Clinical Geropsychology News

Society of Clinical Geropsychology, APA Division 12

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INSIDE

SPECIAL APA EDITION

Editor's Note:

In this edition I have featured the efforts and accomplishments presented at the 2006 American Psychological Associate conference in New Orleans. This includes articles from two of our section award winners, Part II of the series on the Geropsychology training conference, the summary from Dr. Intineri's APA presidential address, a special column highlighting training offered in New Orleans to Area on Agency workers providing services to Hurricane Katrina survivors and much more!

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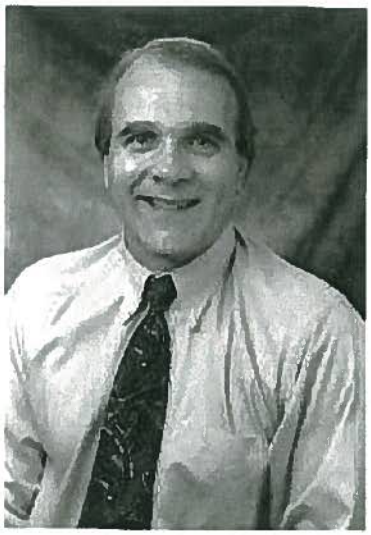
*Published articles do not necessarily represent the official views of Section II, Division 12, or APA

President's Column:

Pragmatism, Purpose, and Passion = Clinical Geropsychology

Bob Intineri, Ph.D.



*H*ave you ever been asked why you want to work with older adults? For many the answers come quickly. I wanted to work with older adults because I felt a kinship with that population. It was a group I found I made a "special connection" with. Many say they did not realize they would find working with older people so intellectually stimulating and clinically rewarding until they completed a practicum or a clinical rotation during their internship or postdoctoral years. I ask and challenge you to define the point in your career when the information was crystallized in your consciousness. At the very least I think you will find this to be an interesting exercise and perhaps you will identify your "Tipping Point" (Gladwell, 2001). Gladwell's point applies to understanding why social transformation and change may occur in swift and unexpected ways. I would argue that personal shifts happen in a similar fashion.

However, it is also important to take a very pragmatic and reasoned look at what is about to happen over the next 20 years in American Society.

Over the next two decades American Society will transform itself into a "Graying Society." Current population estimates suggest the aging of the baby boomers will produce an unprecedented shift in the dynamics of the population. This shift is often illustrated through a series of population pyramids showing older cohorts at the top of the pyramid nearly equal to the younger cohorts at the bottom (U.S. Census Bureau, International data base). The practical implication of this rectangularization is enormous growth in the 65+ population. For example, in 1900 those 65 and over represented about 12-13% of the population. If current projections are accurate, by 2050 those 65+ should make up about 20-22% of the population. More dramatic is the potential tripling of the oldest old, from 1.2% in 1990 to a projected 3.8% in 2050. We must also be mindful of the increasingly diverse composition of our population, such that nearly 40% of those 65 and over in 2050 will be members of racial and ethnic groups (compared to 18% in 2004). This is not new information. Gerontologists have been talking about this data for at least 25 years. It will not be enough to simply train Geropsychologists in life-span development issues. It will also be necessary to train future clinicians to be sensitive to issues of racial and ethnic diversity. Further, we must also consider what the growth in older adults means for the provision of residential services. Data collected in 2003 (CMS, Medicare Current Beneficiary Survey, 2003) shows the oldest group (85 and over) needs higher levels of supportive community housing with services. This need will only increase with the changing demographic structure. For example, data from the National Nursing Home Survey (CDC, National Center for Health Statistics) suggests that despite recent declines in the number of older adults in residence, the nursing home will be a frequent residence especially for those 85 and over. The take home message from this vast aggregation of information is clear: If you are a clinician and you are going to provide mental health services, you are going to have to work with older adults.

When examining the changing population dynamics, one should be struck by the fact that if the current prevalence and incidence rates for the development of mental disorders in the population hold we will have a preponderance of older adults requiring focused mental health attention. What we know based upon current epidemiological data from both the Epidemiologic Catchments Area Study (ECA) and the National Comorbidity Study (NCS) and NCS-R (Myers, et al., 1984; Regier, et al., 1988; Regier, et al., 1993; Kessler et al, 1994; Kessler et al, 2004; Kessler, Berglund, et al., 2005a, 2005b; Kessler & Merikangas, 2004) is that mental illness will directly and indirectly affect health care outcomes, utilization of services, and costs. Data also suggest that while psychological treatments are effective they are not reaching those in need. To further underscore a point, government has severely under-invested in knowledge dissemination of currently effective treatments, service development, and research to meet future population needs. Thus, the growth in older persons with diagnosable mental disorders will increase to a projected 15 million in 2030 (Jeste, et al., 1999). When you consider Alzheimer's Disease and other memory disorders (of which about 30 to 40% are complicated by depression or psychosis), major depressive disorder, anxiety disorders, alcohol abuse, severe mental illness (late life psychosis), and suicide, you begin to understand why mental disorders in older adults are considered a "silent epidemic." Most troubling is that it appears mental illness takes its largest toll on those 75 and older (Hoyert, et al., 1999).

Three common forms of mental disorders in older adults are memory impairment, depression, and suicide. Recent data from the Health and Retirement Study (Steffick, 2000) suggests the percentage of people over 65 with moderate to severe memory impairment (defined as recalling 4 out of 20 words on delayed recall tests) increases correspondingly with age. Older adults 85 and over showed the highest impairment levels for men and women respectively (34% and 31%). In addition, older adults (85 and older) had

the highest levels of clinically relevant depressive symptoms of any age group with women demonstrating more symptoms than men. Research supports the idea that depression is associated with poorer health outcomes for hip fractures, myocardial infarction, and cancer (Mossey, 1990; Penninx, et al., 2001; Evans, 1999). Depression also produces increased mortality rates for myocardial infarction (Frasure-Smith, 1993, 1995) and long term care residents (Katz, 1989; Rovner, 1991; Parmelee, 1992; Samuels, 1997). Further, those with depression experience worse health outcomes and are more costly to the health care system because they generally use more medications and higher levels of health services (such as, medical outpatient visits, emergency room visits, and hospitalizations). Depression is widely unrecognized and untreated in older adults. Compounding the under-recognition is the fact that depression is the most common disorder associated with suicide in older adults (Conwell, 1996; Conwell and Brent, 1995; Turvey, et al., 2002). The data show that people 65 and older have the highest suicide rate of any age group while those 85 and older have a suicide rate twice the national average (CDC, 1999). In terms of peak suicide rates, suicide risk increases continuously for older men. By comparison, suicide rates for older women peak at midlife and generally decline through old age. Given that older men present the greatest risk, they also potentially present the greatest clinical challenge. Some data suggests that 33% of older men saw their primary care physician in the week before completing suicide while approximately 70% saw their primary care physician within the month prior to completing the suicide act.

While concerns regarding the mental health of older adults in the community are well-documented, considerable attention has also been given to the mental health of nursing home residents. For example, some estimates suggest that 65-80% of nursing home residents may have a diagnosable mental disorder with dementia, depression, anxiety, and psychosis the most frequently identified (Burns & Taube, 1990, Burns et al., 1991; Rovner et al., 1990). Some estimates are so high that nursing homes have been dubbed the "defacto" psychiatric hospital for older adults (Rovner et al, 1990). More disturbing than the high prevalence rates among institutional residents is the data suggesting that over a one-month period only 4.5% of mentally ill residents received mental health services (Burn et al, 1993). Additional studies have demonstrated that over a one-year period only 19% of those residents in need of mental health services received them; the least likely to receive mental health services were the oldest and most physically impaired (Shea et al., 2000: Smyer et al., 1994). When examining unmet mental health needs in community dwelling samples, Shapiro (1986) found that only 33% of older community dwelling adults who need mental health services receive them. In addition, less than 3 % receive outpatient mental health services by specialty mental health providers (e.g., psychiatrists, psychologists) (Olfson et al., 1996).

In summary, there is a great need for mental health care among older groups, both institutionalized and community dwelling. The needs demonstrated through the prevalence data are rarely met in either long-term care facilities or within communities. As Geropsychologists, we have an obligation and a duty to address their conditions.

Let's begin with a general question… As a clinical Geropsychologist what is our primary goal or purpose? When it comes to aging (or growing old), what do we assume is the desired outcome? To grow old well. In other words, our mission is to help older people "grow old well." We can translate this statement into some very discrete outcomes. For example, through our efforts as clinical Geropsychologists we hope to enhance independence in old age by enabling people to participate in meaningful daily activities and remain integrated in their communities. Further, we do our best to allow people to age with respect and dignity. It should also be our responsibility to advocate for greater access to mental health services (e.g., achieve parity with physical health services). So how should we approach this stated mission? First, we have to address work force issues. Current estimates

suggest that by 2020 the US will need at least 5000 trained geriatric Psychiatrists and clinical Geropsychologists. Work force numbers for these two groups currently fall substantially below the estimates (Jeste et al.,1999; Halpain et al., 1999). Second, we need to highlight the importance and necessity of clinical Geropsychology. For example, C. Everett Koop (Abdellah & Moore, 1988) stated "The capacity of an individual with mental or behavioral health problems to respond to mental health interventions knows no end-point in the life-cycle. Even serious mental disorders in later life can respond to clinical interventions and rehabilitation strategies aimed at preventing excess disability in affected individuals." Koop emphasized the idea that we must retain our hope that everyone can be helped no matter their diagnosis. It is important to again emphasize here that the pragmatics of our aging society dictate that as a clinical psychologist in the 21st century you will likely be working with older adults. We need to be mindful and wary of our role as clinical Geropsychologists. It is not enough to be competent clinically but we must also be competent advocates and well versed in policy perspectives. By becoming effective advocates and familiar with public policy we can more effectively serve those individuals that are falling through the cracks because community mental health centers frequently lack personnel trained to address the specialized mental health needs of the old (e.g., this is especially true in rural areas). Currently, our strongest hopes lie with primary care physicians or long term care institutions. The research demonstrates that when older adults do get care it is typically of poor quality. Bartels et al (1997, 2002) have pointed out that older adults are at an increased risk for inappropriate medication treatment while Zahn et al. (2001) note that 1 in 5 older people are given inappropriate prescriptions. Moreover, older adults are less likely to be treated with psychotherapy despite the evidence that older adults respond just as well to these interventions as younger people (Bartels, et al., 1997). Druss (2001) demonstrated that patients with a mental disorder received poorer quality health care and generally died sooner than those without a mental health disorder. Poor quality mental health care highlights the current state of our mental health system – It is fragmented. Approximately five years ago the Administration on Aging (2000) released a statement, which emphasized that community-based treatment settings for older adults were being undermined because of the "fragmentation and insufficient availability of services." As clinical Geropsychologists we have no choice- whether we like the political scene or not we must make Policy Areas and Issues a Priority. Examples of where we should be spending our time and resources include urging federal legislative action on Medicare mental health parity as well as encouraging legislative action to create a comprehensive and integrated health care system. We should also be working to develop an initiative to disseminate and implement evidenced-based mental health practices. We need to advocate for funding of programs that educate people about mental health conditions and the stigma associated with treatment. In making "policy a priority" in our lives as clinical Geropsychologists, we need to encourage legislatures to fund research on mental health and aging by designating the mental disorders of aging as a priority. Further, we need to advocate that federally funded grants address the inclusion of people 65 and older. Finally, clinical Geropsychologists must relentlessly contact Congress to tell them what you do and why your job is important.

In summary, I am reminded of a poem:

The woods are lonely, dark, and deep,
But I have promises to keep,
And miles to go before I sleep,
And miles to go before I sleep.
- Robert Frost
Stopping By Woods on a Snowy Evening

We must be passionate about our purpose…our purpose is to enhance the life quality of older adults, to help the people we serve "grow old well." We must be committed to the purpose and convince others to do the same. We have accomplished much but we need to do much more before we rest.

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Executive Board Meeting Summary: 8/10/06 APA Conference New Orleans, LA

Bradley Karlin, Ph.D.
Secretary

The meeting was called to order by President Bob Intrieri at 1:15p. In attendance were Bob Intrieri, Forrest Scogin, Brad Karlin, Jon Rose, Deborah King, Martha Crowther, Angela Lau, Karyn Skultety, Donna Rasin-Waters, Suzanne Meeks, Ann Pearman, Dan Segal, Debbie DiGilio, and Diane Elmore.

Introductions – Bob Intrieri

The meeting began with introductions. New terms on the Board beginning this year include President (Bob Intrieri) and Secretary (Brad Karlin).

Secretary Report – Brad Karlin

Minutes from the November 19, 2005 Executive Board Meeting were approved. The minutes were previously distributed via e-mail and hard copies were distributed at the current meeting.

Upcoming Board Meetings

Due to low Executive Board member turnout, Executive Board Meetings will no longer be held at the Gerontological Society of America (GSA) convention. In-person Executive Board Meetings will be held at the American Psychological Association Convention. There will be two upcoming telephone Board Meetings to be held in October and November 2006.

Committee Appointments – Bob Intrieri

Caitlin McEntarfer was announced as the new Section Student Representative. Bob stated that he would like the Executive Board to consider funding priorities for Section committees. He suggested considering whether it is worthwhile for committees that are not very active to continue, which the Executive Board will discuss further during the upcoming telephone Board Meetings.

Election Results – Bob Intrieri

Suzanne Meeks was elected Section President and Deborah King was reelected as Section Representative to Division 12. The proposed amendment to the Section Bylaws to change the name of the Section to the "Society of Clinical Geropsychology" passed. Voting went smoothly, with a great majority of individuals voting online.

Current Issues – Bob Intrieri

Bob reported that several members of the Section provided a workshop on stress management to the aging network in the local New Orleans community. The workshop was well-received, and a representative to the Governor's office expressed interest in having the workshop repeated in the future.

Forrest provided a summary of the National Conference on Training in Clinical Geropsychology, which was held June 15-18, 2006, in Colorado Springs, CO. Section II was a co-sponsor of the conference and involved in the conference planning. Forrest noted that several Section members were delegates to the conference. The conference was a working conference designed to develop aspirational educational models at the pre-doctoral, internship, post-doctoral, and post-licensure levels for training psychologists with specialized preparation for providing psychological services to older adults (Pikes Peak Model). Forrest reported that the conference was very productive. The decision was made at the conference to pursue the establishment of a geropsychology training council. A meeting of several Training Conference delegates and planning committee members was scheduled to meet at the current APA convention to further discuss the creation of such a council. A presentation on the Training Conference will be provided at the APA convention by Training Conference co-chairs, Bob Knight, Ph.D. and Michele Karel, Ph.D.

It was announced that Mary Harper, long-time advocate and champion for clinical geropsychology, has died. The Board acknowledged her dedication to and significant impact on the profession and the public.

Representative to Division 12 – Deborah King

Deborah reported that Division 12 (the "Division") is very pleased with the Section's activities. Due to increasing budgetary

constraints, the Division has placed increased emphasis on the requirement that 50% of the Section's (non-student) membership also be members of the Division, which is a provision of the Division's bylaws. There had been some question whether Section II met this requirement, though when student members, who do not count toward this requirement, are appropriately subtracted out from the total in the calculations, Section membership was believed to likely meet this requirement. Martha will perform the necessary calculations to confirm if this is the case. Deborah further mentioned that because of financial concerns, the Division will likely be more conservative in funding proposals for special projects, two of which the Section has had recently funded – ProfNet and the geropsychology training conference. Deborah recommended that the Section continue with ProfNet. She noted that the Division has been pleased with ProfNet and the Section's advocacy efforts. Requests for funding will be considered twice per year if submitted at least 30 days prior to Division 12 Board meetings. Deborah indicated that requests for funding for special projects should be submitted by the Section to the Division 12 Treasurer, with a copy provided to the Section Representative (Deborah), by the end of the calendar year, if possible. Deborah provided a written summary of the Division 12 Board of Directors Meeting.

Treasurer Report – Jon Rose

Jon provided the finance report. Although the Section anticipated a small deficit due to the $3000 committed to the "Pikes Peak" geropsychology training conference, the Section will be close to breaking even at the end of the FY due in significant part to spending well below than projected on travel and website maintenance. Income is basically in-line with the same time last year, though donations are down. Expenses are in-line with expectations after accounting for some 2005 expenses that were postponed until 2006. Changes proposed for the 2007 budget include no funds for html programming, and an as-yet undetermined amount to subsidize student meals at the Convention dinner. Jon agreed to investigate the possibility of investing our cash reserves in a CD to obtain a higher interest rate. John also provided information on grant programs potentially of interest to the Section. The APA Interdivisional Grant Program provides grants for collaborative projects sponsored by two or more APA divisions (or Sections of two or more divisions.). Grants range from $500 to $2500. John suggested possibly developing the annual Section convention dinner into a mentoring activity with other divisions (e.g., Aging, Rehab.) and perhaps use a grant to subsidize student meals. The application deadline is September1.
http://www.apa.org/about/division/divofficers.html.

APA Office on Aging and Public Policy Office Report – Deborah DiGilio and Diane Elmore

Debbie reported that Toni Zeiss will be receiving the 2006 CONA Award for the Advancement of Psychology of Aging, to be presented at the APA convention. Debbie noted that CONA is soliciting nominations for 2 new members. Debbie next provided a verbal and written summary of recent APA Office on Aging activities. She noted that the *Life Plan for the Life Span* brochure was completed in March and is available online at the APA website. The brochure offers guidance to younger and older psychologists in planning for issues that often arise in later life. The Office on Aging has worked with others to promote the inclusion of mental health issues on the agenda of the White House Conference on Aging (WHCoA). Mental health was ranked eighth among the final resolutions adopted by the WHCoA. Debbie declared that the final report from the WHCoA is at the printer and should be released shortly. Debbie and Diane reported that the APA Office on Aging and Public Policy Office (PPO) are working with the National Coalition on Mental Health and Aging to host a post-WHCoA congressional event concerning mental health in the fall. Diane provided a report of PPO activities. She stated that the PPO has been monitoring several pieces of legislation relevant to mental health and aging. In particular, she noted that the PPO has been working to include key provisions of the Positive Aging Act in the Older Americans Act Reauthorizing

Amendments of 2006. Other legislative proposals advocated for by the PPO include the Elder Justice Act, Lifespan Respite Care Act, and the Kinship National Family Caregiver Support Act. Brad identified recent legislative proposals to enhance mental health screening and treatment in older adults that the PPO may also wish to monitor and support. There was next some discussion about the geropsychology GPE program. Diane stated that there is no current champion in Congress for the program, as there has been in the past. Brad noted the importance of agenda setting and the important impact of media involvement in this regard among Section members. The Board supported Donna and the Section's continued involvement in the media. Finally, Diane noted that the APA *Monitor on Psychology* has recently included several articles on mental health and aging issues. The November issue of the *Monitor* will focus on aging issues.

Membership Committee – Martha Crowther

Martha provided the current membership report. We have 237 paid members. This is significantly lower than last year's paid membership. This is mainly due to the fact that many members have yet to send in their dues payment for the year. There was some discussion of different options for increasing timely payment of membership dues (e.g., multiple year membership, "early bird" reduced rate payment option). Martha stated that she and the Membership Committee will send out reminder renewals later this month to those that have not yet submitted their dues payments. The Executive Board offered to assist with personal contacts. The Membership Committee is developing a brochure to help increase membership. The Section membership directory will be sent out in September/October.

APA Program Committee – Forrest Scogin

Forrest reviewed the Section program hours at the APA convention. Michele Karel and Bob Knight are presenting a two-hour symposium on the Geropsychology Training Conference. The Presidential Address will be delivered by Bob Intrieri. The Section Business Meeting will be held at the convention. The annual social event will again consist of a joint dinner with Division 20. The Section is currently allocated 3 hours at the convention, which was recently reduced from 5-6 hours. There was discussion about pursuing reinstatement of the previous allotment of hours. Deborah stated that she will follow-up with Division 12 regarding such.

Awards and Recognition – Paula Hartmann-Stein

Bob reported award recipients on behalf of Paula. Award winners include Steve Zarit (M. Powell Lawton Award for Distinguished Contributions to Clinical Geropsychology), Deborah King (Distinguished Clinical Mentorship Award), and Caitlin McEntarfer (Student Award).

Newsletter - Karyn Skultety

Karyn reported that electronic distribution of the newsletter has been proceeding smoothly. Approximately 20-30 hard copies are sent out via snail mail. A discussion of advertising in the newsletter was undertaken. The Board decided to keep the current advertising rates. New ideas for future columns were discussed, including the possibility of a case example column.

Website Coordinator – Norm O'Rourke

Bob announced that Norm O'Rourke has resigned as Section Website Coordinator. The position is now vacant. Bob suggested that to relieve some of the burden of the Website Coordinator the Board consider having someone with content knowledge draft material to be placed on the website and have an administrative support person make the technical changes. Norm had been fulfilling both of these roles. The website will need to have a new host site. It is currently hosted by Simon Fraser University. Bob and Forrest have been looking into having Division 12 as the Section's host site. Forrest noted that the Section is one of the few sections of the Division that is not hosted by the Division.

Public Policy Committee – Donna Rasin-Waters and Peter Kanaris

Donna reported that the Public Policy Committee (PPC) has focused its efforts on the public media campaign, which has been going well. Donna stated that we are now establishing relationships with journalists. She encouraged greater

participation among Section members in the media campaign. A media training workshop was provided by Rhea Farberman earlier today. Michael Duffy has stepped down as the Section liaison to the Division 12 public policy workgroup. Donna noted that workgroup activity has been limited. A workgroup meeting is scheduled for this Friday, though it is unclear how much participation there will be. Following from her recent work on increasing voter turnout, Donna proposed an initiative to increase voter registration and participation among older adults by advocating for the placement of voting booths at nursing homes. Donna also suggested that the Section consider paying for someone to attend the $1000 black tie event at the State Leadership Conference as an opportunity to have one-on-one contact with legislators. This decision was tabled pending a more thorough discussion by a smaller group. Donna invited Section members interested in being active members of the PPC to join the committee.

Continuing Education Committee – Ann Pearman and Dan Segal

Greg Hinrichsen and Leah Siskin provided a pre-convention workshop on IPT and CBT for late life depression at the current APA convention. Dan noted that there should be more opportunities for continuing education programs following the recent Geropsychology Training Conference.

Diversity Committee – Angela Lau

Angela reported that the Diversity Committee has been engaging in outreach with other organizations inside and outside of geropsychology to increase attention to diversity issues in late life. The Committee is still recruiting members (particularly students) and is especially interested in individuals who have an interest in contributing to the committee's outreach to other organizations.

Treatment Guidelines Task Force – Forrest Scogin

Forrest reported that the Treatment Guidelines Task Force has produced four content papers on evidence-based treatments (EBTs) for late life insomnia, caregiver distress, anxiety, and behavioral problems associated with dementia. The articles will be published in a Special Section of *Psychology and Aging*, with accompanying introduction, method, and commentary (by Margy Gatz). A review of EBTs for depression was previously published in *Clinical Psychology: Science and Practice*.

Education and Training Task Force – Erin Emery

Erin submitted a written report for the Education and Training Task Force, which Bob summarized. The committee has created surveys to assess geropsychology training opportunities in both graduate and internship programs. Surveys were posted online, with the help of Norm O'Rourke. The committee has been collaborating with Nancy Pachana (Australia) and Candy Connert (Canada) to include training programs from other countries. The committee is in the process of contacting training directors via email requesting that they complete the survey.

Mentoring Committee – Amy Fiske

Bob provided an overview of a report submitted by Amy. The committee has conducted business via e-mail and conference calls. The committee has been examining existing mentoring programs within and outside of geropsychology and is currently developing a report summarizing existing programs and will provide conclusions regarding possible areas of unmet need. The committee is also preparing a survey of Section members, to be administered online, to assess their mentoring experiences and current needs. Based on the results of the survey, the committee will submit recommendations to the Board. The Committee requests that its term be extended for an additional year. The Board did not take up this issue at the current meeting. It will be discussed further during the upcoming telephone Board Meetings.

New Business

Bob mentioned the idea of establishing a lifetime membership option for the Section. After some discussion, the Board elected to consider this option further at a later time. There was also some discussion about the possibility of establishing a Development Committee, to be discussed further at a later time.

Meeting adjourned at 4:06p.

APA Office on Aging and Committee on Aging Update

Deborah DiGilio
Director, APA Office on Aging

The last issue of this newsletter included a report from APA Committee on Aging (CONA) member Barry Edelstein who provided an overview of CONA and its efforts. I thought for this issue, I would first provide an update of some of the efforts I am involved in as Director of the APA Office on Aging which extend beyond my role as APA Staff Liaison to CONA, and then bring you up to date on CONA's activities since Barry's column.

The APA Office on Aging has provided staff support and hosted the meetings of the National Coalition on Mental Health and Aging (NCMHA) since 2001. AARP provided this support since NCMHA's inception in 1992 until 2001. In May of 2005, I was elected Chair of NCMHA . Over the past 18 months, NCMHA and its 50 member organizations have focused their attention on advocating for the inclusion of mental health as one of the 2005 White House Conference on Aging (WHCoA) policy recommendations. We were successful with mental health (#8) and health workforce issues securing spots in the top 10. This work continues with the Coalition about to begin work on a document that delineates concrete actions that federal and state governments can take to implement the resolutions and strategies voted upon by the WHCoA delegates this past December. In addition, Diane Elmore of the APA Public Policy Office is currently planning a WHCoA Congressional Briefing, which will include members of the WHCoA Policy Committee, early next year. NCMHA will cosponsor this event.

I also serve as staff for the new APA Presidential Task Force on Integrative Healthcare for an Aging Population. This is one of President-elect Sharon Stephens-Brehm three presidential initiatives. The Task Force held the first of its two meetings on October 6th – 8th. It was determined at this meeting that the Task Force's initial product will be *Blueprint for Change: Achieving Integrative Health Care for an Aging Population,* which will provide guidance to psychologists on how to enter and function within an integrated team for care of older persons. Task Force members are: Toni Antonucci and Toni Zeiss (co-chairs), Gregory Hinrichsen, Deborah King, Peter Lichtenberg, Martita Lopez, and Jennifer Manly.

Since arriving at APA in 2001, one of my primary missions has been to secure a seat for geropsychology at the table with other health and aging organizations on issues of import to older adults. Over the years, many of you have heeded my calls to represent APA on a variety of projects and provide comments on a variety of reports, and I am grateful. Two recent efforts were providing input to a chapter on older adults authored by Steven Bartels in a report commissioned by SAMHSA titled, *A Thousand Voices: The National Action Plan on Behavioral Health Workforce Development,* and commenting on the American Psychiatric Association's "Practice Guideline for the Treatment of Patients with Alzheimer's Disease and Other Dementias of Late Life." This month, I served as a member of the older adults review committee on innovative practices for *The Registry of Innovative Practices in Workforce Development* managed by The Annapolis Coalition on the Behavioral Health Workforce, a not-for-profit organization committed to improving the quality and relevance of workforce training and education in behavioral health and the effectiveness of recruitment and retention. I believe these efforts go a long way in educating others of the significant contributions geropsychology makes in addressing the needs and supporting the strengths of older adults, their families and caregivers.

And, as you know, there is still work to be done to promote awareness of aging issues within APA itself and among its members. One way I do this is by maintaining regular communication with *Monitor on Psychology* staff advocating for increased coverage of aging issues. I believe success in this effort is evidenced by the almost monthly coverage of aging issues. September and October stories have included the "National Training Conference

in Professional Geropsychology," John Santos being featured in "Retired and Inspired," and the Div. 12-2, 20, CONA workshop for aging service providers in Louisiana. Look for the November *Monitor* and its cover story, "AGING IN AMERICA: Are psychologists prepared to respond?" This is very exciting as the last time aging was a cover story was in 2000! The *APA Aging Issues Newsletter* is another mechanism by which I hope to increase awareness and interest in geropsychology. If you would like to be put on the distribution list for this quarterly electronic newsletter, please send me an e-mail (ddigilio@apa.,org). Past issues (and many other resources) can be found on APA Office on Aging webpage, www.apa.org/pi/aging.

As mentioned at the outset of this article, I have the privilege of being the APA staff liaison to the wonderful, hardworking group of people who are (and have been) members of CONA. The Committee currently has two new projects in the works. The first, "Priming the Geropsychology Pipeline," will involve working with two other APA Committees, Teachers of Psychology in Secondary Schools and Psychology Teachers in Community Colleges to increase students' interest in making a career of working with older adults. CONA is also requesting 2007 APA Council of Representatives Discretionary funds to initiate the "Toward Cultural Competency in Geropsychology" project. The funds would be used to convene a working group to explore the burning questions and issues regarding the infusion of multicultural diversity throughout geropsychology and psychology graduate training. A report will be prepared that identifies existing and needed tools and resources psychologists can use to improve their own cultural competence in working with older adults, and outlines a plan for future action addressing practice, research, training and public policy issues related to multicultural competence in geropsychology. The call for nominations for the working group will be posted to the 12-2 list serve in February.

As always, I appreciate the opportunity to represent geropsychology interests within and outside of APA and I welcome your suggestions and feedback.

APA Student Paper Award: Psychosocial and Vascular Risk Factors for Depression in the Elderly

Caitlin Holley, B.A.

Full Citation:

Holley, C., Murrell, S.A., Mast, B.T. (2006). Psychosocial and Vascular risk factors for Depression in the Elderly. *American Journal of Geriatric Psychiatry, 14,* 84-90.

Late-life depression is a serious health problem, with a wide range of possible risk factors (Lebowitz, 1997). More accurate detection and prevention of late-life depression relies upon correctly identifying its risk factors. Cerebrovascular risk factors (CVRFs), such as heart disease, hypertension, and diabetes, may cause small vessel disease in the brain, which can lead to depression in geriatric patients (Lyness, Caine, Cox et al., 1998). However, the literature is mixed on the relationship between depression and CVRFs (Kales, Maixner, Mellow, 2005). Why do some older adults with vascular vulnerability (i.e., multiple CVRFs) develop depression while others do not? One possibility is that the impact of CVRFs on depression may be influenced by moderating variables leading them to predict depressive symptoms in some but not all older adults. Alexopoulos et al (1997) proposed that non-biological factors might be necessary in order to trigger depression in those predisposed to it by cerebrovascular disturbance. Stressful life events and difficulties have been shown to increase the likelihood of a depressive episode in the elderly (Brilman & Ormel, 2001). It is possible that the depressogenic effect of stressful life events is larger in the presence of CVRF's. Alternatively, some propose that those who suffer from late-onset depression comprise a heterogeneous group in which depression may have developed via different etiological pathways.

It is known that both vascular risk factors (Kales, Maixner, & Mellow, 2005; Mast,

Neufield, MacNeil, 2004), and psychosocial stressors (Kales, Maixner, & Mellow, 2005; Brilman & Ormel, 2001) have been found to increase the probability of significant depressive symptoms in the elderly. The current study aimed to examine the interaction of these two sets of variables on depressive symptoms in terms of two competing hypotheses. The *stress-vulnerability model* of depression (Oldehinkel, Ormel, Brilman, 2003) predicts that the depressogenic effect of stressful life events will be larger in the presence of CVRF's. Alternatively, *the independent pathways hypothesis* predicts that psychosocial risk factors and vascular risk factors are independent pathways to depression and that there is no combined effect of vascular and psychosocial risk factors.

Method

Participants

Data from the Resources, Stress, and Older Persons Panel Study (Murrell, Himmelfarb & Wright, 1983) were utilized, made up of persons aged 55 years and over in the state of Kentucky. The goal was to predict new episodes of elevated depression at 6 and 12 months after enrollment in the study in those participants who had low depression scores at wave 1 (i.e., CES-D below the median = 8). Of the 2845 community-dwelling elders enrolled in the study 1474 had CES-D scores less than 8 at wave 1 and were selected for these analyses. From this sample, 1037 remained in the study 6 months later (Wave 2) and 66 were depressed. At 12 months (Wave 3) 995 participants remained in the study and of those, 83 were depressed.

Measures

Vascular Risk Factors: Self-report data on the presence or absence of hypertension, heart disease, diabetes, and arteriosclerosis were summed into a composite of CVRFs (ranging from 0 – 4). Participants with two or more CVRFs were designated High CVRF, with the remaining characterized as Low CVRF.

Depression: Depression was measured using the 20-item CES-D.

Loss: Loss events were measured with the Louisville Older Person Event Scale (Murrell, Norris, & Hutchins, 1984) which focuses on loss events common in late life. Those with no loss event were defined as having "no loss", and those with one or more loss event were defined as having "loss"

Stress: Perceived level of stress was rated using a 7-point likert scale, with higher scores indicating greater subjective stress.

Analyses

All analyses were conducted using only participants with a CES-D score of less than 8 at baseline to predict elevated levels of depression in waves 2 and 3. In order to test the stress-vulnerability hypothesis against the independent pathways hypothesis four 2 X 2 ANOVAs were used (two for Wave 2, two for Wave 3). We tested the interaction between high (2+) and low (0-1) levels of CVRFs compared to high (5-7) and low (1-4) levels of stress on CES-D score (Figure 1, which appears on next page). A second 2 X 2 ANOVA tested the interaction between CVRF's and loss events (1+ and 0) on depression (Figure 2, which appears on next page).

Results

The results of the test of CVRF's and stress revealed overall main effects of CVRF's and stress at 6 and 12 month follow-ups of depressive symptoms. Consistent with the stress-vulnerability hypothesis, there was a significant interaction between CVRF's and stress ($F_{(1,1996)} = 12.65$, $p < .001$) such that stress was a stronger predictor of wave 2 depression in participants who had 2 or more CVRF's (Figure 1). At a descriptive level, the correlation between stress and depression was higher for those with high CVRF's ($r = .57$) than for those with low CVRF's ($r = .45$).

The results of the test of CVRF's and loss revealed significant main effects of CVRF's and loss on waves 2 and 3 depressive symptoms. There was not a significant interaction between CVRF's and loss on depressive symptoms (Figure 2).

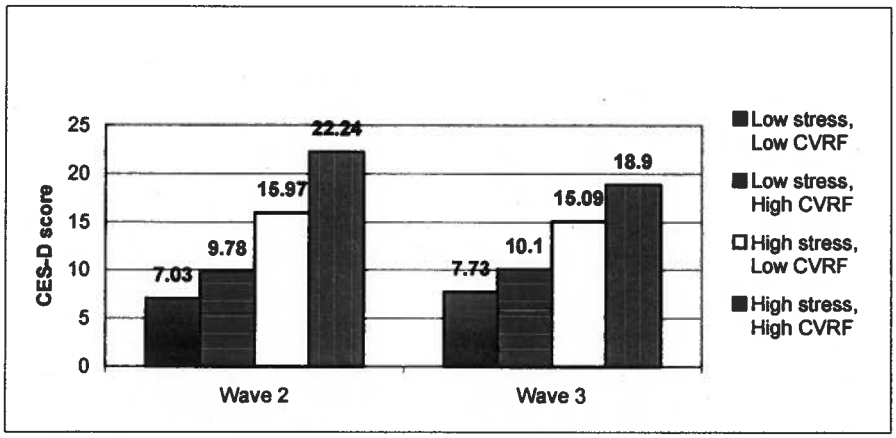

Figure1: Stress by CVRF interaction on depressive symptoms

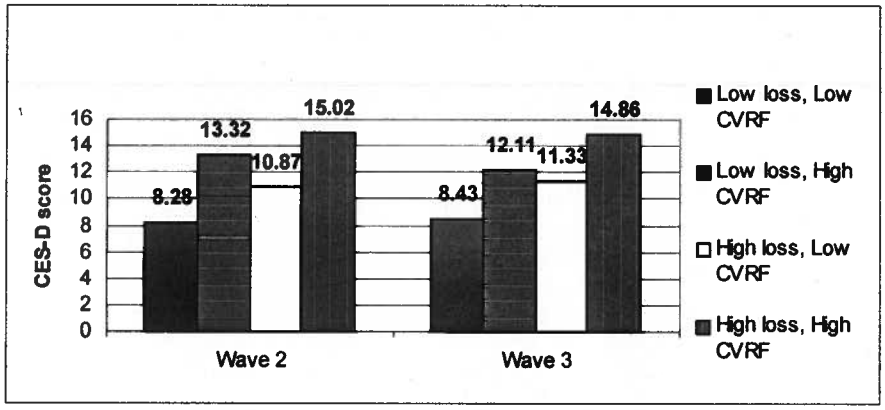

Figure 2: Loss by CVRF interaction on depressive symptoms

Discussion

The significant interaction between CVRF's and stress on depressive symptoms support the stress-vulnerability hypothesis reflecting that the depressogenic effect of stress is stronger in the presence of CVRF's. Vascular risk may increase vulnerability to depression by exacerbating the impact of stress on depression.

These results corroborate Alexopolous et al. (1997) suggestion that non-biological factors might be necessary to trigger depression in those predisposed to it by cerebrovascular disturbance. Previous literature has also demonstrated that other vulnerability factors, such as personality factors, can increase the depressongenic effect of psychosocial risk factors such as stress (Mazure, Maciejewski, Jacobs, & Bruce, 2002). This study is unique in that it investigated a biological vulnerability factor (vascular risk) which had a significant interaction with psychosocial risk.

Despite the strengths of the current study, there are limitations that should be recognized. First, rather than directly detecting cerebrovascular disease using MRI, we used several vascular risk factors that have been associated with the disease, and therefore can only speculate about the hypothesized mechanism for the observed findings. In addition, information regarding the severity of the vascular risk factors was not obtained, which may limit our ability to more accurately assess vascular risk.

Despite these limitations, these results highlight the importance of being aware of the interactive effect of psychosocial stressors and vascular disease in detecting late-life depression. Stress associated with life events might be more likely to trigger a depressive episode in someone with an underlying vascular vulnerability to depression.

-References can be found on Page 20-

Consider This: Toward a Bold Future in Clinical Geropsychology

Steve H. Zarit, Ph.D.

Editor's Note: In this edition of the "Consider This" column, we feature the 2006 M. Powell Lawton Award Winner, Dr. Steve Zarit. Dr. Zarit is Professor and Head of the Department of Human Development and Family Studies at Penn State University. He conducts research on family caregiving and on psychological functioning in very late life, and is co-author with his wife, Judy M. Zarit, of the new book, Mental Disorders in Older Adults.

It was an honor to be recognized by my colleagues, and particularly to receive this award named in memory for M. Powell Lawton. Powell set a standard of excellence that all of us in Clinical Geropsychology can strive for. He was an engaged scientist who applied his skills to intriguing problems that advanced the field and contributed to improving the quality of lives of older people. He also played a key role in the development of geropsychology, including serving as the first editor of Psychology and Aging, and as a member of the planning committee that established the Committee on Aging (CONA).

I want to take the opportunity to reflect on my own career, and to make some observations on the development of Clinical Geropsychology. I found my way into Clinical Geropsychology not because of an organized plan but through a series of chance events. For my doctoral studies, I wanted to focus on adolescence and to combine research and clinical training, so I went to the Committee on Human Development at the University of Chicago, which offered those possibilities. I was soon drawn to the strong program there in adult development and aging. The faculty at that time included many of the founders of the field, including Bernice Neugarten, Robert Havighusrt, and William Henry, and younger faculty like Morton Lieberman and Sheldon Tobin, who were advancing into new areas. Another faculty member, Robert L. Kahn, was among the first group of psychologists and psychiatrists who integrated an understanding of aging with clinical principles appropriate for working with older adults. Kahn taught me to look beyond the status quo in thinking about standards of care, and to be guided by what he called the "Principle of Minimum Intervention," that is, choosing interventions that were least intrusive and that did not undermine the older person's remaining areas of independence or control. Minimum intervention was possible by identifying treatable aspects of a situation. An older person with severe dementia, for example, might not be able to initiate changes to improve his or her situation, but the family might be able to make changes or there might be changes in the environment or routines that could support the person's autonomy.

Over the course of my career, I have often been asked whether I find it boring to work with older people. That has never been the case. Clinical practice and research with older people is always intellectually challenging and emotionally satisfying. Assessment and treatment depend on drawing on a wide array of knowledge and experience. Older people, too, have a lifetime of learning and experience that they can draw upon in addressing their current problems. Practice and research are quite satisfying, because it is possible to make a difference by applying sound clinical principles to the problems of aging. Even the most difficult circumstance can be improved through a careful assessment that leads to accurate diagnosis and identifies antecedents and consequences of current problems, and by interventions that target treatable aspects of the situation.

I have never looked back with regret on my decision to specialize in Clinical Geropsychology, but I am continually amazed at how slowly the field has grown. There have been advancements, such as the creation of Section 12/2 and CONA, but there are still very few doctoral programs that offer specialized training, or even the occasional course or practicum in Clinical Geropsychology. As a result, current and projected needs greatly exceed the availability of trained geropsychologists. One needs only to venture into the nearest nursing home, where residents' mental health problems go largely untreated, and, if there is a psychologist at all, that person lacks the background and skills to make a difference.

To address this situation, we need to renew our efforts to bring new people into the field and to expand training opportunities, including for established clinicians who want to acquire specialty training. But I also think we should be less polite about how we go about it. Efforts to persuade our colleagues in psychology have not been particularly effective up to now, and so I want to suggest some new approaches for 12/2 and CONA.

The starting point is to recognize that many psychologists have strong ageist biases that lead them to thwart actively the development of Clinical Geropsychology. When I served on CONA, I had the opportunity to go to APA's joint meetings that bring together all the organization's various committees. In conversations with psychologists from other specializations, I was continually amazed at their ignorance of the most basic facts about aging and the biased views they held. Our colleagues are people who rightly have recognized that the field cannot be based only on a psychology of white men, but must incorporate an understanding of women, minorities, people with disability and those with varied sexual orientations into our research and clinical practice. But mention aging, and they have all sorts of excuses for omitting from research and clinical training the 13 percent of the population that is 65 and over.

Since persuasion has not changed this situation, we need to look toward enforceable standards. Recognizing the social need, Britain requires that most clinical psychologists in training get at least some exposure to clinical geropsychology. We should do the same. One place to target is accreditation. Just as it would be inappropriate for APA to endorse a program that actively omits training about women or minorities, so should accreditation depend on the inclusion of appropriate training about older people. This requirement could be flexible, that is, allowing programs to offer either geropsychology or to address another group that is relatively underserved, children. Our colleagues will complain that they already have to meet so many requirements that they cannot add one more, but I am sure we could find a way to help them integrate geropsychology into their programs.

We can also approach this issue at the licensure level. Licensure is designed to assess some minimum proficiency, so it makes sense that anyone who is intending to work with adults should have some knowledge about what happens when adults grow older. They will have clients who are older or whose concerns involve parents or grandparents. Our colleagues sometimes give their clients the most appalling advice about a parent or grandparent.

Training in Clinical Geropsychology needs to be a national priority. Although some new training money has become available, it remains the case that the field will not grow unless there are incentives to bring new people into it. The availability of federal support for training has to be expanded, not just at the postdoctoral level where most of the federal effort has been placed, but at creating specializations at the predoctoral level, so that students can incorporate geropsychology perspectives as they get a basic foundation in the field. APA also needs to look for private support for training. The Hartford Foundation has an excellent program of support for training in aging for nurses and social workers, but not psychologists. These programs have seemed promising, and so we need to encourage a foundation to come forward that will support training in psychology.

We also need broad guidelines for current clinical psychologists to obtain specialized training in aging. These guidelines need to be matched with a proactive approach of providing accessible training at appropriate levels by people with expertise in Clinical Geropsychology.

Finally, there need to be undergraduate courses in the psychology of aging at every university. Students do not know that there are opportunities to work with older adults. Undergraduate courses can open up students to the array of possibilities of careers in aging. Many students have done service learning with older adults, and they are interesting in learning how they might incorporate that experience into a career. It has always been my experience that showing them that aging is interesting and important and that it is possible to treat older people helps students look upon gerontology in a new light.

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

Michele J. Karel, Ph.D.
Bob Knight, Ph.D.

In the previous newsletter, we detailed the background, goals, planning process, and our experience of the 2006 National Conference on Training in Professional Geropsychology. In this column, we want to share preliminary conference outcomes and detail some "next steps" for which we will be seeking your input and participation.

The Pikes Peak Model: Major Conference Themes

Several major themes emerged from conference deliberations, regarding key elements of training for developing geropsychology competence.

Levels of specialized training: The conference wrestled with the dialectical tension between, on the one hand, wanting to assure a supply of trained specialists who can provide competent services to older adults and their families and, on the other hand, our commitment to encouraging large numbers of practitioners to increase their work with older adults. We recognized that many practitioners see older adult clients who are similar to their younger adult clients, and we did not see a need for specialized training for this level of practice. Training for geropsychology competence is desirable for newly trained professional psychologists and for more senior psychologists who begin working with older adults later in their careers, who desire to work with older adults for a large part of their practice or who see older adults with needs differ from those of younger clients. This level was the main focus for this conference. We also spent some time defining a leadership level of expertise for professional geropsychology, which was seen as representing an ABPP level of clinical expertise and/or a level of expertise acquired by those who would train the competent geropsychologist.

A Focus On Competencies: One major outcome of the conference was to focus on developing competencies for geropsychology practice, rather than to define specific courses, semester hours, practicum hours, internship rotations, and other program elements needed for training. This approach puts geropsychology in line with current trends in professional psychology training (Kaslow, 2004; Rodolfa et al., 2005) and provides for flexible pathways to geropsychology competence. A draft list of attitude, knowledge, and skill competencies for geropsychology practice was presented to the conference delegates. The draft was extensively revised at the meeting, and the planning committee is further polishing the list before seeking final review by all conference participants. It includes sections on Attitudes, Knowledge Base in Aging, Foundational Skills, Assessment Skills, Intervention Skills, Consultation and Training Skills, and a section on Leadership/Expertise. The competencies list will be disseminated broadly in publications coming from the conference. There are also plans to develop assessment and self-assessment tools that can be used to evaluate one's attainment of geropsychology competencies.

Multiple pathways: The conference strongly endorsed the concept of multiple pathways to competence in professional geropsychology. Further, the conference highlighted two important principles to guide training efforts: (1) to define high standards for competent professional geropsychology practice, and (2) to open pathways for entry into the field and for generalists to enhance competence for working with aging clients. We recognized that trainees may enter specialized training programs in professional geropsychology at graduate school, internship, or postdoctoral fellowship levels. The conference delegates agreed that any of these paths is valid, as long as broad competence is attained in the sense spelled out in the list of competencies. In a move that is likely unique among developed training models, the Pikes Peak model also recognizes that most professional psychologists working with older adults come to the specialty after formal training and licensure in the practice of psychology. Conference delegates agreed that post-licensure training is an important pathway to working with older adults. Thus, there is a need for extensive development of training resources to include both didactic geropsychology training as well as professional consultation on

clinical work with older adults, to allow post-licensure psychologists to attain the same level of competence as would be expected of a new graduate from existing programs for trainees.

Core elements of training: The Pikes Peak Model pointed to a variety of elements considered central for attaining geropsychology competence, including: didactic training equivalent to that included in a graduate level course in adult development and aging plus a graduate level course in clinical geropsychology; didactic and clinical training by competent geropsychologists; training experience that includes more than one clinical setting; clinical training with a wide variety of older adult clients; clinical experience working with interdisciplinary teams; a focus on ageism, including personal ageism; cultural competence and awareness of cultural and individual diversity issues as they affect older adults, communities, and care systems; and training that includes both didactic and clinical training, with clinical training including some observation of the trainee/mentee's work (directly or through taping of sessions).

Next Steps

After reviewing the major outcomes, we discussed a range of possible steps to move towards implementing the Pikes Peak model.

Creating a new training council: One unexpected outcome of the conference grew out of conference delegates' frequent comments about their excitement in getting together and talking about training issues. Many delegates have been trainers in professional geropsychology for a number of years, but remarked that the conference offered the first opportunity to sit down and talk in detail with persons at other programs, at other levels of training, and across other ways of dividing up specialties (e.g., clinical, counseling, health psychology, neuropsychology). At the end of the conference, this excitement merged with the recognition that there were a number of tasks needing follow up work (assessment tools to evaluate competencies; program development for post-licensure training, and others), and the thought that it could be strategically valuable to have an organization of training programs that is, like other training councils, separately incorporated and independent of APA. We are doing preliminary work, in collaboration with conference delegates, in defining the structure for such a council, and then will be inviting broad participation from you all.

Sharing Resources: Delegates agreed it would help all of us to share tools we have developed for our own training programs, such as reading lists, seminar syllabi, practicum models, competency evaluation tools, and so forth. A training council may be a forum to facilitate sharing, but it may be possible to begin this process sooner.

Developing Assessment Tools: Delegates agreed that it would be very useful to develop geropsychology self-assessment and training evaluation tools, based on the geropsychology attitude, knowledge, and skill competencies defined and elaborated through the conference work. Such tools would be useful within formal training programs, but also for post-licensure psychologists to help determine individual needs for education and training within professional geropsychology.

Publishing conference outcomes: The conference planning committee is working to publish a series of papers to summarize the Pikes Peak Model for training in professional geropsychology. We hope such publications will be useful for training program directors, those interested to develop new programs, students, and practicing psychologists in developing individual or formal programs of study/training in the field.

Advocating for funding: We all recognized that, without funding for geropsychology training, it is impossible to develop, expand, or maintain training programs. We must continue to work to advocate, within APA and as citizens, for support for training future generations of geriatric health and mental health care providers.

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Special APA Report: Post-Katrina Stress and Resiliency

Victor Molinari, Ph.D.

When I first became a member of APA's Committee on Aging, I had no idea what exciting and fulfilling things that I would become involved with! Rosemary Blieszner, CONA committee member and chair-elect, mentioned at our spring meeting that her colleague at Virginia Tech, Dr. Tammy Henderson was collecting data on the psychological effects of hurricanes. Dr. Henderson suggested that concurrent with the APA convention, perhaps CONA could develop a program to provide assistance in reducing the distress of Area Agency on Aging (AAA) workers who were providing services to older Hurricane Katrina victims and in the process help with her data collection. As one of the 'clinical' members of CONA, I offered to assist with this project if Debbie DiGilio, Director of APA's Office on Aging, would negotiate the logistical details. Division 20 President Neil Charness generously proposed to help defray some of the financial costs of this endeavor. Section 2 was also approached, and Bob Intrieri (President), Suzanne Meeks (President-elect), and Lee Hyer eagerly volunteered to conduct the workshop.

Although I had worked for many years with WWII and Korean War veterans, stress and PTSD were never my particular areas of expertise. Luckily, it is doubtful that there are three more qualified people in the area of stress management and the effect of stress on older adults than Lee, Suzanne, and Bob. Indeed Suzanne had recently prepared a stress management workshop with her colleague Tamara Newton, which was easily altered for our purposes. We quickly went to work drafting such modifications and fashioned the goals of the workshop: to discuss the definition of stress; sources of stress; effects of stress; strategies to prevent/reduce stress and improve self-care; signs of stress in oneself; and finding help. Since CONA members felt that the sessions should be positively focused and personally relevant, we arranged 'break-out' exercises at various points during the didactic presentations to give voice to their personal stories.

In consultation with Catholic Charities, Catholic Community Services, and the Governor's Office of Elderly Affairs, we chose to hold sessions both in Baton Rouge and New Orleans for those service workers who were still in the 'thick of things' trying to assist older Hurricane Katrina victims and who were at high risk for developing 'compassion fatigue'. Debbie DiGilio and Bob Intrieri did yeoman's work in making the final arrangements. Ten people attended the morning workshop session in Baton Rouge; the afternoon session had five. Approximately 35 attended the morning session in New Orleans, and 25 went to the afternoon session. I must acknowledge that Lee and Suzanne did the bulk of the 'heavy lifting' regarding the didactics in Baton Rouge and New Orleans respectively. Bob and I assisted in making comments and posing relevant questions to the participants. The breakout groups were facilitated by Shirley Watkins, Miguel Lewis, and Jenie Liang, three fellows from the GPE-funded geropsychology post-doctoral program jointly sponsored by USF and the Tampa VA. This experience certainly fulfilled the spirit of the GPE mission of training students to serve disadvantaged older adults in underserved settings (even though the workshop targeted formal caregivers). Let's hope that the GPE specially earmarked geropsychology funding gets re-instated so that Fellows can continue to gain such important experiences. Katherine Yeager (a student of Lee's) and Bob Intrieri also provided able assistance with the exercises.

As the one organizer who had free time to spend observing the participants, it was clear to me that we had achieved our purpose of providing stress management material in a user-friendly format. We offered a forum to allow the ventilation of AAA workers' feelings and concerns. Participants particularly emphasized how the 'trauma' was ongoing, and how tension is generated by the great need for services far outstripping available resources to satisfy them. One of the group assignments asked participants to gauge their levels of satisfaction with a variety of aspects of their lives (e.g., intimacy, work, spirituality), and allowed them time to discuss how these aspects might be balanced in a more rewarding manner. We ended with a relaxation exercise, a kind of parting gift from the presenters.

All attendees were also given a community mental health resource guide list compiled by Debbie DiGilio and were encouraged to take care of themselves.

After the morning session was finished, one of the supervisor participants from the Governor's Office in Baton Rouge was so impressed that she literally began making phone calls to draw more participants to the afternoon group. I understand that the New Orleans participants were equally generous in their praise. The presenters all recognized that our program was a small step in alleviating some of the emotional distress of the AAA workers, but it was a symbol that members of APA, CONA, Division 20, and Section 2 cared deeply enough to provide support during the busy convention to these stressed, resilient, and courageous relief workers.

THANKS TO SOCIETY OF GEROPSYCHOLOGY CONTRIBUTORS!!

On behalf of the Board and members of the Society of Geropsychology, we give our great thanks and appreciation to the following colleagues who generously made contributions to the Section over the past year!

Rebecca Allen	**Joan Cook**
Paul Duberstein	**Bob Knight**
Elizabeth Kolin	**Peter Lichtenberg**
Margaret Norris	**Elaine Oxman**
Thomas Reid	**Antonette Zeiss**

CONGRATULATIONS AGAIN TO WINNERS OF 2006 SOCIETY OF GEROPSYCHOLOGY APA AWARDS!!

The Distinguished Clinical Mentorship Award: Dr. Deborah King

The Student Research Award: Caitlin (McEntarfer) Holley

Powell Lawton Award Winner: Dr. Steve Zarit

Student Paper Award (Continued from Page 14)

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The Student Voice

Caitlin K. Holley, B.A.
Student Representative

I am very excited and proud to serve as your new junior student representative, and would like to take this opportunity to tell you a little about myself. As I first became interested in the field of geropsychology, I was somewhat surprised. The reason for my surprise is that I can recall as a young girl many trips to the nursing home to visit my grandfather, who suffered from Alzheimer's disease, which were rather upsetting to me. I did not understand the nature of the devastating disease and therefore chose to avoid it. Years later, I pursued my interest in psychology as an undergraduate at Nazareth College of Rochester, NY and was offered a job at a nearby nursing home as an activities coordinator. I was assigned to work on a unit with individuals suffering from dementia, and decided to take this opportunity to face an old fear of mine, in honor of "Mac," my grandfather. I quickly found I loved the job and the people I worked with. This experience allowed me to realize the compassion I feel toward this population, as well as the immense need for improved mental health services.

Since that time, I have continued to pursue education and experience working with older adults as a graduate student at the University of Louisville. Clinically, I have really enjoyed working with elders in inpatient settings, such as nursing homes and hospitals. In my work with Dr. Benjamin Mast, I have explored my interest in late-life depression through research examining the effects of vascular and psychosocial risk factors. As I dove deeper into my studies, I began to focus my interests more specifically in the area of depression and spousal bereavement. Now, as I begin by third year, I am continuing to study the phenomenon of anticipatory grief and spousal care giving and further exploring my clinical interests in geropsychology as well.

As your new student representative, one of my goals for is to get more students involved with each other and with their membership in Division 12-II. One upcoming opportunity I hope you will take advantage of is attending the division's student breakfast being held at GSA this year. The purpose of this event is to share ideas and thoughts about how we can make student membership more meaningful and rewarding. It is also a great opportunity to meet, get to know and share your experiences with other student members. If you are interested or have ideas you'd like discussed, please contact me (c.holley@louisville.edu) for more information on this event. I also encourage you to contact me with any ideas of how student involvement can increase, or with any questions about membership. Kathryn Moss (moss024@bama.ua.edu) and I are excited to serve as your student representatives and hope that you will utilize our services in any way possible to ensure that you are satisfied with your membership.

NOW THAT'S FUNNY!

Karyn Skultety, PhD

THE SENILITY PRAYER: Grant me the senility to forget the people I never liked anyway, the good fortune to run into the ones I do, and the eyesight to tell the difference.

- Submitted anonymously

Life is like a roll of toilet paper -- it spins faster as you near the end.

- Submitted by Jerry P. Nims, J.D., Ph.D

Now that I'm older…
…my wild oats have turned into prunes and All Bran.
…I finally got my head together; now my body is falling apart.
…I don't remember being absent minded…
…all reports are in; life is now officially unfair.
…it is easier to get older than it is to get wiser.
…I wish the buck stopped here; I sure could use a few…
…kids in the back seat cause accidents…accidents in the back seat cause…kids.
…I'm finally holding all the cards and everyone else is play chess.
…it's not hard to meet expenses…they're everywhere.
…I spend a lot of time thinking about the hereafter…I go somewhere to get something and then wonder what I'm here after.

- Submitted anonymously