CLINICAL GEROPSYCHOLOGY NEWS

SECTION 2 OF THE SOCIETY OF CLINICAL PSYCHOLOGY, APA DIVISION 12

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Please contact Karyn Skultety at: karynskul@yahoo.com if you wish to comment on the contents of this Newsletter or wish to share ideas.

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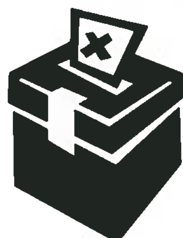
*Published articles do not necessarily represent the official views of Section II, Division 12, or APA

Check out all of the 12/2 activities at this year's APA conference! A full listing is on page 21! See you in New Orleans!



IT'S ELECTION TIME! VOTE NOW FOR YOUR 12/2 OFFICERS! Read about how to cast your vote on-line on page 19!

President's Column: What's in a Name?

Bob Intineri, Ph.D.

What's in a name? That which we call a rose
By any other word would smell as sweet?
From Shakespeare – Romeo and Juliet (II, ii, 1-2)

Shakespeare's point is well taken. The name given to something and/or someone should have no effect on the actual object. In other words, calling a tree a flower will not magically transform the tree into a flower; it is still a tree. Given this truth, why do we expend so much time, effort, and perhaps money, worrying about names? Consider this: What if we all decided tomorrow to create different names for the various psychological disorders that we assess and treat? It would be chaos, similar to the tower of Babel, and communication within our discipline would be difficult, if not impossible. Names provide us with a means to organize our world and reality. Names allow us to describe succinctly what we do. For example, when you identify yourself as a clinical psychologist to someone at a cocktail party, they know exactly what you do. More often

than not, they will make a comment (pro or con) about what you do and venture a nervous guess that you are applying your analytical abilities to them as they are speaking. As an aside, people are always disappointed when I candidly admit that I'm just drinking my wine and enjoying pleasant conversation. Clearly, words are powerful and important conveyances of what we think and believe. And, a name should convey specific meaning. Clinical Geropsychology is defined as "a proficiency in professional psychology concerned with helping older persons and their families maintain well-being, overcome problems, and achieve maximum potential during later life." One is recognized as such if they demonstrate that they have the knowledge, skill, training, and experience related to aging-related processes (http://www.apa.org/crsppp/gero.html). Recently, the Section 2 Board of Directors voted to recommend a name change for the section. BOD members believed our name should more closely reflect our professional identities as Clinical Geropsychologists. We collectively agreed the organization should be known as the Society of Clinical Geropsychology (SCG). The vote reflects our desire to have an organizational name that clearly communicates who we are professionally. Shortly, you will receive an invitation by e-mail or regular mail to vote on this resolution. I ask you vote to approve the name change.

In addition to the invitation to vote on the organizational name change, you will also have the opportunity to elect new officers for the coming year. The Board of Directors is happy to have this slate of fine candidates. Without individuals willing to sacrifice some of their limited personal time in order to serve if elected, our organization could not exist. I can honestly say that while much of the work that officers do is not exciting, it is necessary in order for the organization to function effectively. This brings me to a very important point: WE NEED YOUR HELP! Yes, that's right, we need you! Whether you are a graduate student, a professional who has just joined the organization or someone who has been lurking on the listserv for years and thinking about getting involved – we need you to step forward now! I know...time is limited and it's difficult to think about taking on additional responsibilities. But please, if you have thought about getting involved in the organization but hesitated, rethink that hesitation. Make this organization (Section 2 – soon to be the Society of Clinical Geropsychology) **YOUR ORGANIZATION**. Much has been said recently about the value of civic engagement and responsibility; become engaged with us. Please contact me personally. I will help find a place for you in the organization. My phone number and e-mail address are 309-298-1336, mfrci@wiu.edu.

This and That

1. Please notice that there is a full page flyer for the "Article of the Year Award." Deadline for submission of nominations is September 15, 2006. Please make your nominations today.
2. The winner of the humor contest was Frederick J. Kier, Ph.D. Here is his joke: Two dementia unit residents were sitting watching the 6:00 news on TV. They are showing a man about to jump off of a bridge. Resident A states, "I'll bet you $20 he will jump." Resident B replies, "I'll take that bet." The two of them wait...Eventually the man jumps off the bridge. Resident B sighs, "OK, you win, here is 20 bucks." Resident A states, "No, I gotta be honest with you, I watched the early news, and they had the coverage of this man on the bridge then." Resident B replies, "No, you win it fair and square...I watched the 5:00 news too...I didn't think the guy was going to jump twice!" Now, who said Geropsychologists can't be funny? Think you can do better? E-mail me your best joke, funny story, humorous piece, and I'll consider paying your dues. **Also, check out the new humor column on page 19!**
3. We are quickly approaching the APA convention. I hope to see many of you there, particularly at our joint dinner with Division 20. This year's event will be **Saturday August 12th at 6:30 PM at Gordon-Biersch New Orleans**. The restaurant is less than 3 blocks from the Hilton which is the primary convention hotel. I hope all of you will come celebrate not only our new organizational name, but more importantly, the resiliency of the great city of New Orleans.

Cheers, Bob

The Society of Clinical Geropsychology

Article of the Year Award

The Society of Clinical Geropsychology is pleased to present the Article of the Year Award to recognize and honor the single best article dedicated to clinical-aging related research published in a peer-reviewed journal during the previous calendar year.

This Award:

- Recognizes the author(s) for significant intellectual contributions that promise to advance the state of the art in Clinical Geropsychology research methods, theory, or practice.

- Will include any Clinical Geropsychology research article written by any author(s) published for the first time during the previous calendar year (January - December 2005) in a peer reviewed journal. The article will be eligible if nominated by an active member of The Society.

- Includes nominations by any Society member who completes and submits a nomination package. Self-nomination is permitted. If more than one person nominates a particular published article for this award, a Lead Nominator will be assigned to assemble all nomination documents, submit the nomination package, and serve as the correspondent for all questions regarding the nomination.

The deadline to submit a nomination is September 15, 2006 and must include:

1. A complete copy of the published article.
2. A nomination letter that states why the article represents an outstanding contribution to Geropsychology and describes how it advances aging research, clinical application, or how it affects health policy.
3. Identification of the author(s) and full citation for the article.
4. The Award winner(s) will receive:
   a. The first author of the winning paper will receive a plaque recognizing their outstanding research contribution. Additional authors will receive a certificate.
   b. In addition, four one-year memberships in SCG will be awarded and divided among the authors.

For more information about the award, please contact

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Executive Board Meeting: 11/19/05 GSA Conference
Forest Scogin, Ph.D.
Secretary

*T*he meeting was called to order by Barry Edelstein at 1:05. In attendance were Molinari, Edelstein, Intrieri, Scogin, Crowther, O'Rourke, Fiske, Karlin, Balsis, Pearman, DiGilio, Emery, Segal, Cernin, and Hinrichsen.

Introductions – Barry Edelstein
Barry began the meeting with a round of introductions.

Secretary Report – Forrest Scogin
Minutes from the 2005 Summer Executive Board meeting were approved. The minutes had been previously circulated via email and corrections made.

Awards Committee – Victor Molinari
Steve Balsis was officially presented the student research award that was announced at the APA2005 meeting.

CONA Report – Deborah DiGilio
Deborah reported that Margy Gatz would receive the CONA award winner for the advancement of the psychology of aging at the GSA conference in conjunction with the Mental Health and Aging Interest group. Debbie indicated that work on the CONA project "Life Plan for the Life Span" was continuing. A request for funding to support the National Training Conference on Geropsychology will be made to the APA Council of Representatives from 2006 discretionary funds. Bob Knight and Norm Abeles will introduce the request as members of the Council. Debbie reported that the Board of Educational Affairs has contributed $2000 for the conference. Debbie also provided a brief update on the White House Conference on Aging, indicating that mental health issues are more prominent in the current agenda due to efforts by various stakeholders.

Treasurer Report – Jon Rose
Jon was unable to attend but submitted a proposed budget for 2006. Barry indicated that the Executive Board will hold a conference call on December 13th to discuss the budget because only three voting members were in attendance. Jon's report suggested we were in deficit spending for 2006, approximately $2,900. Vic pointed out that this is nearly identical to the amount ($3000) we committed to the Geropsychology Training Conference and, assuming this is a one-time cost, makes the deficit spending a bit less problematic. Travel is a significant item in the budget. It was determined that we need to revisit the utility of the travel allocations periodically to assess their value. Much discussion followed on ways to increase income for the section. Included were ideas about advertising on the website and the newsletter and seeking private funding from sources such as Springer Publishing. The consensus was that concerted effort should be directed to fundraising and Bob indicated this was a priority for his Presidential year.

Membership Committee – Martha Crowther
Martha provided a written membership report. We have 339 members, 143 are also D12 members. We currently have 69 student members. Renewals via the website seem to be going well and there have been no complaints about the recent dues increase. Martha is forming a membership committee and proposed Norm O'Rourke, Laura Phillips, and Amy Fiske as members. Martha distributed membership forms for us to distribute during the GSA meeting and beyond.

Webpage Coordinator – Norm O'Rourke
Norm reiterated that the membership renewal process was streamlined via the webpage. He approached the APA legal office regarding the legality of paid advertising on our site and learned that there does not appear to be a prohibition. He raised the question of whether there was some ambivalence about advertising on the website. Advertising for publishers seems less problematic than advertising for specific service providers or products such as medications. Norm introduced the idea of having exclusive advertising rights on the "splash" page; a link would direct interested parties to the advertiser's site. Income from such an approach could add significantly to the

income of the section. Continuing education advertisements could do likewise.

Newsletter - Karyn Skultety

The transition to the new editor Karyn Skultety is underway. Special thanks were extended to Merla Arnold for her advancement of the newsletter. A discussion of advertising in the newsletter was undertaken. The board suggested a standard rate of $250 per advertisement.

Archives – Greg Hinrichsen

Greg has continued his commitment to being the 12/2 archivist. He reported that he has a fairly complete compilation of newsletters and minutes. He will send out a request to past officers to locate some missing documents in his archives.

Training Directory – Greg Hinrichsen

Greg and Norm plan to update the training directory that currently resides on the 12/2 website. Information on predoctoral, internship and postdoctoral opportunities will be included.

Student Report – Kathryn Moss

Forrest presented a report prepared by student representative Kathryn Moss. A letter to Clinical Training programs, D20, and D40 encouraging student participation in 12/2 was prepared and sent. The student listserv is operational. PDF links to 12/2 member publications were requested as an information resource. A clinical hours database template is in preparation and may become available on the website. 12/2 student members are interested in participating in section committees and would like to post opportunities on the listserv.

Mentoring Committee – Amy Fiske

Amy overviewed the purpose and activities of the committee. A report will be prepared that will present mentoring models and opportunities at all levels of training.

Diversity Committee – Angela Lau

Barry provided an overview of a report submitted by Angela. Dolores Gallagher-Thompson has joined the committee and active recruitment of student, new professional, and postdoctoral members is in process. Contact is underway with other divisions and organizations on collaborative actions to increase awareness, education/training opportunities, and mentoring on issues of diversity and aging.

Education and Training Task Force – Erin Emery

Erin reported that a survey was being drafted that would sent to graduate programs and internships to determine what opportunities exist for aging training. Information on the number of faculty, research opportunities, mentoring, number of students, and funding would be sought. This information could be a part of the website resource on training.

Name Change for Section – Barry Edelstein

Barry introduced the idea that a name change might give the section greater recognition and would make explanation of who we are less cumbersome. Barry suggested "Society for Clinical Geropsychology" to be consistent with mane changes undertaken by other organizations within APA. A vote on the name change was delayed until a fuller representation of the board was able to participate.

Awards – Vic Molinari

Vic solicited nominations for the Lawton Award. The question was raised as to whether students can simultaneously apply for awards from various divisions/sections for the same project. The pros and cons of establishing a policy that would limit simultaneous applications was discussed. A vote on this matter was tabled pending receipt of further information.

APA Program Chair – Forrest Scogin

Forrest reviewed the emerging plan for 12/2 program hours at the 2006 convention. Michele Karel and Bob Knight have been approached about organizing a two-hour symposium as a follow-up to the summer conference on training in professional geropsychology. The Presidential Address will be delivered by Bob Intrieri. The annual social event will again be coordinated with D20. Plans are for an informal setting with opportunities for interaction.

Respectfully submitted by Forrest Scogin, Secretary.

Society of Clinical Psychology, Division 12 - Board Meeting, June 10-11, 2006

Submitted for Deborah King, Ph.D. By Bob Intrieri, Ph.D.

*T*he Division 12 Board of Directors met in sunny Santa Monica, CA. Suffice it to say that a lot of ground was covered during the two days so if I just published the minutes of the meeting that I took it would probably take about 1/3 of the newsletter. So I am providing the "Cliff Notes" version of the meeting emphasizing some of the salient points.

Sadly, we started out the meeting by discussing two very prominent Division 12 figures that recently died. Michael J. Mahoney, who was a well-known figure in the early days of the development of cognitive-behavioral therapy and wrote extensively on the human change process recently died. While there is no current provision to honor Dr. Mahoney at the APA convention there are plans to honor him in the coming months at the Association for Cognitive Behavioral Therapies in November. Second, Ivan Mensch who was a long-time member of Section 2 died. Dr. Danny Wedding and his colleagues will have a tribute for Ivan Mensh at the upcoming APA convention. The tribute is entitled "Ivan Mensh: The Man and His Work" and will be chaired by Joe Matarrazo.

The D-12 board spent a large portion of time discussing issues related to the Undergraduate curriculum. Jerry Davison, current D-12 president, explained that this is a crucial issue for several reasons. First, it speaks to the type of training that students at the undergraduate level are receiving. This was initially being addressed because quite a few graduate program directors were raising concerns that students were not prepared to do graduate work. Second, while the first issue may be true according to many of the board members, APA's attempt to make recommendations as to what should be included in the undergraduate curriculum could be construed as an attempt to develop a mechanism to accredit undergraduate psychology programs. Movement in this direction was seen as unduly meddlesome and for some strikes at the heart of academic freedom. While most board members agree that accreditation may be necessary for graduate training programs, it is not seen as the solution for addressing problems in the undergraduate curriculum. A resolution was drafted to voice objections to APA's attempt to do this. BOD voted on and passed the resolution to send a letter of objection to APA.

APA convention programming for New Orleans appears to be stellar with a total of 48 sessions. These include and incorporate all of the presentations offered by the sections. Please be aware the Symposium: Pikes Peak Models for Training in Professional Geropsychology will take place on Friday August 11, from 3:00-4:50 at the Morial Convention Center, Room 261. The 12-2 Presidential Address will be delivered on Friday August 11 at 9:00-9:50 in the Morial Convention Center, Room 274. The title of the Presidential address will be "Pragmatism, Purpose, & Passion = Clinical Geropsychology." I hope that you will attend these presentations.

The membership committee for D12 presented information about sectional and divisional membership. In particular, D12 has a total of 4,256 members, 144 hold Section 2 membership (about 3.4%). Only Section 3 boasted more members in D12 with 148. However, the numbers presented by Barry Hong also showed that Section 2 membership of Division 12 was 42% (144/339). While the percentage of D12 members in Section 2 is not the lowest of the Sections (there were 3 Sections that had lower percentages) it is a point of concern for Divisional leadership. So, if any of you have been on the fence about becoming a D12 member I ask you reconsider and join D12 today. I have found the D12 newsletter and Journal that I get as part of dues to be valuable. There is an effort afoot to recruit D12 members from Divisions 53, 54, 42, 40, 38, & 29.

Finally, because this "Cliff Notes" version is becoming too long I want to add something about activity in the Section. I presented information about issues related to our sectional membership – it is strong and hopefully

growing (Way to go Martha!). In addition, The Pike's Peak conference will be instrumental in shaping the education and training for future Geropsychologists, and the Public Policy Committee, chaired by Drs. Donna Rasin-Waters and Peter Kanaris is helping to get us on the map. Dr. Davison's commented that the Section's work was "very impressive." Not that I want to cling to those words but I think you all should know that we have an exceptional group of people working on your behalf and are excellent stewards of our section (with the exception of me, of course).

Respectfully submitted in Deborah King's absence.

News from the Treasurer

Jon Rose, Ph.D.

*A*t mid-year, we seem to be pretty much on target for our 2006 budget. As you may recall, we expected a small deficit this year after contributing $3,000 toward the geropsychology training conference in Colorado. We have collected approximately $4,214 in dues against $5,000 projected for the year (this amount is approximate due to currency fluctuations). Contributions of $1,244 are above our $944 target. Our major fundraiser, the CE offering at the APA Convention, has yet to occur. We forgot to budget for our Student Paper Award for both 2005 and 2006. This oversight will cause us to be $500 over-budget for "Grants." Otherwise, all expense categories are appropriately under budgeted amounts, with expenses related to the convention, travel expenses for representatives to the APA Interdivisional Health Care meetings, and web-site expenses still not realized. Our total income at half-year is $7,311.22 vs. $8,373.00 expected by year-end. Our total expenses thus-far are $4,477.53 vs. $8,985 budgeted for the year. Our balance so-far is $2,833.69 vs. an expected year-end deficit of $612.

Next month the Board will draft a budget for 2007. That budget may be refined as we learn more about our actual expenses for 2006. The budget process and fiscal discipline by your Board have kept Section II fiscally sound.

APA Office on Aging and Committee on Aging Update

Barry Edelstein, Ph.D.
CONA Member

*T*his column is a brief description of CONA and some of its recent activities and product.

What is CONA?

For those of you who are unaware of CONA, CONA is one of the many APA Committees. Its parent Board is the Board for the Advancement of Psychology in the Public Interest (BAPPI). BAPPI also overseas the activities of the Public Interest Directorate. "The goal of CONA is to advance psychology as a science and profession and as a means of promoting human welfare by ensuring that older adults, especially the growing numbers of older women and minorities, receive the attention of the Association. CONA works toward the optimal development of older adults, expanded scientific understanding of adult development and aging, and the delivery of appropriate psychological services to older persons."

CONA is comprised of six members. Three of the six current members of CONA are Section 2 members and former officers: Victor Molinari, Peter Lichtenberg, and Barry Edelstein. Deborah DiGilio, is the CONA Staff Liaison and Director of the APA Office on Aging. She also is the heart of CONA who ensures that CONA continues to address its mission and meet its objectives. She has the energy and enthusiasm of any two individuals and is able to leap tall buildings in a single bound.

CONA is busy throughout the year, monitoring the activities of relevant APA boards and committees, and developing projects which typically have very practical products. CONA is very diligent about ensuring that aging receives appropriate attention in the activities and products of these bodies, and is always seeking ways to raise the awareness of APA governance regarding aging issues.

CONA Projects

In recent years, CONA has devoted its efforts to projects that further the goals of the Committee and enhance our visibility within and without psychology. One set of projects resulted from the efforts of the APA/ABA Workgroup. The APA/ABA project workgroup members are Barry Edelstein, Ph.D.; Gregory Hinrichsen, Ph.D.; Daniel Marson, J.D., Ph.D.; Jennifer Moye, Ph.D.; David Powers, Ph.D.; Charles Sabatino, J.D.; and Erica Wood, J.D. CONA member Peter Lichtenberg, PhD, ABPP will join the Work Group. The first product of this group was the publication entitled *Assessment of Older Adults With Diminished Capacity: A Handbook for Lawyers*.

The second product of the APA/ABA Workgroup will a handbook for judges entitled *Judicial Determinations of Capacity of Older Adults in Guardianship Proceedings.* Jennifer Moye and Dan Marson have been the APA Workgroup members involved in the development of this product. Jennifer is the editor. Half of the document will be in hard copy, the other half with expanded information, will be web-based. Future project activities will include educational material development and continuing education for psychologists.

The latest CONA project involved the development of a magnificent brochure that translated the results of current research into practical steps for assisting young, middle-aged and older psychologist in planning with regard to several domains: health and health care, legal and financial matters, work life and retirement, psychological issues, and social roles and resources. The brochure, entitled *Life Plan for the Lifespan for Psychologists*, was developed by CONA with assistance from a panel of expert advisors. **All of these CONA documents are available at www.apa.org/pi/aging** Check it out.

CONA at the 2006 APA Convention

CONA is offering a Conversation Hour at the APA 2006 Convention that will focus on public policy. The title is *No Older Adult Left Behind: Public Policy and Aging.* There will be two elements – soliciting participants' public policy priorities, and discussing strategies by which they might be accomplished. Diane Elmore,will also discuss current aging policy efforts. Diane is the Senior Legislative and Federal Affairs Officer in the APA Public Policy Office who recently returned to APA after a stint in the office of Hillary Clinton. ***You are encouraged to attend on Thursday, August 10th in Mardi Gras Ballroom G of the Marriott from 6:30 to 8:00 PM. CONA will present its 2006 Award for the Advancement of Psychology and Aging at the Convention during the CONA Conversation Hour. The award will be presented to Antonette Zeiss, Ph.D., a former Section 2 President and renaissance woman. Please plan to attend and congratulate Toni.***

CONA and the National Training Conference on Professional Geropsychology

CONA requested and received $15,000 in funding from the 2006 Council of Representatives Discretionary Funds to support the National Training Conference. The conference successfully attained its goal to outline competencies and aspirational educational models at the doctoral, internship, postdoctoral, and post-licensure levels for preparing psychologists to provide psychological services to older adults. The conference proceedings and outcomes will be published in 2007.

CONA 2007 Call for Nominations

This year the call for CONA nominations was broadened in an attempt to get early and mid-career geropsychologists involved with CONA. CONA hopes this change will provide a mechanism to mentor early and mid-career geropsychologists for increased participation in APA Governance as well as a way to reach out to a cohort of geropsychologists who are more ethnically diverse than previous cohorts.

The deadline for nominations is September 1st, 2006. For a copy of the Call for Nominations contact mpal@apa.org.

Consider This: Bridging the Gap in Mental Health Treatment for Older Adults

Bradley E. Karlin, Ph.D.

I would like to ask you to take an imaginary journey with me. Imagine if you will that older adults with depression, anxiety, and other mental health and substance abuse problems regularly receive prompt, efficient, and effective treatment for their psychological ailments. That all seniors, including the young-old and old-old, the healthy and the chronically ill, the rich and the poor, suffering from despair, hopelessness, pain, and unrelenting worry are routinely recognized for their mental health needs and fully treated. Unfortunately, such a scenario is not today's reality for most older Americans with mental illness. Although we have pioneered and witnessed great developments in mental health and aging over the last several decades, we continue to face great challenges in our efforts to meet the mental health needs of older adults. Indeed, the more things change, the more they often stay the same.

Despite the increasing availability of effective treatments and other important developments, very few older adults with mental illness today receive treatment (Karlin, Duffy, & Gleaves, 2004; Karlin & Norris, in press; Wei, Sambamoorthi, Oflson, Walkup, & Crystal, 2005). In a recent study examining rates of mental health care use throughout the nation, older adults were found to be three times less likely than their younger counterparts to receive treatment, with the most in need often least likely to be treated (Karlin, Duffy, & Gleaves, 2004). In fact, the current rates at which older adults receive mental health care are similar to those documented 20+ years ago. This is true in the private as well as the public mental health care systems, though the latter was specifically charged by Congress over two decades ago with targeting the mental health needs of older adults (General Accounting Office, 1982). At the individual level, older adults often fail to recognize symptoms of mental illness and lack awareness of formal and informal mental health resources (Karlin, Duffy, & Gleaves, 2004). When older adults do present for treatment, they overwhelmingly present to primary care physicians, often with vague complaints or medical concerns. It is at this systems level where many older adults with mental health problems slip through the cracks. Primary care physicians often fail to detect mental health problems in their older patients and are less likely to refer their older patients, than they are their younger patients, for specialized treatment (Alvidrez & Areán, 2002; Tai-Seale et al., 2005). This is often due to lack of awareness of the availability and efficacy of geropsychological treatments. Of course, the increasing burdens placed on primary care physicians, reduced patient contact time, and the lack of follow-up resources available to most primary care practitioners also contribute to limited mental health detection and referral in primary care. When older adults do, in fact, receive treatment for mental health problems, they often receive an insufficient amount of treatment, well below recommended guidelines (Harman, Edlund, & Fortney, 2004).

In addition to and compounding systems-level barriers to mental health treatment for older adults, are enduring policy barriers. In the late 1980s, there was much celebration in the psychology profession, as legislative changes to the Medicare program allowed psychologists for the first time to directly bill the Medicare program for services provided, and caps on psychotherapy services were eliminated. However, these changes had less than dramatic effect on mental health care use by older adults. In fact, the last two decades have witnessed a variety of new regulatory policy and administrative barriers under Medicare, in addition to the longstanding high 50 percent copayment requirement for psychotherapy services (Karlin & Duffy, 2004). During this time, professional psychology has had limited involvement in shaping public polices governing the delivery of mental health services for older adults. The current fragmented system in which we provide care to older adults reflects this.

Innovative and Real Opportunities for Change

Changes in the way in which we provide mental health care and important political and policy developments offer significant and, in fact, unprecedented opportunities for better meeting the mental health needs of older adults in the years ahead. Integrating mental health care services into primary care offers particular promise for reducing psychological and physical access barriers to mental health treatment and reducing unmet need among older adults.

Initial efforts to integrate mental health into primary care focused on enhancing mental health (namely depression) detection in primary care settings. As a result, a number of screening measures have been developed and validated for use in primary care over the last decade (Areán & Ayalon, 2005). The availability of valid and efficient screening measures led the U.S. Preventive Services Task Force in 2002 to recommend screening for depression in older and younger adults in primary care, whereas just six years earlier the Task Force had concluded that there was insufficient evidence for a recommendation for or against routine depression screening.

Although a necessary step, enhanced mental health detection by itself has been found to have little effect on reducing unmet mental health need among primary care patients. In addition to detection, polices and practices for adequate treatment and follow-up must also be in place, particularly for older adults. When such mechanisms do exist, increased rates of treatment and larger benefits have been consistently documented (Pignone et al., 2002).

Recently, integrated models for providing mental health treatment services in primary care have been developed. Integrated care models take different forms and vary in the level of mental health integration and professional collaboration (see Gatchel & Oordt, 2003, for a description of different models). Especially promising are collaborative care models in which a mental health specialist works in tandem with the primary care provider in the same clinic and provides consultation, psychoeducation, and, often, brief psychological treatment. Brief forms of psychotherapy have been adapted for use in primary care, including problem solving therapy (PST–PC) and interpersonal therapy (IPT–PC) (Areán & Ayalon, 2005). One such collaborative care model, the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) for late-life depression, has led to significantly higher rates of treatment and levels of treatment effectiveness among older adults, compared to usual care for depression (Unützer et al., 2002). Moreover, relative to enhanced specialty referral models, integrated care approaches to depression in primary care have led to higher rates of treatment and greater treatment satisfaction among older adults (Bartels et al., 2004; Chen et al., 2006). Thus far, mental health screening and management approaches in primary care have focused almost exclusively on depression. It is important that future initiatives and research include screening and treatment for other forms of mental illness often undetected in older adults, such as anxiety and substance use disorders.

Increasing mental health screening and collaborative care in primary care settings were key recommendations of President Bush's New Freedom Commission on Mental Health in 2003. A current leader in this effort is the Department of Veterans Affairs (VA). As the nation's largest integrated health care system, the VA offers unique opportunities for modernizing mental health care delivery, as called upon by the President's New Freedom Commission. Following from the Commission's recommendations, the VA has included expanding collaborative care as a key initiative in its Action Agenda and Strategic Plan for transforming mental health care. The VA has also established the Translating Initiatives for Depression into Effective Solutions (TIDES) program, an evidence-based collaborative care model that incorporates both in-person and telephone care management for depression, which has been found to improve quality of care and outcomes for older and younger adults. Additional information on the TIDES program and clinician and consumer resources is available at: http://www1.va.gov/tides_waves/.

Beyond primary care, there is an important role for mental health service integration in specialty medical settings.

In many VA medical centers, for example, psychologists and psychology trainees work in a variety of specialty medical settings, including cardiology and oncology clinics. During my internship and postdoctoral training at the VA Palo Alto Health Care System, I had unique opportunities to witness firsthand the advantages of the collaborative care model in specialty medical settings. For example, as the behavioral medicine provider in the Cardiac Comprehensive Care Clinic, I saw patients during their medical follow-up visits to the clinic, many of whom had recent hospitalizations. I saw each patient initially in conjunction with their medical provider (a nurse practitioner); afterwards, I met with the patient one-on-one. The last patient I saw during this experience was a soft-spoken 85 year-old gentleman who appeared in good spirits. His wife sat in while the nurse practitioner asked about cardiac symptoms and related medical issues. All seemed to be in good order – that is, until the patient and I met individually. After some discussion, he disclosed to me that he had been quite depressed and thinking of committing suicide due to his decreasing physical abilities and marital stress (the latter of which I had suspected based on my observation of the couple's interactions while meeting with the nurse practitioner). At the conclusion of the session, the patient expressed his "pleasant surprise" at having an opportunity during his medical appointment to talk with someone about his life and previously undisclosed thoughts of self-harm. He noted that he was reluctant to seek treatment in a specialty mental health setting and had believed there was nothing that could be done to improve his mood. He agreed to meet again and begin individual psychotherapy, which (to his stated surprise) he significantly benefited from. Had it not been for our chance meeting during his medical appointment, this patient's mental health problems would likely have remained untreated like the great majority of today's mentally ill older adults.

In order to truly realize the potential of mental health integration in primary care and increase our ability to meet the mental health needs of older adults, changes to enduring policy barriers and new funding mechanisms are needed (Karlin & Duffy, 2004). In a unique opportunity for psychology to inform and influence public policy, this past Fall I was extended an invitation by the Centers for Medicare and Medicaid Services (CMS) to present at the Coverage and Analysis Group's (CAG) Evidence Forum on the current state of geriatric mental health care (Karlin, 2005). The agency acknowledged the importance of mental health screening and collaborative care and discussed its efforts to include these in the new "Welcome to Medicare" exam for new enrollees and in the Medicare Chronic Care Improvement Program, a pilot program for beneficiaries with chronic conditions established by the Medicare Prescription Drug, Improvement and Modernization Act. CAG staff were also particularly interested to hear about the utility and efficacy of psychological and psychosocial interventions for neuropsychiatric and behavioral symptoms associated with dementia. As luck would have it, that same day the *Journal of the American Medical Association* (Vol. 294, No.15) was published, which includes a meta-analysis concluding that the use of atypical antipsychotics increases death risk in dementia patients (Schneider, Dagerman, & Insel, 2005). I fortunately stumbled upon a newspaper article reporting the findings of the study while sipping my coffee the morning of the briefing. I freely shared the article with a curious CMS audience while discussing the evidence base for psychological services with dementia patients. (Leave it to serendipity and the *USA Today* to serve as effective advocacy tools for psychological practice!) My visit to CMS was a unique and very positive experience, and I hope we can continue to work with the agency to improve mental health care access for older adults. I (along with Keith Humphreys) am currently writing an article on the future of Medicare and mental health care in which we discuss unprecedented opportunities and specific proposals for improving coverage of psychological services under Medicare. With genuine opportunities for change at the systems and policy levels, available, effective, and accessible mental health services may soon be a reality for our nation's seniors!

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Profile On . . .
Sara Honn Qualls, Ph.D.

*G*eropsychology has been the career home that has nurtured my professional identity, personal and professional development, and structured my work life for the past 30 years. In many ways, my development has paralleled that of the field as a whole because I was in the first generation of undergraduate students who decided to work with older adults. With the advantage of an early start, I had opportunity to sample many learning and work opportunities related to geropsychology. My career path has often required me to build bridges across domains of gerontology, clinical psychology, and adult development, merging into a clear focus on clinical geropsychology as I pass the mid-point of my career.

As is common for most of you I suspect, I am often asked why I focused on aging, a rare career commitment for a 20 year old. The richest answer probably lies in my experiences within my family of origin. My parents were late in the birth order of their families (5th of 5; 7th of 9) so family gatherings included many older individuals that were just a generation or two away from me. I joined my parents on various caretaking visits to trim toenails or sit by the hospital bedside during surgery.

A salient memory from my early childhood was when I accompanied my mother on her annual week of respite service for her eldest sister's primary caregiver, her teenage daughter. Aunt Aileen lived for years with severely crippling arthritis that restricted her from making her renowned gooseberry pies and ultimately left her bedridden with arms and legs drawn up into wing-like contortions. During one of those visits I recall my aunt beckoning me from the safe distance from which I observed her engage in the excruciating task of sitting up in bed with my mother's support. With her frail wing-like arm and distorted hands around my waist, she explained to me that painful movements were somehow easier when one moaned, so I need not be frightened by the signs of pain. Her kind smile was reassuringly congruent with the logic of her pragmatic approach to daily life with such a debilitating, painful disease.

My mother and father provided another key lesson for me about elder care by taking me with our church group to visit the county nursing home on a monthly basis. The regularity of the visit allowed me to form relationships with people who lived "behind the gate", in a locked unit for residents with dementia. The group began each visit by singing hymns for 30 minutes, after which most singers left the unit. My parents, however, talked with my siblings and I about the greater importance of what happened *after* the singing when we visited and touched individuals who rarely saw outsiders, especially children. My mother offered to accompany me so I always felt safe, and she reminded me that the smells and sights of aging bodies were not dangerous or bad, just part of normal life. She taught me to see the person inside. I still hold the warm image of Lottie, my African-American friend who rocked in the sunlight of tall windows in her 6 person ward room at the end of the hall.

Although my interests in aging were sparked early, my academic roots were less well planned and certainly did not progress linearly. After a particularly rigorous undergrad semester I looked for an intersession class with a light workload and hit the motherlode when I took a Workshop in Gerontology. Sociologist Frank Glamser organized a field trip to agencies that served seniors, and led us through M. W. Riley's classic *Aging and Society*. The intellectual challenges of linking population structure issues to the practical problems and personal well-being we witnessed daily were exciting to me. My timing was great - during that class, Middle Tennessee State University was awarded an Administration on Aging training grant and I was offered a fellowship to stay there to work on my MA in Psychology with a minor in Gerontology.

After the year of work on my MA, I knew I was headed for a doctoral program, but was absolutely clueless about how that process worked. After some disappointing responses to applications, I talked with a Bob DeMonbreun, a

clinical faculty member about how to prepare for re-application the following year. He coached me on how the process worked (and didn't), encouraged me to stay focused on further education, and asked about my interests in clinical work and aging. The next day, Bob called me at my library job to ask me if I would go to Penn State if the opportunity arose – I laughed initially and then was simply stunned when he told me that Ed Craighead was offering me an unfunded admission to the clinical program at Penn State if I would hustle in my application.

The Penn State experience was my first significant academic research experience. Ed put me through the paces in my first year – I collected 2 week longitudinal data from 700 participants for my MA thesis! Margaret Baltes offered me a paid assistantship collecting data on her early nursing home dependency studies which led to remarkable learning opportunities for me. Hours spent observing life in nursing homes was at least as rich as learning how to use what we thought were amazingly modern hand-held computer notebooks to collect data that were transferred by cable to the campus mainframe (a lovely contrast to managing keypunched data cards!). After that first year, I was lucky enough to be chosen for the Gerontology training fellowship overseen by Joe Britton, an experience that thrust me into a cohort of outstanding peers who remain friends and colleagues to this day. Our low-budget travel arrangements for GSA and APA provided us with many long hours in buses, public transportation, and interesting hotels to share our intellectual and personal development! And weekly seminars with outstanding scholars were quite exciting.

I was extraordinarily fortunate that the clinical psychology faculty allowed me to construct my curriculum from courses in the Human Development college as well as within Psychology. This was another bridge experience – the cultures, paradigms, and politics of the two academic units were quite different. I found both settings to be stimulating and useful.The blend of the two approaches was remarkably rich, even as I found it hard to figure out how my path was going to emerge from the mixture. Although I was clearly focused on becoming a practicing psychologist within a community mental health center, I loved the developmental and systems frameworks that were part of daily conversation in Human Development. Mick Smyer provided the mentorship I needed to keep working at building the bridge while Ed Craighead and Mike Mahoney gave me the intellectual and practical freedom needed to do so. One summer at the Philadelphia Geriatric Center gave me my first and only opportunity in graduate school to work with aging clients in a clinical setting. During the long hot evenings living in a row house across from the PGC campus, I read the only book I could find in the field (*Clinical Psychology of Aging???, Storandt, Siegler, & ??)* and kept trying to figure out where the rest of the literature was.

The selection of my internship was about as flukey as my graduate school application process. Although Dolores Gallagher-Thompson called me weekly to try to talk me into joining what she was building at Palo Alto VA, I was focused on settling back in the Midwest and had latched onto the idea of training in family therapy or psychodynamic psychotherapy. In retrospect, I truly had no model of clinical geropsychology, so presumed I would proceed to integrate aging into clinical service delivery models. When I landed at the PAVA, I was shocked to find rich clinical service structures, emerging interdisciplinary training structures, and the exciting clinical research setting that Dolores and Larry Thompson had created. As I look back I realize that Dolores and Larry provided me with my first model for creating a hybrid organizational structure to do important work – they linked across units within the VA, and between VA and Stanford, with ties to USC, NIH, and Beck's therapy institute among others.

Initially, I was disappointed to be assigned to a cognitive-behavioral supervisor on internship because I was so ready to broaden my training, but Toni Zeiss (the unlucky supervisor!) patiently helped me explore richer models within CBT than I had known previously while encouraging me to create bridges to other interventions such as family therapy. I consider

my training under Toni during that internship year and the post-doc year that followed to be life-changing in many ways for me. To this day, when I am lost among political messes, clinical challenges, or interpersonal complexities, I ask myself "What would Toni do/say/think?" Many years ago, I learned that there is a whole cadre of disciples of her unique problem-solving abilities and profound respect for human diversity.

During my postdoctoral training year I was married and began job hunting. Toni encouraged me to at least raise the question of why I was not considering academic jobs when the roles seemed suited for my abilities and interests. The truth was that I had seen few women in academic roles at Penn State but was duly impressed with the pressure that tenure put on young males, their marriages, and their families. I also had literally never seen an academic whose interests in clinical work were as strong as mine. With no plan or preparation to develop a research program of my own, I assumed I could neither get nor succeed at an academic job. But Toni's questions were haunting, because I realized that seeing 6 clients per day was also not how I pictured my career unfolding. I loved the diversity of teaching, clinical work, and research that I was enjoying as a post-doc. I also knew I was unprepared to succeed in a Research I institution. Toni suggested that I simply put out my applications, interview if the opportunity arose, and see what happened.

By the time I interviewed at the University of Colorado at Colorado Springs, I had realized that I wanted to at least start in the academic world. The existing vision of the Psychology Department at UCCS was to develop a special strength in aging, which intrigued me. Furthermore, the campus was at the easternmost boundary to which Mark (my husband) would move (from his California perspective, Colorado is part of the Midwest), and a developing campus afforded me the chance to try my wings to see what might happen. Even after taking the job, I was not certain that this would be my career path. We bought a house that could be re-sold quickly so that the 3 year experiment we imagined could go into phase 2 if we decided to go back to the west coast! Twenty-two years later I have moved less than a mile from that original house, added 3 lovely children, 2 dogs, a ferret, and Grandma next door! This is home.

The years I have spent here at UCCS have been a surprising, often-frustrating, and stimulating ride. I have been privileged to participate in the maturation of this campus as it emerged into a substantial regional university. From today's vantage point, I cannot imagine a better match for my personality, skills, and interests. I have been truly privileged to work with a remarkable set of colleagues as we built a strong MA program, and more recently a doctoral program specializing in geropsychology and an annual clinical training opportunity for post-licensure professionals. My roots in clinical work are evident in the curriculum and structure of the programs which engage the clinical students in extraordinarily rich clinical experience while engaging them in heavy research activity. I thoroughly enjoy serving as Director of Clinical Training. The Gerontology Center I direct draws together faculty from multiple disciplines to work on linkages between basic science and housing, health care, and social services in real community settings. The newest wild ride is that we have branched into the business world to explore options for commercializing our findings in order to more rapidly disseminate them.

The CU Aging Center that opened in 1999 is a personal dream come-true. This university-run community mental health center addresses a wide range of elderly clients, from wealthy to impoverished. Basic science, clinical science, and clinical services research are woven together to benefit students, professionals, and clients. My own day to day work includes tasks as diverse as clinical supervision of the caregiver team, leadership of a research lab, teaching classes, raising funds in the community, writing grants for program or research expansion, collaborating with community leaders on innovative service models, and laying groundwork for aging to be an organizing theme in the university master plan. I love the diversity and thrive on my daily juggling act.

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Eye on Education and Training: The National Conference on Training in Professional Geropsychology: Part I

Michelle Karel, Ph.D.
Bob Knight, Ph.D.

Editor's Note: In the issue, we continue our focus in the Eye on Education column on the Geropsychology Training Conference recently held in Colorado. I feel very fortunate to have the conference co-chairs as authors of a two part series. In Part I, they share a description of the conference, its' goals and their initial impressions. In Part II, which will appear in the next edition, they will feature the conference recommendations and outcomes.

*W*ow! What a terrific weekend we just had! We have just returned home from the "National Conference on Training in Professional Geropsychology," held in Colorado Springs from June 8th-11th. In this column, we want to share with 12-2 membership a bit of background on the conference, and describe the goals, methods, and our experiences at the meeting. In a future column, we hope to share an overview of the conference recommendations, which will be disseminated in a variety of forms once we have time to digest the extraordinarily productive and creative output of the meeting. In keeping with the tradition of naming conferences after geographical markers, typically the city in which the conferences are held, we are calling the training model emerging from the conference recommendations the "Pikes Peak Model for Training in Professional Geropsychology."

Background

This training conference represents an important step in the ongoing development of the field of professional geropsychology. As many of you know, previous conferences ("Older Boulder" in 1981 in Boulder, CO, and "Older Boulder II" in 1992 in Washington DC) helped to define the knowledge base for professional geropsychology practice. The 1992 conference group obtained recognition for clinical geropsychology as a proficiency in professional psychology from APA's Commission on the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP) in 1998. In 2003, after over a decade of effort, the Guidelines for Psychological Practice with Older Adults were developed and approved as APA Policy (APA, 2004). In 2004, Section II and APA Division 20 decided to apply for specialty recognition for professional geropsychology. CRSPPP rejected the application, with the primary recommendation that our field needs to specify a training model – i.e., how do we teach psychologists to develop competence for geropsychology practice? And, as has been true in many other fields of professional psychology, a training conference that brings together various experts and stakeholders in the field is a great way to specify a training model. So, through the joint efforts of 12-2 and Division 20, a planning committee was formed and a conference has now been held!

Conference Goals

The mission statement for the conference is: *The National Conference on Training in Professional Geropsychology will develop aspirational educational models at the doctoral, internship, postdoctoral, and post-licensure levels for training psychologists with specialized preparation for providing psychological services to older adults.* From the very beginning of conference planning, the planning committee agreed that we wanted the conference to focus on rich discussions of geropsychology training, unrelated to the issue of specialty recognition. The hope is that conference outcomes will ultimately help training programs to develop or improve geropsychology training opportunities, and help individual psychologists working with older adults to identify training needs and plan individual training programs.

Conference Planning

A planning committee was formed of both APA 12-2 and Division 20 representatives. Bob Knight was co-chair representing Division 20, and Michele Karel was co-chair representing

12-2. Other planning committee members were: Debbie Digilio (APA Office on Aging Consultant), Michael Duffy, Barry Edelstein, Deb Frazer, Paula Hartman-Stein, Greg Hinrichsen, Jennifer Manly, Victor Molinari, George Niederehe (Consultant), Sara Qualls, Forrest Scogin, Sue Whitbourne, Toni Zeiss, and Richard Zweig. The group worked in subcommittees to address fundraising, delegate selection, conference agenda, and conference resources.

Fundraising: We were fortunate to have support from multiple organizations. Our major supporters are the Retirement Research Foundation, APA, and APA Division 20. Other supporters include: APA Division 12, Section II; APA Divisions 40 (Neuropsychology), 42 (Independent Practice), and 12 (Clinical); APA Board of Educational Affairs (BEA); APA Committee on Division/APA Relations (CODAPAR), Psychologists in Long Term Care (PLTC); Association of Psychology Postdoctoral and Internship Centers (APPIC); and Council of University Directors of Clinical Psychology (CUDCP).

Delegate selection: We planned to have 50 delegates at this working meeting. In addition to the planning committee, conference delegates included both organizationally-sponsored and at-large delegates. Eight delegates were sponsored by organizations whose interests they represented: APA Divisions 35 (Psychology of Women), 40 (Neuropsychology), 42 (Independent Practice), 44 (Psychological Study of Lesbian, Gay, and Bisexual Issues), and 45 (Psychological Study of Ethnic Minority Issues); APPIC; Council of Counseling Psychology Training Programs (CPTP); and PLTC. In addition, we sought applications for 19 at-large delegate positions and 7 student delegate positions. We received many outstanding applications, and our selection subcommittee chose delegates to ensure adequate diversity across geographical, ethnic, gender, stage-of-career, work setting, and special interest considerations.

Conference agenda: The conference entailed two series of working groups: the first set of groups focused on geropsychology competency domains (aging knowledge and general clinical issues; professional geropsychology functioning; assessment; intervention; consultation; and leadership), and the second set of groups focused on levels of training (graduate, internship, postdoctoral fellowship, and post-licensure training). Each delegate was assigned to one of each of the sets of working groups. On the first day of the conference, competency domain groups met in the morning and level of training groups met in the afternoon, to "brainstorm" how we teach the competencies, and what the goals and methods are at each level of training. On the 2nd day, the working groups reconvened to refine their recommendations. On the final morning, Bob and Michele summarized emerging themes and recommendations, and Toni Zeiss facilitated a large group discussion addressing reactions and next steps.

Conference resources: The planning committee compiled a list of primary and secondary readings for delegates to review before the meeting. If anyone is interested to see this reading list, please contact Michele Karel at Michele.Karel@va.gov.

Conference Experience

The conference work exceeded our most optimistic fantasies of what might occur during 2.5 working days. Delegates were clearly excited to be there, and had tremendous collaborative spirit, seriousness of intent, energy, and creativity to the work. It was truly a **working** meeting; if anyone wanted to explore Colorado Springs, they had to do so before or after the conference! However, the hotel was lovely and the view of Pikes Peak from outside was beautiful.

Many delegates commented on the inclusive spirit of the meeting – that we are all dedicated to figuring out how we can invite more psychologists to practice competently in this field, rather than being motivated to keep people out of the field. There was an openness to hearing different perspectives and, by and large, a tremendous degree of consensus regarding the core features of geropsychology training.

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Student Voice: The APA Convention and Beyond

Anna MacKay, M.A.

*A*ugust 10th and the 2006 APA convention are fast approaching! APA can be overwhelming to students attending for the first time, so much so that books are published on the topic of how to navigate conference planning. Here are a few suggestions based on my own experiences with APA which will help you get the most out of your time at the conference and make it a fun experience.

1) Know your top 3 divisions

If you tend to find everything interesting, you can easily start to feel saturated with information before the end of day one. A good plan is to choose the most important sessions based on your top three areas of interest. Obviously, Division 12/2 sessions are a must. Next, maybe Division 20 (Aging) or division 40 (Neuropsychology) or forensic or health psychology… you get my point. The important piece is that you limit your scope so you can get the most out of the information packed program.

2) Meetings

There are a lot of meetings. As a student you might wonder why you should go to these if you have nothing you need to do at them. This is an important piece of the conference because it is a brief view of how a division functions. I think the organizational side of APA is remarkable and you may hear about projects that are of interest to you. For example last year at APA, I learned about members who are acting as liaisons to media and about collaborative projects with Division 20. It's also a great time to introduce yourself and express interest in becoming more involved. And that leads nicely to my final tip, human interaction…

3) Human Interaction

We spend so much time at computers, reading articles, meeting with clients, emailing, etc. One of the most valuable aspects of the convention is the opportunity to get together with those rare individuals that find the same areas of psychology as interesting as you do! Unfortunately, too often I find myself going from poster session to symposium to poster session without taking the time to make personal connections. Here are some ideas to have more interaction amid the sea of psychologists bustling from one event to the next:

- Go to the events. APAGS will have an event. Look for it. Also, be sure to contact the divisions that you are interested in and find out about organized dinners. Ask your advisor if he/she has heard about anything. Maybe you can convince her/him to go with you!
- What if nothing is organized? Then organize it! And here is a very specific plug. Use our STUDENT LISTSERV to connect with other students who are going to APA. Arrange to meet for lunch or before/after a talk of common interest. This is a resource available to you. Use it to set up an event before you get to New Orleans and use it when you are there! After the conference, let us folks who couldn't make it know what you found interesting. I would appreciate it! The STUDENT LISTSERV is available to any student who is interested in clinical geropsychology (Email me to join: ajmackay@wustl.edu). You don't need to be a member to start using it, but we encourage you to become a member.

Benefits of Membership include:

• A subscription to Clinical Geropsychology News and access to the 12, II Listserv
• Access to the student Listserv as a tailored forum for student interests and discussion
• Access to the Members Only area on the 12/2 website
• Up-to-date information regarding conferences, internships, and postdoctoral opportunities
• Participation on 12/2 committees as student representative
• Eligibility for annual student awards

To apply, simply visit our website at http://www.geropsych.org/index.html and click on the 'Members Information' link and download the membership form.

I hope you have a good conference experience this summer and bring the momentum that is often generated from these opportunities to connect and share common interests to our forum for continued discussion throughout the year!

ELECTION NEWS
Here's How to Vote!

Barry Edelstein, Ph.D.
Chair of Nominations and Elections

It is time to exercise your democratic privilege and vote for candidates running for the offices of Section 2 President-Elect and Section 2 Representative to the Division 12 Board of Directors. We have three very strong candidates. Suzanne Meeks and Merla Arnold are running for the office of President-Elect, and Deobrah King is running for the office of Section 2 Representative. Deborah is running unopposed, and is completing the term originally begun by Dolores Gallagher-Thompson, and would like to be elected to a full term of office. Candidate statements can be found at the election web-site.

The second item on the ballot is a proposed name change for the Section. The rationale for this change can be found at the election web site.

Please remember that according to our bylaws, student members are not permitted to vote.

TO VOTE:

1) Go to the Section 2 webpage at http://www.geropsych.org
2) Under the heading of Quick Links, click on Members Area.
3) Type your APA membership number in the space provided to log in.
4) On the Members Page, click on "Election of section officers." You will have to give your APA number again to submit your votes.

Please vote as soon as possible and no later than July 31st, 2006. Thank you for your continued participation!

NOW THAT'S FUNNY

Editor's Note: In an effort to bring some fun to the newsletter and in accordance with Bob Intineri's presidential mandate (ie, to prove Geropsychologists have a sense of humor), I have a new column featuring jokes, stories and observations celebrating the lighter side of aging and/or working with older adults. Enjoy!

You have to stay in shape. My grandmother, she started walking 5 miles a day when she was 60. She's 97 today and we don't know where she is.
- Ellen DeGeneres

An older patient reaches for a cup of yellow fluid. His buddy stops him "Never drink apple juice in hospitals, especially if someone's name is on the cup." His friend replies "Hey, that's urinalysis of the situation!"
- Submitted anonymously

Stories from the Pittsburgh VA Nursing Home:
- I asked a veteran, "What did you do in the service?" He replied, "Whatever they told me to do!"
- I overheard one of our rather gruff dementia unit residents got upset and into a verbal tussle with another resident. The gruff resident angrily told the other man "Oh, blow it out your a$$!" After he said this, however, he looked a bit scared and added sheepishly "But don't fart!!!"
- When giving the 3 part command MMSE item (take paper in your right hand, fold in half, put it on the floor), if a patient does successfully put the paper on the floor, I reply "That's a $50 fine for littering on VA property!"

- Submissions from Frederick Kier, Ph.D.

I'll never forget one of my first geriatric assessments as a practicum student at Long Island Jewish Hospital. I nervously asked my patient, who had just had her 80th birthday, what brought her in to see me. She replied, "Isn't it obvious? I'm having a mid-life crisis."
- Submission from Karyn Skultety, Ph.D.

DO YOU HAVE A STORY OR JOKE TO TELL? Submit it for our next edition! Submissions can include your name or be anonymous. Send them to:karynskul@yahoo.com.

Profile On: Sara Honn Qualls (Continued from Page 15)

I feel deeply grateful to be able to link with students and colleagues in work I consider important. I have created my ultimate dream clinical/research/ academic/community environment. The community has supported us remarkably, challenged us to do something useful, and recently, began to share dreams with us.

Several years ago, Mick Smyer and Bob Knight engaged in a post-Div 20 dinner conversation that changed my life. As we walked back from the boat in Toronto, they were trying to convince me to run for an office in Section 2. The gist of the impact of the conversation on me was that I realized I *was* prepared to provide leadership; I belonged "at the table"; my "time had come"; there was no "generation ahead of me to take a turn first" (these phrases were my rationale for not running for office!). I suppose midlife moments like this sneak up on everyone. Once again, I received the supportive challenge to step up to the plate because what I had to offer was useful, at least in the eyes of colleagues I respected. I have learned to pay close attention to others' views of my work, my opportunities, and my roles, with far less worry about fitting into a particular professional structured role. While clinical training was probably my best foundation for the myriad of professional roles I play, organizational development training has been invaluable to me in recent years as I learn to create hybrid organizations that link university and community to support research, training, and service innovation.

Finally, I share with students my inner process because they need to know that incongruence between what one feels and what one can do is normative. They are surprised that I still see myself as the little girl in the room who doesn't know what everyone else knows. However, I find it hard to provide leadership and be insecure, so have worked hard on that issue. Usefulness has always been my litmus test and my anxiety-management strategy. I could tolerate my fears of inadequacy, my knowledge of limitations, and my awareness of eminently more qualified persons around me if I could view my work as truly useful. I am grateful to say that I continue to find more ways to be useful than I need. A local colleague describes our current circumstance as being surrounded by "insurmountable opportunity." Exciting, scary, meaningful, poignant, and ultimately worthwhile only if it is USEFUL.

I have to say that I found this task of writing my professional story to be odd and satisfying. I often share my professional story with students because I want them to see that career development involves unpredictable transitions, a lot of "fluke" factor, and incongruence between feelings and performance. I hope that some of those experiences resonate with colleagues reading this as well as with students, and that the messages are, well, useful!

Eye on Education (Continued from Page 17)

It was very helpful to have delegates representing a range of professional training and diversity concerns, who helped us to broaden our thinking about training in this field. The seven student delegates were active participants whose perspectives were very valuable.

Dissemination Plans

The conference delegates discussed a wide range of possible "next steps" for this meeting. Certainly, we are planning to publish one or more papers that summarize the training model and conference recommendations. We will present an overview of conference outcomes at an APA symposium in New Orleans. Other ideas included developing self-assessment and evaluation tools for geropsychology competencies, and possible formation of a Geropsychology Training Council. We look forward to sharing an overview of conference outcomes in the next 12-2 newsletter.

Reference

American Psychological Association (2004). Guidelines for psychological practice with older adults. *American Psychologist*, *59*, 236-260.

The American Psychological Association Conference 2006

12/2 Sponsored Presentations and Symposiums

Presidential Address and Presentation of the Powell Lawton Award

Friday August 11, 9- 9:50 AM
Convention Center Room 274
President: Bob Initeiri, Ph.D.
Powell Lawton Award Winner: Dr. Steve Zarit

Symposium on the Pike's Peak Training Model for Professional Geropsychology

Friday August 11, 3- 4:50 PM
Convention Center Room 261
Symposium Co-Chairs: Bob Knight, Ph.D. and Michelle Karel, Ph.D.

12/2 Meetings

Executive Board meeting

Thursday Aug 11 1-4 PM
Hilton D12 Hospitality Suite TBA

Member/Business Meeting and Presentation of 12/2 Awards

Friday August 11 1-2 PM
Hilton D12 Hospitality Suite TBA
The Distinguished Clinical Mentorship Award will be presented to Dr. Deborah King.
The Student Research Award will be presented to Caitlin (McEntarfer) Holley.

12/2 and Division 20 Pre-convention CE Workshop!

Title: CBT and IPT: Two Empirically Supported Psychotherapies for Late-Life Depression
Faculty: Gregory A. Hinrichsen, Ph.D. and Leah Siskin, Ph.D. from The Zucker Hillside Hospital, North Shore-Long Island Jewish Health System

Date: Wednesday, August 9, 2006
Time: 8:00 a.m.-3:50 p.m.
Location: New Orleans Marriott Hotel
CE Credits: 7
Fees: Member - $245, Non-Member - $315
On-Site registration only available at this time.

12/2 and Division 20 APA Social Event!!

Where: Gordon Biersch Restaurant, 200 Poydras St.
When: Saturday, August 12th
6:30 pm (cocktails), 7:15 (dinner)
Cost: $45 for faculty, $22.50 for student
Checks should be received by August 5th!
Who to contact: Bob Intrieri, Ph.D. for payments and info on all the menu options!

Bob Intrieri, Ph.D.
Address: Department of Psychology, 1 University Circle, Western Illinois University, Macomb, IL 61455 Office Phone: 309-298-1336
E-mail: mfrci@wiu.edu

Public Policy Announcement: Media Training Workshop!

*W*e are highly encouraging all geropsychologists to attend the Media Training Workshop and learn how to convey your knowledge about geropsychology and speak to the media! This workshop will feature a talk from Rhea K. Farberman, APR, the Executive Director of Public and Member Communications at APA. It is designed to help psychologists, whether clinicians, researchers, educators or consultants succeed as spokespersons for psychology and their own work. The program will include discussion about how news media work and what the media outlets want from news resources as well as the best way to prepare for an interview and how to develop message points for news interviews.

Date: Thursday, 8/10/06
Time: 8:00-9:50am
Place: Convention Center, Room 337
Sponsoring Division: 46 (Media)
Chair: Donna Rasin-Waters, PhD, Division 12 Federal Advocacy Coordinator, 12/2 Public Policy Co-Chair