships that will last far beyond any term in office. I love psychology and what it offers as a field of scientific inquiry and professional service. I feel privileged to serve the APA through various roles on Governance and would encourage other members of Division 40 to become even more actively involved in the Association. If we don't participate in setting policy for the field of neuropsychology, somebody else will do it for us. Thus far, it is my impression that "somebody else" does not understand our specialty within psychology nearly as well as we do as researchers and practitioners in the field.

Who Do They Think They're Kidding:

Continued from page 1

performance in children. Therefore, the use of objective assessment measures to detect poor effort/motivation/potential malingering in children would seem wise.

Need for Symptom Validity Tests for Children Increasing?

From my clinical experience, the need for symptom validity tests for children seems to be on the rise. Why might this be? One explanation is that neuropsychologists are more frequently finding themselves in forensic settings related to personal injury cases. One of the more common reasons for litigation or compensation-seeking is due to traumatic brain injury (TBI). TBI occurs more often in children than adults. Personally, I have increasingly been requested to assess children involved in litigation to determine the severity of a TBI and the level of disability it is expected to cause. Parents and attorneys often have a financial stake in these proceedings.

In another area, President Bush's "No Child Left Behind" legislation has also put more pressure on schools and children to do well on standardized tests (Heath, 2004). Such pressure may lead some students to seek accommodations for "disabilities" under the Individuals with Disabilities Education Act. These students typically are seeking extra time and/or resources to compensate for their "disability" so that they might score better on exams. Some may also wish to be exempt from required classes (e.g., foreign language or advanced mathematics).

Lastly, the modal form of treatment for attention deficits is currently psychopharmacological (Jensen, 2001). The most commonly prescribed medication has abuse and resale potential (i.e., secondary gain). I have found it increasingly necessary to insure valid assessment and diagnosis of these disorders before a physician prescribes medication that might be used recreationally, as an "educational steroid", or sold for profit.

Whether children engage in suboptimal performance intentionally or unintentionally is beyond the scope of this review. Furthermore, even if a child's performance is considered to be

intentionally poor, it is possible that a "concerned" parent or a "savvy" attorney with financial incentives was instrumental in coaching the child to respond to some questions incorrectly. Some children may believe that these authority figures' advice should be followed unchallenged, even if it runs contrary to their experience.

Other problems occur when co-opting the adult template for malingering directly onto children. For example, in adults suboptimal performance more frequently occurs in the presence of secondary gain. Secondary gain is often thought to be synonymous with financial incentives. I believe this to be too narrow a definition for children. To a child, secondary gain may simply be the belief that poor performance will help them acquire "love" and/or attention from a parent, a teacher, or a trusted friend of the opposite sex. Historically, "playing ill" has been a common experience for children who want to avoid negative consequences (e.g., taking a difficult exam), yet obtain positive attention for such avoidance (e.g., a warm cooked meal at home with mom). As children, who among us never had a "tummy ache" when we needed a "mental health day" from school? To acknowledge this phenomenon is to assert that children are capable of feigning.

Review of SVTs Design Issues and Use in Adult Evaluations

A common technique used to generate symptom validity tests for use with adults has been to create items that appear relatively difficult, but in reality are quite easy. SVT items are typically generated from cognitive domains that are associated with neurological impairment (e.g., memory). Researchers hope that such a design strategy will improve the sensitivity of their SVT to suboptimal performance.

Memory impairment is the most frequently complained of symptom in referred patients (Rohling, Allen, & Green, 2002). However, one type of memory, recognition memory, tends to remain relatively immune to a variety of insults to the CNS (e.g., diseases or traumas), making it ideal for SVTs. The stimuli selected by SVT designers are often words, numbers, or symbols, which may or may not have a semantic association to one another. These

tests are then "normed" using a sample of independently verified moderate-to-severely neurologically impaired patients. This is done to substantiate that the SVT is indeed easy as severely brain damaged patients can successfully complete the task. Thus, the clinician can better conclude that low scoring patients have put forth suboptimal effort, particularly when they are doing much worse than patients with more severe injuries. In fact, SVTs work best (i.e., low scores can be attributed to low effort) when normative samples of brain-injured patients have been shown to perform nearly as well as non-impaired normal control participants and/or patients who suffer from other orthopedic or psychiatric disorders. Moreover, this design-strategy has been used to generate some of the more popular SVTs, such as the Word Memory Test (WMT; Green, Allen, & Astner, 1996; Green & Astner, 1995), Test of Memory and Malinger (TOMM; Tombaugh, 1996), and the Computerized Assessment of Response Bias (CARB; Allen, Condor, Green, & Cox, 1997).

In adult forensic and disability samples, the assessment of suboptimal performance has come to be considered routine (Sweet, 1999). The importance of assessing effort has been emphasized by Iverson and Binder (2000), as they wrote, "A forensic evaluation that does not include a careful consideration of possible negative response bias should be considered incomplete" (p. 853). Such a conclusion has been supported by the empirical findings of Green, Rohling, Lees-Haley, & Allen (2001). In their analyses, a composite score generated from several SVTs accounted for nearly 50% of the variance of a composite score that was generated from examinees' scores on a comprehensive assessment battery. These authors reported that patients who failed a symptom validity test evidenced far greater cognitive impairment than patients who suffered severe traumatic brain injury, even though they had sustained far less neurological injury.

Review and Critique of Recent Studies

Courtney et al. (2003) noted that numerous articles, literature reviews, and texts have been written concerning the phenomena of symptom

exaggeration in adults, but similar research with children has been nearly "nonexistent." Such a lack of research seems odd, since statements regarding the validity of a child's performance within an assessment battery are often considered necessary when writing reports (Sattler, 2001).

As an exception, Child Neuropsychology (Volume 9) recently published three papers on the use of SVTs in children. The various researchers (Constantinou & McCaffrey, 2003; Courtney et al., 2003; and Green & Flaro, 2003) took slightly different methodological approaches to the question, which led to different conclusions based on the resulting data. Green and Flaro (2003) assessed 135 children who ranged in age from 7 to 18 ($M = 12.6$, $sd = 2.7$). All the children had been referred for the clinical assessment of neurological (e.g., FAS, TBI, etc...) and/or psychiatric disorders (e.g., schizophrenia, ADHD, conduct disorder, etc...). Referral sources requested diagnostic clarification and treatment planning. The status of the sample regarding litigation was not reported, but it would seem that none of the children were involved in litigation or were seeking disability. Along with a comprehensive assessment, all participants were given the WMT. Only 19 of the 135 participants (14%) fell below the adult cutoff for suboptimal performance. Green and Flaro reported that neither age nor intelligence had a significant influence on WMT scores. However, the authors noted that children with reading ability below 3rd grade performed relatively poorly compared to those who had reading ability at or above this level. They concluded that, as long as the child is able to read at or above the 3rd grade equivalent they should be capable of performance that is equivalent to that of the adult normative samples.

Courtney et al. (2003) conducted a similar study, as they assessed another "convenience" sample of 111 children who had been referred for academic and/or behavioral problems. Ages ranged from 6 to 17, with a mean of 11.2 ($sd = 3.5$). Note that these children were on average younger than those assessed by Green and Flaro (2003). As with Green and Flaro, these children had been referred for both diagnostic purposes and treatment planning. Courtney et al. reported results from both the WMT

and the CARB. They found that children under the age of 10 scored significantly lower on the WMT and CARB than older children, who performed as well as adults did in the normative samples. They also found that reading skills influenced performance on the WMT and CARB, with children whose reading ability was below a 3rd grade equivalent scoring particularly poorly on the two SVTs. They recommended that the use of the adult norms for children under 10 was ill advised, until further research has been conducted to determine a more appropriate cutoff. Furthermore, they believe that SVT cutoffs will likely have to vary to take into account a child's age, intelligence, and/or reading ability.

Finally, Constantinou and McCaffrey assessed 128 children within a public school setting with the TOMM and the Rey-Fifteen Items Test (FIT). Approximately half of their data was collected in Cyprus ($n = 61$) and the other half was collected in the public schools of upstate New York ($n = 67$). Participants ranged in age from 5 to 12, with a mean of 8.1 ($sd = 2.0$). Note that these children were even younger than the participants in the prior two studies. However, none of these participants had been referred for diagnostic assessment or clinical treatment, as was the case in the prior two studies. Only two children (1.6%) fell below the adult cutoff for suboptimal performance on Trial 2 of the TOMM. There was also no age or gender effect observed. However, on the FIT there was a significant positive association between age and FIT scores, with older children scoring higher than younger children in both Cyprus ($r = .72$) and New York ($r = .61$). There were no gender effects found with the FIT in either location. There were also no location effects evident with either of the two instruments.

The three reviewed studies have proven to be quite informative on the issue of SVT use in children. Briefly examining the combined results, three main points can be summarized: (1) some children engage in suboptimal performance, particularly in clinical settings, and use of SVTs to assess children's level of effort aids diagnosis and treatment planning. (2) SVTs cannot be used indiscriminately with children who suffer from

neurological dysfunction without considering the child's age, intelligence, and reading ability. However, if a child has either a 3rd grade equivalent reading level and/or is older than 10 years of age, the use of adult cutoffs for suboptimal performance appears reasonable. (3) SVTs vary in their sensitivity to very young age, extremely low levels of intelligence, and poor reading skills. As a result, it is unclear which of the SVTs is best at assessing effort in children very young children or dyslexic children below the age of 10.

As with any set of initial studies in an area, one can easily identify methodological flaws, which limit their generalizability and utility. First, these studies used "convenience" samples or volunteers, in the absence of control or comparison groups. Early in the adult effort literature a number of analog studies, in which normal volunteers were asked to feign neurological dysfunction, were conducted. This design has not yet been used with children. While many, including myself, have concluded that there is little more to learn from this type of study conducted with adults, this design still has the potential to advance our understanding of suboptimal performance in children. Furthermore, the more recent designs in the adult SVT literature have reported results from referred patients with real world incentives, who are compared to a set of feigning volunteers. The most complex design generally includes four groups: (1) normal controls, (2) neurologically impaired patients, (3) non-impaired participants who are instructed to feign impairment, and (4) patients who have been referred for assessment as part of compensation claim. The last group may or may not have independent evidence of neurological dysfunction. The benefit of such a design is that the normal controls and neurologically impaired patients can be compared directly, as can the "actors" and compensation seekers. Finally, the genuine and exaggerating participants from the first two groups can be compared to the genuine and exaggerating participants from the latter two groups.

Revisiting the three existing published studies using SVT with children using the four-group model described above sheds light on why different conclusions were reached by these three author

groups. First, in the Green and Flaro (2003) study, it was not apparent which of the four groups were represented by their heterogeneous sample of psychiatrically and/or neurologically impaired children. Clearly, they were not normal controls or feigning volunteers. However, based on the description, it is impossible to disentangle data representing children who had objectively defined neurological impairment versus those who may or may not have objective impairment but who were seeking compensation.

Similar difficulties appear when considering the Courtney et al. (2003) design. These researchers also used a clinical sample of convenience, and also failed to delineate which of their participants had independently verified neurological dysfunction. Finally, the compensation status of the sample was also not described. Thus, readers cannot properly evaluate the meaning of these results for the same reasons that were given for the Green and Flaro (2003) study. Furthermore, the assessment of intelligence and reading skills was often not concurrent with the SVT administration. Nor did all of the participants have reading assessment data available. There may be significant sampling bias introduced with these procedures.

In contrast, the Constantinou and McCaffrey (2003) study appeared to use the purest of sampling procedures. That is, it was clear that they had assessed "normal volunteers". However, in the adult literature, this group, the normal "control" group is often the least informative - both from a clinical and a test utility and validity perspective. Clinically, examiners rarely are referred patients who have no referral question and/or no incentives to perform poorly. Instead, the most common scenario is to be asked to determine whether there is impairment, how severe it is, and what event it can be attributed to, if any. In this situation, when a child performs poorly on a cognitive ability test, an examiner must determine if the child's low score was valid or not before it could be attributed to an accident or disease process. In the adult effort literature, analyses contrasting scores from the moderate-to-severe brain injured normative sample (Group 2) to scores obtained from patients instructed to feign impairment (Group 3) have proven to be the most

helpful in making this diagnostic discrimination. Unfortunately, data obtained only from normal controls, as in the Constantinou and McCaffrey study, are of little use to clinicians in making this discrimination. What these authors did show with their data is that, when children as young as 5-years-old have no identified neurological or developmental disorders they are capable of performing as well as adults on at least one of the SVTs, but clinicians should be cautious about over-generalizing this finding to other symptom validity tests (e.g., FIT).

Both studies that used convenience samples (i.e., Courtney et al., 2003; Green & Flaro, 2003) also examined a large number of "independent" variables to better "explore" the ramifications of their findings. For example, both sets of researchers attempted to statistically control for confounding variables (e.g., Verbal IQ) and they excluded data that they believed would have resulted in erroneous conclusions (e.g., patients whose reading level was below the 3rd grade equivalent). However, these manipulations failed to "fix" problems inherent in their research design. Specifically, both datasets had age and reading ability inextricably confounded. One cannot "covary" out the influence of one of these variables without doing considerable damage to the conclusions that can be drawn from an analysis of the other variable. In another example, reading ability and intellectual ability were also inextricably confounded. This has been far less of a problem in the adult SVT literature. Even severe TBI sufferers often retain their reading recognition skills, while suffering from significant memory and speed of processing deficits. However, in children who have not fully automated the reading process, intelligence and reading skills cannot be easily disentangled. This highlights the additional variable that has little to no influence in the adult literature on this topic: neurocognitive development. How researchers and clinicians can take this into account when assessing and diagnosing malingering in children is still a bit confusing.

Future Research

The main question to yet be answered is not whether SVTs should be used with children (they should), but rather which of the available tests are most effective in determining suboptimal performance and what cutoffs should be used for which children? My own thoughts on this issue have been influenced by the SVT data that we have collected on children at our university-based outpatient clinic (n = 75). Also, Dr. Randi Most has provided me with data from her outpatient private practice, where she administers SVTs to all of the children who have been referred to her (n = 40). Preliminary analyses of these two "convenience" samples show greater WMT score variability than do the published reports summarized above. In fact, Dr. Most initially contacted me to ask for statistical consultation on how best to interpret the WMT scores she was obtaining from the children she had assessed. She was obtained a 50% failure rate with children when she used adult cutoffs, which is far higher than that which was reported in the two samples that were just reviewed. In our own clinic, we initially obtained a 15% failure rate with children (based on one year of data), but this rate has been steadily rising over the past year, with some unexpected assessment results. Our sample includes volunteers from the community, who have no referral question, but came to our clinic to allow graduate students to practice test administration. Until this year we had no child volunteer who had failed the WMT using adult cutoff scores. This year, the failure rate of child volunteers has soared to 25% in a sample of young children. In our data, reading skills, level of intelligence, and age appear to be influencing scores obtained from the WMT, which has raised my concern about using adult cutoffs for children. It is possible that new norms will need to be generated.

Furthermore, to enhance our understanding of SVTs in children, I am currently conducting a study utilizing the four-group design that was detailed above. The first group will consist of child volunteers from the community, who will be administered SVTs along with a comprehensive test battery of commonly used instruments (e.g., WISC-IV, WRAT-III). We have already collected 20 such

participants for this group. Second, Dr. Joseph Ackerson from the Department of Pediatric Neurology at the University of Alabama Birmingham will be collecting SVT and intelligence/achievement data from children in an inpatient setting. His caseload typically includes various brain-injured and developmentally disabled patients, all of whom have independently verified neurological disorders. These patients will be tracked longitudinally and their litigation status will be known. Finally, we will be training some child volunteers to "feign" brain injury to see how well they perform compared to the other groups. All volunteer participants will be matched to the clinical samples with respect to age and year in school. We think our design approaches the level of sophistication that has been developed in the SVT literature with adults. We hope that our findings will help establish appropriate norms for children when using existing SVTs commonly administered to adults.

A remaining concern regarding the assessment of feigning in children comes from Larrabee's (2000) perspective of this issue when applied to adults. Specifically, Larrabee has demonstrated that malingering is multidimensional. Our proposed study, and the reviewed manuscripts, has only examined suboptimal performance in the cognitive domain. Understanding the multidimensional nature of malingering would include consideration of children's feigning of somatic (e.g., pain) and/or psychiatric symptoms (e.g., depression or anxiety).

Thus, an advanced understanding of malingering in children is likely to evolve from more sophisticated research designs, perhaps modeled after the adult literature; a consideration of developmental trajectories in children that may result in new SVT's that are specifically designed for children, and a more thorough operational definition of the multi-faceted construct of malingering that may help us identify different manifestations of suboptimal performing.

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Important Announcement to Division Members

We are pleased to inform you that Division 40 now offers a listserv through which you can receive information about new divisional activities as well as current advocacy initiatives that are relevant to clinical neuropsychology. APA policy prohibits us from enrolling our members in this listserv without their explicit consent; therefore, you will only be added to the list if you request to join. To join the list, send an e-mail message to listserv@lists.apa.org. The subject line should be blank. The message should read: SUBSCRIBE DIV40ANNOUNCE First Last [substitute your own first and last names]. We look forward to having you join the new listserv so that we can contact our members effectively about new initiatives. If you have any questions about the listserv, please feel free to contact Paula Shear at paula.shear@uc.edu.

Newsletter 40 is the official publication of Division 40. The Editor is Joel E. Morgan. The Associate Editor is Nancy Chiaravalloti. Dr. Morgan's address is UMDNJ-New Jersey Medical School, 12 Main Street, Suite 2, Madison, NJ 07940. Email: joelmor@comcast.net. Dr. Chiaravalloti's address is: Neuropsychology Laboratory, Kessler Medical Research Rehabilitation and Education Corporation, 1199 Pleasant Valley Way, West Orange, NJ 07052. Email: nchiaravalloti@kmrrec.org. Division 40's Website is: www.div40.org. Webmaster is Dr. Lloyd Cripe.