as penicillin and spectinomycin. It is because such effective treatments for syphilis exist that it is extremely rare for this disease to develop into neurosyphilis, an advanced stage which effects the brain and spinal cord. In fact, only 3% to 7% of individuals who contract syphilis ever develop neurosyphilis (Ross, 1997). The patient, C.B., was a 41-year-old, Caucasian male who contracted syphilis approximately 20 years before the present assessment. Initially misdiagnosed, the infection remained untreated for years and developed into advanced neurosyphilis before the condition was diagnosed. Although an MRI scan showed just 2 small areas of involvement in the left centrum semiovale, neuropsychological test data reveals that C.B. was suffering from severe, diffuse, and microscopic brain damage. Both Verbal and Performance IQ scores (78 and 72, respectively) on the WAIS-R were in the borderline range. His scores on language tasks were impaired on the Boston Naming Test, the WRAT-R (an achievement test), the WAIS-R, and the Luria-Nebraska Neuropsychological Battery-Third Edition (LNNB-III). Constructional apraxia was noted on the direct copy phase of the Rey-Osterrieth Complex Figure Test and on the WAIS-R (Block Design and Object Assembly subtests). C.B.’s borderline range Full Scale IQ score (72) on the WAIS-R was 24 points below his estimated premorbid IQ. On the WRAT-R, C.B. obtained standard scores (SS) reflecting severe impairments on the Reading (SS = 67), Spelling (SS = 68), and Arithmetic (SS = 74) subtests, performing 6 to 8 grade levels below what one would expect given the fact he had obtained a GED. His score on the Attention/Concentration Index (SS = 68) of the WMS-R, although impaired, was significantly better than his performance on the memory indices of this test, which were all severely impaired (SS = < 50). This finding, combined with his performance on other neuropsychological tests such as the Stroop Interference task (T-Score = 78), provide evidence that the subcortical basis of attention has been impaired the least in C.B. compared to his other neuropsychological abilities. For C.B., although the brain damage he suffered was bilateral, neurosyphilis caused greater dysfunction on the left as opposed to the right hemisphere of his brain. This was determined by the results of tests such as the Grip Strength Test and the Tactile Discrimination subtests of the Luria-Nebraska Neuropsychological Battery-Third Edition (LNNB-III), in which he showed significantly greater impairment on the right side of his body than the left. This case study shows that advanced neurosyphilis can severely impact neuropsychological functioning, to the point of causing dementia, and diffuse brain damage. The minimal variability in C.B.’s test scores connotes a pervasive impairment in neuropsychological functioning that could happen with a disease that has progressed to affect all of the nervous system. No neuropsychological functions were spared by the disease.

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Ethical issues in neuropsychological life and death decisions: a rehabilitation case study
Bush S.

Neuropsychologists in rehabilitation settings work to increase their patients’ functional independence and their ability to derive meaning from life. Neuropsychologists in such settings are frequently asked to assess the cognitive skills underlying a patient’s capacity to make decisions for himself or herself regarding their medical and rehabilitative treatment. The determination of such skill in patients who have sustained a severe brain injury and are in a minimally responsive state often depends on the consistency of the patients’ responses to commands and questions. In rare instances, the neuropsychologist may be asked to assess a patient’s ability to express his or her wishes concerning having life sustaining measures, such as feeding tubes, discontinued. Such wishes may have been previously
expressed in a Living Will or consistent with their pre-injury discussions with their healthcare proxy. Being asked to make a determination that could directly result in the patient's death contradicts the goals of rehabilitation settings and raises a number of ethical, moral, legal, and professional issues. The purpose of this investigation was to present a case that illustrates the clinical challenges involved in determining a minimally responsive patient's ability to make such a decision and the ethical, moral, legal, and professional conflicts that the neuropsychologist may experience throughout such a process. The patient was a 69-year-old, married, white, right-handed female who sustained a grade IV subarachnoid hemorrhage, followed by a craniotomy to clip a PCoA aneurysm. Two months post injury she was admitted to an acute rehabilitation unit and began a multimodal sensory stimulation program. Scores on the Coma Recovery Scale placed her in the minimally responsive range upon admission. During the first 2 months of rehabilitation she gradually transitioned into the emergent awareness phase. Her family frequently conveyed the patient's prior wishes that she not live in even a moderately impaired state. Three months after admission, while still making gains, the family requested that her feeding tube be pulled in order to let her die, consistent with their knowledge of her prior wishes. Her neuropsychologist was consulted on matters related to the patient's cognitive skills and was closely involved with all concerned parties throughout the process. Ultimately, the patient's family removed her from the rehabilitation setting and had her feeding tube removed, thus ending her life. Limitations of the APA Ethics Code are discussed, and recommendations are offered.

Litigants' performance on the memory assessment scales as a function of the Test of Memory Malingering: preliminary findings
O'Bryant S, Constantinou M, Weber M, McCaffrey RJ.

The increased role of neuropsychologists in the courtroom has led to an increased effort in the detection of possible symptom exaggeration/malingering. The Memory Assessment Scales (MAS) and Test of Memory Malingering (TOMM) are commonly used in neuropsychological evaluations. The purpose of this study was to compare scores on the MAS and TOMM in a sample of litigants. Archival data on 34 subjects were utilized. Subjects that scored below 45 on TOMM Trial 2 (Group 1) were compared to those that scored above 45 on TOMM Trial 2 (Group 2). Significant differences between the 2 groups were found on all 4 MAS indices (p<0.003, Bonferroni correction). It was also found that Group 1 scored significantly lower than Group 2 on the immediate Names and Faces and delayed Names and Faces. The response patterns of the 2 groups were also different. Specifically, Group 1 scored higher on the delayed Names and Faces than on the immediate Names and Faces, whereas Group 2 showed the opposite pattern. The results of this study indicate that response patterns on the MAS may aid the clinical neuropsychological practitioner in assessing for atypical patterns of performance. The clinical application of the current findings must await a cross-validation study.

Validation of the Lees-Haley Fake Bad scale for the MMPI-2 to detect somatic malingering among personal injury litigants
Eyler VA, Diehl KW, Kirkhart M.

In the rapidly growing field of forensic neuropsychology, there is an increasing need to determine if personal injury litigants are intentionally exaggerating their symptoms for the purpose of secondary gain. This study provides a unique contribution to the field by examining the co-