STATE OF MICHIGAN

IN THE SUPREME COURT

ALIAMA X. SCHAUMANN-BELTRAN,

Plaintiff-Appellant,

vs.

JOSEPH GEMMETE, M.D.,

Defendant-Appellee,

Supreme Court No. 162507

Court of Appeals No. 347683

Washtenaw County Circuit Court
No. 17-000132 NH

Consolidated With

ALIAMA X. SCHAUMANN-BELTRAN,

Plaintiff-Appellant,

vs.

BOARD OF REGENTS OF THE UNIVERSITY OF MICHIGAN, d/b/a UNIVERSITY OF MICHIGAN HEALTH SYSTEM (a/k/a Michigan Medicine), UNIVERSITY OF MICHIGAN MEDICAL CENTER and C.S. MOTT CHILDREN'S HOSPITAL,

Defendants-Appellees.
_____/

Supreme Court No. 162508

Court of Appeals No. 347684

Court of Claims No. 17-000038 MH

INDEX TO APPENDIX FOR DEFENDANTS-APPELLEES' SUPPLEMENTAL BRIEF
(ATTACHED SEPARATELY)

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Presence of Third Party Observers During Neuropsychological Testing

Official Statement of the National Academy of Neuropsychology

Approved 5/15/99

Forensic neuropsychological evaluations are often constrained by the demand that a third party observer be present during the course of interview and formal testing. This demand may originate from counsel's desire to ensure that the neuropsychologist does not interrogate or unfairly question the plaintiff with respect to issues of liability and to ascertain if test procedures are accurately administered. In general, neuropsychologists should have the right to carry out their examination in a manner that will not in any way jeopardize, influence or unduly pressure their normal practice.

The presence of a third party observer during the administration of formal test procedures is inconsistent with recommendations promulgated in The Standards for Educational and Psychological Testing (APA, 1985) and Anastasi (1988), that the psychological testing environment be distraction free. More recently, standardized test manuals (for example, The WAIS-III, WMS-III Technical Manual; The Psychological Corporation, 1997) have specifically stated that third party observers should be excluded from the examination room to keep it free from distraction. The presence of a third party observer in the testing room is also inconsistent with the requirements for standardized test administration as set forth in the APA's Ethical Principles Of Psychologists and Code Of Conduct (APA, 1992) in that it creates the potential for distraction and/or interruption of the examination (McSweeny et al., 1998).

A second issue that relates to the potential influence of the presence of a third party observer is the reliance upon normative data. Neuropsychological test measures have not been standardized in the presence of an observer. In fact, neuropsychological test measures have been standardized under a specific set of highly controlled circumstances that did not include the presence of a third party observer. The presence of a third party observer introduces an unknown variable into the testing environment which may prevent the examinee's performance from being compared to established norms and potentially precludes valid interpretation of the test results (McCaffrey, Fisher, Gold, & Lynch, 1996). Observer effects can be such that performance on more complex tasks declines, in contrast to enhanced performance on overlearned tasks, leading to a spuriously magnified picture of neuropsychological deficit (McCaffrey et al., 1996). Likewise, observation of an examination being conducted for a second opinion may fundamentally alter the test session, in comparison to the initial examination that the patient has already undergone, potentially creating an adversarial atmosphere, and increasing the risk of motivational effects related to secondary gain. Observer effects can be magnified by the presence of involved parties who have a significant relationship with the patient (e.g.

legal representatives who have a stake in the outcome of the examination; cf. Binder and Johnson-Greene, 1995). Thus, the presence of a third party observer during formal testing may represent a threat to the validity and reliability of the data generated by an examination conducted under these circumstances, and may compromise the valid use of normative data in interpreting test scores. Observer effects also extend to situations such as court reporters, attorneys, attorney representatives, viewing from behind one-way mirrors and to electronic means of observation, such as the presence of a camera which can be a significant distraction (McCaffrey et al., 1996). Electronic recording and other observation also raises test security considerations that are detailed in the National Academy of Neuropsychology's position statement on Test Security.

It should be noted that there are circumstances that support the presence of a neutral, non-involved party in nonforensic settings. One situation might be when students or other professionals in psychology observe testing as part of their formal education. These trainees have sufficient instruction and supervision in standardized measurement and clinical procedures, such that their presence would not interfere with the assessment process. Other situations might include a parent's calming presence during an evaluation of a child.

The weight of accumulated scientific and clinical literature with respect to the issue of third party observers in the forensic examination provides clear support for the official position of the National Academy of Neuropsychology that neuropsychologists should strive to minimize all influences that may compromise accuracy of assessment and should make every effort to exclude observers from the evaluation.

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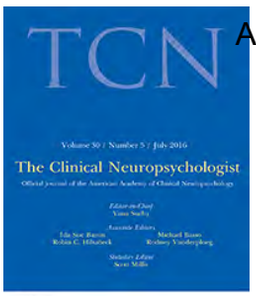

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American Academy of Clinical Neuropsychology (AACN) Practice Guidelines for Neuropsychological Assessment and Consultation

Board of Directors

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AMERICAN ACADEMY OF CLINICAL NEUROPSYCHOLOGY (AACN) PRACTICE GUIDELINES FOR NEUROPSYCHOLOGICAL ASSESSMENT AND CONSULTATION

Board of Directors
American Academy of Clinical Neuropsychology

This document is the first set of practice guidelines to be formally reviewed and endorsed by the AACN Board of Directors and published in the official journal of AACN. They have been formulated with the assumption that guidelines and standards for neuropsychological assessment and consultation are essential to professional development. As such, they are intended to facilitate the continued systematic growth of the profession of clinical neuropsychology, and to help assure a high level of professional practice. These guidelines are offered to serve members of AACN, as well as the field of clinical neuropsychology as a whole.

INTRODUCTION

Clinical neuropsychology has experienced tremendous growth in recent years, whether measured in terms of the number of practitioners, scientific studies, meetings, journals, training programs, or assessment tools. Organizations devoted to neuropsychology have formed and have become well established, yet are still maturing. Within the American Psychological Association (APA), the Division of Clinical Neuropsychology (Division 40) was formed in 1980 and clinical neuropsychology was recognized as a specialty in 1996. Definitions of "neuropsychology" and core training requirements have been developed (Hannay et al., 1998) and a number of general approaches to performing valid and appropriate neuropsychological assessment are recognized as having common core features (cf. Lezak, Howieson, & Loring, 2004).

Identification of professional issues and explication of standards is essential to providing quality neuropsychological services to the public and to developing neuropsychology as a science and clinical specialty. Development of guidelines for neuropsychological assessment is the next logical step in the growth, development, and maturation of the field of clinical neuropsychology. In the era of evidence-based practice in psychology (EBPP), such guidelines should be "... based on careful

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systematic weighing of research data and clinical expertise'' (APA, 2006). The present document is founded on the assumptions that standards for neuropsychological assessment and consultation are essential to professional development and protection of the public, and that such standards can be articulated as general aspirational guidelines despite theoretical and practical diversity within the field (APA, 2005). Consistent with its mission, the American Academy of Clinical Neuropsychology (AACN) is in a position to take on this responsibility. The present Guidelines are offered to serve members of AACN, as well as the profession of neuropsychology as a whole.

The American Board of Clinical Neuropsychology (ABCN) is a member specialty examining board under a unitary governing body, the American Board of Professional Psychology (ABPP). Founded in 1947, ABPP is the oldest peer-reviewed board for psychology and grants board certification in several specialty areas of psychology, including clinical neuropsychology. Within ABPP, ABCN is responsible for the examination process for clinical neuropsychology board certification candidates, with AACN being the membership organization for individuals who have been awarded board certification by ABCN. Inherent in this examination process are de facto and consensually accepted standards for training, knowledge, and clinical practice in neuropsychology (updated policy and procedures are available online at http://www.theabcn.org).

This document is intended to serve as a guide for the practice of neuropsychological assessment and consultation and is designed to promote quality and consistency in neuropsychological evaluations. Psychologists may use these Guidelines to evaluate their own readiness to perform neuropsychological evaluations and as a framework for performing this type of work. Psychologists who desire to upgrade skills, knowledge, and experience may also use these Guidelines as a reference. Other organizations, disciplines, professionals, entities, and individuals are encouraged to consider these Guidelines as principles for the provision of neuropsychological services. Because they apply to the current practice of clinical neuropsychology, these Guidelines will require periodic review and are intended to remain in effect until a point in time at which the AACN Board of Directors (BOD) determines that a revision is necessary.

The present Guidelines are intended to be compatible with the current APA (2002b) Ethical Principles of Psychologists and Code of Conduct (EPPCC) and follow the recommendations of other APA documents, including the Criteria for Practice Guideline Development and Evaluation (2002a) and Determination and Documentation of the Need for Practice Guidelines (2005). The EPPCC are intended to describe standards for competent and adequate professional conduct. In contrast to applicable codes of ethics, the present Guidelines are intended to describe the *most desirable and highest level professional conduct* for neuropsychologists when engaged in the practice of clinical neuropsychology. In the event of a conflict, the EPPCC or other AACN policy statements can inform the practical use of these Guidelines. Similarly, applicable federal and state laws supersede these guidelines.

The term ''guidelines'' refers to statements that suggest or recommend specific professional behavior, endeavors, or conduct for psychologists. The primary purpose of practice guidelines is to promote high-quality psychological services by providing the practitioner with well-supported practical guidance and education in a particular

practice area. Practice guidelines also "inform psychologists, the public, and other interested parties regarding desirable professional conduct" (APA, 2005). Guidelines differ from "standards" in that standards are mandatory and may be accompanied by an enforcement mechanism, whereas guidelines are aspirational in intent. Guidelines are intended to facilitate the continued systematic development of the profession and to help assure a high level of professional practice (APA, 2005). They are not intended to be mandatory or exhaustive, and may not be applicable to every professional and clinical situation. They are not to be promulgated as a means of establishing the identity of a group or specialty area of psychology. Likewise, they are not created with the purpose of excluding any psychologist from practicing in a particular area, nor are they intended to take precedence over a psychologist's judgment.

OUTLINE OF THE GUIDELINES

1. Definitions
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1. DEFINITIONS

Clinical neuropsychology has been defined as "an applied science concerned with the behavioral expression of brain function and dysfunction" (Lezak et al., 2004). Vanderploeg (2000) noted that neuropsychology studies "the impact of brain injury or disease on the cognitive, sensorimotor, emotional, and general adaptive capacities of the individual." In a similar vein, Prigatano (2002) offered that neuropsychology is "the scientific study of how the brain produces mind and how disorders of the brain cause a variety of mental and personality disturbances." Integrating these statements, *clinical neuropsychology is an applied science that examines the impact of both normal and abnormal brain functioning on a broad range of cognitive, emotional, and behavioral functions*. The distinctive features of neuropsychological

evaluations and consultations in assessing brain function and dysfunction include the use of objective neuropsychological tests, systematic behavioral observations, and interpretation of the findings based on knowledge of the neuropsychological manifestations of brain-related conditions. Where appropriate, these evaluations consider neuroimaging and other neurodiagnostic studies and inform neuropsychologically oriented rehabilitation interventions.

2. PURPOSE AND SCOPE

Clinical neuropsychologists conduct their professional activities in accord with the EPPCC (APA, 2002b), and any AACN position statements that apply to particular issues or areas of practice that are relevant to their professional activities. They are also aware of and may seek guidance from the standards of practice and principles of other relevant professional organizations (e.g., American Academy of Forensic Psychology, American Academy of Pediatrics).

While the professional standards for the ethical practice of psychology are addressed in the EPPCC, these principles are not fully inclusive with respect to the current aspirations of desirable professional conduct for clinical neuropsychologists. By design, none of the present Guidelines contradicts any of the principles of the EPPCC; rather, they exemplify those principles in the context of the practice of clinical neuropsychology, as herein defined. The Guidelines have been designed to be national in scope and are intended to conform to applicable state and federal law. In situations in which the clinical neuropsychologist believes that the requirements of law are in conflict with these Guidelines, attempts to resolve the conflict should be made in accordance with the procedures set forth in the EPPCC.

The present Guidelines specify the nature of desirable professional practice by clinical neuropsychologists within any sub-discipline of this specialty (e.g., child, forensic). The term ''psychologist'' designates any individual whose professional activities are defined by APA and by regulation of title by state registration or licensure, as the practice of psychology. ''Clinical neuropsychologist'' refers to psychologists who engage in the practice of clinical neuropsychology as defined above.

3. EDUCATION AND TRAINING

Early in the development of the field of clinical neuropsychology, neuropsychologists were in limited demand, and there were few formal training programs. By 1979, the International Neuropsychological Society (INS) had published broad guidelines indicating alternative pathways for obtaining competence in this discipline (Rourke & Murji, 2000). At one point, a formal re-specialization program of continuing education was suggested as one means of helping psychologists gain the necessary skills to practice neuropsychology. Continuing education, however, is only intended to expand or elaborate on established skills and is not regarded as an adequate modality for establishing competence in neuropsychology (Bornstein, 1988a). Formal training programs are now widely available (Cripe, 2000; Donders, 2002), and the nature of specialized neuropsychological training has been defined (Bornstein, 1988b; Hannay et al., 1998) and is the basis for the Guidelines proposed herein.

As evident from the definition of *neuropsychology*, a neuropsychologist possesses skills beyond simply administering and scoring a particular set of tests (Matarazzo, 1990; Meyer et al., 2001). A neuropsychologist is "a professional psychologist trained in the science of brain-behavior relationships" (Hannay et al., 1998). Kane, Goldstein, and Parsons (1989) pointed out that "the unique competence of the neuropsychologist is that of conceptualizing assessment results within a brain-behavior framework." The prefix "neuro" in neuropsychologist means that the psychologist is a specialist who has had explicit training in neuroscience and neurological bases of behavior. To fulfill this role, neuropsychologists must have specialized knowledge and training, a fact that is incorporated into the existing definitions of a neuropsychologist (Barth et al., 2003; Bieliauskas, 1999). Both APA Division 40 (Clinical Neuropsychology) and the National Academy of Neuropsychology (NAN) definitions require 2 years of specialized training. The APA Division 40 definition requires formal university training in neuropsychology and the neurosciences, and recommends a peer review process as an indicator of competency. The NAN definition (National Academy of Neuropsychology, 2001) requires, for individuals receiving training after 2001, "the equivalent of two (fulltime) years of experience and specialized training, at least one of which is at the post-doctoral level, in the study and practice of clinical neuropsychology and related neurosciences. These two years include supervision by a clinical neuropsychologist."

4. WORK SETTINGS

Clinical neuropsychologists comprise a relatively small group compared with other specialists in the healthcare marketplace. Indeed, according to recent SAMHSA Mental Health Information Center statistics (http://www.mentalhealth.samhsa.gov/publications/allpubs/SMA01-3537/chapter20.asp), there are over 77,000 licensed doctoral-level psychologists in the United States. At present, there are roughly 4,000 individuals purporting to practice clinical neuropsychology in the United States as reflected by membership in APA Division 40. This is a small number relative to other organizations including the 7,000 members of Division 12 (Clinical Psychology) of APA, 17,000 members of the American Academy of Neurology (AAN), and over 150,000 members of APA. Nonetheless, from the beginning of its development in the United States in the 1950s and 1960s, clinical neuropsychology has flourished as a discipline because of its unique focus and clinical utility.

The settings in which clinical neuropsychologists practice are richly varied. To illustrate, a neuropsychological text edited by Lamberty, Courtney, and Heilbronner (2003) includes chapters from practitioners who work in independent practice, collaborate with physicians in a medical practice, forensic settings (e.g., civil and correctional), or have adult and child practices in rural or urban communities, university-affiliated medical centers, university-based attention deficit-hyperactivity disorder (ADHD) and learning disorder clinics, Veterans Affairs medical centers, general hospital settings, medical rehabilitation units, or schools. Other practice environments include military bases, pharmaceutical companies, surgical centers, and practices in which patients for social security and disability benefits are evaluated (Sweet, Peck, Abramowitz, & Etzweiler, 2000). Neuropsychologists have established themselves

and the utility of neuropsychology as a specialty practice, in a number of medical, legal, social service, and other professional settings (Prigatano & Pliskin, 2003).

5. ETHICAL AND CLINICAL ISSUES

The following section identifies four ethical and clinical issues that are particularly relevant to the practice of clinical neuropsychology and to the development of these guidelines. However, many other practice-related issues, such as effects of third-party observers and the use of psychometricians, are not covered. The reader is referred to relevant AACN position papers or documents from other membership organizations for discussion of these and other issues (see www.theaacn.org and www.nanonline.org).

A. Informed Consent

Neuropsychologists are aware of, and sensitive to, ethical and legal issues of informed consent, confidentiality, autonomy, and related human rights that arise in the context of evaluating children and adults. This is also true for ''vulnerable adults,'' such as patients with mental retardation, developmental disabilities, or dementia, including those who already have designated legal guardians. The limits of confidentiality are explained to all examinees (or to parents or guardians, when appropriate) at the outset of a neuropsychological evaluation. The neuropsychologist establishes a clear understanding of examiner–examinee relationship issues, and ensures that this understanding is shared with the examinee and, if necessary, with relevant third parties, such as a referring physician, social worker, special education administrator, or attorney, and in some cases with insurers (Johnson-Greene & NAN Policy & Planning Committee, 2005). Consideration of such relationships is critical in identifying the person legally entitled to consent to the evaluation and to a release of information about the examinee. The following questions might be asked in these situations: For a patient with dementia or mental retardation, is there a court-appointed guardian? For a child, if the parents are divorced, who has legal custody to give consent for the evaluation and who has a right to receive full disclosure of the findings?

B. Patient Issues in Third-Party Assessments

Neuropsychologists may evaluate someone at the request of a third party (e.g., insurance carrier, attorney, judge, or special education hearing officer), as part of a legal proceeding, a disability evaluation, or special education due process hearings. In such cases, the neuropsychologist clarifies the nature of the relationship with the referring third party by establishing that the neuropsychologist will provide a candid and objective opinion based on the evaluation results (Bush & NAN Policy & Planning Committee, 2005a). In a legal dispute, such an opinion is offered regardless of whether the referral comes from someone advocating for the examinee or for a different party.

At the outset of the evaluation, the neuropsychologist establishes the aims of the assessment, describes in clear language the sorts of information requested of the patient and types of testing procedures to be performed, the general information-gathering procedures to be followed (e.g., whether the evaluation will involve

formal standardized testing, interview, observation in the office, observations in natural settings such as school, home, or daycare, or collection of information from collateral sources where deemed appropriate, such as care providers, teachers, health aides, parents, spouse), the means of providing feedback (e.g., oral and/or written), and to whom and when a neuropsychological report will be sent. The neuropsychologist and referring parties discuss in advance who will pay for the evaluation, what costs are anticipated, and what payment arrangements can be made. In the case of a third-party referral, the neuropsychologist explains to the examinee (or guardians) that the party requesting the evaluation, rather than the patient being evaluated, is considered the "client," at least in the sense that it is this party that will receive the evaluation findings and report. The examinee is helped to understand that his/her responses, and the neuropsychologist's opinions about him/her, will be shared with the referring party, and that the referring party will decide how to use the information (e.g., whether it will be given to opposing attorneys, read aloud in court, etc.). The information from the examination may also be used in future or separate legal or administrative proceedings. The examinee is entitled to decline to participate, but the neuropsychologist should advise him/her to consult with his/her attorney or agent to clarify the possible consequences of consenting, or refusing, to be evaluated. Written reports, in these circumstances, clearly avoid the implication of patienthood or ongoing treatment and identify the examinee as distinct from the name and social/legal identity of the referral source.

In forensic cases, neuropsychologists are careful to distinguish between the role of an "expert" and the role of a "clinician." The expert's role is to inform the attorney(s), as well as the "trier of fact" (e.g., a judge, jury, or hearing officer) of the neuropsychological findings and to present unbiased opinions and answers to specific questions pertinent to the case, based on relevant scientific and clinical evidence (i.e., to be an "advocate of the facts") of the case. In contrast, the treating clinician's role is to be an advocate for his/her patient. Taking on the role of a patient advocate in a forensic situation might be perceived as biasing the clinician's opinions in favor of the patient. The neuropsychologist acting as a forensic expert typically does not conduct a feedback and treatment-planning conference with examinees (or their representative). A neuropsychologist who has treated a patient generally will decline to serve as an expert with regard to that case. If called upon to testify, the treating clinician responds in a manner consistent with original role limitations and qualifies his/her role when answering questions about the patient.

Neuropsychologists may provide a "second opinion" based on a review of another neuropsychologist's report, at the request of a judge or an attorney, an insurance company, or another psychologist. In this situation, the neuropsychologist is careful to base such an opinion only on available data and to express caution when lacking the information to provide a more substantive basis for their opinion(s). For example, the neuropsychologist may not be certain about the quality of examiner–examinee rapport or the accuracy of test administration procedures for the evaluation under review, or may find it difficult to form opinions based on the tests administered. Therefore, the "second opinion" might be limited to statements regarding whether or not the other examiner chose appropriate tests, reported the scores accurately, and made inferences, conclusions, and recommendations that are supported by the data provided in the report; whether alternative conclusions

or recommendations, not mentioned in the report, should be considered; and whether any further neuropsychological tests or other information gathering (e.g., medical examinations) should be carried out to answer questions relevant to the case.

C. Test Security

Appropriate test security is the assumed responsibility of any practicing neuropsychologist and reflects several different levels for maintaining the safekeeping and utility of any test. Likewise, how the test results are disseminated to patients also falls under the guidelines for test security (NAN, 2000c) and for copyright protection. It is inappropriate and unethical to make copies of actual tests for patients or other parties as a means of providing feedback on assessment findings (EPPCC; APA, 2002b). Because of the time and expense in properly standardizing psychological and neuropsychological instruments, the clinician is entrusted to safeguard and protect the proprietary aspects of such tests to the fullest degree possible. Test publishers routinely include a section on their recommendations for test security and these should be strictly followed in the best manner possible by each clinician. Unique pressures may arise in certain forensic settings, but again the responsibility of the clinician is to maintain the integrity and security of test materials as far as the law and practice guidelines of psychology apply in the relevant jurisdiction(s) of service or practice. In particular, neuropsychologists are aware of the EPPCC and federal, state, provincial, or local policies that govern the content, security, and release of psychological and neuropsychological reports, test protocols, and raw test data or responses, including mandates from state boards of psychology, the Health Insurance Portability and Accountability Act (HIPAA) and the Centers for Medicare and Medicaid Services (CMS).

D. Underserved Populations/Cultural Issues

The present guidelines augment the ''cultural competence'' provisions of the EPPCC by defining the issues to be considered and recommending some specific competencies for the neuropsychological evaluation of individuals belonging to minority and underserved populations. Consistent with these provisions, neuropsychologists are aware that cultural, linguistic, disability, and other demographic and socioeconomic factors influence individuals' participation in the process of neuropsychological assessment, and may alter the meaning of the information obtained from testing (see, for example, Artiola i Fortuny et al., 2005; Brauer, 1993; Cohen, Mounty, & Martin, 2005; Manly et al., 1998; Mason, 2005; Ortiz, 2001; Perez-Arce & Puente, 1998; Vernon, 2005; Wong & Fujii, 2004). Neuropsychologists are also aware of the risks inherent in administering and interpreting tests with individuals from groups for whom there are insufficient or limited test adaptations, normative data, or validity studies (see Artiola i Fortuny, Heaton, & Hermosillo, 1998; Manly, 2005). These groups include individuals with unusually low levels of education (in the United States or elsewhere), those whose primary language is other than English and who belong to distinctive cultural or sociodemographic groups, and those with physical or mental disabilities that limit the ability to participate meaningfully in the examination as originally intended.

Neuropsychologists who agree to evaluate members of special populations are specifically educated about issues and have experience in administering and interpreting procedures relevant to the patient in question (Echemendia & Westerveld, 2006; Hauser, Wills, & Isquith, 2006; Ortiz, 2001; Vernon, 2005; Wong & Fujii, 2004). Alternatively, neuropsychologists show (1) that they have sought a local colleague better qualified to accomplish the task, (2) that the potential harm to the patient of deferring or declining the referral has been assessed and is considered to outweigh the potential dangers of proceeding with an evaluation, notwithstanding acknowledged limitations in the neuropsychologist's population-specific competencies, and (3) that they have attempted to ameliorate or compensate for all such limitations by consulting appropriate colleagues and research literature.

Neuropsychologists describe in their report how well they have communicated with the patient, their own level of fluency in the patient's language, and their uncertainty about the fidelity of interpreter-mediated translation and quality of interpersonal communication, including not only literal content, but also culturally mediated meanings, affective tone, and nonverbal "body language." They further note the inevitable effects of using an interpreter on the validity of the test results and interview data (Dean & Pollard, 2005; Glickman & Gulati, 2003; Harvey, Artiola i Fortuny, Vester-Blockland, & De Smedt, 2003; Hindley, Hill, & Bond, 1993; Marcos, 1979). Interpreters are employed in a manner that respects the patient's autonomy and competence (Artiola i Fortuny et al., 2005; Cohen et al., 2005; Dean & Pollard, 2005). Neuropsychologists avoid using family members, friends, or other untrained individuals as interpreters, whenever possible, to preserve patient confidentiality and autonomy as well as to optimize the fidelity of translation.

Neuropsychologists recognize the threats to validity that can occur with the introduction of cultural bias in both translated and adapted instruments. These threats may occur at three levels: item, method, and construct (Van de Vijver & Hambleton, 1996). When working with populations for whom tests have not been standardized and normed, neuropsychologists place particular emphasis on using direct observation and relevant supplementary information about a patient's adaptive functioning within his or her "real-world" community. They may employ assessment strategies that do not require a standardized normative approach, including, but not limited to, direct observation, charting of behavioral changes over time, criterion-referenced testing, direct comparisons with a group of demographically similar peers, or comparison with demographically similar groups in published research studies (Manly, 2005; Simeonsson & Rosenthal, 2001).

6. METHODS AND PROCEDURES

A. The Decision to Evaluate

Before initiating neuropsychological testing, the neuropsychologist clarifies the referral source and the referral questions, determines that he or she is competent to evaluate the patient and answer the referral question(s), concludes that it is ethically acceptable to do so, and decides that a neuropsychological evaluation is pertinent to the issues raised. Otherwise, the neuropsychologist contacts the referral source and discusses whether some other type of evaluation may be better to address the referral

questions, such as a psychodiagnostic evaluation, functional behavior assessment, clinical interview, psychiatric evaluation or other medical assessment. Alternatively, the neuropsychologist suggests that the evaluation may be more appropriately conducted by a different neuropsychologist owing to conflict of interest or the fit of the patient's needs to the neuropsychologist's clinical competencies or cultural or language expertise.

B. Review of Records

Having access to information from sources other than the patient and their family members usually allows for a more comprehensive neuropsychological evaluation. Memories may be inaccurate or historical reports distorted, previous information may have been misunderstood or pieced together from the recollections of others, or patients simply may not know important facts. When conducting a comprehensive evaluation, the neuropsychologist attempts to obtain relevant background information from written records whenever possible. By gathering historical information, the neuropsychologist may improve diagnostic predictive accuracy, better describe cognitive and behavioral functioning, and assist treatment planning. In the case of an injury, medical condition, or neurological event, medical records from emergency personnel, hospitals, and outpatient facilities help to establish facts related to the time frame of the presenting problems, presence or absence of critical medical factors, type and degree of injury or impairment, and circumstances under which problems may have become manifest. Historical information is also relevant in assessing patients with histories of psychiatric illness, developmental disabilities, or learning or attentional disorders, and for whom the time sequence of the problems and interventions used to manage these problems may be important in clinical decision making.

In the case of suspected cognitive changes, an attempt to obtain a patient's earlier medical records is advisable in most cases. Although not a common practice in adult neuropsychological assessment, information gathered from available childhood health records helps to determine if pre-existing difficulties may account, in part, for a patient's current level of functioning. In the evaluation of children, adolescents, and young adults, information contained in the school records often enhances understanding of the child's past and current cognitive and behavioral functioning. Records of school or work histories for adults may be similarly useful in providing information on premorbid level of functioning, but are often unavailable.

The aims of the evaluation typically determine the extent to which the neuropsychologist gathers information from collateral sources. Extensive review of records may be a worthwhile goal in conducting some assessments, but may not be warranted in all cases and will depend on the nature of the referral questions. In many routine clinical scenarios, such as evaluations undertaken to facilitate ongoing medical care, the patient's best interests may be better served when an interpretive report is provided expeditiously, without the delays that often accompany a request to complete a review of external records. Writing a subsequent addendum summarizing a review of obtained records may be considered as a means to supplement information not available at the time of the original report.

Finally, the nature of the questions asked of a neuropsychologist in a forensic evaluation may require a more extensive review of records than is typically required for a clinical evaluation. In a forensic case, the neuropsychologist reviews as much relevant information about the past and present functioning of the patient as can be made available to him/her. Neuropsychologists do not, when conducting an examination for a forensic purpose, assume primary responsibility for the discovery and production of historical records.

C. Interview of Patient and Significant Others

A neuropsychological evaluation consists of more than a review of records and the administration of psychological and neuropsychological tests. Indeed, some information critical to the evaluation may only be available via a patient interview. Information from the patient may enable the clinician to gain perspective on the patient's experience, including self-perceptions of problems and stresses, and to integrate this information with data from other sources (e.g., test results, record reviews, interviews with significant others). In this way, the clinician may come to a more complete understanding of the patient's history and current situation and be better able to apprehend how the patient or examinee views his/her life circumstances.

Neuropsychologists may employ actuarial (i.e., purely data-driven) approaches to understanding and interpreting brain–behavior relationships, including those that focus solely on lateralization and/or localization of brain dysfunction (Russell, Russell, & Hill, 2005). However, a comprehensive neuropsychological evaluation generally entails identification and description of the cognitive and behavioral correlates of brain disease or neurodevelopmental disorder, opinions regarding prognosis, and formulation of treatment plans. A clinical interview and gathering of historical information, often including neuroimaging or other medical findings, is critical to this process.

When interviewing a patient, the neuropsychologist typically considers the events that led to the referral for an evaluation, the duration of the presenting problems or condition, the primary symptoms and changes in symptom presentation over time, the effect of the presenting symptoms or condition on daily functioning, the results of previously conducted tests and procedures, and the patient's strengths and interests. Relevant historical details may include prenatal history, birth and developmental background, educational history (including any history of learning disabilities or weaknesses), work history, current and past medical and psychiatric history, history of alcohol or substance abuse, current and past medications, legal history, and family medical, psychiatric, and substance abuse history.

Although interviewing a family member or friend of the patient is not always possible, doing so may yield useful information not otherwise available. Because of problems with motivation, memory, language, reduced awareness of their illness, or other neurobehavioral symptoms, patients may not always be reliable informants for past or current events. Information from a person who knows the patient and who can talk about the patient's premorbid history, and the effects that the illness/injury has had on the patient and family, can be critical in understanding the functional consequences of the illness/injury. Such individuals may sometimes be the only source of information regarding the onset, clinical course, and magnitude of deficits. However, it is important to communicate to the family or significant other that a

doctor-patient relationship does not exist; thus, issues such as confidentiality, release of records, etc., should be discussed in advance. Whether used in evaluating the patient or to obtain information from other informants, a structured interview can help to reduce bias and ensure thoroughness and consistency across examinations. It may also provide a means for standardizing data collection of potential use in clinical research.

D. Measurement Procedures

Neuropsychological evaluations vary in content depending on their purpose but they typically assess multiple neurocognitive and emotional functions. Primary cognitive domains include: intellectual functions; academic skills (e.g., reading, writing, math); receptive and expressive language skills (e.g., verbal comprehension, fluency, confrontation naming); simple and complex attention; learning and memory (e.g., encoding, recall, recognition); visuospatial abilities; executive functions, problem-solving and reasoning abilities; and sensorimotor skills. Ideally, assessments should also include measures designed to assess personality, social-emotional functioning, and adaptive behavior. In some settings (e.g., testing the acutely medically ill), comprehensive testing may be contra-indicated; in such situations, measurement of selected neurocognitive domains and/or a screening of cognitive skills is preferred. Additional guidelines for test selection can be found in APA's Standards for Educational and Psychological Testing (1999).

Neuropsychological tests and measures used for clinical purposes must meet standards for psychometric adequacy (with exceptions as noted below). These standards include: (1) acceptable levels of reliability, (2) demonstrated validity in relation to other tests and/or to brain status, including evidence that the test or measure assesses the process, ability, or trait it purports to assess, and (3) normative standards that allow the clinician to evaluate the patient's scores in relation to relevant patient characteristics, such as age, gender, and sociodemographic or cultural/linguistic background. In general, tests published with large, stratified normative samples—"Heaton norms" (Heaton, Avitabile, Grant, & Matthews, 1999); Mayo's Older Americans Normative Studies (MOANS; Ivnik et al., 1992, 1996), and Mayo's Older African Americans Normative Studies (MOAANS; Lucas et al., 2005)—provide a sound foundation for accurate interpretation. Comparisons of results from tests that are co-normed are advantageous in examining differences between two or more cognitive domains. The neuropsychologist is aware of the source of normative data and is cautious about using tests for which sample sizes are small or restricted (e.g., by geographic region or sociodemographic characteristics). Sample size considerations are particularly important in child assessments, where developmental changes in skills demand adequate sampling across a variety of ages.

Measures that show promise, but have not met the most rigorous standards, may be considered to assess skills, behaviors, or influences that are deemed important to elucidate patients' or others' concerns. However, these more "provisional" tests and measures are selected to complement rather than replace those with better-established properties. Preliminary evidence for psychometric adequacy is needed even for measures considered provisional in nature; and the neuropsychologist is aware of the level of support for their use in interpreting the findings.

Some common conditions that justify exceptions to the general principles elucidated above include: the need to evaluate an individual whose neuropsychological functioning falls at the extremes of the normal distribution (e.g., those with mental retardation or the exceptionally gifted), individuals with sensory or motor disabilities that require modifications to standardized test administration (e.g., creating a bedside assessment for a patient with neglect following a right hemisphere stroke), and individuals from linguistic or cultural groups for whom no normed test exists. In such cases, the neuropsychologist recognizes the importance of ecologic validity or external "real-world" validation of the test findings and for determining the reliability of the findings across multiple tests. The neuropsychologist also explicitly acknowledges in the report the modifications of test administration and scoring and their potential effect on the validity of the assessment results.

A comprehensive neuropsychological evaluation should be thorough but also efficient and respectful of a patient's time and resources. Some patients, such as those who fatigue easily, may require more than one session. Furthermore, in clinical practice, clinical neuropsychologists often find it necessary and advisable to administer a selected set of subtests instead of the complete test battery or test. An advantage of using multiple tests from single or co-normed test batteries is that patient strengths and weaknesses, including levels or laterality of performance, can be assessed relative to the same normative sample. A further advantage is that administration of test batteries can provide for the assessment of a broad range of functions. Disadvantages include a predetermined number and restricted selection of subtests in the existing test batteries, and associated time constraints, which may preclude administration of complete batteries when given in combination with other measures of interest. Breadth of assessment can be provided by administering multiple individual tests and/or combinations of subtests from different test batteries, depending on the goals of the evaluation. The practice of using selected subtests or individually developed tests can be justified by reference to research literature employing these measures and the availability of appropriate normative standards (e.g., Baron, 2004; Heaton et al., 1999; Lucas et al., 2005; Steinberg & Bieliauskas, 2005).

E. Assessment of Motivation and Effort

A growing literature suggests that the assessment of motivation and effort is critical when conducting a neuropsychological evaluation (Bush & NAN Policy & Planning Committee, 2005b). This area has received the greatest emphasis in forensic assessment, in which symptom magnification, impression management, or even feigning of impairment can occur (Mittenberg, Patton, Canyock, & Condit, 2002). However, the assessment of effort and motivation is important in any clinical setting, as a patient's effort may be compromised even in the absence of any potential or active litigation, compensation, or financial incentives. Approaches for assessing motivation and effort include: behavioral observations from interview or testing of behaviors such as avoidance, resistance, hostility, and lack of cooperation; examination of the pattern of performance among traditional neuropsychological measures; identification of unexpected or unusually slow and/or impaired levels of performance; identification of cognitive profiles that do not fit with known patterns typical of brain disorders; and consideration of suspect performance on objective measures of effort. Clinicians

utilize multiple indicators of effort, including tasks and paradigms validated for this purpose, to ensure that decisions regarding adequacy of effort are based on converging evidence from several sources, rather than depending on a single measure or method.

Neuropsychologists utilize commonsense methods to optimize patient performance, such as attending to the lighting, seating, and other aspects of physical comfort during testing; treating patients respectfully; establishing rapport; asking the patient about his/her understanding and acceptance of the evaluation process; and encouraging and reinforcing effort. The purpose of these methods is to establish a physically and interpersonally comfortable testing environment, with the goal of minimizing anxiety, resistance, physical discomfort, or other factors that may interfere with optimal motivation and effort.

F. Assessment of Concurrent Validity

The neuropsychologist typically draws inferences about a given skill or ability from more than one test or test score, and considers the influences of the patient's state of engagement, arousal, or fatigue on test performance. To illustrate, issues of test validity may be raised when performance on an attention measure early in a test battery is better than performance on another attention task toward the end of the battery. Cultural and language-mediated effects on test performance are also considered, and caution is exercised in administering and interpreting tests to individuals from a demographic, linguistic, or cultural group for which the tests have not been appropriately normed, validated, and translated (see section 5C). The neuropsychologist should be aware of limitations of making comparisons among standard scores arising from different normative samples and should make efforts to include norms that are most similar to the demographics of the patient being examined.

G. Test Administration and Scoring

Standard procedures are followed in test administration and scoring (see *Standards for Educational and Psychological Testing*, APA, 1999). Tests are administered, scored, and interpreted in ways that are consistent with evidence regarding the utility and appropriate application of these methods. The clinician attempts to prevent misuse of the test materials, and to determine and report circumstances in which norms may have limited applicability or test procedures may be inapplicable or require modification (EPPCC). Neuropsychologists may "test limits" (e.g., by changing test demands or providing extra time) to investigate the effects of accommodations on test performance, but findings from such procedures are clearly labeled as such and norms that apply to standard administrations are not used to describe the results. The presence of third-party observers during test administration is also strongly discouraged (AACN, 2001; NAN, 2000a). If a third party or monitoring device is present, the neuropsychologist states how and to what extent this circumstance may have affected the test results.

Accuracy of scoring is essential for appropriate interpretation of test results. The neuropsychologist is familiar with scoring methods and criteria for specific items, procedures for aggregating scores, and the meaning of the scores (i.e., the normative base used for converting raw to standard, or derived scores). Scoring is

performed with care, with double-checking of scores, sums, and conversion tables to ensure accuracy. If novel scoring procedures are used, they should be justified by previous research. Computer scoring programs, because of the "hidden" nature of their operations, are used only if validated against other reliable and previously validated procedures. Neuropsychologists are responsible for the accuracy of scores when a psychometrist or computerized scoring program are utilized (APA, 1992; NAN, 2000b).

H. Interpretation

Accurate interpretation of neuropsychological test data requires extensive relevant training and experience, and knowledge of current empirically based professional opinions gathered from continuing education and the published literature. A neuropsychologist's clinical interpretation of the evaluation findings is based on information regarding the patient's history and problems, direct observation of the patient, levels or patterns of test performance associated with specific clinical presentations, and the current theory and knowledge regarding the neurological and psychosocial/cultural influences on test performance and daily functioning. This interpretation is highly individualized and does not follow a "cookbook" approach. Results from computer scoring and interpretation programs are also considered within the context of the individual patient; the neuropsychologist does not exclusively use automated computer printout interpretation as a substitute for a carefully considered and individually tailored clinical interpretation.

Information about the patient's sociodemographic status, cultural and linguistic background, and work, school, and family characteristics can be obtained through interview or formal measures. These factors are taken into consideration in making judgments as to the extent to which the test performance deviates from expected levels (see section 5C). This information is also useful in determining if environmental or motivational factors are contributing to or exacerbating the patient's problems.

The inferences made by neuropsychologists in interpreting the evaluation findings include judgments regarding: (1) the nature of the cognitive deficits or patterns of strengths and weaknesses, (2) the likely sources of, or contributors to, these deficits or patterns, and (3) their relation to the patient's presenting problems and implications for treatment and prognosis. The first type of inference is based on knowledge of the cognitive constructs measured by neuropsychological tests. Judgments regarding relative strengths and weaknesses also rely on knowledge of expected levels of test performance relative to background patient characteristics or to the patient's performance on other tests (as in making judgments regarding inter-test score discrepancies). In rendering conclusions regarding a patient's strengths and weaknesses, the clinician considers the consistency of findings across multiple tests and alternative explanations for high or low test scores (e.g., development of compensatory test-taking strategies, poor effort) or the overall pattern and profile of neuropsychological test scores.

The second type of inference, regarding causal or contributing factors, relies on knowledge of the cognitive, behavioral, and emotional consequences of brain insults or constitutional-genetic anomalies. If a brain insult or neurodevelopmental

anomaly is *known*, a judgment is made as to whether the insult or anomaly has contributed in some way to the patient's problems. The insult or anomaly may be a primary cause of the problems. In circumstances in which several causal factors are potentially contributory, it may be difficult to conclude with reasonable certainty that a particular event or disease is the primary cause, or to isolate the specific influence of a particular condition on a behavior or learning problem. Inferences regarding causation take into account not only the pattern of the test results, but also the history of the patient's problems, the nature of the potential causal event and its relation to symptom presentation, the strength of research supporting a relation between the type of brain insult or anomaly of the patient and the test findings, the base rate of the problem in the general population, and alternative explanations for the patient's test findings. These same considerations apply if the brain insult or anomaly is *unknown*. In this latter instance, the judgment to be made involves the extent to which the problems are consistent with or suggest the presence, nature, or localization of a neurological abnormality. Inferences in this regard are again based on the degree of consistency of the patient's test results to those of other patients with similar insults or anomalies, the likelihood of a neurological insult or anomaly as having occurred, the patient's history and timing of symptoms in relation to a potential insult or anomaly, and consideration of other possible causes for the patient's problems.

In making judgments regarding brain insult or anomaly as a cause for the patient's presenting problems, co-morbidities, or ability deficits, the neuropsychologist considers factors that may ameliorate or exacerbate these effects. Such moderating variables may include patient behavior and background characteristics, environmental supports or stressors, the effects of various medications, and the patient's current level of cognitive functioning. Environmental and maturational influences on outcomes of brain insult or anomaly are also considered in making judgments regarding causation.

The third type of inference pertains to the validity of neuropsychological test results in identifying and forecasting social-behavioral or learning problems and in predicting responsiveness to different interventions. Test validity in this sense is supported to the extent that the patient's identified deficits, or patterns of strengths and weaknesses, have been related in past research to problems similar to the patient's. Further support for validity comes from studies indicating that specific deficits or patterns of strengths and weaknesses predict other difficulties or future outcomes, or inform treatment for the patient's problems. In drawing conclusions about the relevance of cognitive skills to identification and management of a patient's problems, the neuropsychologist considers the possible contributions of non-cognitive factors (e.g., the effects of pain, sleep disruption, medication effects, psychological distress or history of maladaptive behavior unrelated to the patient's cognitive deficits, social or educational supports).

New technologies for evaluating brain–behavior relationships are emerging, including advances in neuroimaging, genetic analyses, metabolic tests, and other measures that reflect physiological and psychological functions. All of the major areas of clinical psychometric assessment, as defined earlier in these guidelines, are being standardized for research and clinical purposes using an array of neuroimaging methods, such as functional magnetic resonance imaging (fMRI). To illustrate, APA

Division 40 has endorsed the role of neuropsychologists in clinical use of fMRI (APA, 2004). In the coming years, standardized assessment protocols for assessing a broad spectrum of neuropsychiatric and cognitive disorders are likely to be developed wherein clinical neuropsychologists will use neuroimaging as part of their neuropsychological evaluation and assessment.

I. The Evaluation Report

Neuropsychological findings generally are summarized in a written report to be provided to the referral source or responsible party (Axelrod, 1999), except in special circumstances (e.g., certain forensic or research contexts). The EPPCC (APA, 2002b, 6.01: Documentation of Professional and Scientific Work) notes that the written report serves "... to facilitate provision of services later; to ensure accountability; and to meet other requirements of institutions or the law."

Report-writing styles vary with the purpose of the report, background and training of the neuropsychologist, requirements of the work setting, and even, on occasion, the specific guidelines established by the referring party. Neuropsychological evaluations are typically requested for a specific purpose or to answer specific referral questions. The purposes of the assessment may include provision of differential diagnoses, documentation of cognitive strengths and weaknesses, delineation of functional implications of the identified deficits, and recommendations regarding interventions. Generally speaking, the aims of the report are (1) to describe the patient and record the findings, (2) to interpret the patient's performance on tests in light of other assessment information, (3) to answer questions and make judgments regarding the nature and sources of the presenting complaints/concerns, (4) to assess prognosis and make recommendations for future care, and (5) to communicate the results to the patient or significant others with permission, to the referral source, and other service providers such as teachers and therapists (Axelrod, 1999).

Despite the absence of a universally accepted outline or format, the report usually is organized to assist the reader in identifying the patient and learning of the reason for referral and presenting problems, the patient's history and level of functioning, the patient's behavior during the evaluation, the test results, and the clinician's impressions, interpretations, and recommendations. Some of the most commonly used report sections include: Identifying Information and Reason for Referral; Background Information/History; Tests Administered; Behavioral Observations; Test Results/Interpretations; Summary & Conclusions; Diagnostic Impressions; and Recommendations. Consultations or short reports are more annotated versions of the above format, typically consisting of a few paragraphs describing the test results and recommendations. Abbreviated reports are more common when evaluating patients whose background is already known to the referral source (e.g., primary physician) or when the assessment is being conducted for more circumscribed reasons (e.g., to assess cognitive function as part of a multidisciplinary inpatient assessment). Test reports contain information regarding the patient's age, gender, educational level, occupational background, need for special services or accommodations in conducting the assessment, racial identity/ethnicity, the persons who conducted the assessment (neuropsychologist, psychometrist) and others

present during testing (e.g., translator, student trainee), and (as appropriate) the language(s) in which testing was conducted and the examiner's and patient's fluency in the language(s).

One recommended practice in clinical neuropsychology is to include numerical data (including scaled scores or percentile ranks) in reports (Donders, 2001; Friedes, 1993). Neuropsychologists may choose to append test scores in a summary sheet, or insert scores in the report text. Including test scores allows for the comparison of a patient's performance over repeated evaluations, minimizes the need for obtaining multiple releases of information, and increases the efficiency with which raw data can be shared with other professionals for the purpose of further assessment or management of the patient. Inclusion of scores also increases accountability and may even minimize and clarify any interpretation biases or idiosyncrasies on the part of the writer (Matarazzo, 1995). Finally, in certain situations, such as documenting a learning disability or ADHD for higher education, the guidelines issued by testing organizations and used by academic institutions universally require the reporting of test scores (Educational Testing Service (1998a, 1998b). When used in conjunction with scores, use of words describing test scores (e.g., "below average," "impaired") may facilitate understanding of test data.

Multiple normative data sets are available for many neuropsychological instruments, and test score percentiles or standard scores may differ depending on which norms are employed. As appropriate, citations may be provided for the normative sets, which can assist the reader in understanding how specific standard scores were derived. Further, because some test norms allow adjustment for age, while others also correct for additional factors, such as education, gender, and/or ethnicity, some practitioners may choose to specify the demographic characteristics that were considered in deriving norm-based scores (e.g., 10th percentile for age and education; Selnes et al., 1991).

J. Providing Feedback

Although documentation of the results from a neuropsychological evaluation usually takes the form of a written summary or report, feedback is often provided directly (i.e., in a face-to-face meeting or phone call) to referral sources, patients, families, third-party payers, and the legal system. Feedback to clinical referral sources is provided in a timely manner and addresses the relevant referral questions and concerns. The neuropsychologist also makes additional inferences and recommendations as appropriate for the benefit of the patient or referral source. For example, the need for patient counseling or special school placements may be advised, even if questions regarding these matters were not raised by the referral source.

Feedback regarding the evaluation findings and recommendations are provided in a manner that is comprehensible to intended recipients and which respects the well-being, dignity, and rights of the individual examinee. Ethical and legal guidelines pertaining to the provision of feedback should be identified and followed. As noted earlier (section 5B), feedback typically is not given in forensic evaluations, but it is part of most clinical evaluations. The neuropsychologist adheres to professional ethics (EPPCC) and federal, state, and local laws related to the autonomy

and decision-making capacities of patients who are legally competent. When cognitive impairments interfere with the patient's ability to understand the implications of the test results, or in the case of a child examinee, feedback may be provided to a responsible party (legal guardian or parent), with or without the patient present. The neuropsychologist consults with the responsible party to decide whether or not to provide direct feedback to a minor child or vulnerable adult. In some such cases, sensitive and developmentally appropriate discussion of results and recommendations may enhance the person's well-being; in other cases, direct feedback about test findings could be detrimental, particularly if the child or vulnerable adult misconstrues what is said.

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APPENDIX 1: BACKGROUND OF THE GUIDELINE DEVELOPMENT PROCESS

At its June 2003 annual meeting in Minneapolis, MN, AACN sponsored a forum, chaired by Robert Heilbronner, to discuss the need for and feasibility of developing practice guidelines for neuropsychology. There was general support for considering this project, with due circumspection, and there were no dissenting opinions. Subsequently, noting that such a project was consistent with its mission and bylaws, the AACN Board of Directors (BOD) approved the formation of a Practice Guidelines Working Group under the auspices of its Practice Committee, initially co-chaired by Robert Heilbronner and Michael Schmidt. Beginning in 2004, following Dr. Schmidt's resignation, the group was chaired by Dr. Heilbronner.

The working group was assembled from AACN members by invitation of the co-chairs, to include individuals who would provide broad representation in the field of neuropsychology. The group included neuropsychologists who work in a variety of settings, including independent practice, clinics, hospitals, and universities (see Practice Guidelines Subcommittee below). Professional emphases encompassed the adult, child, forensic, and research arenas. The group included individuals who had held elected offices in various neuropsychological organizations and who had served on the editorial boards of a number of professional journals.

The co-chairs assembled a packet of core references, including a number of published position papers relevant to the practice of clinical neuropsychology, as well as policy statements and ethical guidelines of APA and other scientific and professional organizations. The references were provided to each working group member. In addition, individual working group members used their professional judgment and discretion in considering the professional literature within their areas of expertise.

An initial working group meeting was held during the 2004 INS meeting in Baltimore, MD. A general outline of the guidelines was approved, and group members volunteered to take primary responsibility for portions of this outline, based on their specific areas of interest and expertise. To ensure a broader perspective, at least two individuals were assigned to each area. Initial drafts were compiled, and revisions were made based on input from all working group members.

The committee met again in St. Louis, MO at the 2005 INS Meeting and further revisions were made. After that meeting, the draft document, including literature citations, was approved by a general consensus from working group members. The document was then submitted to an independent peer-review panel of senior neuropsychologists for comments (see Senior Level Peer-Reviewers below). Following further revisions based on this review, a revised document was submitted to the AACN BOD and reviewed first by the President (R. Mapou) and Vice-President (J. Sweet). Revisions were recommended and made by Dr. Heilbronner and selected group members. The document was submitted to the BOD on November 15th where it was reviewed by all members of the BOD. Consolidated comments were provided from the BOD to the Practice Guidelines Committee on January 7th, 2006. A number of revisions and changes were recommended. These were made and a final document was submitted to the BOD on May 1st 2006. It was reviewed by all members of the BOD and accepted in its current form on June 16th, 2006.

Practice Guidelines Subcommittee

Robert L. Heilbronner (chair), H. Gerry Taylor, Karen Wills, Kyle Boone, Erin Bigler, Lidia Artiola i Fortuny, Neil H. Pliskin, Richard F. Kaplan, Greg Lamberty, and Michael Schmidt.

Senior Level Peer-Reviewers

Ken Adams (chair), Carl Dodrill, Wilfred van Gorp, and Ida Sue Baron.

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SPECIAL PRESENTATION

Policy Statement on the Presence of Third Party Observers in Neuropsychological Assessments*

American Academy of Clinical Neuropsychology

Purpose

The purpose of this policy is to clarify what is the appropriate response of a clinical neuropsychologist when a request is received for the presence of a third party during a medicolegal consultation and patient examination.

Definitions

For the purposes of this policy, two classes of third party observers are recognized, viz., involved and uninvolved parties.

Involved third parties are those who, directly or indirectly, have some stake in the outcome of an examination of a particular plaintiff in civil litigation. This stake may derive from a legal, financial, family, social, or other relationship or benefit. Involved parties may or may not be known or familiar to the plaintiff patient. For example, an unfamiliar agent of the plaintiff's attorney would be deemed an involved party for the purposes of this policy.

Uninvolved third parties have no stake in the outcome of a plaintiff patient's examination, directly or indirectly. Instead, uninvolved third parties do have an interest in the behavior of the examiner or in the examination process or in the behavior of the patient during the assessment as an exemplar of such relevant entities as a disease (e.g., cerebrovascular disease, closed-head injury), a condition (e.g., dementia, aphasia), or a phenomenon (e.g., visual neglect, right hemiparesis), or others (e.g., malingering, manifestations of personality disorders). An uninvolved third party does not have an interest in the particular individual who serves as the exemplar. The purpose of the presence of uninvolved parties generally is to learn about or practice the administration of neuropsychological tests, procedures, interviews, and so forth, and to observe how patients respond to the administration of such tests or to receive critical feedback concerning their performance in the role of an examiner. Uninvolved parties include health-care professionals and student professionals, for example, student neuropsychologists, other student psychologists, student psychometrists, and cognate professionals or technical personnel.

Medicolegal Consultations

Scope of Application

The context for this policy pertains to medicolegal consultations in which the consulting clinical neuropsychologist is being asked to formulate professional opinions about a patient's condition within their area of expertise in the specialty of clinical neuropsychology in relation to tort litigation, or related insurance benefits involving third parties. This policy is not intended for application to clinical (medical) consultations in which the clinical neuropsychologist has direct responsibility for the assessment, diagnosis, or treatment of

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the patient. Likewise, this policy is not intended for application to criminal forensic consultations that involve issues of criminal liability or culpability because the right to legal representation and a third party observer is absolute in criminal matters.

Policy

It is not permissible for involved third parties to be physically or electronically present during the course of an evaluation assessment of a plaintiff patient with the exception of those situations specified below.

Exceptions

In the case of toddlers and young children, when their physical separation from the parental or caretaker figure results in, or is known to result in, a behavioral reaction (e.g., disruptive behavior, dysphoric state, social withdrawal) such as to invalidate the outcome of a neuropsychological or neurobehavioral assessment, it may be permissible to allow the caretaker (e.g., parent) to be physically present, at least initially until rapport is established, if this exception results in the cessation or mollification of the behavioral reaction or otherwise allows more useful assessment data to be obtained. For example, it might be facilitative to allow a family member, who may otherwise have a distorting influence, to be present in the testing room when a child simply will not stay in the examination room without that family member.

Likewise, so long as the latter principle obtains, viz., it would allow more useful assessment data to be obtained in the professional opinion of the clinical neuropsychologist, this exception may be extended to certain cases involving older children and adult patients with extreme behavioral disturbances, for example, severe mental illness, delirium.

When the circumstances are such that the presence of an involved third party may have both a potentially distorting and a potentially facilitating influence on the collection of assessment data, it shall be the sole responsibility of the clinical neuropsychologist employing their best clinical judgment to determine whether or not to proceed with the assessment of the plaintiff patient on the particular occasion. As always, it remains incumbent upon the clinical neuropsychologist to make known any limitation regarding the reliability and validity of their conclusions and other professional opinions.

Fundamental Issue

The fundamental issue with which this policy is concerned is the validity of the results obtained from a clinical neuropsychological assessment process. As a general principle, it is important that the clinical neuropsychologist not deviate from their ordinary clinical practices when called upon to do the same in the execution of an evaluation or in their treatment of a plaintiff patient. The greatest degree of validity is understood to be obtained when the patient is motivated to cooperate with the examiner by performing in an optimal fashion in compliance with instructions, and in a candid or unbiased fashion, and that this occurs in the context of a controlled environment simulating or comporting with psychological laboratory conditions.

The presence of an involved third party observer potentially introduces a distortion of the patient's motivation, behavioral self-selection, and rapport with the examiner(s). For example, the patient's rapport may be more attached to, and their behavior at least somewhat directed toward, the involved third party. This introduces threats to the validity of the neuropsychological evaluation in ways potentially unknown to, and perhaps not perceptible by, the examiner.

Because the surreptitious eavesdropping on a patient during an examination or treatment is ethically proscribed, the mere displacement of the involved third party from the examination room to a remote site does neither necessarily eliminate nor lessen the above described threats to the validity of the obtained psychometric or other evaluation data upon which the clinical neuropsychologist will rely in formulating their professional opinions. That is, a stealthy presence via such mechanisms as a one-way mirror, audio monitoring, video monitoring, or audiovisual monitoring, does not constitute a tolerable exception to the above-stated policy.

DOCUMENTARY SUPPORT

Observer Adverse Effects

The presence of an involved third party observer during the neuropsychological examination may distract the examinee or distort patient motivation which could adversely affect test performance.

The distraction effect can come in different forms, that is, as an external distraction or an internal distraction, or some combination thereof. External distractions refer to stimuli that arise external to the patient and are potentially observable. These include, for example, sights and sounds. Under sights, the distracting stimuli could be simple physical movements, such as the involved third party observer turning their head in anticipation of a cough or sneeze. Also, the distracting visual stimuli could be more complex, such as postures ('body language') or facial expressions. Although it would be a wholly unsatisfactory solution, as discussed below, removal of the involved third party from the examination room may greatly reduce the source of external distractions. Internal distractions, on the other hand, generally are not directly observable as they arise from within the patient. These involve such stimuli as perceptions, attitudes, and social expectations on the part of the patient. For example, given that it appears that the financial rewards of a lawsuit may increase in some proportion to the severity of subjective complaints or claimed disabilities on the part of the patient, and knowing they are being observed by a representative of their own attorney, a patient may behave during the period of involved third party observation (by whatever means, including remotely) in such a way as they perceive would please this involved observer. Or the patient may suffer internal distraction from simply wondering how the involved third party observer is evaluating their behavior and test performance rather than being fully focused on the task at hand, (e.g., if an involved third party observer were to insist on access to such observation, it would be reasonable for the patient to assume that how they behaved during observation was particularly important to the involved third party). In regard to internal distractions, the use of remote observation by audio or visual monitoring or videotaping does not greatly reduce the source of this type of distraction.

Psychologists are obligated to create a testing environment relatively free of distractions. Standard 15.2 of the *Standards for Educational and Psychological Testing* (American Educational Research Association, 1985) states, "The testing environment should be one of reasonable comfort and with minimal distractions" (p. 83).

The *Standards for Educational and Psychological Testing* also direct psychologists to follow the procedures for administration specified by the publisher in the test manual: "In typical situations, test administrators should follow carefully the standardized procedures for administration and scoring specified by the test publisher" (Standard 15.1, p. 83). The *Wechsler Adult Intelligence Scale – III, Administration and Scoring Manual* (Wechsler, 1997) specifically states that involved third parties should be excluded from the testing area:

> As a rule, no one other than you and the examinee should be in the room during the testing. Attorneys who represent plaintiffs sometimes ask to observe but typically withdraw this request when informed of the potential effect of the presence of a third person. (p. 29)

An almost identical statement against the presence of an involved third person is presented on page 30 of the *Wechsler Memory Scale – III, Administration and Scoring Manual* (Wechsler, 1997).

In her authoritative work, *Neuropsychological Assessment, Third Edition*, (1995) Lezak notes that distractions in the testing environment adversely affect performance, and thus, jeopardize the validity of a neuropsychological assessment. She states:

> It is not difficult to get a patient to do poorly on a psychological examination. This is especially true of brain damaged patients, for the quality of their performance can be exceedingly vulnerable to external influences or changes in their internal states. All an examiner need do is make these patients

> tired or anxious, or subject them to any one of a number of distractions most people ordinarily do not even notice, and their test scores will plummet. . .
>
> Eliciting the patient's maximum output is necessary for a valid behavioral assessment. Interpretation of test scores and of test behavior is predicated on the assumption that the demonstrated behavior is a representative sample of the patient's true capacity in that area. (pp. 139–140)

Binder and Johnson-Greene (1995) demonstrated the negative effect that an involved observer had on test performance in a single case study. McSweeny, Becker, Naugle, Snow, Binder, and Thompson (in press) have detailed many of the ethical implications of the use of third party observers. Some of the adverse effects of observers on test performance have been systematically investigated in a body of literature that has come to be known as social facilitation research. McCaffrey, Fisher, Gold, and Lynch (1996) summarized the recent literature on social facilitation in their article on the presence of third party observers during neuropsychological evaluations. The social facilitation literature provides empirical evidence that the presence of a third party observer can alter cognitive and motor test performance whether or not the patient has a brain injury or disease.

The social facilitation effect causes examinees to perform better than usual on tests of simple or overlearned skills and poorer on tasks that are more difficult for them (McCaffrey et al., 1996). These adverse effects have been shown to occur even when the observer is behind a one-way mirror. Although there are no studies at present that demonstrate a social facilitation effect during video or audio taping, these alternatives to the physical presence of an observer in the room raise other important ethical and professional concerns (such as, problems involving test security, allowing testing materials to become part of the public domain, or potential misuse of assessment results by third parties for purposes unrelated to the current case).

Test Administration and Interpretation

Psychological and neuropsychological tests have not been standardized in the presence of involved third party observers, and thus, it is inappropriate to compare the examinee's results to the normative results from the standardization sample. Departure from a standardized testing procedures may diminish the utility of the normative data. Thus, any factor that compromises the standard administration of a neuropsychological test may jeopardize the validity and reliability of the test's fingings.

In a highly regarded book on the nature and use of psychological and neuropsychological tests, Anastasi (1988) stresses the importance of test standardization, ''Standardization implies uniformity of procedure in administering and scoring the test. If the scores obtained by different persons are to be comparable, testing conditions must obviously be the same for all. Such a requirement is only a special application of the need for controlled conditions in all scientific observations. In a test situation, the single independent variable is often the individual being tested.'' (p. X).

The *Standards for Educational and Psychological Testing* (American Educational Research Association, 1985) stress the importance of following standardized procedures in Standard 15.1,

> In typical applications, test administrators should follow carefully the standardized procedures for administration and scoring specified by the test publisher. Specifications regarding instructions to test takers, time limits, the form of item presentation or response, and test materials or equipment should be strictly observed. Exceptions should be made only on the basis of carefully considered professional judgment, primarily in clinical applications. (p. 83)

In the American Psychological Association's ethical principles of psychologists (American Psychological Association, 1992), ethical standard 2.04(c) *Use of Assessment in General with Special Populations* states in part, ''Psychologists attempt to identify situations in which particular interpretations or assessment techniques or norms may not be applicable or may require adjustment

in administration or interpretation because of factors such as. . .'' Because no norms exist for testing in the presence of involved third parties, misinterpretation of test results may be common, and psychologists should be aware of the potential ethical difficulties involved in interpretation of test results under these circumstances.

If an involved third party were present during a neuropsychological examination, neuropsychologists should include in their report any concerns regarding limitations that this places on interpretation. This is made clear in ethical standard 2.05, *Interpreting Assessment Results*:

> When interpreting assessment results, including automated interpretations, psychologists take into account the various test factors and characteristics of the person being assessed that might affect psychologists' judgements or reduce the accuracy of their interpretations. They indicate any significant reservations they have about the accuracy or limitations of their interpretations.

Ethical principle 2.02 (a), *Competence and Appropriate Use of Assessments and Interventions*, states, ''Psychologists who develop, administer, score, interpret, or use psychological assessment techniques, interviews, tests, or instruments do so in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.'' Thus, psychologists should be aware that the presence of an involved third party may alter the validity of test results and either refuse to administer tests under these circumstances or alter their interpretations if an observer has been present. The presence of an involved third party may especially impact on determinations made about the integrity of brain function, change over time intervals, and effects of treatment in individuals prone to easy disruption of function such as those with neurological conditions.

Test Security

Involved third party observers may undermine the neuropsychologist's ethical responsibility to maintain test security. This ethical principle is most clearly presented in Ethical Standard 2.10, *Maintaining Test Security* (American Psychological Association, 1992):

> Psychologists make reasonable efforts to maintain the integrity and security of tests and other assessment techniques consistent with law, contractual obligations, and in a manner that permits compliance with the requirements of this code.

The same principle is also delineated in the *Standards for Educational and Psychological Testing* (1985). Standard 15.7 states that, ''Test users should protect the security of test materials.'' These standards would be applicable whether the observation occurred in the testing room, behind a one-way mirror, or through audio or video monitoring or recording.

Test Misuse

The neuropsychologist has little or no control over how an involved third party observer will use the content of testing in the present or future cases. This lack of control over the data generated during a neuropsychological assessment may be incompatible with our ethical responsibilities. The American Psychological Association's (1992), Ethical Standard, 1.16, *Misuse of Psychologists' Work* states, ''Psychologists do not participate in activities in which it appears likely that their skills or data will be misused by others, unless corrective mechanisms are available.''

Involved third party observers could take notes and record specific test questions and answers to be used in preparing or coaching future litigants with neuropsychological claims. Moreover, poor performances could be misinterpreted by the third party resulting in incorrect conclusions. All these difficulties which could arise from the presence of an involved observer could result in a potential conflict with Ethical Standard, 2.02 (b), *Competence and Appropriate Use of Assessments and Interventions*:

> Psychologists refrain from misuse of assessment techniques, interventions, results, and interpretations and take reasonable steps to

> prevent others from misusing the information these techniques provide. This includes refraining from releasing raw test results or raw data to persons, other than to patients or clients as appropriate, who are not qualified to use such information.

As with the problem of test security, potential test misuse may occur regardless of the method of observation (i.e., actual presence in the same room, behind a one-way mirror, or audio or video monitoring/recording).

Responsibility in Forensic Situations

Because the presence of an involved third party observer is most commonly requested within a medicolegal context, several ethical principles may help to guide neuropsychologist's decisions regarding this issue. Ethical standard, 7.06, *Compliance with Law and Rules*, appears to indicate that it is the responsibility of the neuropsychologist to inform lawyers, judges, and others that the presence of an involved third party observer represents a potential ethical conflict. Ethical standard, 7.06, *Compliance with Law and Rules*, states:

> In performing forensic roles, psychologists are reasonably familiar with the rules governing their roles. Psychologists are aware of the occasionally competing demands placed upon them by these principles and the requirements of the court system, and attempt to resolve these conflicts by making known their commitment to this Ethics Code and taking steps to resolve the conflict in a responsible manner.

In a similar vein, Ethical Standard, 1.02, *Relationship of Ethics and Law*, explicitly explains that, ''If psychologists' ethical responsibilities conflict with law, psychologists make known their commitment to the Ethics Code and take steps to resolve the conflict in a responsible manner.''

Confidentiality may also encompass the issue of involved third party observers. Ethical standard, 5.02, *Maintaining Confidentiality*, states that ''psychologists have a primary obligation and take reasonable precautions to respect the confidentiality rights of those with whom they work or consult...'' Neuropsychologists need to communicate the potential limitations to confidentiality with all parties involved but especially with the patient.

Ethical standard, 7.01, *Professionalism*, informs the psychologist that the APA Ethics Code applies to the atypical professional activities that take place within the forensic context. Standard 7.01 states in part, ''Psychologists who perform forensic functions, such as assessments, interviews, consultations, reports, or expert testimony, must comply with all other provisions of this Ethics Code to the extent that they apply to such work activities.'' This ethical standard makes clear that all ethical issues raised by the presence of an involved third party are applicable whether or not the neuropsychological assessment occurs in a forensic setting.

Ethical standard, 7.04, *Truthfulness and Candor*, emphases the need to communicate the bases for conclusions as well as any threats to the validity of an examination when an involved third party has been an observer.

> 7.04 (a) ''In forensic testimony and reports, psychologists testify truthfully, honestly, and candidly and, consistent with applicable legal procedures, describe fairly the bases for their testimony and conclusions.''
>
> 7.04 (b) ''Whenever necessary to avoid misleading, psychologists acknowledge the limits of their data or conclusions.''

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Ethics Committee

The Michigan Psychological Association membership represents the interests of psychologists and the mental health needs of the public by maintaining the highest standards of psychology through the promotion of professional excellence, leadership, scholarship, advocacy and training.

Michigan Psychological Association
Recommendations for Ethical Standards of Practice

Ethical Standard of Practice 5

Title: Ethical Considerations Regarding Third Party Observation (TPO) And Recording Of Psychological Test Administration For Licensed Psychologists Practicing On The State of Michigan

Date: Adopted by the Ethics Committee at the February 2014 meeting, Alan Lewandowski, Ph. D., Chair

1. General

1.1. Licensed psychologists practicing in the State of Michigan are frequently presented with requests from parents, attorneys, nurse case managers, insurance representatives, school personnel, allied health professionals, family members or other interested parties who have some type of relationship with a patient or client examinee to directly observe or record the administration of psychological tests. Consequently, this has raised a number of legitimate ethical concerns for psychologists that include, but are not limited to, the effects on the examinee's performance and the psychologist administering the test, violations of testing guidelines, the impact on standardization procedures, the appropriateness of applying test findings to normative samples established under standardized circumstances, and test security. These requests can become even more problematic and complicated when the request occurs within the adversarial process associated with the legal system, such as competency hearings, custody evaluations, divorce proceedings, civil litigation, and criminal investigations (McSweeny et al., 1998; Sweet, Grote, & Van Gorp, 2002; Duff & Fisher, 2005; McCaffrey, Fisher, Gold, & Lynch, 2005; Howe & McCaffrey, 2010).

1.2. The purpose of this document is to clarify the ethical issues involving the observation of psychological testing by third parties. The position adopted by the Michigan Psychological Association Ethics Committee regarding this topic is based on a consensus of the existing literature and provides guidance for all psychologists licensed in Michigan from an ethical perspective.

2. Definition Of Third Party Observation

2.1. Third Party Observation (TPO) is defined in this practice guideline as the direct or indirect presence of an individual other than the patient or client and the psychologist or their technician administering a published psychological test in order to obtain objective data under standardized conditions for clinical, counseling, or forensic purposes in order to render clinical conclusions, opinions, interpretations, or recommendations based on the data collected.

2.2. Direct presence means a person(s) physically present in the room other than the psychologist or his/her technician and the examinee.

2.3. Indirect presence means viewing through a window, two-way mirror, use of any camera, or audio or video recording device, or any electronic or communication device. The act of recording includes the on-site transcription by a court recorder during an examination by either direct or indirect involvement (McCaffrey, Fisher, Gold, & Lynch, 1996; Constantinou, Ashendorf, & McCaffrey, 2002; Constantinou, Ashendorf, & McCaffrey, 2005; Barth, 2007; Eastvold, Belanger, & Vanderploeg, 2012).

3. Ethical Considerations

3.1. The Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association (hereafter called the Ethics Code) helps guide the thinking and behavior of psychologists, and provides direction with regard to clinical practice standards. Relevant to TPO in the Ethics Code are both the General Principles and a number of the Ethical Standards.

3.2. Within the Ethics Code a series of General Principles are outlined with the intent of guiding psychologists to practice at the highest professional level. Relevant to TPO are General Principle: A (Beneficence and Nonmaleficence), B: Fidelity and Responsibility), C (Integrity), and D (Justice).

3.3. In contrast to the General Principles, the Ethics Code offers specific standards that represent obligations to which psychologists are bound, and consequently form the basis for ethical violations and consequently the basis for sanctions. Most relevant to TPO are Ethical Standards 2 (Competence) and 9 (Assessment). (American Psychological Association, 2010).

4. Principle A: Beneficence and Nonmaleficence

4.1. Principle A is applicable and is described as follows: “Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the

welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence. Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work."

4.2. It is incumbent on psychologists to be vigilant about the impact of their professional opinion on others, particularly with regard to diagnostic testing. Psychologists' scientific and professional judgments and conclusions should be based on data from psychological assessments gathered in a standardized manner, and therefore without the influence of extraneous factors that might influence the collection of behavior samples. Psychologists must always be mindful that their verbal and written opinions affect the medical, social, and legal lives of others, and therefore must safeguard those with whom they interact professionally to do no harm.

5. Principle B: Fidelity and Responsibility

5.1. Principle B is applicable and is described as follows. "Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work. Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues' scientific and professional conduct. Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage."

5.2. It is the responsibility of all psychologists who elect to perform diagnostic testing, to do so within the established parameters of the instrument(s) they employ and therefore in a standardized manner. Whether or not a psychologist is engaged in a patient-doctor relationship, acting as an independent clinician, a clinician for an institution, state or federal agency, or an independent examiner for an insurance carrier or legal counsel, a professional obligation exists to uphold standards for the delivery of scientific work commensurate with the responsibilities to the profession, community and society in general.

6. Principle C: Integrity

6.1. Principle C is applicable and is described as follows. “Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not steal, cheat, or engage in fraud, subterfuge, or intentional misrepresentation of fact. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.”

6.2. The practice and promotion of clinical assessment requires that psychologist present themselves and their work to others in an accurate and honest manner, and to avoid any misrepresentation of their findings. TPO alters the accuracy of test findings, and to ignore the considerable body of evidence supporting this fact, results in conscious misrepresentation.

7. Principle D: Justice

7.1. Principle D is applicable and is described as follows. “Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices.”

7.2. In an attempt to provide fair and just treatment to all patients and clients, psychologists do not modify assessment procedures or alter their work on the basis of personal opinion or professional bias, nor do they neglect to maintain an awareness of their competency level and the limitations of their expertise. To this end both APA and MPA provide multiple continuing education opportunities for psychologists to learn, maintain, and improve their professional expertise, and avoid practices that are irregular or not commensurate with accepted clinical practice. Given the body of literature that exists regarding the negative effects of TPO, it is incumbent on psychologists who provide assessment services to not avoid this practice, but make clear to patients, families, and co-professionals that they do not condone the use of TPO.

8. Ethical Standard 2: Competence

8.1. Ethical Standard 2 is applicable to TPO and the recording of test administration. Section 2.04, Bases for scientific and Professional Judgments describes the following: Psychologists’ work is based upon established scientific and professional knowledge of the discipline. (See also Standards 2.01e, Boundaries

of Competence)."

8.2. Ethical Standard 2.04. Ethical Standard 2.04 requires psychologists to conduct their practice within the boundaries of scientific knowledge. Texts on psychological testing have long cited the need to conduct testing in a distraction-free environment (Anastasia and Urbina, 1997). With the publication of the Wechsler Adult Intelligence Scale-Third Revision (WAIS-III) the Wechsler manuals have since stipulated "no one other than you and the examinee should be in the room during the testing session." Administration further states, "Attorneys who represent plaintiffs sometimes ask to observe but typically withdraw this request when informed of the potential effect of the presence of a third person." (WASI, WASI-II, WAIS-III, WISC-III, WMS-III, WAIS-IV, WMS-IV). Some test manuals indicate that the testing room should be quiet and distraction free limited to "A table or desk and two chairs, one for the examiner and one for the subject."(WCST) Similarly, the manual for the California Verbal Learning Test- Second Edition (CVLT-II) states "as a rule, no one other than you and the examinee should be in the room during testing."

9. Ethical Standard 9: Assessment

9.1. Ethical Standard 9 is applicable to TPO and recording. In Section 9.01, Bases for Assessments, the code notes "(a) Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)"

9.2. Test results generated in nonstandard methods that negatively impact the validity of the findings are insufficient. In forensic settings, psychologists are often required to use their findings in comparison with other evaluations. The ability to compare separate data sets, when one evaluation was conducted following proper testing procedures and the other evaluation had inherent threats to validity such as a third party observer is dubious. Under 9.01 (a) the psychologist cannot provide opinions or evaluative statements because TPO presence yields the evaluation of questionable validity.

9.3. (b) Except as noted in 9.01c, psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions, and appropriately limit the nature and extent of their conclusions or recommendations. (See also Standards 2.01, Boundaries of Competence, and 9.06, Interpreting Assessment Results.)

9.4. (c) When psychologists conduct a record review or provide consultation or supervision and an individual examination is not warranted or necessary for the opinion, psychologists explain this and the sources of information on which they based their conclusions and recommendations."

9.5. Section 9.02: Use of Assessments. Section 9.02 describes the following: "(a) Psychologists administer, adapt, score, interpret, or use assessment techniques, interviews, tests, or instruments in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques. (b) Psychologists use assessment instruments whose validity and reliability have been established for use with members of the population tested. When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation. (c) Psychologists use assessment methods that are appropriate to an individual's language preference and competence, unless the use of an alternative language is relevant to the assessment issues."

9.6. Section 9.02 (a) indicates that test or instruments used in a manner inconsistent with the standardization of the measure and contrary to the test manual violate this standard. As such, TPO is contrary to this standard.

9.7. Section 9.06: Interpreting Assessment Results. Section 9.06 describes the following: "When interpreting assessment results, including automated interpretations, psychologists take into account the purpose of the assessment as well as the various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, linguistic, and cultural differences, that might affect psychologists' judgments or reduce the accuracy of their interpretations. They indicate any significant limitations of their interpretations. (See also Standards 2.01b and c, Boundaries of Competence)."

9.8. Many authors and organizations (Anastasi and Urbina, 1997; National Academy of Neuropsychology, 2000; Oregon Psychological Association, 2012) emphasize that during test development procedures are standardized without the presence of an observer and subsequently that data obtained outside the parameters of those procedures lack validity and affect interpretation.

9.9. Section 9.11: Maintaining Test Security. Section 9.11 raises the importance of maintaining test security. "Psychologists make reasonable efforts to maintain the integrity and security of test materials and other assessment techniques consistent with law and contractual obligations, and in a manner that permits adherence to this Ethics Code."

9.9.1. Test security is a critical issue, as it addresses the prevention of unnecessary exposure of psychometric materials that would result in diminishing a test to accurately distinguish between normal and abnormal performance.

9.9.2. Several professional organizations have offered an opinion with regard to maintaining test security to include the APA. The APA describes test security as an important issue in the practice of psychology and states that it incumbent on psychologists to protect the integrity of psychological test materials (APA, 1999).

9.9.3. Other state and national psychological organizations as well as a number of authors have raised concerns about the potential for testing material to be used inappropriately by attorneys or become part of public domain where anyone could access this information (Wetter & Corrigan, 1995; McCaffrey et al., 1996; National Academy of Neuropsychology, 1999; American Psychological Association, 1999; American Academy of Clinical Neuropsychology, 2001; Essig, Mittenberg, Petersen, Strauman, & Cooper, 2001; Victor & Abeles, 2004; Kaufman, 2005; Kaufman, 2009; Morel, 2009; Oregon Psychological Association, 2012). Public accessibility would allow clients involved in litigation to be coached on how to perform on certain measures or give patients the opportunity to learn test material prior to an assessment, both of which would invalidate the results of a psychological assessment. As a result, several psychological organizations have taken a formal position against the presence of TPO during assessment.

9.9.4. The National Academy of Neuropsychology (Axelrod et al., 2000) advises that TPO is inconsistent with psychological guidelines and practices and as a result threatens the validity, reliability, and interpretation of test scores. The position of the National Academy of Neuropsychology is that TPO should be avoided whenever possible outside of necessary situations involving a non-forensic setting where the observer is both neutral and non-involved.

9.9.5. The American Academy of Clinical Neuropsychology (AACN) has taken the position that “it is not permissible for involved third parties to be physically or electronically present during the course of an evaluation assessment of a plaintiff patient with the exception of those situations specified below” (page 434). Exceptions are described as including young children who require the presence of a family member, etc.

9.9.6. The executive committee of the Oregon Psychological Association (2012) adopted a clear and unequivocal policy that the observation of a third party compromises test validity and security and therefore advises against the presence of TPO during assessment. Similarly, the Michigan Psychological Association Ethics Committee has advised against TPO for the same reasons.

10. Research Evidence

10.1. In addition to national, local and professional standards of ethical practice, a significant body of research evidence supports the negative impact of TPO. A review of the pertinent literature overwhelmingly supports that both direct and indirect TPO and recording affect the behavior of both the examiner and the examinee, and subsequently the validity of findings obtained in a psychological assessment with by limiting data interpretation and conclusions.

10.2. It is self evident that psychological evaluations *must* be conducted in a standardized fashion consistent with the publisher's directives to ensure valid and reliable results. The consensus among reasonable psychologists is that any attempt by an examiner to modify test procedures or alter administration to accommodate observation or recording compromises test standardization. As a result, findings are likely to be invalid and cannot be determined to reflect a reasonable degree of certainty or fall within an accepted range of probability, as there is no basis for validating an assessment under these (observed or recorded) conditions. Test results therefore lack the normal and accepted parameters of validity and more importantly, do not reflect normal standards of psychological care. Not surprisingly, most publishers of psychological tests have cautioned against TPO in their instruction manuals and national organizations have advised against TPO (National Academy of Neuropsychology, 2000; Committee on Psychological Tests and Assessment, 2007).

10.3. The issue of TPO has been investigated by numerous researchers beginning with a case study by Binder and Johnson-Greene (1995).

10.3.1. A substantial amount of research supports that the presence of an observer negatively affects the data obtained during an assessment, and these significant negative effects on test results have been consistently reproduced in all studies.

10.3.2. More specifically, research has shown a significant impact on test performance on measures involving areas of executive functioning (Horowitz & McCaffrey, 2008), attention and processing speed (Binder & Johnson-Greene 1995; Kerher, Sanchez, Habif, Rosenbaum, & Townes, 2000), and memory/recall of information (Gavett, Lynch, & McCaffrey 2005; Lynch, 2005; Yantz & McCaffrey, 2005; Eastvold et al., 2012). Eastvold, Belanger and Vanderploeg' s (2012) meta analysis found negative effects on multiple cognitive measures and that attention, learning and memory (delayed recall) were most adversely impacted by the presence of an observer.

11. Exceptions To TPO

11.1. Third Party Assistant (TPA)**.** In selected circumstances, the presence of a third party may be necessary to proceed with or complete a psychological assessment. In these cases rather than an involved third party observing or monitoring the behavior of the test administrator or examinee, the third party holds a neutral position and acts in an indirect manner to assist or expedite the completion of the assessment. Given this significant difference of purpose, we suggest that the presence of an additional party during an evaluation in these circumstances is more accurately identified as a third party assistant (TPA).

11.2. A TPA may be deemed appropriate in clinical examinations in which the examiner is acting as a clinical treater with an established patient-doctor relationship, as opposed to an independent psychological examination for an insurance companies or a forensic assessment in civil or criminal proceedings. A TPA may be appropriate in a testing situation in which the presence of a parent, family member or family friend is necessary, and without whose presence the examination could not proceed because of a variety of mental disabilities that require accommodations. Examples include patients diagnosed with autism or developmental disorders affecting intelligence, confirmed brain injury that precludes independent living, children who are either too young or too anxious to be left alone, elderly adults with compromised cognition who are unwilling to participate without the presence of a trusted family member or friend, patient's who have a thought disorder impacting reality testing, etc.

11.3. Alternatively, there are cases in which a language barrier precludes valid test administration. While the preference is for the examination to be conducted in the examinee's native language, in some these cases an interpreter may necessary because a native speaking psychological examiner is not available or within a practical distance. To avoid conflicts, the interpreter should have no relationship (such as family member) to the person being examined.

11.4. Similarly, if an examinee is deaf or hearing impaired an individual versed in American Sign Language (ASL) or a member of the deaf community would be necessary to complete an examination. Absent a qualified examiner fluent in sign language, a certified specialist may be necessary.

11.5. Student training presents another situation in which a TPA is considered appropriate. Not unlike the training of medical students in procedures, psychology students require direct observation and practice in the administration of psychological test procedures.

11.6. In the above cases, the examiner is ethically required to document in the procedures section of the psychological report of any deviations of standardization or modifications in test administration. Clear note must be made of the limitations of normative data with subsequent impact on the generalization of findings.

12. Forensic Examinations, Independent Medical Examinations, and Acting as an Expert Witness

12.1. Psychologists who chose to perform forensic assessments are ethically required to act in a proactive manner and be aware of the pertinent specialty guidelines pertinent to this area of expertise. In forensic situations when retained as an expert witness and in which TPO is requested by opposing counsel or directed by the court, the psychologist should educate the court as to the Ethical Principles of Psychologists and Code of Conduct of the APA, the Michigan Psychological Association Standards of Ethical Practice, and the scientific basis for the negative effects (invalid data) of these intrusions. If counsel or the court insists the psychologists should terminate test administration, and if necessary, seek legal counsel from their own personal attorney.

12.2. It is recognized that often in forensic situations psychological ethics and the adversarial nature of the legal system may not coincide. If directed by the court to proceed with TPO, the psychologist should remove himself/herself form the assessment. Psychologists who regularly provide forensic consultations are expected to inform referral sources ahead of time that if TPO or recording develops as an issue during legal proceedings, they are ethically required to remove themselves from the assessment and assisting as an expert witness.

12.3. In the very rare exception that the psychologist is *compelled* by the Court to evaluate with a TPO, or if the psychologist is in a situation wherein withdrawing will bring clear and substantial harm to the examinee, the psychologist should explicitly document the manner in which the validity of results may be compromised and following existing recommended guidelines for protecting test security including requesting that the test material and intellectual property be provided only to another licensed psychologist who would be bound by the same duty to protect. Alternatively, with a protective order the psychologist should secure an agreement specifically prohibiting either party from copying test material or intellectual property, using them for any other purpose than the matter at hand, and requiring that they be destroyed at the close of the matter.

13. Conclusion

13.1. TPO and/or any recording of psychological tests or their administration has the potential to influence or compromise the behavior of the examinee and the administrator, the validity of the data obtained under these conditions, and consequently any and all subsequent clinical conclusions, opinions, interpretations, or recommendations. Ethical standards of practice require that psychologists do not engage in or conduct assessments complicated by TPO or recording unless justified by the exceptions described above.

13.2. Psychological testing involving TPO should always be avoided. A psychologist who allows TPO and/or any recording of the administration of psychological tests compromises the behavior of the examinee and the administrator, the validity of the data obtained under these conditions and consequently, any and all subsequent clinical conclusions, opinions, interpretations, or recommendations. Ethical standards of practice require that psychologists do not engage in, endorse, or conduct assessments complicated by TPO or recording of any kind. In contrast, TPA is acceptable but only under exceptions involving the most extreme or rare circumstances that require, and is justified only by clinical (not forensic) exception.

13.3. It is the recommendation of the Ethics Committee of the Michigan Psychological Association that psychologists who find themselves in a position in which TPO is requested or advocated, should decline the request and educate the referral source as to the ethical and validity implications. If a referral source or interested party insists on TPO or recording, such as in legal matters, psychologists should extricate themselves from the situation and document the reason for termination.

13.4. In the case of TPA, the psychologist must clarify in the report the rationale for use of TPA, what procedures and standards have been modified, how, and to what degree, and the impact of the findings, results, and conclusions. This should include limitations in the generalization of the diagnostic data and the impact on assessment's findings.

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