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An Issue Devoted To Forensic Neuropsychology

Competency to Stand Trial

Robert L. Denney, Psy.D., ABPN, ABPP-Forensic

U.S. Medical Center for Federal Prisoners

and

Forest Institute of Professional Psychology

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Ever since 1899, it has been established that the U.S. Constitution guarantees the right of a criminal defendant to be competent to undergo criminal proceedings (*Youtsey v. U.S.*). Putting an incompetent person through a criminal trial violates the Due Process Clause of the 14th Amendment. Not only does this requirement pertain to standing trial, the issue of competency can arise during any phase of the criminal judicial process, from the first contact a suspect has with law enforcement to the time of sentencing and even to the point of execution in capital cases (Grisso, 1988).

Neuropsychological evaluation of criminal defendants to assist in legal determinations is a unique endeavor (Denney & Wynkoop, 2000). The diagnostic demands inherent in a referral for neuropsychological assessment of competency to proceed, under most circumstances, requires a thorough evaluation. It usually requires a multi-data source model of information gathering. Acquiring information about the defendant's history from corroborative sources in addition to personal report is optimal. This information should ideally include medical records. The evaluation should include tests of current functioning, including multiple measures of test result validity (Larrabee, in press; Slick, Sherman, & Iverson, 1999). Lastly, the evaluation should include a personal interview regarding the defendant's views on his or her current legal situation. This paragraph included a number of "shoulds," but it is important to recognize that not all criminal defendants are cooperative. Defendants occasionally do not wish to undergo competency evaluation and will choose to remain silent through the process, or they may have substantial mental illness which limits their ability to discuss their perspectives on the legal case. The important issue is for the neuropsychologist to remain flexible and acquire information about the defendant's functioning and history from as many sources as possible. Lastly, it is imperative the neuropsychological evaluator understand the legal concepts pertaining

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Back issues of the Division 40 Newsletter are now available on line at the Division 40 Archives website at Louisiana State University.

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From The Editor

Dear Division Members,

Welcome to the most recent edition of Newsletter40. We are pleased to present this issue of the Newsletter which is focused on Forensic Neuropsychology, a rapidly growing area within our discipline. We have four outstanding articles by some of our division's most well-respected and prominent forensic neuropsychologists and I hope that you enjoy their excellent contributions. These papers/cases deal with important and timely issues which potentially affect us all. I want to publicly thank Drs. Greiffenstein, Baker, Denney, and Fisher for finding the time in their schedules to write their terrific pieces. Likewise, I want to thank Dr. Vanderploeg for writing the obituary for Dr. Ted Blau, a prominent division member and past APA President who recently passed away.

The APA Convention in Toronto looks terrific and I hope that many of you plan to attend. Thanks to Dr. Jennifer Manly for the easy-to-use pull-out of the convention program.

Best wishes for a great and relaxing summer.

Joel E. Morgan, Ph.D.
Editor, Newsletter40

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Mental Retardation & Capital Offenses Case History

Jerid M. Fisher, Ph.D., ABPN and
Laura Samson, Ph.D.

Re: United States vs. Mr. M.
age: 33

Mr. M was charged in 2002 with murder and robbery. The federal prosecutor in the southern district of New York, where this crime was allegedly committed, did not seek the death penalty. He was subsequently overruled by the US Attorney General, Mr. John Ashcroft. Mr. Ashcroft directed that this was a death penalty qualified case. Well known New York state death penalty defense attorney, Mr. T. Kindlon was appointed as Mr. M's counsel. It was Mr. Kindlon's job to assist in defending Mr. M against the possibility of death should he be found guilty of the alleged offense.

Mr. Kindlon relied upon the recent Supreme Court Decision known as *Atkins v. Virginia* (decided 6-20-02). In this decision, the Court argued that executing a Mentally Retarded (MR) individual constituted "cruel and unusual punishments" and was prohibited by the 8th Amendment. The Court argued that by definition, the MR defendant has "...diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses..." The Court indicated "MR defendants in the aggregate face a special risk of wrongful execution because of the possibility that they will unwittingly confess to crimes that they did not commit, their lesser ability to give counsel meaningful assistance, and the fact that they are typically poor witnesses and that their demeanor may create an unwarranted impression of lack of remorse for their crimes."

While the *Atkins* decision declared the death penalty for Mentally Retarded defendants unconstitutional, it was unclear in establishing precise criteria for the diagnosis of MR. Authoritative sources for possible MR definitions include: the *Diagnostic and Statistical Manual-IV* and the *American Association on Mental Retardation's 10th edition of Mental Retardation: Definition, Classification, and Systems of Support (2002)*. These sources both set forth specific criteria for a proper MR diagnosis.

Mr. Kindlon and his private investigator contacted Dr. Fisher in November, 2002 and subsequently retained him to conduct a forensic neuropsychological evaluation of Mr. M. The questions prompting this referral were: Did Mr. M. qualify for a diagnosis of MR and did he possess sufficient cognitive/intellectual resources to understand and appreciate his Miranda Warnings (prior to having signed a confession prepared by police interrogators)?

Dr. Fisher's evaluation initially undertook a detailed review of past academic, medical, and other archival records provided by the private investigator. In addition, 5 third party informants, possessing knowledge or other pertinent information about Mr. M were identified and subsequently interviewed. Detailed neuropsychological testing was conducted.

Developmental & Academic Background of the Defendant

Mr. M was the product of a full term pregnancy with normal delivery (Apgar 8); pre-natal care had begun in the 5th month. Developmental milestones were delayed: walked at 1.2 years, spoke first words at 2.0 yrs, started forming sentences at 4 years (first sentences at 5 years), tied shoe laces at 6 years, used to fall often and required orthopedic shoes until 3.5 years old.

In 1975 (~6 years old) developmental consultation indicated Mr. M was having problems with head banging, poor sleep, hyperactivity with history of slow development. He had attended Head Start the previous year. When going to bed he rocked or banged his head. His biological mother was not interested

in his care; he was in foster care. Evaluation concluded that he had "minimal brain damage (MBD)" with such signs as hyperactivity, decreased attention, perceptual handicap, etc. In the same year, his total score on the Standard Binet was 76 and Mr. M performed poorly on the Bender Gestalt. Further, he had poor language development, poor spatial relationships, and visual motor coordination problems.

A neurologist indicated Mr. M was a child "suffering from neurological impairment."

In 1978 (~8 years old) Mr. M was moved to a special program; he was described as having "MBD (minimal brain damage) plus emotional problems". In the same year, a neurologist indicated MR. M had "borderline intelligence."

In 1982 (~12 years old) School Psychological evaluation yielded: WISC-R VIQ=74, PIQ=88, FSIQ=80, Subtests ranged from average to mildly retarded. PIQ subtests revealed difficulties with visual motor coordination.

In 1983 (~13 years old): Frequently "rocks" the entire day in the classroom which he claimed helped him to feel calm. His academic functioning levels were "seriously deficient in all areas considering that he is a seventh grade student." Noted to be a functional non-reader with 3rd grade math skills. "Christopher has great difficulty functioning independently." He was reclassified (age 13) into a program with greater structure, more individualized attention, and academic remediation.

1984 (~age 14): "Christopher is terribly disoriented in the classroom...needs lot of personal interaction with a teacher as his academic levels are too low to allow to him to work independently yet." Reading at first grade level. Mr. M did not have word attack skills and was described as a "functional nonreader". He had significant expressive and receptive language deficits, delays in reading comprehension, and an "apparent deficit in both auditory and visual short-term memory." WISC-R VIQ-73, PIQ-75 FSIQ 72

1986 (~age 16): Attended school for ~2 1/2 months on a consistent basis. Language skills were noted to be significantly delayed. Mechanical writing skills were extremely poor. Mr. M apparently discontinued school at age 16.

Mr. M has fathered 4 children with 3 women. One son has a speech disorder and is learning disabled and possibly mentally retarded. Another son has an individualized educational plan. Recent school records reveal this son was functioning "considerably below grade level in all curriculum areas...Cognitive skills are in the mentally deficient range both verbally and nonverbally." His daughter has behavior problems but her cognitive abilities are intact. An infant son reportedly already exhibits speech delays and hyperactivity.

BACKGROUND INFORMATION FROM 2002/2003 INTERVIEWS WITH MR. M

Background Information provided by Mr. M

Mr. M was not raised by his parents. He did not know about his biological parents' educational background although he indicated that his father could not read. He denied a mental health or substance abuse history in his mother but did not possess knowledge about this subject with respect to his father. Mr. M's mother worked in day care (although he was uncertain about this) and his father operated a truck that picked up garbage dumpsters.

Prior to incarceration, Mr. M resided with his long-time (~14-16 years) girlfriend in her apartment. She paid the rent with the assistance of Welfare. Mr. M was responsible for the cable TV bill and contributed additional money to cover other living expenses. He indicated that his girlfriend would show him the cable bill; he would then take out his cash earnings from his maintenance work and she would count out the necessary amount to cover this expense. Mr. M and his girlfriend went grocery shopping every 2 weeks. He denied he could shop independently, claiming that if he did he would "just buy a lot of Fruity Pebbles." Mr. M denied more than rudimentary kitchen skills, observing that if he was forced to live alone he would eat TV dinners.

Mr. M denied ever having a bank account. He kept his money in a jar. When asked how he read a restaurant menu, Mr. M claimed to avoid this obstacle by ordering fried chicken or a hamburger.

He operated a motor vehicle although did not possess a valid driver's license because he could not read, hence could not pass the required driver's test.

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Things I Didn't Learn In School: A Look at Forensic Work

W. John Baker, Ph.D.

Looking back on my education and training, like most of us I recognize that the real world patient was not like those I studied in textbooks. Maybe they did not read the same texts. Now that my practice has become largely forensic in nature, I have come to accept that the individuals I evaluate are not like those I saw in the hospital or clinic. This case was chosen to present the differences in forensic practice. It is unlikely that this individual will resemble anyone you might see in clinical practice. Names are omitted to protect both the innocent and guilty.

Ms. G was a 25-year old, married mother of one child, who was seen for independent evaluation in the context of her lawsuit, alleging a closed head injury and permanent brain damage, specifically memory impairment. My examination was approximately four years after her injury.

The facts of the case

Ms. G was exiting a McDonald's Drive thru when she hit a bakery truck broadside just as she entered the roadway. The truck was actually knocked on its side. Ms. G struck her chest on the steering wheel. There was no loss or disturbance of consciousness. She had her 6-month old child in a car seat in the rear seat. He was unharmed. The bakery truck driver was unharmed, as well.

Ms. G was taken to the hospital. Emergency room examination revealed a nondisplaced fracture of the sternum and complaints of chest pain. Also noted was a red area on her forehead that was slightly tender to the touch. She was kept overnight. The next day, Ms. G was somewhat histrionic in her presentation and a neurologist was consulted. He suggested the possibility of some postconcussive symptoms. She was nonetheless released to go home that day.

Ms. G's husband was not at the hospital on the evening of her accident. In his deposition, he explained that he was at the yard where her car was towed. He went with his father-in-law to video tape the car and the failed seatbelt. When asked why he went there instead of the hospital, Mr. B said it was going to be dark soon and he needed to film in good light. I guess one has to have their priorities straight.

Except for follow-up care with her primary physician, Ms. G received no further care for some time. Eventually she was seen by a physician who diagnosed postconcussion syndrome. This eventually became a closed head injury. She was seen by neurologists, neuropsychologists, psychiatrists, and a host of other medical specialists. She was sent for cognitive rehabilitation therapy, speech and language therapy and occupational therapy. By the time I examined Ms. G, she was receiving cognitive rehabilitation three days a week. She had undergone three neuropsychological evaluations, only one of which resulted in a diagnosis of a brain injury.

Symptoms and complaints

Ms. G claimed to have no memory since the date of the accident. She claimed that she still remembered her son as a 6-month old child. According to records and Ms. G's self-report, she could only remember about four hours. After four hours, her memory was lost and she apparently began a new four hour memory loop. (I did not make this up!) She also claimed that if she fell asleep or had a "seizure" her memory for the past period (4 hours or less) would be lost. Ms. G explained that each morning, her husband would bring her up to date (so to speak) and remind her that their son was actually 5 years old. According to Ms. G, she kept photos of family members on display all over her home, so that she could constantly remind herself of who was who and how old they were. Her therapists had Ms. G maintain a computer log of each day's activities so as to help her "regain her memory." In addition to her four hour memory loop, Ms. G also

claimed other symptoms including a loss of her ability to read, spell and perform simple arithmetic.

Other facts and findings

By the time of my evaluation, Ms. G had been written up in the local newspaper. Her tragic story had appeared in *The Globe*. She was on Oprah! I still have a copy of the show. Along with Ms. G, the other guests were brain injured, each with a different story. Oprah, bless her heart, looked for that silver lining and asked Ms. G if there was anything that she could report that was better or of benefit due to her terrible injury. Ms. G responded by pointing out that her husband can now take her shopping and have her pick out and try on clothes, only to put them away for gifts at a later date. Now, if you are saying something like “How does she remember that?” you are not alone. That’s what I said! There were other individuals on the show with Ms. G. For the most part, they appeared to have suffered significant brain injuries. It was interesting when one person kept trying to find something that Ms. G could do now. Ms. G kept denying that she could do whatever was suggested. One young man was obviously impaired and he insisted that he had completely recovered. He was back to college and did have some difficulty, but minimized this. He then said, as an afterthought, “Don’t tell my professor.”

Ms. G’s therapists had her recording every day’s events on her computer. Many of these entries were rich in detail and often recalled by Ms. G at the end of a very long (more than 4 hours) day full of activity. On many occasions, she would make note of the fact that her husband was not with her that day, or that he was in bed and she was writing the events just prior to going to bed. These entries did not comport with claims that she needed assistance to keep her daily log.

Medical findings

All medical studies were negative. CT scans, MRI scans, EEG testing, etc. were all normal. Neuropsychological test results varied considerably, ranging from normal to severely impaired. Neuropsychological findings were inconsistent across examinations and within examinations. Symptom validity testing (when done) was positive.

MMPI-2 profiles were always elevated on scales 1 and 3. Some profiles were also elevated on scales 2 and 8. The MMPI-2 profiles were also elevated on FBS.

In spite of the dearth of objective findings, Ms. G was seen by dozens of doctors. It was my suspicion that many of these referrals were orchestrated by Ms. G’s attorney. The attorney never made a direct referral. Instead, Ms. G was probably told to ask one of her doctors for a referral to a specific doctor. Over the years, I have come to recognize the names of doctors who see a lot of plaintiffs. Ms. G had seen nearly all of those individuals. At least one doctor’s note indicated that the patient had requested a referral to a neurologist (who’s name I recognized) specializing in closed head injuries. To the doctor’s credit, he did not make the referral because he did not know the other physician.

Litigation

Ms. G filed a first party claim against her insurance company. The case was settled out of court. The insurance company agreed to pay for all necessary medical care. The insurance company also agreed to compensate her husband \$50,000 a year for attendant care services. This established the record of Ms. G being disabled and in need of 24-hour supervision.

Ms. G’s liability claim was against three defendants. She sued the company that owned and operated the bakery truck. She sued the car manufacturer, claiming that her seatbelt and shoulder harness failed. She sued the dealership, claiming that they failed to repair the defective seatbelt. Apparently, this malfunctioning seatbelt was identified by Ms. and Mr. G some time after purchasing the car. They had taken the car in for service and pointed this out.

In her complaint, Ms. G, through her attorney demanded \$22-million. The case went to mediation. For those unfamiliar with this procedure, a mediation panel is comprised of three attorneys. One attorney is a plaintiff attorney, one is a defense attorney and the third is allegedly a neutral attorney, meaning he either does both plaintiff and defense work or he has no experience in personal injury

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Testamentary Competence: Antemortem and Postmortem Neuropsychological Analysis

M. Frank Greiffenstein, Ph.D., ABPP-Cn
Psychological Systems, Inc.

The aging American population may require extensive neurological and neuropsychological services to a degree never seen before. Longer life expectancies and improved medical care puts citizens at greater risk for developing cognitive disorders such as dementia. Further, demented persons may survive longer with their diseases. The mental changes associated with dementia may predict growing concern about, indeed outright legal challenges to, the mental capacity to create wills, codicils and trusts. Courts are becoming more receptive to mental health testimony regarding civil competency (Melton, Pettila, & Poythress, 1998) and neuropsychologists are in an excellent position to apply their knowledge base, measurement and reasoning skills to assist the trier of fact in civil competency issues.

The antemortem neuropsychological examination is the practice of determining whether cognitive abilities supportive of legal competencies are present or absent contemporaneous with a will's creation. In cases where inferences about cognitive state are made after a testator dies, the term "neuropsychological autopsy" applies (Greiffenstein, 1996). This article reviews the key legal issues in probate matters and offers procedures for expert consultation, illustrated by one case example.

LEGAL BACKGROUND

The two main challenges to a will are testamentary competence (TC) and undue influence (UI). Exclusive of some variants, the concept of TC is generally uniform across jurisdictions. Translated from "legalese" into plain English, the four basic elements of TC recognized by almost all states, are: (1) Knowledge of the will's existence, (2) Memory for assets, (3) Knowledge of potential heirs, and (4) Anticipation of the will's effects on the heirs. Some states also require the absence of delusions and hallucinations, termed "insane delusions", using a "but for" standard. From a neuropsychological standpoint, some state variants are interesting. Minnesota law seems to require direct evidence of intact working and recent memory: The testator "must be able to hold [nature and extent of property] in his mind long enough to form a rational judgment concerning them" (Estate of Congdon, 1981).

Undue influence (UI) is defined as persuasion based on "coercion, compulsion, or restraint." UI challenges to wills require evidence the testator's "free agency was destroyed" or "subjugated" by a beneficiary of the will. UI is a complex concept, as it involves legal assessment of a deviant social relationship as opposed to a single individual's cognitive capacity. Evidence for UI can take many forms, and the courts recognize several indicia for it, including unnatural provisions in the will, provisions inconsistent with prior statements of testamentary intent, and circumstances allowing the beneficiary to control the testator's preparation of the will (Spar & Garb, 1992). However, of greatest interest to neuropsychologists is one of these accepted indicia: "A mental or physical condition that facilitates subversion of the testator's free will" (Spar & Garb, 1992). Such artistic language may be translated into psychological terms: UI may be present if psychological symptoms or neuropsychological deficits impair the testator's resistance to suggestion. Neuropsychologists never testify that undue influence was present as they rarely get to evaluate the will's beneficiary. Instead, neuropsychologists may testify to the presence or absence of conditions sufficient for supporting UI.

GENERAL LEGAL CONTOURS

The involvement of neuropsychologists in forensic matters requires some skill at mapping legal terms unto neuropsychological terms. There is no accepted lexicon for precise translation, but some general

guidelines assist in providing direction. First, the neuropsychologist must understand that the threshold for testamentary competence is very low (or, the threshold for incompetence is very high). That is, there is a presumption of competence, because a liberty interest is at stake. American society honors its individual citizens' pursuit of many liberties, and only the most clear compelling evidence is necessary for removal of these liberties. Contrast this with personal injury suits, where only damages, not liberty interests, are at stake. Thus, the mere presence of mental illness or cognitive defects, does not automatically rule out TC. The law asks not whether deficits exist, but whether they have sufficient functional impact to undermine the validity of a will. The implication for neuropsychologists is this: Cognitive deficits must be severe and pervasive to serve as an effective challenge to a will.

A second consideration is that UI may be easier to establish from a legal standpoint. In this case, there mere presence of cognitive impairments and even limitations may be sufficient to meet a burden of proof. The presence of a memory disorder of mild to moderate proportions, for example, is not a bar to executing a valid will. However, the same condition may create a state of dependence of the testator on a beneficiary. The testator may require the beneficiary to provide important daily details he or she has forgotten. A memory-impaired testator may also be open to suggestions about events that never happened. It takes much less influence to control the actions of a person whose instrumental abilities are affected by cognitive deficits.

The neuropsychologist's involvement in TC cases may take two forms: (1) Prospective evaluation of the testator's cognitive capacities contemporaneous with a will's creation and (2) retrospective judgment of competence and undue influence.

ANTEMORTEM EVALUATION

The best evidence for testamentary capacity is the testator himself. Unfortunately, evaluations of cognitive competence in association with legal document creation are rare. Only a few attorneys anticipate future challenges to a will, and arrange

capacity assessments during the testator's life. A successful demonstration of minimum cognitive skill will reduce the probability of a later contest.

As a general rule, the neuropsychological examination of a living testator should conform to both the general thrust of the law and to the specific elements of testamentary capacity. With regards to general thrust, recall that the threshold for testamentary competence is low, so that even mild to moderate cognitive impairments, such as mild memory loss, are not a bar to a valid will. Hence, the tests used should be brief and simple measures of cognitive function. Further, the decision model should rest on evidence for severe deficits, perhaps scores in the 5th percentile or less. Examples of brief cognitive measures suitable for this work are the Folstein Mini Mental State Examination (Folstein, Maiberger, & McHugh, 1977; Rovner & Folstein, 1987), the Cognistat (Drane et al., 2003; Engelhart et al., 1999), and the RBANS (Aupperle, Beatty, Shelton Fde, & Gontkovsky, 2002; Randolph, Tierney, Mohr, & Chase, 1998).

Second, the clinical interview is a valuable means of addressing the specific elements of testamentary competence while simultaneously addressing delusions, hallucinations, and undue influence. For example, with regards to knowledge of the will's existence, the testator could be asked why they are preparing the will at this particular time. This single question could elicit evidence for a delusional system ("The newspaper said my death is approaching") or coercion ("My daughter wrote down some ideas for me, she thinks she deserves everything because she is taking care of me."). Questions regarding the second prong of TC (knowledge of property's nature and extent) may include questions on occupation, personal possession, and property. These questions may be open-ended, but some may wish to formalize this question by systematically assessing free recall, prompted recall and recognition memory. This interview could have both standardized and particularized components. For example, if the testator can't recall their property, one could provide them with a three-choice list such as "I own a house in (1) Detroit, (2) Grand Rapids, (3) Los Angeles."

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Competency to Stand Trial

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to competency to proceed.

Dusky v. U.S. (1960) outlined the core standard for competency to proceed in criminal matters:

[The] test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding-and whether he has a rational as well as factual understanding of the proceedings against him. (p. 402)

The *Dusky* standard spells out the minimal level of competency necessary under the U.S. Constitution for all criminal jurisdictions in the United States. It has, consequently, been written into statute in one form or other in most jurisdictions in the U.S. (Favole, 1983). The federal standard (18, U.S.C., § 4241) defines competency as whether or not a defendant is "suffering from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense."

In addition to *Dusky* spelling out the minimal requirements, it also makes a few other key points. Competency is an issue of current ability as opposed to mental state at some time in the past (the exception of course is an evaluation of retrospective competency). The phrase, *ability to consult with his lawyer* implies capacity to do so rather than desire to do so. It is not unusual for criminal defendants to not want to cooperate with counsel for reasons not rooted in mental illness. The ability to identify the motivation for this lack of cooperation is the task of the forensic evaluator. Lastly, the standard also includes the phrase, *reasonable level of understanding* rather than a *perfect* level of understanding; a criminal defendant is not expected to have perfect understanding. While these small components of the *Dusky* standard are important, the core issue of concern remains the nature of "rational as well as factual understanding." Incompetence requires more than simply presence of mental abnormality.

According to Reisner and Slobogin (1990), factual understanding comprises a person's strict understanding. Examples include a defendant's

ability to repeat information provided to them, paraphrasing that information in their own words, and displaying an ability to put the information into use. They present rational understanding as involving a rational manipulation of the information. It can be evaluated by observing how information is used in decision making and includes such abilities as judgment, comprehension, good reality testing, rational weighing of risks and benefits, and relevance of facts to the immediate situation. Although there are various descriptions of specific points within this concept of competency for various activities, the general understanding of competency as outlined in *Dusky* is the core aspect of competency for any point in the criminal judicial process.

Courts have also outlined the differences between procedural competency and decisional competency. Thus far, I have addressed *Dusky* as referring to procedural competency. It also applies to decisional competency, such as when defendants choose to waive certain Constitutional rights. Examples of acts requiring decisional competency include confessing, pleading guilty, acting as one's own attorney, and choosing to forego an insanity defense. While *Dusky* applies to these activities, the U.S. Supreme Court outlined that inquiries should also be made to make sure the defendant's decision is "knowing," "intelligent," and "voluntary" (*Colorado v. Connelly*, 1986; *Friendak v. U.S.*, 1979; *Godinez v. Moran*, 1993). "Intelligent" does not imply that the decision needs to be in good judgment or necessarily in the defendant's best legal interest (*Faretta v. California*, 1975). Lastly, courts have generally held that amnesia for the alleged offense does not necessarily eliminate a defendant's competency; it depends on the facts of the case (*Wilson v. U.S.*, 1968).

Case Example

Mr. Jones¹ was a 27-year-old, right handed, man who was court ordered for inpatient evaluation of his competency to stand trial under 18, U.S.C., § 4241. He was charged with Obstructing Commerce by Robbery, Use of a Firearm During a Crime of

¹ Not his true name. Also minor details of his history have been changed to protect anonymity.

Violence, and Felon in Possession of a Firearm. His competency was in question because he presented as cognitively dull and claimed to have very poor memory and a history of seizure disorder and traumatic brain injury.

At the time of his initial clinical interview, Mr. Jones presented himself as calm, pleasant, and cooperative. He spoke in a relevant manner, but his speech was slow, deliberate, and halting. There was no evidence of thought disorganization. His affect appeared appropriate and mood congruent. He denied suicidal and homicidal ideation. He claimed to sometimes hear the voice of a dead friend but did not otherwise display symptoms of psychosis. When initially seen by nursing staff, he claimed he had injured his head in a motor vehicle accident in 1999. He claimed occasional seizures and headaches.

Personal History

Mr. Jones' responses were unclear, inconsistent, and limited in content when interviewed at a later date. He could provide detailed recollection regarding some areas but only vague recollections in others. He recalled he was born in New Hampshire but did not know the city or county of his birth. He has an older brother but was unsure of his age or if they shared the same father. He did recall that his brother is disabled and proceeded to describe his disability in detail. His mother was his primary care giver. He did not recall meeting his father until he was in the 8th grade. He denied any instances of physical or sexual abuse as either victim or perpetrator. Mr. Jones was unable to recall information related to his formal education. He did not recall grades received, discipline problems, special classes, highest grade completed (he indicated "probably 8th grade"), or if he enjoyed school. During an interview with another clinician, he said he attended regular classes in public schools, received "probably decent" marks, never repeated a grade, and completed ninth or tenth grade. Work history provided by Mr. Jones was limited. He indicated he had never married.

Mr. Jones denied any history of psychiatric treatment or hospitalization. He reported using cocaine, alcohol, and marijuana in his lifetime but did not know if he did so daily or occasionally. In

relating his medical history, he indicated he was told by his mother that he had a history of seizures. When describing his seizures he stated they are "unconscious seizures"; therefore, he does not know when they occur. He recalled a history of hospitalizations and stated, "When I act strange my family takes me to the hospital." He remembered having been in an automobile accident but was unsure if he had sustained a head injury.

Despite efforts to contact family, corroborative information regarding his personal history was not available. Mr. Jones indicated he could not recall the names or locations for prior hospitalizations; consequently, no medical records were obtained.

Medical Assessment

Physical examination results were normal throughout. Cranial nerves II-XI were grossly intact. No sensory or motor deficits were present. Speech was normal. Deep tendon reflexes were 2+/4 throughout. No tremors were noted. All four extremities appeared normally developed without atrophies or weakness. Plantar reflexes were normal. Gait was normal. Tandem walking was normal. Finger-nose test was normal. Romberg test was normal. CT scan of the head was completed, with and without contrast. The radiologist concluded the ventricles and sulci appeared appropriate in size and configuration for the patient's age. There was no midline shift, mass effect, or intracranial hemorrhage. There was a "ringlike area of enhancement" within the left temporal lobe which was believed to represent normal vasculature. The bony calvarium appeared intact.

Test Results

Neuropsychological test and MMPI-2 results are outlined in Table 1. Prior to testing, Mr. Jones said he enjoyed reading the Bible. He then demonstrated reading a portion of the New Testament aloud. Most striking in the results is an overall level of impairment throughout that were inconsistent with his presentation, particularly when observed unobtrusively on the ward. In addition he maintained activities of daily living and independence without trouble. With the exception of the MMPI-2 validity scales, Table 2 contains free

standing and imbedded validity indices. The free standing measures were scattered throughout the testing with simple appearing memory strategies preceding more difficult clinical measures of memory. Mr. Jones must be the "unluckiest person alive" as he placed nearly every forced-choice, two alternative assessment procedure administered to him in the below chance range. There is no way to interpret these results other than as a willful attempt to appear disingenuously impaired.

Clinical Formulation

Mr. Jones never demonstrated objective signs of neurocognitive compromise during this 30 day inpatient evaluation. There were no indications of a seizure disorder. Given the equivocal CT, an MRI would have been helpful. An EEG would have been helpful as well, but these procedures were not done. Given his claimed memory disturbance and seizure history, as well as questionable abnormality in the right temporal lobe, a complex-partial seizure disorder needs to be ruled out. Nevertheless, the presence of such a condition would not have accounted for his inconsistent behavioral presentation and psychological tests results. He was considered to be malingering and to have a history of substance abuse.

Competency Interview

The Revised Competency Assessment Instrument (McGarry, Lelos, & Lipsitt, 1973; Riley, 1998), a structured interview concerning understanding and reasoning about the criminal justice system, was administered to Mr. Jones. When asked about his charges, Mr. Jones responded that his lawyer "said something about a robbery." He claimed he did not know why it was a federal charge and emphasized that the state had dismissed the state charge. When asked about possible sentences he could receive, he claimed he did not know. He said his lawyer at first told him 15 years and then later said he was facing 21 years by a plea or possibly 52 years if convicted at trial. He understood the consequences of guilty and not guilty verdicts and appeared to understand the meaning of the corresponding pleas; although, he adamantly insisted a plea of guilty did not mean an acknowledgment of

guilt but an admission that the "odds were against" the defendant.

When asked about the roles of the various participants in a trial, Mr. Jones seemed to be carefully avoiding revealing too much knowledge, and instead attempted to present minimal or not quite correct answers. For instance, during our discussion he had spontaneously referred to twelve jurors making a decision. A few minutes later when specifically asked about the number of jurors in a trial, he replied, "Thirteen." When asked why there were thirteen, he replied, "because there were thirteen colonies." Following that interchange, he was confronted about his obvious efforts to present himself as lacking knowledge he clearly possessed. He was, subsequently, much more straightforward and informative in his replies. During the course of questioning, he also spontaneously and correctly used terms such as "discovery, indictment, plea bargain, and reduced sentence."

Once Mr. Jones appeared to be answering in a more straightforward manner, he revealed a reasonable understanding of the court system. He was aware that a defendant could not be required to testify. He understood the adversarial nature of cross examination. He knew the meaning of evidence. He had a good understanding of the meaning of plea bargaining, and explained that defendants usually received lighter sentences with a plea than if convicted at trial. He understood the need to collaborate with his attorney and expressed a willingness to share pertinent information with his attorney. He understood the meaning of attorney/client confidentiality. When asked if he had confidence in his current attorney, Mr. Jones replied that he did not really know him well. He also stated he wished he had an attorney he was paying because he believed he would receive a better defense, a belief common among defendants. Nevertheless, he verbalized no delusional ideas concerning his attorney and explained that in the past he has always relied on the advice of his attorneys in making decisions.

Mr. Jones maintained a healthy self-interest in the outcome of his case. He understood appropriate courtroom behavior and throughout the evaluation maintained appropriate behavioral control. He was

able to express his ideas and opinions in an understandable manner when he chose to do so. Although he claimed to have no memory of his activities at the time of the alleged offenses, his claims were not credible given the overall efforts he displayed to malingering cognitive impairment and the investigative records (if correct) which included confessions to the crimes. Mr. Jones did express somewhat overly optimistic expectations concerning the likely outcome of his case, placing a great deal of importance on possible minor inconsistencies in the police reports (which he seemed to recall quite accurately), but these expectations did not appear to be the result of any mental disorder. He was opined to be malingering mental illness/defect and to be competent to stand trial.

Conclusion

This case exemplifies how multiple measures of test validity can be included in a complicated neuropsychological evaluation. Without the strong findings in the test results, evaluating the veracity of this man's presentation would have been difficult, particularly given unusual imaging results and lack of MRI and EEG. It must be remembered that criminal defendants who have definitive neurological injury can also exaggerate their deficits (Wynkoop & Denney, 1999). Moreover, this case demonstrates important issues regarding criminal trial competency and how those issues are addressed in a competency interview.

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ANNOUNCEMENT

Early Career Award in Neuropsychology

Division 40 is seeking nominations for the Division's Early Career Award in Neuropsychology. The award is for outstanding contributions to the field of neuropsychology by a neuropsychologist who is less than ten (10) years post award of the doctorate. The deadline for nominations is January 5, 2004.

Please contact Diane Howieson, Ph.D. for further information.

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Table 1. Test Results for Mr. Jones.

Halstead Impairment Index	0.7	T31#
Booklet Category Test (errors)	157	T12#
Trail Making Test-A	36	T39#
Trail Making Test-B	253	T24#
TPT	Defendant pulled down bandana and "peeked."	
Seashore Rhythm (correct)	6	T23#
Speech Sounds Perception (errors)	42	T22#

Aphasia Screening Test performance suggestive of:

Dysnomia, Dyscalculia, Central Dysarthria, Spelling Dyspraxia, Right/Left Confusion

Spatial Relations	4	T37#
Sensory-Perceptual Errors	41	T29#
Finger Tapping-Dominant	60	T62
-Nondominant	54.4	T65
Grip Strength-Dominant	31.5	T33#
-Nondominant	22.5	T19#L
Grooved Pegboard-Dominant	94	T27#L
-Nondominant	84	T34#
Sensory-Perceptual-Right	25	T25#
-Left	15	T25#
Tactile Form Rec.-Dominant	19	T40
-Nondominant	19	T37#

WTAR-Predicted WAIS-III VIQ: 69

<u>WAIS-III IQ Scores</u>	FSIQ	48	<u>MMPI-2</u>		
	VIQ	54	VRIN	T69	
	PIQ	50	TRIN	T65	
<u>WAIS-III Subtest scaled scores (ss)</u>			F (R27)	T119	
Vocabulary	3	Picture Completion	1	F(B)	T100
Similarities	1	Digit Symbol	3	Fp	T99
Arithmetic	1	Block Design	1	FBS	R
Digit Span	3	Matrix Reasoning	2	L	T92
Information	3	Picture Arrangement	1	K	T54
Comprehension	1	Symbol Search	1	S	T59
Letter-Number Seq.	1			Hs	T66
				D	T93
<u>WMS-III</u>		<u>RCFT</u>		Hy	T76
Auditory Immediate	50	Copy	6, T<20	Pd	T62
Visual Immediate	57	Immediate Recall	2.5, T<20	Mf	T64
Immediate Memory	45	Delayed Recall	1, T<20	Pa	T108
Auditory Delayed	52	Recognition	12, T<20	Pt	T85
Visual Delayed	53			Sc	T108
Auditory Rec. Delayed	55			Ma	T43
General Memory	45			Si	T76

Table 2. Free Standing and Imbedded Validity Indices.

<u>Rey 15-Item¹</u>							(+ suspicious)
Recall	9 items, 3 rows						
Recognition	9 items						
Total	18 items						+
<u>WMT²</u>							Compared to Sev. TBI
IR	12/40	30%	z =	-2.37	p =	0.0089	z = -12.86
DR	12/40	30%	z =	-2.37	p =	0.0089	z = -16.97
Cons1		55%	z =	.47			z = -5.91
Cons 2		75%					z = -0.54
MC	1/20	5%					z = -4.99
PA	2/20	10%					z = -3.45
FR	3/40	7.5%					z = -2.49
Classification: Below Chance Exaggeration							
<u>CARB³</u>							
Block 1	28/37	75.7%	z =	2.96	p =	0.0015†	z = -8.6
Block 2	14/37	37.8%	z =	-1.32	p =	0.093	z = -24.4
Block 3	11/37	29.7%	z =	-2.30	p =	0.011	z = -13.2
Classification: Very Poor Effort							
<u>TOMM⁴</u>							
Trial 1	15/50	30%	z =	-2.68*	p =	0.0037	
Trial 2	5/50	10%	z =	-5.51*	p <	0.0000	
Trial 3	6/50	12%	z =	-5.23*	p <	0.0000	
<u>VIP⁵</u>							
Nonverbal:		Invalid-Malingered (below chance performance)					
Verbal:		Invalid-Malingered (below chance performance)					

<u>INDEX</u>	<u>RAW SCORE</u>	<u>CUTOFF</u>	<u>RESULT (+ suspicious)</u>
<u>WAIS Discriminant Function⁶</u>	.6564474	>0	+
Reliable Digit Span ⁷	5	<7	+
<u>BCT Validity Indices⁸</u>			
Total Errors	157	>87	+
Subtest I & II Errors	18	>1	+
Subtest VII Errors	13	>5	+
Bolter Item Errors	14	>3	+
Rarely Missed Item Errors	14	>2	+
Tapping Combined Mean ⁹	114.4	<63	
Seashore Rhythm Test	6/30	<10	+(z = -3.11 p = 0.0009)*
RCFT ¹⁰ Atypical Recog. Errors	2	>0	+
Recognition Failure Errors	0	>0	

† Better than chance.

* Based on Siegel (1956) formula (1-tail prob.).

1. Boone, Salazar, Lu, Warner-Chacon, & Razani (2002)
2. See Green, Lees-Haley, & Allen (2002).
3. See Allen, Iverson, & Green (2003).
4. Tombaugh (1996). See Tombaugh (2002).
5. Frederick (1997). See Frederick (2002).
6. Mittenberg, Theroux, Aquila-Puentes, Bianchini, Greve, & Rayls (2001). See Mittenberg, Aquila-Puentes, Patton, Canyock, & Heilbronner (2002)
7. Greiffenstein, Baker, & Gola (1994).
8. See Sweet & King (2003).
9. See Larrabee (in press).
10. Meyers & Meyers (1995), pp. 79-81.

HOSPITALITY SUITE

Division 40 is offering the use of its Hospitality Suite in the Fairmont Royal York Hotel. The dates are Thursday August 7 through Sunday August 10. All are welcome to attend the several committee meetings and receptions already scheduled in the suite, which are listed below. Several times are still available... if you have an idea for a Division 40 – related gathering, contact Jennifer Manly at jjm71@columbia.edu or 212.305.8604 no later than August 1. Flyers of our full suite schedule will be available at the convention and on the Division 40 website at <http://www.div40.org>.

The following dates and times have been scheduled:

Thursday August 7

7:00 – 8:15 PM Launch Party: Association of Neuropsychology Students in Training, Hosts: Michael Cole and Chris Loftis

Friday August 8

10:00 – 10:50 PM Program Committee Meeting, Chair: Bob Elliott, PhD
11:00 – 12:00 PM Publications Committee Meeting, Chair: Russell Bauer, PhD
12:00 – 12:50 PM Science Advisory Committee, Chair: Michael Westerveld, PhD
1:00 – 2:30 PM Practice Advisory Committee, Chair: Neil Pliskin, PhD
6:00 – 8:00 PM Division 40 Reception, Host: Antonio Puente, Ph.D.

Saturday August 9

12:15 – 1:15 PM Education Advisory Committee; Chair: Sandra Koffler, PhD
1:30 – 2:30 PM Ethnic Minority Affairs Committee; Chair: Jovier Evans, Ph.D.
2:30 – 3:30 PM Women in Neuropsychology Steering Committee Meeting; Chair: Paula Shear, Ph.D.

2003 APA Division 22 Program

Thursday August 7, 2003

- 12:00 - 12:50 Symposium: New Applications of Cognitive Behavioral Therapy for Chronic Fatigue Syndrome
Chair: Leonard A. Jason, PhD
Metro Toronto Convention Centre, Meeting Room 205D
- 1:00 - 2:50 Symposium: Disability, Gender, Ethnicity, and Community—Using the Participatory Action Research Model
Chair: Paul Leung, PhD
Metro Toronto Convention Centre, Meeting Room 713A
- 3:00 - 3:50 Symposium: National Data Sets Available for Disability Policy and Program Research
Chair: Susanne M. Bruyere, PhD
Metro Toronto Convention Centre, Meeting Room 713A

Friday August 8, 2003

- 8:00 - 9:50 Symposium: Impact of the Model System Programs on the Practice of Psychology in Medical Rehabilitation
Co-chairs: David S. Tulskey, PhD & Mitchell Rosenthal, PhD
Metro Toronto Convention Centre, Meeting Rooms 201E/F
- 2:00 - 2:50 Symposium: APA's New Ethics Code—Implications for Rehabilitation Psychology
Chair: Shane S. Bush, PhD
Metro Toronto Convention Centre, Meeting Rooms 202C/D
- 3:00 - 3:50 Invited Address: Leonard Diller Honorary Lecture
Speaker: Beatrice Wright, PhD; Chair: Daniel Rohe, PhD
Metro Toronto Convention Centre, Meeting Rooms 202C/D
- 4:00 - 4:50 Presidential Address and Fellows Addresses
Chair: Robert G. Frank, PhD
Metro Toronto Convention Centre, Meeting Rooms 202C/D
- 5:00 - 6:50 Social Hour and Awards Presentation
Chair: Stephen T. Wegener, PhD
Crowne Plaza Toronto Centre Hotel, Caledon Room

Saturday August 9, 2003

- 8:00 - 9:50 Symposium: Competency and Capacity—Canada and U.S. Practices
Metro Toronto Convention Centre, Meeting Room 714B
Chair: Patricia R. Babin, PhD

- 10:00 - 11:50 Division 22 Poster Session
Chair: Stephen T. Wegener, PhD
Metro Toronto Convention Centre, Exhibit Hall
- 1:00 - 3:50 Division 22 Executive Committee Meeting
Chair: Daniel Rohe, PhD
Crowne Plaza Toronto Centre Hotel, Oakville Room
- 6:00 - 7:50 Division 40/22 Social Hour
Fairmont Royal York Hotel, Upper Canada Room

Sunday August 10, 2003

- 8:00 - 9:50 Symposium: Persistent and Exaggerated Symptomatology Following Mild TBI - Common Etiological Factors
Chair: George J. Carnevale, PhD
Metro Toronto Convention Centre, Meeting Room 203B
- 10:00 - 10:50 Symposium: Statistical Process Control and Rehabilitation—Reconsidering the N=1 Research Design
Co-chairs: Charles D. Callahan, PhD & Mark T. Barisa, PhD
Metro Toronto Convention Centre, Meeting Room 802A
- 11:00 - 11:50 Symposium: Improving Understanding of the Emotional Experience of Patients in Rehabilitation
Chair: Janet P. Niemeier, PhD
Metro Toronto Convention Centre, Meeting Room 714A

Thursday, August 7th

8-8:50	Executive Committee Meeting Fairmont Royal York Hotel Banff Hospitality Suite (1-263)
9-9:50	
10-10:50	
11-11:50	
12-12:50	Blue Ribbon Award Winners MTCC 718A
1-1:50	Invited Address: Donald Stuss MTCC Reception Hall 104C
2-2:50	Invited Address: Brenda Milner MTCC Reception Hall 104C
3-3:50	
4-4:50	
5-5:50	
6-6:50	Ethnic Minority Mentoring Crowne Plaza Toronto Centre Hotel Oakville Rm
7-7:50	7 – 9:00 PM Launch Party: Association of NP Students Div 40 Hospitality Suite Fairmont Royal York Hotel

Friday, August 8th

Symposium: Emotion Regulation MTCC 801A	Fellows Address: Paula Shear MTCC 803A
Early Career Award: Deborah K. Attix MTCC 803A	Program Comm Mtg: Chair: Bob Elliott Div 40 Hospitality Suite Fairmont Royal York Hotel
Publications Comm Mtg: Chair: Rus Bauer Div 40 Hospitality Suite Fairmont Royal York Hotel	Scientific Advisory Committee Meeting: Chair: Mike Westerveld Div 40 Hospitality Suite, Royal York Hotel
1:00 – 2:30 Practice Adv Comm Mtg: Chair: Neil Pliskin Div 40 Hospitality Suite, Fairmont Royal York Hotel	Symposium: Aging Mind across Cultures MTCC 718A
Poster Session: NP Assessment in Medical and Psychiatric Patients MTCC Exhibit Hall	Symposium: Normative NP & Diagnostic Validity in Caucasian & African American Elders MTCC 801A
Division 40 Committee Member Reception Host: Antonio Puente Div 40 Hospitality Suite Fairmont Royal York Hotel	

Saturday, August 9th

Symposium: NP approaches to prediction of Alzheimer's disease MTCC 718A	Discussion: Culture-fair tests, norms, and interpretations. MTCC Constitution Hall 105
Student Award MTCC Const. Hall 105	Poster Session: General NP, TBI and Rehab MTCC Exhibit Hall
Benton Award: Edith Kaplan MTCC 206A/B	Education Advisory Committee Meeting: Chair: Sandra Koffler Div 40 Hospitality Suite, Royal York Hotel
Ethnic Minority Affairs Committee Meeting: Chair: Javier Evans Div 40 Hospitality Suite, Royal York Hotel	Women in Neuropsychology Steering Committee Meeting, Chair: Paula Shear Div 40 Hospitality Suite, Royal York Hotel
Presidential Address Fairmont Royal York Hotel Salon A	Div 40 Business Meeting Fairmont Royal York Hotel Salon A
Div 40/Div 22 Social Hour Fairmont Royal York Hotel Upper Canada Room	

Sunday, August 10th

Workshop: Forensic Evaluation of Hispanic Emigrants MTCC 801A	WIN Mentors MTCC Summit Room 204	Sym: Meta-analysis in NP MTCC 701A
Discussion: Release of Test Data to Non-Psychologists MTCC 718B	Symposium: NP Practice via Medicare, Managed Care, Incident To, and HIPAA MTCC 718B	Posters: Cog, Aging, Dem MTCC Ex Hall
Posters: Cog, Aging, Dem MTCC Ex Hall	Posters: Ped NP; MTCC Exhibit Hall	
Symposium: An Underdiagnosed Head Inj Population: Women of Color in Prostitution MTCC 718A	Workshop: Assessing change in NP performance across time MTCC 718A	

☐ = CE credit available

2003 APA Convention Schedule: Division 40 Program

Thursday, 8-07-03

- 8:00 - 10:50 Executive Committee Meeting
Chair: Antonio Puente PhD
Fairmont Royal York Hotel, Banff Hospitality Suite, Rm 1-263
- 11:00 - 12:50 Symposium: A Memorial Symposium Honoring Harold Goodglass, PhD 1920-2002 (co-sponsored with Div 18)
Chair: Helen Denison PhD
Metro Toronto Convention Centre, Meeting Room 205A & B
- 1:00 - 1:50 Paper Session: Blue Ribbon Award Winners
Chair: Mark Bondi PhD
Metro Toronto Convention Centre, Meeting Room 718A
- 2:00 - 2:50 Invited Address: Donald Stuss PhD, "Discrete Memory Processes within the Frontal Lobes"
Chair: Antonio Puente PhD
Metro Toronto Convention Centre, Reception Hall 104C
- 3:00 - 3:50 Invited Address: Brenda Milner PhD, "Memory and the Temporal Lobes Revisited"
Chair: Kathleen Haaland PhD
Metro Toronto Convention Centre, Reception Hall 104C
- 6:00 - 6:50 Conversation Hour: Ethnic Minority Neuropsychologists Mentoring Activity
Chair: Jovier Evans PhD
Crowne Plaza Toronto Centre Hotel, Oakville Room

Friday, 8-08-03

- 8:00 - 8:50 Paper Session: Fellows Address
Presenter: Paula Shear, PhD; Chair: Eileen Fennel PhD
Metro Toronto Convention Centre, Meeting Room 803A
- 8:00 - 9:50 Symposium: Bridging Clinical and Experimental Approaches to Emotion Regulation
Chair: Kevin S. LaBar PhD
Metro Toronto Convention Centre, Meeting Room 801A
- 9:00 - 9:50 Paper Session: Early Career Award
Recipient: Deborah Koltai Attix, PhD
Metro Toronto Convention Centre, Meeting Room 803A

- 2:00 - 2:50 Symposium: Neuropsychology as a Public Health Intervention
Chair: Joseph Bleiberg PhD
Metro Toronto Convention Centre, Meeting Room 801A
- 2:00 - 3:50 Symposium: The Aging Mind across Cultures
Chair: Denise Park, PhD
Metro Toronto Convention Centre, Meeting Room 718A
- 3:00 - 4:50 Poster Session: Neuropsychological Assessment in Medical and Psychiatric Patients
Chair: Philip Fasteneau, PhD
Metro Toronto Convention Centre, Exhibit Hall
- 4:00 - 5:50 Symposium: Normative Neuropsychology and Diagnostic Validity in Caucasian and African American Elders.
Chair: John Lucas PhD
Metro Toronto Convention Centre, Meeting Room 801A

Saturday, 8-09-03

- 8:00 - 8:50 Symposium: Neuropsychological approaches to the prediction of Alzheimer's disease.
Chair: Mary C. Tierney PhD
Metro Toronto Convention Centre, Meeting Room 718A
- 9:00 - 9:50 Discussion: Cross-cultural issues in historical perspective: culture-fair tests, norms, and interpretations.
Chair: Jennifer Manly, PhD; Presenter: Corwin Boake, PhD
Metro Toronto Convention Centre, Constitution Hall 105
- 10:00 - 10:50 Paper Session: Student Award Winners.
Chair, Jason Brandt, PhD
Metro Toronto Convention Centre, Constitution Hall 105
- 10:00 - 11:50 Poster Session: General Neuropsychological Assessment, TBI and Rehabilitation
Chair: Maria T. Schulteis, PhD
Metro Toronto Convention Centre
Exhibit Hall
- 11:00 - 11:50 Paper Session: Benton Award Lecture
Recipient: Edith Kaplan, PhD
Metro Toronto Convention Centre, Meeting Room 206A & B
- 4:00 - 4:50 Division 40 Presidential Address by Antonio Puente PhD
Chair: Allan Mirsky PhD
Fairmont Royal York Hotel, Salon A

5:00 - 5:50 Division 40 Business Meeting.
Chair: Antonio Puente PhD
Fairmont Royal York Hotel, Salon A

6:00 - 7:50 Division 40/22 Social Hour
Fairmont Royal York Hotel, Upper Canada Room

Sunday, 8-10-03

8:00 - 8:50 Workshop: Forensic Evaluation of Hispanic Emigrants.
Chair: Ines Monguio, PhD
Metro Toronto Convention Centre, Meeting Room 801A

9:00 - 9:50 Symposium: Meta-analytic approaches in neuropsychology.
Chair: George Demakis PhD
Metro Toronto Convention Centre, Meeting Room 701A

9:00 - 9:50 Conversation Hour: Division 40 Women in Neuropsychology Mentoring Activity.
Chair: Paula Shear PhD
Metro Toronto Convention Centre, Summit Room 204

10:00 - 10:50 Discussion: Release of Test Data to Non-Psychologists.
Chair: Michele S. Macartney-Filgate, PhD
Metro Toronto Convention Centre, Meeting Room 718B

11:00 – 12:50 Symposium: Neuropsychological Practice via Medicare, Managed Care, Incident To, and HIPAA
Chair: Darlyne Nemeth PhD
Metro Toronto Convention Centre, Meeting Room 718B

11:00 - 11:50 Poster Session: Cognition, Aging, and Dementia
Chair: Lisa L. Barnes Young, PhD
Metro Toronto Convention Centre, Exhibit Hall

12:00 - 12:50 Poster Session: Pediatric Neuropsychology
Chair: Jacobus Donders, PhD
Metro Toronto Convention Centre, Exhibit Hall

1:00 - 1:50 Symposium: An Underdiagnosed Head Injured Population: Women of Color in Prostitution.
Chair: Martha Banks PhD
Metro Toronto Convention Centre, Meeting Room 718A

2:00 - 2:50 Workshop: Assessing change in neuropsychological performance across time.
Chair: Robert McCaffrey PhD
Metro Toronto Convention Centre, Meeting Room 718A

Mental Retardation
Continued from page 8

Mr. M was able to find his way around town, indicating that because he grew up there and rode his bicycle, he learned street locations over the years.

Mr. M reported that he attended special education classes limited to 4-5 students. He had difficulties with reading, spelling, and math. When asked his favorite subjects, Mr. M replied "drawing and playing games like musical chairs." He recalled that he also took medications for hyperactivity. He could not specify what grade he completed prior to leaving school, likely secondary to the fact that he was in an ungraded special class.

Developmental and social histories as reported by Mr. M

Mr. M could not provide any relevant developmental history. He recalled that he was raised by his "grandparents" but visited with his mother on weekends (beginning at age 9). Mr. M denied significant emotional or psychological trauma as a child. He returned to his biological mother's home on full-time basis at ~age 12-13 but left to live with friends by age 15. Asked if life was "positive" during this time, Mr. M replied "is that [the word positive] good or bad?" Once this was clarified, he indicated that it was essentially positive.

Medical history as reported by Mr. M

Mr. M denied a wide range of life-time symptoms or disorders. He reported the following history:

Blood clots: had blood clots in his lungs last year, resulting in hospitalization;

Head injury: as a child, was dropped on his head, no details regarding severity;

Gunshot wound to right shoulder, age 18-19.

Work history as reported by Mr. M

Mr. M's job history consisted of primarily "under the table" unskilled labor with cleaning and moving companies. He especially enjoyed power buffing and took great pride in his abilities.

EXAMPLE OF THIRD PARTY INFORMANT INTERVIEWS

Telephone Interview with Ms. E

Ms. E (mother of 2 of his children) was initially provided appropriate informed consent admonitions. She indicated that she first met Mr. M as a teenager (~20 years ago); they had their first child when she was 14 years old. Ms. E noted that Mr. M never sought formal employment involving an interview, application, etc., secondary to his very limited reading and writing abilities. He usually had "off the book" jobs that involved physical labor. Based on her knowledge of Mr. M, Ms. E indicated that he did not possess the necessary abilities to live independently. She asserted that he "leaned on" others to get through life although added that while he needed others he could find ways through life with this assistance. Mr. M could not budget nor did he have a bank account. She observed that he possessed rudimentary math skills. Mr. M could make simple meals, use public transportation, and drive (with assistance reading signs).

2002-2003 NEUROPSYCHOLOGICAL EXAMINATION

Mr. M denied a range of confounding comorbid factors at the time of each evaluative contact including alcohol consumption, excessive caffeine intake, use of illicit drugs, etc. He was taking Coumadin.

Procedures administered

Background Interviews

Wechsler Adult Intelligence Scale-Revised

Wechsler Adult Intelligence Scale-III

Understanding and Appreciation of Miranda Rights (Grisso)

Defining additional Miranda Vocabulary

Memory Assessment Scales

Peabody Individual Achievement Test-Revised (Reading, Reading Comprehension, & Spelling Subtests)

Writing to Dictation/Reading Dictation

Street Survival Skills Questionnaire (Selected Subtests: Functional Signs, Health And Safety, Monetary)

Benton Right-Left Orientation, Form A

Halstead Reitan Neuropsychological Test Battery
(Entire Battery)

Trail Making Test (Parts A & B)

Finger Tapping Test

Grip Strength Test

Reitan-Indiana Aphasia Screening Battery

Reitan-Klove Sensory Perceptual

Examination

Seashore Rhythm Test

Speech Sounds Perception Test

Category Test (Computer Version)

Tactual Performance Test (Portable)

Test of Memory Malingered

Dot Counting

Rey 15 Item Array Recall

Behavioral Observations

Mr. M was interviewed and tested in a room located on the perimeter of the jail.

Mr. M presented as an unmarried 33 year old right handed father of 4 children who appeared his chronological age. Mr. M was dressed in prison garb and was adequately groomed.

Mr. M's running speech was generally fluent (rapid speech rate at times) but difficult to understand secondary to articulation errors, limited expressive vocabulary and ill-formed grammatically limited utterances. His receptive vocabulary was also quite limited. In this regard, he often requested clarification of words used by the examiner (as one example, when asked if had a "restful" night's sleep the previous evening, Mr. M asked the examiner to define what he meant by restful).

Processing of auditory information was concrete (as one example, when being instructed about how to copy a drawing of a simple geometric form using a pencil, Mr. M interpreted the instruction "don't lift the pencil from the paper while copying" to mean that he was not allowed to touch or pick-up the pencil to reproduce the drawing).

Mr. M's mood was euthymic. Eye contact was unremarkable. Motor behaviors were also within normal limits.

Throughout this evaluation, Mr. M worked diligently. His motivation and effort were good, based on direct observation as well as test results sensitive to these variables. Mr. M was entirely

compliant with test taking. He was pleasant and affable, polite and well mannered.

2002-2003 FORMAL TEST RESULTS (selected for case illustration)

Wechsler Adult Intelligence Scale-III

Verbal IQ:67 (1st %ile, Mild Mental Retardation Range; 95% c.i.=63-73)

Performance IQ: 73 (4th %ile, Borderline Range; 95% c.i.=68-81)

Full Scale IQ: 67 (1st %ile, Mild Mental Retardation Range; 95% c.i.=64-72)

Mr. M's WAIS-III PIQ-VIQ difference of 6 points is neither statistically or clinically significant.

Mr. M's average age-adjusted verbal scaled score was 4.57 (average = 10) while his average performance age adjusted scaled score was 5.57 (average = 10). None of his verbal or performance subtests deviated significantly from their overall age-adjusted means.

Verbal Comprehension: 4th %ile

Perceptual Organization: 2nd %ile

Working Memory: 1st %ile

Processing Speed: 10th %ile

Wechsler Adult Intelligence Scale-Revised (WAIS-R)

Verbal IQ: 69 (2nd %ile, Mentally Retarded Range); 95% c.i.=65-75

Performance IQ: 74 (4th %ile, Borderline Range); 95% c.i.=68-83

Full Scale IQ: 70 (2nd %ile, Mentally Retarded/Borderline Range); 95% c.i.=66-76

Mr. M's WAIS-R PIQ-VIQ difference of 5 points is not statistically or clinically significant.

Mr. M's average age-adjusted verbal scaled score was 4.33 (average = 10) while his average performance age adjusted scaled score was 6.00 (average = 10). With the exception of Information (age adjusted scaled score =2, 1st %ile), which deviated significantly and negatively from its' overall age-adjusted mean, none of his other verbal subtests deviated significantly from the overall age-adjusted mean. Among performance subtests, no subtest deviated significantly from the overall age-adjusted mean.

PEABODY INDIVIDUAL ACHIEVEMENT TEST-REVISED

<i>subtest</i>	<i>raw score</i>	<i>grade equivalent</i>	<i>Age equivalent</i>	<i>standard score/%ile (22 year old norm sample)</i>
reading recognition	27	1.9	7-4	<55 (<1st %ile)
reading comprehension	25	1.5	7-0	<55 (<1st %ile)
spelling	20	K.8	6-2	<55 (<1st %ile)

Written and expressive vocabulary/writing

Reciting Alphabet: 5 errors

Writing to Dictation: severely limited; Mr. M wrote very slowly, requiring required multiple repetitions (by the examiner) of the same phrases.

Halstead-Reitan Test Battery

Impairment Index: 0.90 (0-0.30 is normal; 0.40 is borderline; 0.5-1.00 is suggestive of impaired neuropsychological functioning)

General Neuropsychological Deficit Scale score: 58 (moderate neuropsychological impairment range is 41-67).

Memory Assessment Scales (standard battery of cognitive tasks which measures short-term, verbal and visual (nonverbal) memory functioning in adults). Census matched norms revealed the following information about Mr. M's new learning abilities:

Short-Term Memory: 19th %ile (low average range)

Verbal Memory: 3rd %ile (severely impaired range)

Visual Memory: 19th %ile (low average range)

Global Memory: 6th %ile (moderately impaired range)

The difference between Mr. M's verbal and visual memory scale scores was statistically significant but the base-rate for a difference this large would be expected to occur in at least 25% of the general population, hence is not unusual.

STREET SURVIVAL SKILLS QUESTIONNAIRE (SSSQ)

component scales	raw score	scaled score in comparison to normal adults	scaled score for mentally retarded (average IQ of normative group: 58)
<i>functional signs</i>	16	3 (1st %ile)	11 (63rd %ile)
<i>health and safety</i>	18	5 (5th %ile)	14 (91st %ile)
<i>monetary</i>	18	4 (2nd %ile)	12 (75th %ile)

As shown above, Mr. M's performance on subtests measuring very basic abilities to recognize common functional signs in the community, to make the correct decisions for health & safety (health care, hygiene, first aid, and safety skills for daily living), and to use basic monetary concepts (the ability to recognize and handle money) in comparison to normal adults fell very substantially below these means (between the 1st and 5th %iles) but was average (Functional Signs & Monetary) and above average (Health and Safety) in comparison to a sample of mentally retarded individuals (average IQ=58, borderline between mild/moderate retardation).

MALINGERING/EFFORT

Test of Memory Malinger

Trial 1: 47/50 correct

Trial 2: 50/50 correct (credible)

MIRANDA WARNING

Assessing Understanding & Appreciation of Miranda Rights

Performance on Grisso's measure, designed to assess comprehension of Miranda Rights as well as Miranda Vocabulary, revealed scores consistent with those achieved by mentally retarded adults. These results indicate that Mr. M lacks an adequate understanding or appreciation of the meaning and content of the Miranda Rights [As examples, asked to define afford (from "If you cannot afford a lawyer", he replied, "like a Ford car... I like Cadillacs"; asked to define appointed (from "one will be appointed for you"), he replied, "no idea...point over there..."]. This conclusion is consistent with and further supported by the neuropsychological test data presented herein.

SUMMARY/CONCLUSIONS/FORENSIC OPINION

Mr. M is a 33 year old unmarried father of four children who underwent forensic neuropsychological evaluation (~13 hours of direct face to face contact). This forensic neuropsychological evaluation was requested to determine if he satisfied existing and accepted criteria for Mental Retardation and if he was able to fully understand and appreciate his Miranda warnings.

Based on converging data, including historical archival educational, psychological and medical records, test results, observations and interview results from this neuropsychological evaluation and interviews with third party informants, Mr. M's level of functioning falls in the Mild Mental Retardation range.

IQ test results from 1984 and 2002/2003, reveal that Mr. M's Full Scale IQ (based on WAIS-III IQ conversions) has been consistently ~67 (this IQ score falls more than 2 standard deviations below the normal population mean). Consistent with this low level of intellectual functioning is the concrete stimulus bound quality of his general cognitive style.

There is substantial evidence of life-long impairments in functional academic abilities.

There is consistent and substantial evidence of life long neuropsychological and neurological impairments. As early as 1975 (age 6) his pediatrician opined that Mr. M was a child "suffering from neurological impairment.

The current examination revealed substantial evidence of continuing impairments in neuropsychological, central expressive/receptive language, memory, and motor/sensory functions. Mr. M's Halstead Impairment Index was 0.90 (1.00 is the poorest possible score) while his Neuropsychological Deficit Scale Score, based on 42 separate variables derived from the Halstead-Reitan Battery, was 58 (moderate neuropsychological deficit range is 41-67, page 11).

Mr. M's performance on selected subtests of the Street Survival Skills Questionnaire (concepts involving such adaptive functions as functional signs, health/safety, and money) was significantly impaired and consistent with the performance of the mentally retarded normative group.

There is a strong concordance for mental limitations in Mr. M's family blood line as well as in 3/3 of his male children.

The question as to why Mr. M was not previously classified as Mentally Retarded (as a school student) was addressed as well. A detailed phone interview with a pediatric psychologist on staff at a developmental center where Mr. M had been tested and assisted many years earlier, was conducted for background information about this program and the classification systems employed in the 1970's (she had reviewed Mr. M's file materials from his treatment at this facility). This doctor indicated that in the 1970's the minority community vehemently objected to "labels" (such as mentally retarded, special education, autistic, etc.) as well as to the results of standardized tests (typically not standardized on minority subjects). She asserted "IQ tests were not considered valid for minorities at that time" [~1975]. Minority children were given the benefit of the doubt and potentially hurtful labels (such as MR) were avoided whenever possible.

Based on the foregoing, Mr. M satisfies both the American Psychiatric Association's definition of Mild Mental Retardation (DSM-IV) as well as the American Association on Mental Retardation's

definition of Mental Retardation. These are set forth below:

**APA (DSM-IV 317) Mild Mental Retardation
Essential Criteria:**

- * Significantly subaverage intellectual functioning: an IQ of ~70 or below
- * Concurrent deficits or impairments in present adaptive functioning in at least 2 of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.
- * Onset of these limitations before age 18

Mild mental retardation is further noted to encompass the category of "educable." The DSM-IV notes that initially these individuals are "...often not distinguishable from children without Mental Retardation until a later age. By their late teens, they can acquire academic skills up to approximately the sixth grade level. During their adult years, they usually achieve social and vocational skills adequate for minimum self-support, but may need supervision, guidance, and assistance when under unusual social or economic stress. With appropriate supports, individuals with Mild Mental Retardation can usually live in the community, either independently or in supervised settings."

American Association on Mental Retardation (2002)

Essential Criteria:

- * Significantly subaverage intellectual functioning
- * Significant limitations in adaptive functioning (subdivided into 3 major categories - Conceptual, Social, and Practical)
- * Onset of these limitations prior to age 18

Mr. M satisfies the American Psychiatric Association's definition of Mild Mental Retardation as well as the American Association on Mental Retardation's definition of Mental Retardation.

Capacity to understand and appreciate Miranda Warning

The Miranda warning requires ~7th grade

reading level. Thus, if asked to read this warning, Mr. M would not have been able to do so (his reading level is ~2.0 grade level). Evaluation of his auditory receptive and cognitive/intellectual abilities to perceive and understand Miranda was also undertaken. These results revealed that Mr. M lacked an adequate understanding or appreciation of the meaning and content of the Miranda Rights. These findings are consistent with research on this subject by Fulero and Everington, who concluded, after studying mentally retarded individuals, that "As a rule, mentally retarded adults will not have a requisite level of competency to waive their Miranda rights, and some care will therefore need to be taken to prevent improper interrogation and/or confessions." (From Assessing Competency to Waive Miranda Rights in Defendants with Mental Retardation, Law and Human Behavior, 19 (5), 1995). There is no indication that these steps were taken during the interrogation(s) of Mr. M nor was a videotape made to allow independent verification of his understanding.

OUTCOME

Following submission of Dr. Fisher's 2003 report, the prosecution hired Dr. Daniel Martell, associated with the practice of Dr. Park Dietz in California. Dr. Martell was provided with a copy of Dr. Fisher's report and raw test data. Shortly thereafter, Dr. Martell apparently examined Mr. M. Although requests for Dr. Martell's report and raw test data by Dr. Fisher have been ignored to date, it has been reported that Dr. Martell was in agreement with the finding as set forth herein. On 3-18-03, the NY Times featured a detailed investigative story about this case, with the headline "Capital Case, and A Defendant Who May Be Retarded". In the first paragraph of this story, Times reporter Dan Berry conveyed his impression of Mr. M: "While strangers around him discuss the possibility of his execution...[Mr. M] sits as calmly as if he were waiting for a bus. He kills time by copying letters on a legal pad, or asking one of his lawyers how to spell a simple word, or staring somewhere beyond the clock that hangs on the far-side court room wall." This NY Times reporter provided an excellent review of the facts as well as the dilemma posed by

this case.

Two days later, on 3-20-03, the NY Times ran a second story with the heading: *"Ashcroft Won't seek Death Penalty for Retarded Defendant"*. The NY Times indicated that the death penalty qualification had been withdrawn in light of the fact that Mr. M was Mentally Retarded.

While the outcome of Mr. M's trial is still pending, the results of this evaluation in conjunction with the work of his attorneys, ensures that if found guilty of murder, Mr. M will not and can not be punished with the death penalty.

Things I Didn't Learn

Continued from page 6

litigation. The mediation panel placed a very high dollar value on the case. Their opinion was based on the reasoning that though they did not believe the symptoms and condition as stated, there must be some thing wrong, given the massive amount of documentation (meaning reports and medical records). In my opinion, Ms. G's attorney had succeeded in mounting such a massive display of medical records, that the mediators simply could not dismiss the claims, even though they seemed ridiculous. The extreme mediation award all but guaranteed a trial

Each defendant was represented by counsel. Each counsel had his own experts, including neurologists, neuropsychologists and psychiatrists. While I cannot speak for the others, I reviewed all of the records in this case, including those from other defense experts. I was hired by the attorney for the dealership. My diagnosis was Malingering, and Dependent Personality Disorder, likely. Other defense experts had similar opinions. Some did not use the M word, choosing instead to use Factitious Disorder. Of course the plaintiff experts were in support of a traumatic brain injury diagnosis. The records were very supportive of a Dependent Personality Disorder. I chose malingering over factitious disorder based on her subjective total disability, on-going litigation, implausible symptoms, and failure of all symptom validity tests (at or below chance).

<u>Tests</u>	<u>Scores</u>
FSIQ	85
VSIQ	85
PSIQ	89
NAART VIQ	106
WRAT Reading	113
WRAT Spelling	114
WRAT Arithmetic	92
Speech Sounds	4 errors
Rhythm	4 errors
PASAT Series 1	40 correct
PASAT Series 2	46 correct
Trails A	42 secs

Trails B	116 sec
WMS-R LM I	10
WMS-R LM II	9
WMS-R VR I	20
WMS-R VR II	11
RAVLT Total	41
RAVLT I	7
RAVLT V	9
RAVLT short delay	6
RAVLT long delay	3
RAVLT recognition	6 (2 false positive)
Rey Figure recall	8
WCST categories	6
WCST errors	15
WCST perseverative errors	9
Rey 15-Item	6
PDRT-27	63% correct
Word Recognition	3
Reliable Digits	6
RAVLT recog (adj hits)	4
Warrington RMT (words)	40
Warrington RMT (faces)	37

MMPI-2: 2"3' 178-4506/9: L"FK- (DEP = 57T; ANX = 47T)

As test results go, these are fairly benign. Many individuals who are trying to look impaired perform far worse. However, we must keep in mind the specific nature of this individual's symptomatic complaints. She is claiming remote memory. She actually reported fairly normal memory for up to four hours. Thus, I would not expect her to fail a broad range of tests. Nor would I expect her to perform extremely poorly on symptom validity testing. This being said, she did score in the severely impaired range on most of the memory tests, and fail all SVT's. There were other subtle signs of malingering, as well. Note that recognition was worse than first trial recall on the RAVLT as was her Word Recognition score.

Case Resolution

As the trial date approached, I could hardly

contain myself. I was going to have so much fun pointing out all of the gaps in logic. I planned to play excerpts from the Oprah tape. I had selected entries from her daily log to impeach her claims. I had uncovered doctors' notes indicating that Ms. G had asked for referrals to specific doctors (known for working with plaintiff attorneys). I had direct quotes from Ms. G demonstrating excellent memory for events many months ago. I had found entries in her log where Ms. G mused about settling the lawsuit so they could buy that big house they had seen. This was going to be so much fun!

Within a few weeks of the trial date, the case began to slip away. First, the bakery company settled. Ms. G was given over a half million to settle her claim. Then the car manufacturer gave her a cool million. I guess they figured they saved \$20 million? But my client, the dealership, was still in the case. The defense attorney assured me that he was not going to give her a dime, unless the jury told him to pay up. Then the day before the trial, I got a call from the attorney telling me, that against his advice his client had settled. He could not tell me the dollar amount, but assured me that it was less than the bakery company paid. He told me to send him my bill. So there I sat, all the goods on this scam and nowhere to go. Since I figured that Ms. G got about two million dollars, I did not feel guilty sending in my bill. I did regret a lot of other things, though.

In my formulation of this case, I did not believe that Ms. G started out malingering. I saw her as a dependent personality disorder with strong histrionic features. In reviewing the records, including deposition testimony, it was clear that her family members began thinking "law suit" almost immediately. Her husband, who testified that he was extremely distressed about her terrible accident, also admitted that he went to the impound lot first. He had to take pictures of the vehicle while it was daylight. His father-in-law went with him. Ms. G's mother was over-protective and rather manipulative. I suspect that she had some sense of her daughter's limitations. This provided an opportunity to assist and compensate for unspoken deficits. Records also suggested that the parents had loaned money in anticipation of a settlement. There were elements of both primary and secondary gain here, but the

secondary gain was very substantial. It may be said that the family began “malingering” before the patient. They were the early driving force in the case. At many times, efforts were made to maintain claims and resist interventions that moved toward greater independence. It was more important to document difficulties than establish competencies.

With the thousands of cases I have worked on over the subsequent years, this one still stands out as the most outlandish collection of symptoms, the most blatant example of malingering, and the most outrageous outcome. I used to see myself as an expert involved in bringing scientific understanding to the court to assist in resolving disputes of injury and loss. I think this case changed my view of what forensic practice was all about.

Postscript

About two years later, I was out to dinner with a friend and our wives. Early in the evening, I looked to the table next to ours and to my amazement I found Ms. G having dinner with her husband and some friends. Life was treating them well. She was dressed to the nines and clearly enjoying herself. I spent the entire evening looking at my guests and listening to the conversation at the other table. I never heard a word that was spoken at our table, but still remember the discussions that transpired at Ms. G’s table. They talked about their children and school related events. Apparently, she now recalled that her son was older than 6-months. In fact, she knew his teacher, the recent and remote school activities and upcoming events. They discussed home decorating and recent remodeling of a number of rooms. From what I could tell, her amnesia had remitted and she was back to normal. That green poultice probably helped. The next day, I called the attorney to tell him of my evening entertainment. He lamented that had he known, he would have dropped by, since he lived near the restaurant. There was some grumbling of going after Ms. G for insurance fraud, but that never materialized.

Obituary:
Theodore H. Blau (1928 - 2003)

Theodore H. Blau died on January 28, 2003 at his home in Tampa, Florida after valiantly battling prostate cancer for 11 years. Psychology has lost a devoted friend, advocate, and leader whose accomplishments are varied and vast.

Ted was born on March 3, 1928 in Huntington, West Virginia. Following service in the US Army Air Corps, Ted earned his bachelor's, master's, and doctoral degrees from Penn State University. He moved to Tampa, Florida in 1952 and established an independent practice. Not only was he a pioneer in the independent practice of clinical psychology, he was one of the earliest psychologists with a focus in child psychology.

Ted was a legendary story teller, a talent that enhanced his skills as a therapist. He loved to tell a story about being in B. F. Skinner's office when the phone rang. It was from a prominent psychologist who was concerned that this "Theodore Blau, an independent practitioner, was considering running for president of APA." Dr. Skinner handed the phone to Ted, who after an embarrassing moment said, "If you talk Dr. Skinner into running for president, I will fully support his candidacy." Well, "Fred" did not run. Ted did and, in 1975, became the first independent practitioner elected to the presidency of APA. He worked tirelessly to promote standards and credentials for licensed psychologists that assured at least a minimal level of competency. He also advocated for clinical specializations, one of which was neuropsychology.

Following his tenure as APA president, Ted's professional interests shifted toward forensic psychology and neuropsychology. Over the subsequent 25 years he developed a national reputation as an expert witness in both civil and criminal cases. He authored several books during this time: *The Psychologist as Expert Witness* (1984, 2nd edition 1998), *Psychotherapy Tradecraft: The Technique and Style of Doing Therapy* (1988), *The Psychological Examination of the Child* (1991), *Psychological Services to Law Enforcement* (1994), and *The Forensic Documentation Sourcebook: A Comprehensive Collection of Forms and Records for Forensic Mental Health Practice* (1999). In 1985 he began working in police psychology, and lectured regularly at the FBI Academy in Quantico. He was commissioned as chief inspector of the Manatee County (FL) Sheriff's Behavioral Science Unit for more than 10 years, an achievement that was recognized by their serving as an honor guard at his memorial service on February 2, 2003.

For many of us, Ted will be remembered for his contributions to the profession and practice of neuropsychology. His well-attended and highly regarded workshops during the 1980s and 1990s on the application of clinical neuropsychology to forensic settings became a trajectory that neuropsychology has continued. Ted's parting gift to Division 40 (Clinical Neuropsychology) was to serve as one of our Council Representatives. Dr. Tony Puente, who had the opportunity to serve with him noted, "Even though towards the end of his tenure in this role, Ted clearly was making Herculean efforts to attend the meetings (especially due to his dislike for power politics, often found on the floor of APA's Council), he always showed up, dressed to the hilt, with a huge smile on his face, a pleasant comment for all involved, and astute observations on how human behavior was often misunderstood by those in a position to comment on it."

On a personal note, I first met Ted when I came to the Tampa VAMC 17 years ago as a young staff psychologist, and attended Ted's seminar for the psychology interns, which he had taught for many years. One of the first things he would say to each new intern group was: "You are the Best and the Brightest." He truly believed that psychology had much to offer and that psychologists were among the best and brightest

of all professionals. It was a very reinforcing and invigorating experience for me and for each intern class.

I recall an incident about 12 years ago when I was having a relatively difficult day. It was a day Ted was presenting his seminar to the VA interns. He saw me and said, “You really should smile more, you have a wonderful smile.” Well, whenever I saw Ted, I did smile more. It was a pleasure to be around him. He had a way of bringing a smile to my face and many others. When you were with Ted you felt important, understood, and accepted. You always had his full attention. It was impossible to go to see Ted in his office and leave without some gift — either a trip to his “candy store,” a T-shirt, a copy of his latest book, or something else. Ted was always extremely generous with his complements, his time, and his expertise. Many people over the years, family, friends, colleagues, clients, and consultants were far better off for having spent time with Ted.

Ted was the consummate gentlemen. He was an accomplished leader in psychology; and neuropsychology was one of his “loves.” He will be remembered as a wonderful friend, mentor, and colleague to many. He shall be missed.

Ted is survived by his wife of 52 years, Dr. Lili Blau, his brother Dr. Ben Ami Blau and wife Shirl, his two sons, Jeffrey and Richard of Tampa, Florida together with their wives, Sherry and Valarie, and four beloved grandchildren — Hannah, Jennah, Joshua, and Alexander. The Blau family has arranged with the American Psychological Foundation (APF) and the Tampa, Orlando, Pinellas (TOP) Jewish Foundation, Inc. to create a special charitable fund in Dr. Blau’s memory. Contributions will fund an APF award, the Theodore H. Blau Early Career Award for Outstanding Contributions to Professional Clinical Child Psychology. Contributions can be mailed to Dr. Lili Blau, 213 East Davis Blvd.; Tampa, FL 33606.

Rodney D. Vanderploeg, Ph.D.
James A. Haley Veterans Hospital
Tampa, FL

Testamentary Competence

Continued from page 8

In this example, one is correct (Detroit), the second a semantic foil naming a city in the same state, and the third is an easy foil (distant state). Third, the cognitive screening should be videotaped. This not only allows the neuropsychologist's work to be "checked" by third parties, it will also help facilitate the examiner's memory years later if the matter comes to trial. Fourth, the examination should take place as close as possible to the will's execution date as feasible, if not the same day.

RETROSPECTIVE ANALYSES

More often, it is the case that TC is raised after the testator's death. Disputes over wills usually arise when persons believing themselves to be the "natural object" of a testator's bounty were left out. This complicates the assessment, as the neuropsychologist moves from direct observation of cognitive behaviors and direct inference to reliance on records and indirect inference. Greiffenstein (1996) offered a general description of the reasoning steps in the "neuropsychological autopsy".

The first concrete step is to determine the legal competency at issue. Undue influence? Testamentary competence? Insane delusions? All the above? The second step is identification of the legally disputed date. This is usually the day a will or beneficiary change form is signed.

The third step is inspection of archival material from periods just prior to and following the critical legal date. This is the most critical step, as it dictates whether the neuropsychologist has any basis for forming an opinion. Records of interest are medical records, business documents and checkbook, personal documents (correspondence, diaries, notebooks), and the will itself. The executing attorney's notes are also useful, and such material is no longer privileged after death. All these documents may reflect the testator's cognitive levels and their personality. Descriptive information from surviving relatives and neighbors may be helpful, although such evidence must be weighed against the self-interest of the reporter, and correlated with more objective sources. A description of perfect memory from the will's main beneficiary should be considered but given low weight in the absence of

any independent confirmation, as should a claim of severe impairment from a frustrated heir. Medical records are most critical, as they may contain diagnoses of mental or brain illness. The focus should be on collecting instances of both normal and abnormal cognitive behaviors as close to the legally disputed date as possible. This is important, because a testator may shift between competent and incompetent mental states in certain brain disorders, such as acute confusional state. Lacking records from the critical period or records containing few clues about normal or abnormal cognitions dictates the neuropsychologist refuse involvement in the case. As humorously noted by Blau (1998), testamentary competence testimony is difficult because psychologists must frequently state, "I don't know" (pg. 103).

Assuming sufficient medical and other records to be present, the fourth step is determining evidence for neuropsychological disorder. An autopsy with brain cutting would of course be ideal, but this is rarely done in discretionary, noncriminal settings. Neuroradiological findings and neurology reports are usually all that is available for establishing the physical basis for a cognitive disorder. The fifth step is determining what set of cognitive abilities underlie the legal competencies, and whether there is a reasonable probability they were impaired. All four elements of TC for example, require a combination of remote and working memory. Thus, records analysis should focus on documentation of memory acts, that is, behavior that implies intact or abnormal memory. Barring the rare event of medical record containing actual scores on cognitive screening measures, the neuropsychologist is alert for qualitative indicators of cognitive dysfunction. Such examples should have some support in the empirical literature. For example, Marson, Annis, McInturff, Bartolucci, and Harrell (1999) identified 16 qualitative errors associated with failing competence in probable Alzheimer patients.

The 6th step is interpretation. The neuropsychologist organizes his or her interpretations to assist the trier of fact. The neuropsychologist should be conservative, and answer penultimate rather than ultimate questions reserved for the trier of fact, unless the court allows

ultimate issue testimony. Spar & Garb (1992) offer useful guidelines for organizing interpretations in simple fashion: (a) A statement of general cognitive level, (b) the specific weaknesses in mental capacity that are most relevant, (c) the relation of these inferences to elements of TC or UI, and an optional step, (d) formal diagnosis. Most jurisdictions do allow answering ultimate questions, as Federal Rule of Evidence 704(a) states: “Testimony in the form of an ultimate opinion is not objectionable because it embraces an ultimate issue to be decided by the trier of fact.”

In the case of UI, testimony is similarly structured although the emphasis is on conditions favoring UI, not the presence or absence of UI. Even when the neuropsychologist refuses to participate in the TC component of a case, he or she can still serve as an expert who explains background concepts so the trier of fact can understand the evidence. The neuropsychologist may give definitions of dementia, differential deficit patterns, hallucinations and delusions, etc. Further, it should be explained how mental illness and brain disease make sufferers dependent on caretakers and more susceptible to suggestion. Alternatively, depending on the case particulars, it may be that certain personality styles may make the testator unusually resistant to any suggestion, e.g., premonitory stubbornness and suspiciousness aggravated by organic brain disease.

The neuropsychologist should never testify that a party to the suit exerted UI over the testator before their death. If you are hired by the party contesting the will (i.e., the omitted heir), opposing counsel is unlikely to make their client (the beneficiary) available for interview. Second, it is ethically questionable to describe the psychological attributes of a living person one has never met. Third, you could be sued for slander and libel. Remember, per Federal Rule of Evidence 702, the neuropsychologist does not have to provide testimony that determine the facts at issue, but can provide testimony limited to understanding the facts.

CASE EXAMPLE

Two of C.G.’s surviving adult children (hereafter “plaintiffs”) sued to overturn a second will, which left C.G.’s entire estate to their sister (hereafter

“defendant”). The first will, executed in 1995, equally divided C.G.’s estate among her three children. Following C.G.’s death in early 2002, the defendant allegedly “discovered” copies of a new will underneath the decedent’s bed mattress. The second will not only named the defendant sole beneficiary, it also included a long discourse pointedly disparaging the other two children. The plaintiff’s claimed undue influence, testamentary incompetence, and fraud. They retained this author as an expert to comment on cognitive status at the time of the creation of the 1999 will.

The author had access to the original and contested wills, many neuroimaging studies, outpatient and inpatient hospital records, limited correspondence from Ms. C.G. to her children, deposition testimony, and the defendant’s 75 page answer to interrogatories. All parties and witnesses agreed on a core set of biographical and other facts. Ms. C.G. was a devout Catholic who devoted her life to homemaking and church. She completed only 10 grades and disliked writing for fear of exposing her poor spelling and penmanship. A retired judge prepared her first will in 1995 and Ms. C.G. divided her estate equally among her three adult children. Inspection of the uncontested 1995 will revealed an appended handwritten initialed “C.G.” It containing further details such as the location of bank accounts, property addresses, the priest she favored to preside at her mass, and other information. The penmanship was poor, consisting of poorly formed block letters with occasional cursive writing. The grammar was also poor and some sentences were incomplete.

The critical legal date was early March 1999, the time at which the second will was allegedly signed by witnesses. Remote medical records showed a history of blackout spells with falling 1996-1998. A 1996 CT scan showed “diffuse atrophy greater than expected for age.” Ms. C.G. saw a neurologist in January 1999 accompanied by the plaintiff sister, who reported “failing memory the last six months.” C.G. was admitted to a hospital two weeks later with bilateral leg weakness and “confusion increased over baseline.” A physical showed “right sided weakness and Babinski.” A new CT scan showed “diffuse atrophy now extending into the periventricular area with chronic ischemic changes.” A neurologist

started her on Aricept after finding “orientation to person only”, and a Folstein MMSE score of 14. A number of consultant’s also commented on her poor mental status, which was not resolved by discharge; her final diagnosis was “dementia with forgetfulness”. Despite many other documented medical illnesses such as hypertension, polyarthralgias, diabetes, incontinence, and edema, there were no medical records from April 1999 until the last documented medical visit in late 2001: Ambiguously, a cardiologist only noted the decedent “was unable to give a history”, relying instead on the defendant. The defendant did not mention repeated earlier diagnoses of dementia. C.G. died of a heart attack in early 2002.

A contested area was the relationship between C.G., the defendant, and the plaintiffs. The defendant moved next door to C.G. in late 1998 soon after first report of memory problems. The plaintiff siblings claimed their sister kept their mother a “prisoner”, forbade any contact with her, and even intercepted multiple phone calls they made to their mother. Further, the disinherited brother testified he dropped by the defendant’s house, only to be told to leave. The defendant however testified that her siblings suddenly dropped out of sight as Ms. C.G. became sicker and never bothered to offer any care services. She insisted C.G.’s enmity evolved over the course of years since the 1995 will and was based on C.G.’s frustrated expectations of them. Defendant adamantly insisted she did not influence her mother’s attitudes in any way and that her mother was “sharp and not forgetful” until the day of her death.

The plaintiff siblings received an E-mail letter from the defendant sibling in February 2002, announcing C.G. had died. The E-mail contained excerpts from a second will which disinherited the plaintiffs, leaving all assets to the defendant. Per the defendant’s interrogatories, she discovered the new 1999 will under the decedent’s mattress. This author’s inspection of the 1999 will indicated it was three pages long, typed on a word processor, and it left all assets to the defendant. The will contained a 1.5 page discourse that pointedly disparaged all heirs except the defendant. The spelling was perfect and contained complex sentences and uncommon words.

There were two identical copies of the will, but with six different signatories. There was no attorney’s signature. At one point, the defendant testified she was not aware of the will’s existence until its post-mortem discovery. However, in other testimony, she stated she had driven her mother to homes of the will’s co-signatories on the date of execution, claiming she had “no idea” what her mother intended. She acknowledged her mother did not have a typewriter nor could she use a computer.

The author’s conclusions were that Ms. C.G. (1) suffered severe cognitive deficits just prior to the second will’s execution, (2) the most relevant deficit was in recent memory and orientation, (3) her memory deficits were so severe that she was unlikely to remember a will’s existence and (4) the formal diagnosis was mixed dementia of atrophic and multi-infarct types. With respect to the issue of UI, the author opined that conditions favoring undue influence existed. Her severe cognitive deficits made her dependent on the defendant daughter to provide descriptions of daily events. Other factors favoring UI were seclusion and exposure to only one source of information, the defendant. C.G.’s academic deficiencies made her dependent on others to draft and create documents, a difficulty compounded by severe cognitive deficits.

The author was willing to testify in this case, because of the availability of (a) unusually detailed records and (b) relevant cognitive behaviors just prior to critical legal date. There were no records documenting normal cognitive behaviors in the period after the new will. Note that the facts make a compelling argument that the defendant fraudulently drafted the second will. Nevertheless, the author avoided offering any opinions on the behavior or personality of the defendant. Opinions about fraud are outside the scope of neuropsychologist’s training, and fraud is an ultimate legal conclusion to be determined by the trier of fact in a criminal setting.

CONCLUDING COMMENTS

Civil competency may become an important practice area requiring the input of neuropsychologists. Ideally, neuropsychologists should market services for videotaped ante-mortem

examinations. Neuropsychological screening may represent powerful evidence for testamentary competence that will forestall future contests. Instruments designed to measure the impact of cognitive defects on critical daily functions are already being developed (Marson, 2001). Because of the fallibility of human judgment, or just a desire to save money, a neuropsychologist's involvement is more likely to take place post-mortem. No clear rules for such neuropsychological autopsies exist, but with sufficient relevant documentation, the neuropsychologist can still assist the trier of fact.

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Division 40 Highlights for the 2003 Annual Convention

I am pleased to present the final version of the Division 40 component of the American Psychological Association Convention program in this edition of the Newsletter. Our exciting, timely, and educational program includes the largest number of submissions and sessions in several years, and attendees will have the opportunity to earn CE credit. As this year's Program Chair, I want to encourage you to register and reserve your hotel room for the meeting, which will be held in Toronto from August 7 –10, 2003.

You can find registration and hotel information in the APA Monitor and on the APA website at <http://www.apa.org/convention/>

For updates to the program, go to the Division 40 web page at <http://www.div40.org> , click on the “2003 APA Convention” button, and follow the link to the Program Schedule. You will also find a link to an Insider's Guide to Toronto, thoughtfully assembled by native neuropsychologists!

For the first time this year, CE credit can be earned by attending any of the scheduled Division 40 symposia, workshops, and discussions, as well as the invited addresses. Members wishing to claim CE credit will pay a \$15 or \$20 processing fee (depending on number of credits) per session. Please consult the APA website for updated CE information in late June and July.

This year's invited addresses will be delivered by Donald Stuss, Ph.D., titled “Discrete Memory Processes within the Frontal Lobes” and Brenda Milner, Ph.D., titled “Memory and the Temporal Lobes Revisited”. We will also hear from Edith Kaplan, Ph.D., the recipient of the Benton Award, as well as this year's Early Career Award recipient, Deborah Koltai Attix, Ph.D.

I am pleased to congratulate the winners of this year's Division 40 awards. The three Blue Ribbon Awards for highest rated non-student papers will go to: 1) Stephan Kennepohl, Ph.D. and colleagues for “African American Acculturation and Neuropsychological Testing Following Traumatic Brain Injury”; 2) Desiree Byrd, Ph.D. and colleagues for “Neuropsychological Test Performance Among Caribbean and American Black Elderly”; and 3) Keith O. Yeates, Ph.D. and colleagues for “Short- and Long-Term Social Outcomes Following Pediatric Traumatic Brain Injury”.

The Division 40 Student Blue Ribbon Award will go to Robyn M. Busch, M.A. and colleagues for “Role of Executive Functioning in Verbal and Nonverbal Memory”. Student awards from the Division 40 Scientific Advisory Committee for the best papers in the areas of cognitive neuroscience and applied clinical neuropsychology go to: 1) Paula Alhola and colleagues for “Effect of Long-Term Hormone Replacement Therapy on Cognition”; and 2) Jane E. Booth, M.A. and colleagues for “Five-Factor Personality Dimensions and Cognitive Performance in Older Adults”. The Psychological Corporation will be awarding two student scholarship awards as well. One of these will go to Aiko Yamamoto, M.A. and colleagues for “fMRI Differentiation of Frequency and Recognition Memory”, and the other to Lisa M. Holme, Psy.D. and colleagues for “Predicting Verbal Memory Decline After Temporal Lobectomy: IAP Versus SRT”.

I would like to thank and congratulate the Co-Chair, Bob Elliott, Ph.D., and the entire Program Committee for their hard work and invaluable contributions to this year's conference.

Jennifer J. Manly, Ph.D.
2003 Division 40 Program Chair

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