

INTERNATIONAL NEUROPSYCHOLOGICAL SOCIETY LIAISON COMMITTEE NEWSLETTER

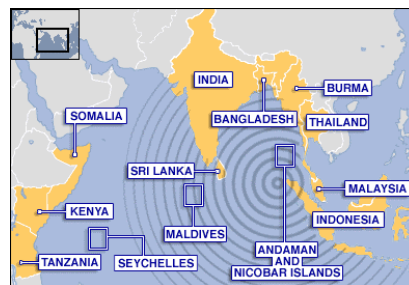
Message from the International Liaison Committee

December 26th 2004 is a day that will not easily be forgotten - a day of terror, heartbreak, and ultimately, tragedy. On this day South Asia was startled, then devastated, by a tsunami. Here are some details of the event and its aftermath:

- A megathrust earthquake occurred off the west coast of northern Sumatra just before 8:00am. The Indian tectonic plate slipped beneath the Burma Plate, causing the tsunami.
- At a magnitude of over 9.0, the quake was one of the world's largest.
- Hundreds of aftershocks were felt throughout Sumatra and the Andaman Islands.
- The tsunami crossed from the Indian Ocean into the Pacific and Atlantic Oceans.
- The waves of the tsunami were up to 15m high.
- Countries directly affected by the tsunami were Indonesia, Sri Lanka, India, Thailand, Somalia, Maldives, Malaysia, Burma, Tanzania, Bangladesh, Kenya, and Seychelles.
- The death toll has now topped 295,000 and is expected to reach 300,000.
- International Labour Organisation estimates that 1 million jobs have been lost in Sri Lanka and Indonesia alone.
- The economic impact of the tsunami is still far from clear, although it is estimated that

reconstruction in Indonesia, Sri Lanka, India and the Maldives will require \$11.5 billion over the next five years.

- Experts have warned that up to 9 in every 10 tsunami survivors are likely to suffer from psychological trauma.



A few days after the devastating tsunami struck in South East Asia, a seven-year-old boy walked into a Red Cross office and donated the contents of his piggy bank, filled with about \$40 – his Christmas money. This young boy's gesture clearly illustrates the profound impact that this tragic event has had on people across the globe.

The extent of the devastation caused by the tsunami is unparalleled in recent times, and has sparked a phenomenal humanitarian effort, with far-reaching aid and assistance extended from all corners of the world. It is inspirational to witness our global village uniting in outreach and support for all those affected by this disaster.

Like many other people in different parts of the world, members of the International Liaison Committee are deeply saddened by the tragic loss of life and widespread destruction caused by this disaster.

We extend our heartfelt sympathy and condolences to all those who were affected by this tragedy.

Bernice Marcopulos
David Shum
Debora Scheffel
William Seidel
Kathy May

Report from the ILC Representative for Africa

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In Africa the number of psychologists relative to the total population is low. For instance, the Zimbabwean Psychological Association has some 100 members, whilst in South Africa there are approximately 6000 psychologists registered with our statutory licensing body – this in a country with a population of approximately 45 million people. As a result, many psychologists in Africa are “generalists” and specialisation in fields such as neuropsychology tends to be rare. In this respect, South Africa has been the exception as, to my knowledge, it is the only African country with neuropsychological associations and an active neuropsychology community. Zimbabwe has a small community of psychologists who are receiving training and support from Norwegian neuropsychologists. There is thus a need to stimulate interest in neuropsychology on the continent, as many psychologists seem not to know

the relevance of neuropsychology versus general psychology, despite the high incidence of brain damage in Africa due to factors such as trauma, diseases/infections, cerebral malaria, malnutrition, and HIV/Aids.

In South Africa, where I reside, neuropsychology is a rapidly evolving field. Neuropsychological research and clinical practice started to develop after World War II. However, it was only in 1981 that the first South African neuropsychology conference was held. At this conference the first neuropsychology society (the South African Society for Brain and Behaviour Studies) was formed. This was followed in 1985 by the formation of the South African Clinical Neuropsychological Association (SACNA). Its aim was to promote the professional development of clinical neuropsychology in South Africa and it defined its role as a credentialing and training body. SACNA initiated negotiations for specialist registration for neuropsychology with South Africa's statutory licensing body, the Professional Board for Psychology of the Health Professions Council of South Africa. These negotiations have been ongoing for the past 20 years and the only progress to date is that two years ago the Board recognised in principle that neuropsychology is a specialised area of practice within psychology. In the interim, SACNA has instituted its own peer credentialing procedures.



For several years both SACNA and the South African Society for Brain and Behaviour Studies co-existed. However, in the early 1990s the latter

ceased to be a national body, and is now based in Cape Town, where it remains active. In 1999 SACNA co-hosted the INS meeting in Durban, and this gave further impetus to the development of neuropsychology in South Africa. In 2001 the Neuropsychology Division of the Psychological Society of South Africa was formed. The aim of this division is to stimulate interest in neuropsychology among South African psychologists and to foster an awareness of the specialised knowledge and skill requirements of the field.

Psychology Departments in South African Universities have for many years been conducting research into neuropsychological issues. This research has been wide-ranging and included adapting and developing assessment procedures that are relevant for the multi-cultural and multi-lingual South African context, cross-cultural issues, rehabilitation for patients with stroke and traumatic brain-injury, as well as studies on issues such as kwashiorkor/malnutrition, parasitic infections, cerebral malaria, HIV/Aids, traumatic brain injury in sports, epilepsy, sleep, drugs, and strokes.

The Departments have also been lecturing in neuropsychology and tutoring graduate students in the field. Notable in this regard for their contribution to the development of neuropsychology in South Africa are the late Dr Gordon Nelson and the retired Professors Shirley Tollman, Victor Nell and Dev Griesel. At present, Professor Anne Edwards spearheads a research program on traumatic brain injury in South African rugby at Rhodes University in Grahamstown. Professor Mark Solms has returned to South Africa after many years in the UK and has set up a neuropsychology research and training program at the University of Cape Town. Research and training programs are also being run by Professor Nonhlube Makunga at the University of Zululand, Professor

Theo Lazarus at the University of Johannesburg, Professor Kate Grieve at the University of South Africa, and Professor Basil Pillay at the University of KwaZulu-Natal.

In the late 1980s and early 1990s a number of neuropsychologists moved from Universities and Institutes to the private sector. In many instances, this was made necessary by the dearth of funding for neuropsychological work and the lack of jobs for neuropsychologists in South Africa's state healthcare sector. As a result, the bulk of neuropsychologists in South Africa are now in private practice. These practices include electrophysiology and neuropsychology centres, as well as neuropsychology units in private hospitals.

Despite the vibrant and active group of neuropsychologists in South Africa, the field faces a number of challenges in this country. Perhaps the greatest challenge that neuropsychology faces is the diversity of our population. It comprises a diverse collection of cultures, languages, beliefs and backgrounds. For instance, we have 11 official languages. South Africa is also a country in a rapid state of transition and change, with the acculturation occurring in our cities presenting a further complication. This includes components such as English language proficiency, educational quality, test-wiseness, and increased urbanisation. Regarding education, in South Africa there is still discordance between years of education and quality of education. This is the legacy of apartheid and the unequal distribution of funds to Black people during the apartheid era, and resultant disparate educational quality and experiences. Thus one cannot assume that people with the same level of education have similar academically acquired knowledge and skills.

Furthermore, there is a dearth of assessment and intervention procedures that are appropriate for use in our country as those available are

usually of North American and/or European origin. As a result common practice in the assessment domain is still, in many instances, to translate existing tests during simultaneous administration and to use the norms that have usually been developed for use in countries such as the US and UK. Obviously this type of approach is fraught with problems both ethically and conceptually, and there is a strong potential for misdiagnosis. A further challenge facing neuropsychologists in South Africa is the paucity of psychologists of different cultures with fluency in our different languages. This is yet another legacy of apartheid as approximately 90% of psychologists in South Africa are still Whites who do not speak an African language.

Thus, at present in South Africa there is an active and vibrant group of neuropsychologists who are in many instances carrying out both clinical and research work. They have also carved a niche for themselves as expert witnesses in the legal forum. However, as there are few of us, most neuropsychologists are “generalists” who have to try and deal with all areas of the discipline. Few have the luxury of specialisation. Furthermore, there are still no formal training guidelines or credentialing procedures for neuropsychologists in South Africa, and the fight for specialist registration for the field continues. In addition, several initiatives with the aim of developing assessment procedures that are appropriate for the South African context are in the pipeline. The profession is also exploring ways to ensure that neuropsychological services become accessible to, and affordable for, all South Africans.

**Report from the ILC
Representative
for Asia**

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To introduce myself briefly, I was born in Hong Kong and received my training firstly in rehabilitation science, then in psychiatry, and finally in experimental neuropsychology and cognitive psychology in Hong Kong. I obtained my Ph.D. in neuropsychology from the University of Hong Kong. Before moving to China in 2003, I worked in the Department of Psychiatry at the University of Hong Kong for several years. I am currently a full professor in the Psychology Department at Sun Yat-Sen University, Guangzhou, while also maintaining my adjunct position in the Department of Psychiatry at the University of Hong Kong.



I have been a full member of the INS since 2000. My close linkage to researchers in China and my established network with collaborators outside China (including Hong Kong) put me in an advantageous position to take up the position of ILC Representative for Asia. I consider my main duties as: (1) updating and coordinating neuropsychological studies and related activities among Asian colleagues (both clinical and experimental neuropsychologists); and (2) bridging the gap between Asians and Westerners. In this article, I am going to briefly describe the history and practice of neuropsychology in China, and discuss the challenges and opportunities of practicing and conducting neuropsychological research here.

History of Neuropsychology in the People's Republic of China

The People's Republic of China is the

biggest country in Asia having a population of 1.3 billion. Despite a long history and the largest population in the world, the development of neuropsychology in China started late in the 1950s when the first two proper neuropsychological case studies were published by Xinde Wang and Hanbai Chen. In 1965, the first formal neuropsychology laboratory was established in the Institute of Psychology, at the Chinese Academy of Science. However, the development of neuropsychology in China was brought to a halt during the period of “Cultural Revolution” from 1968 to 1978.

Neuropsychology in China re-emerged in the 1980s when the “Cultural Revolution” had settled down. A number of significant events for Chinese neuropsychology occurred during this period. A selection of Alexander Luria's work was translated into Chinese by the locals and was used as a textbook for teaching at the undergraduate level in some universities. The Neuropsychology Laboratory at the Institute of Psychology was reformed by Xintian Li. Other similar laboratories were also established by “neuropsychologists”, mainly neurologists, in different places across the country. These included the Peking Hospital by Xinde Wang and Peking Medical University by Sujung Gao. However, neuropsychology as a discipline did not start to take form until the late 1980s. The first national neuropsychology symposium was organized in 1987, followed by the formal establishment of the Neuropsychology Division of the Chinese Neuropsychiatry Society. This was largely due to the efforts of Xinde Wang and Xintian Li who became the first president and vice president, respectively.

The third milestone for neuropsychology in China took place in the late 1980s and early 1990s when the first neuroimaging centre, the Beijing MRI Center for Brain Research, was launched by Lin Chen at the Institute of Biophysics of the

Chinese Academy of Science. The last decade has also witnessed a significant rise in the popularity of all aspects of the neurosciences in China. This renewed interest resulted in an increase in the numbers of neuroscience seminars within academia and the establishment of research-oriented laboratories at universities. Nowadays, there are several neuro-imaging centers established across the country, including the newly established Brain Imaging Center in the Sun Yat-Sen University, Guangzhou. The integration of conventional neuropsychological paradigms and the advanced technologies of functional MRI and Transcranial Magnetic Stimulation have facilitated a better understanding of brain-behaviour relationships and cognitive deficits observed in clinical groups.

Current Challenges and Future Plans

The development of neuropsychology and its related disciplines in China over the last few decades has been fascinating. However, there are lots of problems and challenges facing Chinese scholars engaging in neuropsychological research. The main challenges for Chinese neuropsychology today, similar to most developing countries, are how to stimulate the growth of the discipline and better control the quality of training. Although there is no official registration for neuropsychologists (either clinical or experimental disciplines), the estimated number of neuropsychologists or researchers conducting neuropsychological study is less than 50. That number would probably drop to about 10 if we only counted those who engage in clinical work. This figure is remarkably small for a country of about 1.3 billion. It highlights the need for properly trained neuropsychologists in China.

Moreover, the fields of “clinical psychology” or “clinical neuropsychology” are mainly taught at medical schools and most of the “clinical psychologists” are actually medical doctors. We have a similar

situation in neuropsychology as exists in the Czech Republic (see Suchy, INSNET #13, 2004), where “clinical psychologists” place a strong emphasis on psychotherapy training and are relatively neglectful of the brain-behaviour relationship. Only a few neurologists have chosen to specialize in neuropsychological work. Clinical neuropsychology, in general, is dominated by medical doctors in China. It is very different from our western counterparts who usually receive their neuropsychology training within the discipline of psychology.

However, formal neuropsychology courses are currently being taught at the postgraduate level as part of psychology training in some universities in China. Some even offer elective neuropsychology courses at undergraduate level. Unofficial figures suggest that, from a total of about 1500 psychology masters and doctorate dissertations submitted each year, less than 5% were in the field of neuropsychology. Most of them were submitted to local journals for publication, with very few of them successfully accepted by international neuropsychology journals. This indicates that, apart from the inefficient mastery of English as the main communication language in many international peer-reviewed journals, the quality of research design might not be up to international standards. Better quality control of basic training in neuropsychology, and clinical neuropsychology in particular, should be enforced.

In view of this situation, the government is now reviewing proper training and registration of clinical psychology and related sub-disciplines in China. This is to ensure the quality of services provided to consumers at the community level. The review is still in progress and it may take years to finalize. One expected outcome would be the reform of the course structure and training program of neuropsychology and related disciplines in China. Therefore, it is necessary to increase the number of

practicum and training sites, the number of qualified neuropsychology supervisors, and other backup facilities locally and even internationally. One example of this kind is the launching of the Research-Oriented Clinic at the Department of Psychology in Sun Yat-Sen University. This is a collaborative initiative between local neuropsychologists and Danish clinical psychologists at the University of Copenhagen. We hope this program will attract other western collaborators to join us for future expansion to establish a well-structured neuropsychology program here.

The final challenge will be whether we should adopt an integrated cross-cultural approach within neuropsychology to broader issues of public health and community development in China and other Asian countries, or develop our own approach specific to Asian neuropsychology. The former approach would mainly derive from the western-based neuropsychological approach in validating a cognitive and neuropsychological assessment battery for potential global use. The latter approach would focus on a more specific cultural component found among Asians, and seek to develop our own assessment instruments to document the impact of community, education, and health intervention programs expected to enhance Asian neuropsychology. Either approach has its pros and cons and requires time to validate its clinical usefulness and utility.

Instrumentation and Publication of Neuropsychological Research

China and its neighboring countries have translated and validated several well known instruments for clinical and research purposes, (e.g., WAIS-R, WMS-R, Stroop Color-Word Test, PASAT, Rey Complex Figure Test, etc). However, a recent review paper indicates that only relatively few neuropsychological tests were properly normed among Asian countries, Chinese populations in particular (Chan A. et al., 2003). Recently, a

number of studies have actually been conducted to validate the second-generation tests of executive functions, particularly those based on theoretical framework. These include the Hayling Sentence Completion Test, Sustained Attention to Response Task, Six Elements Test, and the Test of Everyday Attention for Adults and Children (Chan, R. 1999; Chan, R. et al., 2002; 2004). These efforts will not only offer the basic references for clinical comparison, but will focus on the need for neuropsychological theory and practice within public health and community development contexts.

The accessibility to updated information for neuropsychological assessment instruments and related resources is very limited. On one hand, it may be hampered by a lack of dedicated research facilities and access to scientific journals. The increase in electronic access to scientific sources in China and other Asian countries like the Philippines and India over the recent years has enabled dedicated scientists to share ideas and communicate findings with their colleagues in developed countries. On the other hand, there is no dedicated neuropsychology journal in China, including Hong Kong. However, there are about 10 neuropsychology-related journals in Chinese for those neuropsychologists to publish their valuable data.

Funding Sources for Potential Collaboration

There will be enormous benefits in encouraging and supporting international collaboration in neuropsychological research and practice in Asia, and China in particular. One of the opportunities is to increase funding sources to facilitate international exchanges for foreign experts to conduct research in China. My role as the ILC Asian Representative may serve as a middle agent to link up people who are interested in collaborating with scholars in China. To describe briefly here, there are several international funding channels offered by the

National Science Foundation China (NSFC), one for Asian colleagues, and the other for western collaborators (e.g., the NSFC/KOSEF for collaboration with Korean, the NSFC/JSPS for Japanese, and the NSFC/RGC for Hong Kong scholars). We hope that the provision of these funding opportunities not only facilitates a closer linkage among Asians but also extends to a wider network of western collaborators in the near future.

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A Semester in Gaelic Heaven

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For those academic neuropsychologists looking for a break from their routine responsibilities, J. William Fulbright Scholarships offer a wonderful opportunity to work in foreign countries, share your knowledge, and learn about different academic and professional issues

relevant to your area of expertise. Even better, it allows one to become immersed in a different culture, get away from the normal stressors of work and home, and to be treated extremely nicely by everyone you meet.

I had the good fortune of working as a Fulbright Scholar at the National University of Ireland, Galway (NUIG) during the Fall 2004 semester. I was asked to teach courses to undergraduate and graduate students at NUIG, which has the only health psychology graduate program in Ireland. Given my previous collaborations with psychologists from the National Rehabilitation Hospital (NRH) in Ireland, I was also asked to foster additional research collaborations on disability issues, particularly in rural Ireland.

The Important Things

The best things about my Fulbright experience, which I believe are similar for most people who complete Fulbrights, are related to the ability to live in and fully experience a different culture. One sentence can summarize my experience: I was able to live and work in Galway, a medieval city on the west coast of Ireland. My family and I relished the following: pubs, restaurants, and craft shops in quaint 15th century buildings; Saturday morning open air markets in the shadow of an 800 year old church; smelling the sea air along the promenade on Galway Bay; walking through downtown Galway along the Corrib River and many side canals; having a pint or two at the local 1875 pub with the peat fire and Gaelic music, learning what it means to truly relax; having tea and scones with my wife at a different bakery every other day; having my children attend the Irish National schools, learn a little Gaelic, and experience the joys of playing rugby. Did I mention the pubs and scones? We need more of both in the US.

The Professional Experience

Working in another country allowed

me to more objectively evaluate the practice of neuropsychology in the US, and particularly how our practices are limited by our own training and experiences. The Irish students and psychology faculty are all very bright, hard working, and similar to the students and faculty I work with in the US. However, they were much less intense and more balanced in their lives, which was refreshing. We can learn from them. Interestingly, I learned that the typical stressors common in most US academic departments are also evident in Ireland, including tensions over prioritizing teaching versus research, addressing funding issues, and advocating for psychology's position in medical settings and systems.



In contrast, there are obvious differences in professional issues between the two countries. Psychology is a much “younger” profession in Ireland, so I was able to learn from several senior Irish psychologists who were instrumental in developing psychology in Ireland (e.g., setting up the first training programs, establishing the Psychological Society of Ireland, etc.). It made me realize how much US psychologists take for granted the efforts of those psychologists who worked before us and helped establish psychology as a legitimate discipline, particularly in health systems.

Another major difference between the US and Ireland relates to professional practice issues. For example, there are

no licensing laws for psychologists in Ireland, or for many professions for that matter (other than for physicians and nurses). Any individual can practice “psychology” regardless of training, which was surprising to me but not a major concern for many Irish psychologists. Fortunately, Ireland has pending legislation to develop professional licensing programs. As for neuropsychology, there are no formal training programs in Ireland, but there are some exceptionally well trained neuropsychologists. Many have obtained appropriate academic training in their graduate programs, and most traveled to England for fellowship training. It is likely that specific guidelines for neuropsychological training in Ireland will be developed after licensing laws pass, and hopefully the Irish can work better than their North American counterparts to develop unified advocacy organizations and certification boards, and bypass the infighting we suffer.

Rehabilitation Systems

Given I currently work in a rehabilitation hospital, I was very interested in learning about Ireland's rehabilitation system. Ireland has only one rehabilitation hospital for the entire nation, and all individuals with significant disabilities travel to Dublin to receive services. Such centralization of rehabilitation services has obvious benefits. Rehabilitation patients receive wonderful, well-coordinated services during inpatient hospitalization, with the average length of stay being approximately twice as long for TBI patients in Ireland than the US. In addition, services that have been reduced or eliminated in the US are well integrated into inpatient rehabilitation programs in Ireland. For example, Ireland's National Rehabilitation Hospital has a principal and several full time teachers for their students with disabilities, recreational therapy programs including an extensive woodworking shop, vocational rehabilitation programs, etc. US rehabilitation programs can benefit

from modeling many of these Irish rehabilitation programs.

In contrast to the excellent inpatient services, Irish rehabilitation patients often have limited or no access to appropriate rehabilitation professionals or resources after they are discharged to their home communities. Given that 40% of the Irish live in communities of 1,000 people or less, many individuals return home and are at risk of losing the rehabilitation gains they made while inpatients. The Irish health system is currently undergoing consolidation, with an obvious need to improve the delivery of health and rehabilitation services to persons in their home communities. This is an area in which the Irish can learn from the US, including tele-health systems to enhance outpatient services in rural areas.

The most startling difference noted between US and Irish rehabilitation systems is related to the relative importance of finances. Most US neuropsychologists are used to obtaining pre-authorizations for any and all services requested, and are aware of the declining lengths of inpatient hospitalizations over the past decade related to financial concerns. However, in Ireland my Irish colleagues and I requested data on the average cost of inpatient hospitalizations for persons with TBI, yet the hospital could not provide this data. It was welcoming to work in a system in which the delivery of specific services and lengths of stay were solely based on patient needs rather than financial factors. The Irish health system is going through changes with increasing concerns regarding the long term financial costs associated with health care, but my Irish experience made me even more aware of how financial factors dominate our system. I believe US and Irish rehabilitation systems could learn from each other, and develop systems with more balanced attention to both patient needs and financial factors. It is our current plan to conduct collaborative research to evaluate this.

Getting a Fulbright

For those neuropsychologists and students interested in traveling abroad, sharing their knowledge, learning from international colleagues, and immersing themselves in a different culture, I highly recommend pursuing a Fulbright. Applications are due in the fall of each year, and faculties need to apply to programs that are requesting expertise in a specific area (e.g., disability research, brain injury, etc.). Students have more flexibility to propose a specific training program in an area of their choosing, although they will need to identify host universities in their respective countries of interest. Previous international experiences will enhance your chances of getting a Fulbright, as well as existing relationships with other professionals in foreign countries. More information can be obtained about Fulbright opportunities at www.Fulbright.com. For those who have the good fortune of getting a Fulbright, be sure to frequent the pubs wherever you go.

Conducting Neuropsychological Research in the West and East

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It is my pleasure to share with you some of my experiences in conducting research in the eastern and the western parts of the world. My experience may provide you with some understanding of the different research approaches across countries and cultures.

I was born and raised in Hong Kong. I then went to the United States to receive my undergraduate and graduate education. When I was a postdoctoral student at the University

of California in San Diego, I happened to learn that there was an opening in Neuropsychology at The Chinese University of Hong Kong. I therefore took the opportunity and returned to my hometown. That was eight years ago.

It was a reverse culture shock for me when I first returned to work in Hong Kong. The research culture in the US is one of specialisation. A researcher usually focuses on one area and develops it into a lifelong career. The funding system and the academic climate in the US allow a scientist to develop his/her expertise in one field/topic in a very in-depth manner. For instance, the grants awarded in the US are usually for five years, and sometimes can be extended for another five. Ten years is a sufficient period for an in-depth study of many issues.

The situation, however, is quite different in Hong Kong and other Asian countries. Due to limited resources in funding and supporting personnel, scientists may not be able to study one topic in depth. For instance, in Hong Kong, funding is usually awarded for one or two years, and the amount is relatively small (on average about US \$40,000 per grant) compared with those in the States. With this "quick fix" research climate, it is difficult to sustain any long-term project. Initially, I was very frustrated with the situation and seriously considered returning to the US, as I thought such an academic climate would not help my professional development. I knew that some young scientists in other Asian countries and in China shared my feelings, and were worried that we would not be able to conduct quality research with such limited funding and resources.

I have now been in Hong Kong for almost eight years. I have come to appreciate the environment and have become a productive researcher. In Hong Kong, although the funding is limited, there are others advantages for conducting research. First, I do not have to spend a lot of time applying

for grants like most of my US colleagues do. Thus, I have more time to think and conduct research. Second, as very few researchers here study patients with a brain injury, I rarely have problems recruiting participants. As specialisation is less focused, I have been able to study a variety of patient groups, including patients with Alzheimer's disease, schizophrenia, temporal lobe amnesia, depression, frontal lobe dysfunction, and autism. Thus, I was able to compare the memory disorders of patients with different pathologies, and this has enriched my understanding of memory processes. There are advantages in being a "big fish in a small pond".



I have seen both the advantages and disadvantages of conducting research in the East and West. It would be a biased point of view to think that there is only one "best" approach to conducting research. I hope in the future there is more communication between researchers and scientists in the East and West, so that together we can make the best of both situations.

The Informant Questionnaire for Cognitive Decline in the Elderly (IQCODE)

The IQCODE is a short questionnaire designed to assess cognitive decline and dementia in elderly people. The IQCODE was developed by Dr Anthony Jorm in affiliation with the Centre for Mental Health Research, Australian National University, Canberra. The IQCODE is one of the most widely used informant instruments to assess cognitive decline.

The IQCODE measures change in cognitive functioning rather than present level of functioning. In this way, it has been found useful for testing populations with little or no formal education. The questionnaire is to be completed by a relative or friend who has known the elderly person for at least 10 years. Therefore, the IQCODE is especially useful for individuals who are unable to be tested directly, due to either acute illness or lack of co-operation.

The IQCODE complements brief cognitive tests, such as the MMSE, and can therefore be used to increase screening accuracy. The IQCODE is available in 15 languages: English, Chinese, Dutch, Finnish, French, French Canadian, German, Italian, Japanese, Korean, Norwegian, Persian, Polish, Spanish, and Thai.

Reliability and validity of the test have been tested in many different cultures and countries around the world. The test has high reliability, with coefficient alphas between 0.93 and 0.97 being calculated across different studies. Test-retest reliability is also high, reported at 0.96 over three days and 0.75 over one year (Jorm, 2004).

The IQCODE is available in a long version, with 26 items, and a short version, with 16 items. The short form has been shown to have a correlation of 0.98 with the long version (Jorm, 2004). The questionnaire has been shown to reflect past cognitive decline, and is relatively unaffected by education, premorbid ability, or proficiency in the culture's dominant language (Jorm, 2004).

Factor analysis has demonstrated that the IQCODE measures a broad general factor of cognitive decline. The questionnaire predicts incident dementia, and correlates with a wide range of other cognitive tests (Jorm, 2004). Care must be taken, however, in interpreting results gained from a depressed or anxious informant, as these informant characteristics can affect the IQCODE outcomes.

The IQCODE can be downloaded without cost from the IQCODE website: www.anu.edu.au/iqcode. The test is available to download in both short form and long form, and in 14 languages. A literature review of the IQCODE can also be downloaded from the site.

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**Bilingual
Neuropsychologists
Wanted!**

The ILC is currently developing an online database of neuropsychologists who are able to provide evaluations in a foreign language. If you are able to conduct neuropsychological testing in a language other than the native language of the country you are living in, please consider submitting your contact details to this registry on the ILC website. To join the registry, email your details to Bernice Marcopulos: Bernice.Marcopulos@wsh.dmhmrzas.virginia.gov

**Conference
Bulletin Board**

NEW DATE

The 9th International Conference on Cognitive Neuroscience (ICON9) 5 – 10 September 2005
Havana City, Cuba
For more details:
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Miriam Levav	<i>Middle East</i>
Ali Al-Ghatani	<i>Middle East</i>

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