

INTERNATIONAL NEUROPSYCHOLOGICAL SOCIETY LIAISON COMMITTEE NEWSLETTER

Message from the Incoming INS President

The London Bombings

The INS mid-year meeting in Dublin was in full swing on Thursday morning and after a good first session we were lining up for coffee, chatting excitedly about issues raised, when my husband appeared, white-faced, to inform us that terrible bombings had occurred in London, including an explosion near Russell Square. Several of the British contingent in Dublin work near Russell Square, at the National Hospital Queen Square or at Great Ormond St Hospital for children; others had friends at these hospitals. A group of us rushed to the TV lounge in the Burlington Hotel to watch the news. At that point it was unclear how many bombs had exploded although there was no doubt that this was a terrorist attack. Later, of course, we learnt that there had been three bombs on the Underground and one on a bus.

Looking around the TV lounge I could see that some people were crying and all were looking very shocked. With only minutes to go before the start of the second session, we considered whether we should continue and decided that, of course, we should. I was about to introduce one of the invited speakers, Jenni Ogden from New Zealand, and wondered if I should say anything about the bombings. Elizabeth Warrington advised me, saying, "Yes, but keep it low key." I warned Jenni Ogden that I would be mentioning the incidents in London and that she should go on with her talk as planned. I informed the audience, some of whom knew

already, that there had been some attacks in London; that there were few details at present but Tony Blair, the Prime Minister, was due to make a televised announcement at noon.



Not surprisingly, the feeling of intellectual excitement at the Dublin meeting was halted as a result of the news from London and the mood remained subdued throughout the conference. Most of the participants were able, by phone or email, to reassure themselves that their friends, family, and colleagues in London were safe. Sadly, however, I discovered later that one of the neurologists working in London lost a brother in the bus that was bombed. On behalf of all members of the INS I send our deepest condolences and sympathy to him and his family.

As a bereaved parent I also send compassion and wishes for strength and solace to the bereaved parents and other family members of the 56 people killed in London on July 7th. My daughter, Sarah, died just over five years ago in Peru in a white-water rafting accident. Her body has never been found so I know how awful it is to lose a child and how painful the early days, months, and even years can be.

I would just like to add that I was in London in early August, four weeks after the attack and although I traveled by car rather than train, and by taxi rather than underground, life was in most ways much the same as ever. I can report that London was full of tourists enjoying the sunshine, the museums, the art galleries, the theatres and the restaurants. The city looked and felt good. Those who lost loved ones will grieve for a long time to come but the human spirit will not be repressed.

Barbara Wilson
Cambridge, UK
Incoming INS President
Barbara.Wilson@mrc-cbu.cam.ac.uk

Neuropsychology in Australia

By Skye McDonald, Ph. D.
Associate Professor
School of Psychology
University of New South Wales
E-mail: S.McDonald@unsw.edu.au

Australia is a large, dry continent with a population of around 20 million, the majority of which is clustered in several cities along the eastern seaboard (and Tasmania in the south) with Perth as the one city on the west coast. Australia's original inhabitants, the Australian aboriginal peoples, lived in small communities across the continent in close relationship with the land. Since English settlement 230 years ago, Australia has become increasingly urbanised and multi-cultural. Reflecting both English colonisation and its position in the Asia-Pacific region, the current

population is heavily influenced by English, European and Southeast Asian cultures.

Despite its small population, Australia has an active neuropsychology community. There are several programs in Melbourne, Sydney and Brisbane that offer specialised training for clinical neuropsychologists. In addition, clinical psychology, speech pathology, physiotherapy and occupational therapy programs are increasingly incorporating awareness of neuropsychological conditions and their management into core training. This increasing focus upon neurological conditions in health professional training mirrors a growing sophistication in service delivery resulting in a demand for appropriately trained professionals. Most cities in Australia have well-developed multi-disciplinary services for many neurological conditions.



Australian researchers and clinicians have a long-standing reputation for innovative approaches to research and service delivery in many areas of neurological disorders. As in other Western countries, children and young adults with traumatic brain injuries, mainly from motor vehicle accidents, constitute a major target for rehabilitation services. In addition, the Australian population, as a result of the post-war “baby boom” of the 1940s and 50s and a decreasing birth rate, is facing a rapid aging of its population. Consequently, brain

disorders associated with aging are a major focus for research and health service delivery.

Traumatic Brain Injury

The first dedicated service for young adults with traumatic brain injuries opened in Lidcombe in Sydney in 1976. Since then units across Australia, especially in Melbourne, Sydney and Brisbane, have been the source of many research studies examining all facets of brain injury from mild to severe, including assessment of the minimally conscious patient and post-traumatic amnesia (for example, development of the Westmead PTA scale by the Westmead Hospital group) through to assessment and remediation of disorders in motor function, language, attention, executive control, behaviour and emotion. Several large-scale outcome studies have been conducted – in Tasmania (Royal Hobart Hospital), in Melbourne (Bethesda/Epworth Hospital) and Sydney (Lidcombe/Liverpool Hospital) examining outcomes from the first few years to, in the latest Sydney study, 25 years later. Such studies are important for informing service development as well as providing insights into long-term sequelae.

The prominent role that Australia has played in traumatic brain injury rehabilitation was highlighted this year with the hosting of the 6th World Congress on Brain Injury. This international conference convened locally by David Burke, Jennie Ponsford and John Olver, was held in Melbourne in May 2005 by the International Brain Injury Association in conjunction with both the Australian Society for the Study of Brain Impairment and the Australian Faculty of Rehabilitation Medicine. This conference was the largest congress to date with over 1,300 conference delegates attending and an eminent list of international guest speakers, including Graeme Teasdale, Erin Bigler, Bob Robinson, Donald Stein, John Whyte, Lynne Turner-Stokes,

Stefan Hesse, Catherine Mateer, Michael Oddy, Mary Anne McColl and Roberta dePompeii. This forum provided the opportunity for Australian researchers as well as our close New Zealand and Asian neighbours to profile recent innovations in the area.

One area highlighted at the conference was the assessment and remediation of disorders of prospective memory (i.e. remembering to do something in the future in a timely and appropriate manner). A symposium on this topic included David Shum and Jenny Fleming (Brisbane), Beth Plowright (Melbourne) and Nick Titov and Robert Knight (Dunedin, New Zealand) and covered both practical and theoretical issues concerning prospective memory. Theoretical research is currently aimed at examining the effects of increasing the demands of co-existing cognitive tasks upon prospective memory efficiency. Of particular interest was the development of the “Virtual Street” by Nick Titov and Robert Knight. Their computer simulation of an everyday New Zealand shopping street provides an ecologically valid and theoretically driven assessment tool for examining prospective memory under a variety of conditions affecting both memory load and attention.

A second area in which Australian researchers are making a major contribution, is adding to the growing sophistication in understanding emotional processing and how this may be affected after TBI. In a symposium focused upon children and adolescents, several speakers from Melbourne (Vicki Anderson, Rian Dob, Julian Dooley), Sydney (Skye McDonald), the USA (Keith Yeates) and the UK (Peta Sharples) spoke about disorders of emotion following TBI that reflect both psychological reactions to the trauma, i.e. post-traumatic stress and changes to the way in which emotional information was processed and enacted upon as a result of brain injury.

Of immense interest to current rehabilitation practice is the emerging use of computer and other electronic devices to assist in assessment and remediation. The "Virtual Street" as a prospective memory measure is one good example of the use of computer technology to simulate real world memory demands. In other presentations at the IBIA conference, focus was upon the use of a range of technology, from mobile phones (Corne Mackie, New Zealand) and digital organizers through to sophisticated expert systems (David Man, Hong Kong) to enhance everyday memory functioning after TBI.

In a related, although different vein, Robyn Tate of Sydney featured Australia's own PsycBITE™ (www.psycbite.com), a web-based tool for clinicians and researchers, providing them with a database capable of producing instant information on all trials examining the efficacy of treatments for psychological disorders after acquired brain injury.

Finally, the IBIA conference highlighted new advances in the medical field regarding traumatic brain injuries' acute effects. Building upon the topic of brain recovery introduced by Donald Stein, neuropharmacological research was presented examining the role of specific genes in recovery from TBI (Dion Rudzski, Melbourne), identifying the complex interplay of influences such as cerebral inflammation (Jeffrey Rosenfeld, Cristina Morganti-Kroszman, Melbourne) on recovery from TBI and discussing agents that may combat early neuronal death (Robert Vink, Adelaide).

Ageing and Dementia

Most cities in Australia now provide assessment and management services for people with dementia. In addition, there is an active research community focused upon the natural progression of ageing and dementia-related illnesses in order to better understand

both early indicators and long-term prognosis.

The Sydney Older Persons study (lead by Tony Broe, Helen Creasy, David Grayson, Olivier Piguet and others) recruited over 630 healthy adults without dementia over the age of 75 in 1993-1994 and has, to date, reviewed their psychological, medical and neurological status at 3, 6 and 10 years. The 10-year follow-up in 2003 collected data on over 90% of traceable participants including informant reports of medical, cognitive and behavioural changes between the 6-year and 10-year review. Participants who received a brain MRI at 6 years (n = 123) received a more comprehensive cognitive assessment again. A large proportion of participants have also been enrolled in the brain bank that will allow the team to investigate clinicopathological correlations.

The Australian Longitudinal Study of Ageing (ASLA) is another large, prospective, population-based study of adults aged 70 years and over begun in Adelaide in 1992, led by Gary Andrews, Mary Luszcz, Michael Clark and others. This study is a psychosocial and behavioural study of 2087 older adults residing in the community and in residential care. Assessments have occurred in 6 waves over 8 years thus far. Data are being used to determine the inter-relationships among decline in sensory and cognitive functions and also the mediational role of processing resources in memory ageing. Australian norms for several frequently used tests of language, memory, executive function, speed of processing and NART are also being collated for adults aged 70 to 100 years.

Long-term studies of people with, or at risk of, specific dementias have also been a focus. In Queensland, Brona O'Dowd and colleagues are conducting a longitudinal study that commenced in 2001 to identify and annually monitor a community

dwelling sample of 70 adults with mild cognitive impairment and 70 matched normal adults over the age of 50 in order to characterise the pattern of intellectual decline of those who later develop clear dementia. These decline profiles are then related to regional rates of anatomical, functional and biochemical changes in the brain obtained from magnetic resonance imaging (MRI). Bill Brooks in Sydney is leading a team that is prospectively examining a cohort of members of approximately 25 families with familial Alzheimer's in order to identify early markers of the gene. In a 20-year follow-up study of a group of adults with Parkinson's Disease Wayne Reid and his team have identified a different trajectory of decline in those with early versus late onset of the disease.

Specific research is also being conducted into the neuropsychological sequelae of dementia. For example, in Melbourne (Monash University) a research group led by Greg Savage is focused upon the development of more sensitive and specific tests for the earliest detection of cognitive changes in Alzheimer's disease, including an examination of components of language and memory failure in Alzheimer's disease and declining MCI, Lewy body dementia, frontotemporal dementia, and static MCI using both conventional testing and novel learning tasks as well as changes in olfaction. Changes in functional abilities are being correlated with functional imaging (PIB-PET) of in-vivo amyloid load at the Austin Hospital.

Challenges in the Assessment and Management of People with Neuropsychological Disorders in Australia

Health care in Australia has traditionally been publicly funded but, nonetheless, the long term needs for those with traumatic brain injuries and other chronic conditions, especially the elderly, represent a major health service challenge. Many victims of TBI are assisted by monies provided

by motor vehicle insurance but this is not a uniform system, varying from state to state and uneven in its coverage from lump-sum payouts restricted to those covered by “third party” insurance to a “no-fault” scheme that provides services and assistance for the life-time of all affected individuals. Those who have significant disabilities and who rely upon public health care alone can be poorly resourced. Thus, there is a great need for uniform, equitable and appropriate services for everyone who suffers brain injury in Australia. Similarly, while services for the elderly are appropriately seen as a public health issue, the magnitude of the needs of the ageing population has not been visibly reflected in health and services planning to date.

Another challenge that Australia faces in terms of providing assessment, treatment and research in the area of neuropsychology is, to a great extent, shared with other multicultural, multilingual nations. The vast majority of professionals with appropriate training are monolingual English speakers using tests and resources that are developed by similarly experienced researchers. The added difficulty for Australians, is that wording, content and norms of most widely used tests overwhelmingly reflect their USA or UK origins, resulting in significant cultural and demographic differences that render comparisons crude at best and invalid at worst.

The fact that Australia’s population is relatively small, and its community of psychologists and other professional consumers of test materials even smaller, makes it difficult to convince large test publishers of the need, or economic viability of producing Australian standards and norms. Studies such as the ASLA (Adelaide) and the normative study for young adults on the Wechsler scales (lead by Arthur Shores and Jane Carstairs, Macquarie University, Sydney) go some way to providing local norms but are, necessarily, limited in scope.

In addition, it is difficult to provide appropriate services to clients with brain disorders when the clinicians do not speak the language of their clients, nor understand their cultural perspectives. By way of example of the significance of this issue, I live in an inner city suburb in Sydney, the largest city in Australia. The local schools in my suburb have up to 93% of their students from non-English speaking backgrounds. I have also trained clinical psychologists at one of the largest of Sydney’s universities for the last 13 years where the majority of applicants to this (and other) programs are mono-lingual English speakers, although this is slowly changing. Australian training programs need to encourage more multilingual and indigenous clinicians. Research, too, is required to address the specific needs of people from the many different cultures that make up Australia.

First INS/ILC Online Survey Yields Ideas, Reveals Satisfaction and Surprises

***By Kathy May
ILC Program Assistant***

- *Why did you join the INS?*
- *What is most beneficial about your membership?*
- *Would you encourage colleagues to join?*
- *What new or additional programs do you hope to see?*
- *What would you like to change?*

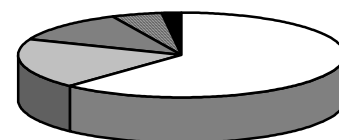
These are a few of the nineteen questions from the first on-line survey of INS members who live and work outside the U.S. and Canada. The survey, initiated and developed by Dr. Bernice Marcopulos, Chair of the International Liaison Committee (ILC) and Kathy May, ILC Program Assistant, with the help of UVA’s Center for Survey Research, was designed to discover how the ILC

could best fulfill its mission to “promote increased communication and collaboration among neuropsychologists worldwide” and is an effort to reach out directly to non-North American members.

The survey questions were first sent for review and revision to ILC committee members, INS board members, and ILC regional representatives from every continent. The survey was posted on-line using a professional survey hosting service and was open from March 29 to May 18, 2005. Survey results were compiled and analyzed in a formal report by the Center for Survey Research at the University of Virginia in Charlottesville.

E-mail letters with direct hyperlinks to the survey web site were sent to 723 non-North American INS members with 270 completing the survey for a 37% response rate. The majority of respondents practice in Europe (62%), 19 % practice in Australia, 12 % in Asia, almost 5% in Central and South America, and 1.5% in Africa.

Survey Respondents by Country of Practice



Most respondents report joining INS to keep current with new research and to make professional contacts. The greatest benefits are the full subscription to JINS and the INS conferences. Of the 255 who use the

INS web site (<http://www.the-ins.org/>), most do so to gather information about INS meetings, for online access to JINS and for official contact information. Almost 62% of respondents attend an INS conference once every few years and 19% attend once a year. However, 16% have never attended an INS conference, primarily because travel and hotel costs are too high. A significant number of this 16% (30%) cite high conference fees while another 30% cite schedule conflicts.

Surprisingly, 69% of respondents report never having used any ILC services or programs. Of the 31% who have used ILC services, most work in Asia and Central and South America and most report the INSNET newsletter to be the most beneficial service. Although use of the ILC web site (<http://www.ilc-ins.org/>) is also low, the 30% who have used the site report the list of Conferences (<http://www.ilc-ins.org/news.html>) and the list of Neuropsychological web site Links (<http://www.ilc-ins.org/links.htm>) as the most useful parts of the ILC web site. Again, respondents from Central and South America are more frequent visitors to the ILC web site than members from other parts of the world.

Nearly 70% indicated the need for a scholar/scientist exchange program. 57% would like to see Internet or distance learning courses with respondents from Central/South America requesting support for local conferences. An overwhelming majority said they would encourage colleagues to join INS and cited a number of positive reasons. However, a number of respondents expressed concerns about the representational balance between scientific and clinical neuropsychology, difficulty in accessing member benefits in their countries, concerns about costs of conferences, and lack of emphasis on international issues.

What would international members like to see changed about the INS?

One-fifth of the 65 respondents who gave substantial answers to this question would like to see more emphasis on research, especially dealing with children and clinical issues such as cognitive rehabilitation and interventions. Some members feel as though the INS is too U.S. oriented and others think there should be more variation in conference subject matter and speakers. A number of people suggested reducing conference fees for those traveling internationally.

To benefit neuropsychologists in their own countries, a good number of respondents requested more international contact and an international system for neuropsychology qualifications. Others suggested supporting regional meetings in addition to annual conferences.

The ILC would like to thank those members who took the time to answer the survey questions. The committee is studying the survey data to determine where to best focus its efforts and hopes to use this information to make INS membership more meaningful and valuable for non-North American members. Please send comments and suggestions for increasing international collaboration to Bernice Marcopulos at bmarcopulos@ilc-ins.org

Volunteer Psychological Relief Work in Thailand

***By Christine Mathiesen, Psy.D.
Neuropsychologist
Atascadero State Hospital
California, USA***

Email: Cmathiesn@dmhash.state.ca.us

Wanting to Volunteer

As a neuropsychologist, I enjoy using my skills to help people and their caregivers. Eight of my childhood and teen years were spent living in Indonesia and Malaysia. The December 26, 2004 tsunami in South and Southeast Asia was vividly

brought home to me through the news footage and pictures of Banda Ache, reminding me a great deal of the area on Borneo (East Kalimantan) where I had lived. I had volunteered at Rape Crisis Centers in years past and the tsunami prompted my return to psychological-oriented volunteering.

Trying to Volunteer

Although I've lived in the States for the past 21 years, I felt a bit like my Asian home had been hit by the earthquake and subsequent tsunami. Within two days of the tsunami, I received an email from a friend with whom I had graduated from high school in Malaysia. She is now a physician and she too wanted to help. We began an active, weeks-long series of daily emails to identify organisations with which we might volunteer for a few weeks. Those of you who volunteer with larger organisations (e.g. Medicine sans Frontiers or the Red Cross/Red Crescent) know that it is a lengthy process to be put on their volunteer roster. And they often have minimum service requirements, anywhere from three to 24 months, rarely taking on first-time short-term volunteers which was all my friend and I could commit to. We continued surfing the web and sharing information about smaller organisations that were on the ground in the affected countries. Volunteering through smaller organisations often requires that you pay all or some of your expenses, such as travel, lodging, etc. At first, I had a somewhat negative reaction to the idea of paying to help. Thinking about it, however, I realised the costs of transporting, housing, and feeding volunteers are very high, and avoiding the allocation of vast sums to indirect services such as transporting volunteers means donated funds go much further towards the real objectives.

I finally settled on volunteering with United Planet, which was organising psychological help in Khao Lak, Phang-nga province in Thailand, the country's hardest hit area. It is about 100 kilometres north of Phuket Island,

the popular resort area most often depicted in the media. Being a 501.3c non-profit charity, all volunteer fees and costs were tax deductible and people who donated to my costs received a tax deduction. Originally uneasy with the idea of asking people to donate, a friend strongly encouraged me to fundraise. I discovered friends and colleagues liked donating to a cause where they knew exactly how their money would be spent, something missing when donating to a large organisation. Along with a co-worker who had been in Thailand in the mid 1960s for the US government (where he had learned the Thai language), I committed to just over two weeks in Thailand.



Hitting the Ground

It was almost 60 days post-event when we arrived. Most areas had been cleaned and affected land bulldozed. Nevertheless, we experienced awe at the swath of land that had, in only minutes on 26 December 2004, been washed over by a tall, fast-moving, powerful wall of water. Three and four-storey resort hotels, still standing, had been gutted and looked as if they were new construction still needing windows, paint, etc. A military boat remained stranded across the road, approximately three hundred meters from the ocean.

We were originally slated to stay in a large tent but it had been dismantled and so we stayed in a small local hotel in the old-town part of Takuapa,

several kilometres inland. These accommodations were more than adequate, and it really felt luxurious given the circumstances and expectation of staying in a tent. We visited the largest of the displacement camps daily, where people had settled into a new type of normality. The camp director had done a fabulous job. Two types of temporary housing had been erected in the camps, one of which would not survive the coming rainy season, and the Army was building brick-and-mortar temporary housing as quickly as possible.

Providing Help

The founder of Greenway, the local charity through whom we worked, told us that our presence provided multiple benefits. Tents of large aid organisations had recently been taken down as their acute services came to an end. The day I arrived was the day the World Vision tent was pulled down. Our arrival showed that the outside world knew there were still needs to be met and that the individuals affected by the tsunami were still in the world's thoughts. Second, because psychological services traditionally have not been highly regarded in Thailand, our presence heightened the regard for psychological services, at least for a few medical teams and some of the local people. Finally, of course, we provided assistance to the individuals with whom we spoke.

For our first week we were linked with the team staffing the medical tent, which was becoming less busy week by week. We even noticed a shift in camp activity in our two weeks. In the second week, due to the lack of "business" at the medical tent, we walked around with a translator borrowed from one of Greenway's other volunteer missions. We were clearly identified as people to talk to and would be invited to sit down with individuals and often a grouping of family or friends, to talk about their difficulties. We let them lead the way in discussing whatever was pressing, and did our best to acknowledge and

validate their losses and emotions. We provided psycho-education regarding the diminishing of many symptoms over time, and encouraged whatever healthy coping strategies and distracting activities they employed and had available to them (e.g., work, cleaning, visiting the Buddhist tent). We received warm smiles when we again saw individuals days later at the camps, and one woman wanted to throw us a papaya party in thanks.

It was a slower pace than I had expected but for all good reasons. The displacement camp was very well organised. Some people were back at work and families were moving out daily, to cleaned-up homes, moving in with friends and family in other areas of Thailand, or to new, stronger temporary housing.

Mental Health Issues

I am very happy to say that most of the people we met were doing remarkably well given the extent of their losses and, almost certainly, their community orientation and spirituality were very strong protective factors. In a few sentences it's difficult to provide a worthy explanation of the Buddhist principles that aid one in dealing with an event like the tsunami. There is a basic acceptance that life is full of suffering. There is also an idea of impermanence: it may be uncertain when death will come, but we can be certain that death will eventually come. Living these beliefs may enable one to endure hardships without perhaps tending toward the "why me" distress.

Although most people were adjusting adequately to the camp and managing the varied losses of family, friends, homes, and livelihoods, of course there were difficulties. In some cases, it was lack of resources to rebuild a boat or business. The most salient issue was grief for lost family - children, parents, husbands, and miscarriages. One woman felt guilty because her parents were visiting that weekend and were babysitting while she and her husband went out to fish. Out at sea, she and her husband were saved but her parents

and children perished. Another woman was grateful for the survival of her four-year-old grandson, but was having trouble managing his requests to see his father, who had died. Next most pressing was probably difficulty falling asleep, followed by intrusive thoughts and nightmares. One woman, whose child died, remarked that her husband was drinking more alcohol than he used to. These sound like common symptoms one might find in our Western DSM and they may be universal reactions to extreme stress. But there were also more culturally specific experiences, such as the people who reported seeing ghosts, usually of *farangs* (foreigners) walking in the street or reflected in mirrors. As I was told, some Thais believe that these ghosts were confused because they died in unfamiliar surroundings. Perhaps most acutely distressing was a rumour started by a well-known fortune teller that there would be another tsunami. This was unfortunately reinforced when people heard the Army had stopped their housing construction work the first day of the possible second tsunami. The Army's break in construction was almost certainly coincidental, but people in the camp were frantic, trying to find a new place to live, or considering moving out of the area all together.

Translation Difficulties

Any of you who have provided services through translators know it can be difficult even when working with medically trained translators or working under structured testing situations. Thai medical students who had provided translation services prior to our arrival had to return to school for exams, so we worked one week with a medical team with moderate English skills and another week with a translator who usually works with construction volunteers. It is difficult to inquire about such abstract concepts as nightmares or being unconscious (which I acted out with another psychologist who pretended to get knocked out and then revived). Perhaps the thorniest symptom to

assess was appetite. It is almost a standard greeting in Thai social convention to ask people if they have eaten, and to respond with something like "just eaten". Food and drink were offered to us wherever we went, even the head monk at the Buddhist tent offered us to "leave your stomachs here" and partake in the food they received from the community, after the monks had had their fill, of course. We had to train translators to discriminate whether or not an individual was truly eating adequately or if they had significantly reduced appetite and were simply providing the socially appropriate standard "no problems" because they did not want us to get them something to eat. I identified a few opportunities to provide neuropsychological assessment (e.g., post low-speed motorcycle accident) but unfortunately was without adequate translation services each time and was disappointed not to be able to assist in that way.

Heading Home: Phuket Town

I was more profoundly sad during the day and a half I spent in Phuket town just before my flights home than during the two weeks north in the affected towns and displacement camps. Due to the vastly reduced tourist population, shops that are usually open seven days a week were closed and restaurants were quite empty. Hotels were reportedly very empty. As was stated repeatedly in the media, the economic toll of lost tourism may indeed be a serious second trauma to the region. Having grown up for eight years in Southeast Asia I am biased, but Asia is a wonderful place to experience, whether as a volunteer or tourist, and I invite the readers to visit tsunami-affected countries. They are ready and waiting for us.

Future Volunteering

All in all, it was a great experience. I had the opportunity to help, to see first hand some of the damage, to see how wonderfully communities had come together to help each other, and how

families and individuals demonstrated their resilience. I got to go "home" to Southeast Asia. Though I'd never lived in Thailand, the food and environmental details reminded me a lot of one of the places I lived in Indonesia. Once back near the airport I got to shop in some of my favourite Asian stores, perhaps my way of doing a last bit of economic assistance for the region.

I highly recommend short-term volunteer work. I think it is always important to remember there are so many in need in the world, whether from AIDS, malaria, malnutrition, natural disasters, wars, and the other difficult circumstances that life serves up. Animals are often affected by these same events. You can donate to animal-oriented, non-profit organisations or even travel to Thailand and other countries to volunteer with animals. This experience also prompted me to remember those in need closer to home. I've contacted my local Red Cross chapter about volunteering, and later this year I hope to complete training to provide pro bono evaluations for refugees at a human rights clinic here in California. I hope you will all consider volunteering, donating, or touring to affected areas of your home countries and other parts of the world. For me, this was truly a very rewarding experience.

Changes to ILC Website

Recently, some exciting new changes have been made to the ILC website. The three databases – education, funding, and societies – now have individual links in the navigational bar on the left side of each page and can be directly accessed from most pages of the web site.

Two societies have been added to the Societies Database – the Catalan Neuropsychological Society in Spain and the Israeli Neuropsychological Society in Jerusalem. Thanks to Nancy Pachana, the educational

programs in Australia have been updated in the Education Database.

The "International Positions" page now contains information about several Fulbright positions.

Please check out the ILC website at <http://www.ilc-ins.org> and inform Bernice Marcopulos of upcoming conferences, funding or research opportunities, any curriculum or address changes for educational programs, and changes in leadership for regional societies.

Announcement

The first administration of the Certified Specialist in Psychometry examination, the credentialing program for Psychometrists, will be given at the annual conference of the National Association of Psychometrists (NAP) in November. All qualified individuals are welcome to participate.

When: Friday November 4th, 2005

Where: Mayo Clinic, Rochester, Minnesota

For further information regarding the examination or to request a candidate handbook for registration, please visit our website at www.napnet.org

Conference Bulletin Board

4th International Conference on Memory (ICOM-4)

When: July 16-21, 2006

Where: Sydney, Australia

The theme for the 4th International Conference on Memory in 2006 is "A Celebration of Memory Research". The conference will once again blend academic excellence with a relaxed social atmosphere, and 10 internationally renowned memory researchers will give keynote addresses. The deadline for

submissions is Friday 16 December 2005. For more information please visit the ICOM-4 website <http://www.psy.unsw.edu.au/Groups/ICOM4> or send an email to icom4@psy.unsw.edu.au

Information on other upcoming conferences can be found on the Conferences, Courses & Events Page of the ILC Website at <http://www.ilc-ins.org/news.html>

International Liaison Committee Members

Bernice A. Marcopulos, Chair
Neuropsychology Lab
Western State Hospital, Box 2500
Staunton, VA 24402-2500, USA
E-mail: bmarcopulos@ilc-ins.org

David Shum, INSNET Editor
School of Psychology
Griffith University
Nathan QLD 4111
Australia
E-mail: d.shum@griffith.edu.au

William Seidel
Book & Journal Depository Coordinator
71 Cochrane Avenue
Hastings On Hudson, NY 10706
E-mail: wtswts5@yahoo.com

Kathy May, Program Assistant and Web Site Assistant
E-mail: kmay2k@earthlink.net

ILC Support Consultant Position Needed

A new International Liaison Committee Member is needed to coordinate the Research and Editing Consultation Program. This position involves INS members who volunteer to work with international colleagues who wish to publish their research in English language journals. Support consultants may assist in such areas as research design, methodology and/or statistics, as well as language editing.

If you are interested in joining the Committee and would like to know more about this position, please contact Bernice Marcopulos at bmarcopulos@ilc-ins.org

Regional Representatives of the ILC

Raymond Chan	Asia
Emilia Lojek	Eastern Europe
Niall Pender	Western Europe
Jorge Alvoeiro	Southern Europe
Laura Hokkanen	Scandinavia
Knut Hestad	Scandinavia
Skye McDonald	Australia & NZ
Ann Watts	Africa
Ramiro Coello-Cortes	Central America
Alberto Fernandez	South America
Miriam Levav	Middle East
Ali Al-Ghatani	Middle East

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