CLINICAL GEROPSYCHOLOGY NEWS

SOCIETY OF CLINICAL GEROPSYCHOLOGY

APA DIVISION 12, SECTION II **VOLUME 14, NUMBER 2**

INSIDE*

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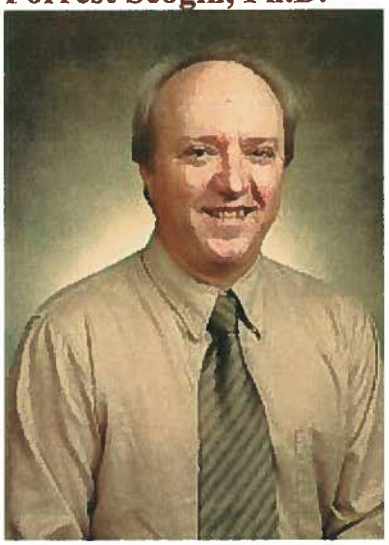
*Published articles do not necessarily represent the official views of Section II, Division 12, or APA

Check out all of the Society of Geropsychology activities at this year's APA conference!
A full listing is on page 10!

ELECTION TIME IS AROUND THE CORNER! Watch your e-mail and mail for information soon!

President's Column:

Forrest Scogin, Ph.D.



*H*ello again everyone! The Society's big event of the year-the APA Convention-is just around the corner and we have a terrific slate of events. I hope many of you will be able to join us in San Francisco. Suzanne Meeks, President-Elect, has arranged several noteworthy events including a symposium on future directions in intervention research on late life mental disorders featuring Society members George Niederehe and Dolores Gallagher-Thompson and our M. Powell Lawton Award for Distinguished Contributions to Clinical Geropsychology address, to be delivered by Professor Gallagher-Thompson. Please plan to attend the Society's Business meeting on Sunday August 19th at 3 PM during which we will present our Student Research Awards and our Mentor Award as well as take care of the more mundane business of a Business meeting. To cap it off, we will have our annual shared dinner event with Division 20 on Sunday evening.

In my previous column I shared with you my Presidential Initiative: Advancing training in clinical geropsychology. More specifically, I

pledged to contact at least one private foundation to determine their interest in receiving a full proposal to fund predoctoral training in clinical geropsychology. With the help of several people smarter than me, I prepared a two page prospectus that laid out the advantages of building infrastructure in clinical geropsychology for the well-being of older adults. I sent the prospectus to a large private foundation, thinking they might want to hear more in a full proposal…but alas they said, "Thanks, but no thanks." I will have more to say about this in my Presidential Address at APA but I have not given up the fight yet. I have six months to go as President and one year as Past-President and I vow to continue to knock on doors. By the way, if you know any benefactors who may be interested in the above let me know!

Big thanks to Steven David and Rachel Rodriguez (Website coordinator) for making information on training opportunities in geropsychology more timely. Steven saw a need and asked not what his Society could do for him but what he could do for his Society. The need was for a mechanism whereby information on internship and postdoctoral training could be updated as needed rather than on an annual (or more) basis. The information will be of great help to students and those who advise students.

I wanted to say a few words about our listserv. What a useful tool and everyone is so nicely mannered! We are alerted to advocacy opportunities (or should I say responsibilities), share useful clinical and research information, and keep connected to one another. Barry Edelstein, the bashful one, has maintained this listserv since the inception of 12/2, I believe. Thanks Barry for your service to the Society!

Something that I didn't know about until recently was that we also have a student listserv. The address is: D12_2_STUDENTS@ ARTSCI.WUSTL.EDU. Our student representatives, Caitlin Holley and Kathryn Moss, have endeavored to increase traffic on the student listserv. Kathryn is rotating off as one of the student representatives and I am pleased to introduce our newest student representative, Sarah Yarry from Case Western Reserve University. We had several outstanding students volunteer for this position and we would have done no wrong in choosing any of them.

This leads me to a very important topic. Soon you will be receiving information on elections for the Society. This year we will be selecting our President-elect and Treasurer. Please take time to vote! Let's have a good turnout!

I have continued with presidential duties which include writing letters of support to advance interests of the Society, maintaining contact with APA through the Committee on Aging, Division 20, and Division 12, and conducting periodic telephone Board meetings. It's been a fair amount of work but fun so far. Finally, thanks to the Board of Directors for being such a hardworking yet agreeable set of collaborators! Carry on.

Editor's Note: San Francisco!

Karyn Skultety, Ph.D.

With APA just around the corner, I thought I would take this opportunity to welcome you to San Francisco! I feel incredibly lucky to call San Fran home and encourage you to explore our great city. In addition to enjoying the Union Square and Fisherman's Wharf attractions (which you can read about in any guide book), I thought I'd give a few recommendations for those looking for San Francisco experiences a bit more off the beaten path (a quick Google search on the bolded terms will get you more info). Note: I won't be responsible for you not enjoying any of these recommendations or enjoying them so much that you miss your conference events! First, explore **the Castro and Mission neighborhoods**. Take a walk around historic **Dolores Park** (Dolores & 18th street) or **Harvey Milk Plaza** (Castro and Market streets) and then head out to find great restaurants, shopping and true San Francisco diversity and culture. Restaurants include **Delfina, Levende Lounge, 2223** and more! Next, try a great cup of coffee from one of **Philz' coffee shops (www.philzcoffee.com)**. Phil himself may brew your cup! Then, for a healthy and unique experience, visit **Rainbow Grocery** and/or **Café Gratitude** which highlight vegetarian, vegan and raw cooking, as well as San Fran spirit! Finally, visit an art **gallery in the SOMA** neighborhood, walking distance from Union Square (http://sanfrancisco.about.com/od/artsentertainment/a/sfartgalleries3.htm). Enjoy and welcome to San Francisco!

Executive Board Meeting Summaries: 3/19/2007 & 5/14/07

Bradley Karlin, Ph.D.
Secretary

Executive Board Meeting of March 19, 2007 Society of Clinical Geropsychology Meeting held via telephone conference

The meeting was called to order by President Forrest Scogin at 4:05p ET. In attendance were Forrest Scogin, Brad Karlin, Jon Rose, Martha Crowther, Deborah King, Suzanne Meeks, Karyn Skultety, Dan Segal, Paula Hartman-Stein, Amy Fiske, Kathryn Moss, Margaret Norris, and Deborah Digilio.

Secretary Report – Brad Karlin: Minutes from the January 22, 2007 Executive Board Meeting were approved. The minutes were previously distributed via e-mail.

APA Convention 2007 – Suzanne Meeks: Suzanne reported that there is little new information to provide for the convention. Plans for the joint dinner at the convention with Division 20 are taking shape. The dinner will be held on Sunday evening.

Division 12 Representative Report – Deborah King: Marsha Linehan, the new Division 12 President, has expressed interest in updating the list of evidence-based psychological treatments. Forrest plans to contact her regarding his work on evidence-based psychotherapy for depression in older adults.

Division 12 is developing a diversity initiative. The Board agreed that Angela Lau, Chair of the Society's Diversity Committee, should be the Society's liaison to this effort.

Linda Sobell is chairing a Division 12 Identity Task Force, whose charge is to further define the identity of the Division. The Task Force will have four main areas of focus: (1) evidence-based practice, (2) attracting early career members, (3) enhancing attention to diversity, and (4) greater collaboration among sections of the Division. There was some discussion of the value of showcasing and promoting Sections' scholarly efforts.

Treasurer Report – Jon Rose: Expenses are thus far in line with projections. Jon noted that because the CE workshop submitted for the APA convention was not approved (see below), the $500 projected income from the workshop will not be realized. Jon has looked into options for the Society to open an interest-bearing bank account. Most banks have restrictions on non-personal accounts; however, the Society could open a money market account with the Franklin Money Fund. Although the account would not be FDIC insured, Jon reported that the company has a longstanding, solid reputation. A motion was made by Suzanne, seconded by Forrest, and passed by a majority of Board members present to authorize the Treasurer, Jonathon M. Rose, to open an account for APA Division 12, Section II, with the Franklin Money Fund. The President, Forrest Scogin, is also authorized to deposit and withdraw funds from the account. Funds may be transferred from the Section's account at Washington Mutual at the discretion of the Treasurer or the President.

Membership Report – Martha Crowther: The Society currently has 148 paid members. Of these 148 paid members, 29 are student members. More than 45% of full, paid members are also members of Division 12, as required by Division 12. Martha reminded the Board that this is her last year as Membership Chair. The Board discussed beginning to look for candidates interested and available to serve as Membership Chair following Martha's term. There was some discussion among the Board about providing first year membership (currently $10) free to students; however, Kathryn indicated that the $10 membership fee was not a barrier to student membership. The Board elected to consider this issue further at a later time, perhaps after seeking further student input.

Newsletter – Karyn Skultety: Karyn reported that the newsletter is running smoothly, with the next issue scheduled to come out the end of the month.

Website Update – Steven David and Rachel Rodriguez: Forrest read the report submitted by Steven and Rachel. Steven and Rachel are working on updating information on psychology training programs (graduate, internship, and postdoc) with a geropsychology emphasis or track. A request from student members was made to update the student section of the website to include an updated reference list and list of training program contacts.

Interdivisional Healthcare Task Force – Margaret Norris: Margie reported on the meeting of the Interdivisional Healthcare Task Force. She reported that in attendance were representatives from a number of APA divisions and the Practice Directorate. She noted that pediatrics was heavily represented. Issues of interest to the Task Force include Medicare cuts, Health and Behavior (H&B) CPT codes, and Medicaid issues. The Society still needs to identify one more representative to serve on the Task Force.

Continuing Education Committee – Ann Pearman and Dan Segal: Dan provided the CE Committee report. Dan reported that the workshop proposal submitted for the APA convention by Delores Gallagher-Thompson and Pat Areán was not accepted, though it was not clear why this was. Additional information will be requested from the convention submissions office.

Mentoring Committee – Amy Fiske: Administration of the web-based survey of Society members regarding mentoring experiences and practices has been completed. The Mentoring Committee is about to begin data analysis.

Student Representative – Kathryn Moss and Caitlin Holley: Kathryn reported that student members are interested in hearing more about job opportunities. As noted above, student members have expressed interest in additional updated information on the student section of the Society website.

Office on Aging Update – Deborah DiGilio: An APA workgroup on Cultural Competency and Geropsychology has been developed. Several members of the Society serve on the workgroup.

Senators Clinton and Kennedy will be re-introducing the provisions of the Positive Aging Act to support the integration of mental health services in primary care settings. These provisions comprise Title II of the Positive Aging Act of 2005 (109th Congress). Significant proivisions from Title I have already been enacted as part of the reauthorization of the Older Americans Act last year.

APA President Sharon Brehm has initiated a Presidential Taskforce on Integrated Healthcare for an Aging Population, co-chaired by Toni Zeiss and Toni Antonucci, with representation from several other members of the Society. The Society will have a formal representative on the Task Force.

CMS Quality Performance Initiative – Paula Hartman-Stein: A workgroup comprised of psychologists and social work has recently been established by a company, Quality Insights of Pennsylvania, which has a contract with the Centers for Medicare and Medicaid Services to develop outcome measures for bonus payments to Medicare providers, including psychologists and social workers that submit outcome data. This initiative is an outgrowth of the pay-for-performance trend in Medicare, and healthcare generally. Paula is serving on the workgroup, which has held several conference calls. The initial task of the work group is to advise Quality Insights on best practices. The Board discussed with Paula gold standards and best practices related to psychological screening, which the workgroup has been the focus of the recent meetings of the workgroup. Brad recommended adopting procedures recommended by the United States Preventive Services Task Force (USPSTF).

Recommended Guidelines in Postdoctoral Training in Psychopharmacology for Prescription Privileges and Model Legislation – Forrest Scogin: The Society has been asked to comment on the *Recommended Guidelines in*

Postdoctoral Training in Psychopharmacology for Prescription Privileges and *Model Legislation*. The guidelines vaguely refer to "developmental status," but do not specifically address geriatric issues. The consensus of the Board was that the guidelines should be more specific to account for important aging-related issues in pharmacokinetics and psychopharmacology. The Board agreed that the Society would submit a comment addressing the importance of specifically addressing geriatric issues in psychopharmacology.

Current Issues – Forest Scogin: The Board prepared a letter in support of a conference being proposed by the Healthy Aging Network that would focus on the topic of depression. If funded, several Society members would be presenters at the conference.

The Board prepared materials for the nomination of George Niederehe for the Board of Scientific Affairs (BSA) Meritorious Research Service Commendation.

Forrest followed-up with Routledge Publishing about the possibility of establishing a geropsychology journal to be sponsored by the Society. Routledge expressed strong interest in talking with the Board. Forrest agreed to try and arrange for the representative from Routledge to talk to the Board at the next Board Meeting.

Presidential Initiative – Forrest Scogin: Forrest has approached the Hartford Foundation about establishing a scholarship/fellowship program for psychology trainees focusing on aging, similar to other programs the Foundation has funded for other disciplines, such as social work. Forrest reported that the Foundation indicated that it is not interested in receiving a proposal. Forrest said that he would try and follow-up with the Hartford Foundation to get some additional information and explore other potential funding sources, including possibly the Brookdale Foundation. In addition, there was some discussion about the possibility of establishing an achievement award, similar to the Margaret Baltes Award, for early career professionals in geropsychology. The Board supported this idea.

Executive Board Meeting of May 14, 2007 Society of Clinical Geropsychology Meeting held via telephone conference

The meeting was called to order by President Forrest Scogin at 4:05p ET. In attendance were Forrest Scogin, Brad Karlin, Jon Rose, Suzanne Meeks, Bob Intrieri, Barry Edelstein, and Deborah Digilio.

APA Convention 2007 – Suzanne Meeks: The Society Business Meeting, Board Meeting, and joint dinner with Div20 have all been scheduled.

Division 12 Representative Report – Deborah King: Forrest read the report submitted by Deborah King. The Division 12 Identity Task Force, which Deborah reported on at the last Society Board Meeting, has begun its work. The charge of the Task Force is to further define the identity of the Division and develop recommendations for ways in which the Division can better serve the Sections. The Task Force will have four main areas of focus: (1) evidence-based practice, (2) attracting early career members, (3) enhancing attention to diversity, and (4) greater collaboration among Sections of the Division. The Board has emphasized the potential value of this group in promoting collaborative opportunities for scholarly achievement among Sections.

Treasurer Report – Jon Rose: Expenses remain in line with projections. Jon requested that Board members contact him with items they would like included in the 2008 budget.

Membership Report – Martha Crowther: There was no membership report. Ann Pearman will become our Membership Chair once Martha completes her term at the end of the year.

Newsletter – Karyn Skultety: Forrest read the report submitted by Karyn. The last newsletter was released as scheduled.

Website Update – Steven David and Rachel Rodriguez: Forrest read the report submitted by Steven and Rachel.

Consider This: Never Too Old to Be Too Thin

Trisha Gura, Ph.D.

Trisha Gura, Ph.D, is author of "Lying in Weight: the Hidden Epidemic of Eating Disorders in Adult Women." (Harper Collins, May 2007). website: www.trishagura.com.

She died of pneumonia. At least that is what her death certificate noted. On a Sunday evening in March, G.G. (for great grandmother), 87, threw up so violently that she aspirated her vomit and infected her lungs. Her death was an unfortunate accident.

Or was it?

Before she threw up on that fateful evening, G.G. attended a party. She "stuffed herself," as she often did upon these uncommon occasions when she went out. Then she stuck her finger down her throat. "Every so often you just have to have a good upchuck," she once told her granddaughter.

This practice was born out of decades struggling with diverticulosis. She felt the stomach pains, ran for the bathroom and did what she did to relieve her discomfort. But diverticulosis was more than a physical condition for G.G. It was a catch-all for all of her aches and pains, physical as well as mental. Over the years, diverticulosis became the name she gave to all her negative feelings. And out of that she acquired bulimia, in late life. This is an occurrence considered so rare by the mental health community, perhaps a case report in a medical journal.

Indeed, few practitioners are reporting that women in later life are seeking treatment for eating disorders.[1] There are a handful of scattered medical reports of women in this age group with anorexia, fewer about those with bulimia and none about binge eating disorder. However, this paucity does not make sense. Multiple studies have demonstrated that eating disorders linger, sometimes in active form, for decades.[2,3] Therefore, why would mental health practitioners accept that a woman who had been ill through midlife would wake up on her sixty-fifth birthday, suddenly free of her eating disorder?

Some explanations for this apparent discrepancy include a simple misinterpretation of the facts. The general public, including many health care practitioners not specialized in mental health, fail to discern that an eating disorder is an eating disorder in individuals who are entering the last third of their lives. The common perception is that behaviors tied to weight loss in late life are a natural part of growing old.

Indeed, geriatrician John Morley, M.B., B.Ch., at St. Louis University in Missouri, was one of the first researchers to study eating disorders in older patients. He notes that it is not uncommon for a person in later life to overuse purgatives.

"You get a few true laxative abusers," he says, "but it is usually because they have a fear that they are not going to have a stool rather than a desire to lose weight."

Thus, general physicians overlook symptoms of eating disorders in late life, and the diseases go undetected -- and untreated.

A second possible explanation for why researchers are reporting so few elderly patients with eating disorders is misdiagnosis. The general public has linked eating disorders to teenage girls who want to look like fashion models. The dismissal of an eating disorder in a patient such as G.G. arises from the corollary: How would a 68-year-old woman fit the premise of a teenager's model of disease?

The answer to the question is that she does not. The initial premise is erroneous. Anorexia in later life is typically not about the desire to look like a runway model. Rather, actions such as dieting, bingeing and purging, which comprise eating disorders, stem from habit, a need for control, and power-seeking -- even moreso than appearance. For this reason, researchers have classically called the most common eating disorder in later life "anorexia tardive" (meaning symptoms appear much later) to differentiate it from the anorexia nervosa defined by the DSM-IV. [4]

When the Eating Disorder Comes Second

Morley says that his group sees three general types of patients in late life with eating disorders.

The first, and most common, acquire eating disorders secondary to another physical or mental problem.

Late life eating disorders are diagnostically slippery; they tangle up with other ailments such as rheumatoid arthritis, cancer, heart failure, pulmonary disease, AIDS, Crohn's disease, anxiety and depression. But just as mental illnesses such as depression are often dismissed by even general physicians as a normal consequence of aging, so too is weight loss bound up in a number of other medical conditions.

"Mental illnesses are very underdiagnosed in this population because of stigma and discrimination," says psychologist Stephanie Townsend, program manager and policy analyst for the National Mental Health Association, based in Alexandria, Virginia.

Indeed, one in five adults older than 65 suffer from a significant mental disorder for which they receive no help.[5] Thus, eating disorders, part of that mix, go untreated in their own right, complicating recovery from physical problems and leading to costly and devastating emotional consequences.

At the same time, eating disorders often coincide with depression.[6] For example, a woman loses her husband. She stops eating. Did she get depressed and therefore lose interest in cooking? Or did she fear for her own mortality, embark on a weight and fitness campaign to stay vital, and as she lost too much weight and lapsed into anorexia, got depressed?

The chicken and egg dilemma is important to consider because studies show that anorexia typically fails to respond to anti-depressant and other medication. Therefore treating a person in late life with medication may ultimately fail to help her gain back weight. And the eating disorder component is, in essence, going untreated.

When the Eating Disorder Comes First

Next in number of individuals in late life with eating disorders are those who have been weight restrictors all their lives; an eating disorder in this case is merely a continuation of a lifelong problem or a relapse from a previous one.

"Those who suffer even a single, successfully treated episode in their youth, and therefore appear to have made a good recovery, may remain vulnerable to relapse even 50 years later," write Paul Cosford and Elaine Arnold, in one of the few medical reviews of the issue.[1]

This group is likely to increase in number soon as baby boomers, now edging beyond 60, will eventually move into later life, carrying with them their unprecedented attitudes and behaviors about diet and exercise. At present, eating disorders treatment centers are reporting triple and quadruple the number of women in mid-life checking in for treatment.[7] These are the very same women who comprised the eating disorders' epidemic in the 1980's, when bulimia first became an official diagnosis. Studies show that individuals with a history of an eating disorder are more prone to relapse later in life.[8 9 10] Therefore, Townsend and others predict that geriatric therapists will see in the next decades a corresponding rise in patients with late life eating disorders. They are aging baby boomers failing to deal with end of life issues.

Is It Really a First-Time Disorder?

The smallest group of individuals with eating disorders in late life is those who acquire the illnesses in later life for the first time; illness in these cases is "an adjustment problem" to the difficult circumstances of this life stage, perhaps after the death of a spouse or relocation to an assisted living facility.

It is important to note that eating problems in these cases usually do not emerge "out of the blue." A classic risk factor for an eating disorder at any time is a history of depression. For example, one woman who suffered two depressive episodes earlier in life experienced her first episode of bulimia at the age of 62, two years after the death of her husband, 23 years after the last depressive episode.[11] She became embroiled in a family argument at a wedding reception, became so upset that she went to the ladies' room and vomited. Two years later, she had repeated the eating and vomiting practices enough to meet the criteria for bulimia nervosa. It may be accurate to view the history of depression as a flag for her vulnerability to an eating disorder.

The death of her husband and family tumult only awakened the eating disorder beast, lying in wait for more than 23 years.

Late Life Trigger Points

Factors that trigger an eating disorder in late life include:

- Death of a loved one, in which the eating disorder is reaction based in grief
- Loss of autonomy, such as inability to drive, perform basic self-care or relocation to an assisted living facility
- Social isolation, in which meals are often eaten alone
- Loss of status in the family
- The battle against aging in which dieting and exercise is taken up as a perceived "fountain of youth" to ward off the ills of growing older.

The latest in this vein is the use of calorie restriction to prolong life. The longevity claims are based on animals studies in which young mice fed about 40 percent less than normal live up to 50 percent longer than mice fed normal diets.[12] More recently, researchers asked 48 people to cut back on their daily caloric intake by 25%, some exercising in tandem, and others, eating as little as 890 calories a day for two or three months.[13] The widely-publicized results celebrated decreases in blood sugar and insulin levels, body temperature, DNA damage and other signals linked to longer life. Even though the researchers cautioned against over-hyping the results or concluding that cutting calories long-term will make you live longer, people are jumping on the bandwagon, forming groups such as the California Restriction Society, which promotes a Spartan diet for long life.

Meanwhile, studies such as this alarm eating disorders professionals. They counter by saying that these studies have never been conducted long enough to draw any firm conclusions. Mice are not people. And, in fact, Morley points out that when the researchers conducted the same calorie-restriction studies in older mice, dieting did not protect the older mice against age-related declines.[14]

Who are Late Lifers and Why Do They Get Eating Disorders?

Generally, it is also important to note that late life is not homogenous. Individuals in late life split into two general categories. Psychologist Margaret Norris, a private therapist in College Station, Texas, who focuses on the psychology of aging, describes the first group as "young olds," individuals who are retired, relatively healthy, financially comfortable, independent, and actually living some of the dreams that they were not able to fulfill when young.

"Some people are very lucky, and this phase lasts a long time," Norris says. "But then illness or a life event strikes and the golden years become much more burdensome."

A "young old" is then forced to become an "old old." And this shift is not necessarily based on chronological age. Some 85-year-olds are quite healthy and vibrant. By contrast, some 65-year-olds suffer severe impairments. Mental illness can emerge in the transition. It is one thing to lose the ability to run due to knee problems in midlife and another entirely, to lose control of one's bladder, eyesight, or ability to drive an automobile.

Townsend notes that adults 64 and older often have trouble coping with these realities. The age group has the highest suicide rate of any segment of the population, nearly twice the national average.[15] Suicide expresses depression in its most tragic and severe form; an eating disorder is also a form of slow and very painful suicide.

Treatment Needs to Expand "Outside the Box"

The field of geriatric psychology and psychiatry is relatively small. In 2003, there were 2,285 American psychiatrists with a subspecialty certification training in geriatric psychiatry, and between 200 and 700 geropsychologists, far short of the 5,000 professional needed to meet future demands.[16,17] In some locations, health care practitioners with this specialty are nonexistent. Therefore, the onus is likely to fall on general mental health professionals to detect eating disorders, often buried in a mass of other mental and physical conditions, and often "secreted" by the individual who is suffering.

Diagnosis is key. Morley says one glaring indicator is weight loss. "When I see

somebody losing weight," he says, "I've got to work my way through all of these psychological and medical things that might be going on." To simplify matters, his team has come up with the mnemonic MEALSONWHEELS to describe the varied causes of weight loss in older adults. (For example, M stands for medication effects and E stands for emotional problems.)[18]

Medication such as anti-depressants may work in causes of bulimia or binge eating disorder.[19] Some cases of anorexia nervosa, especially those that come second to other conditions, respond to Megace (megestrol acetate), a synthetic version of the hormone progesterone.[20] Since 2005, patients have the option of newer form of the drug, Megace ES, which they can take on an empty stomach.

However, drugs often fail to treat deeply established eating disorders. Thus, treatment has to move toward psychotherapy. In that vein, one of the pioneers in late life psychology is Robert Butler, professor of geriatrics at Mount Sinai and president of the International Longevity Center. In the early 1960s, Butler came up with a promising concept called "life review."[21] It encourages reminiscing as a means for people to finally come to terms with unresolved conflicts, past hurts, and regrets from former years.

Norris notes the importance of tailoring therapies to both the strengths and limitations of this age group. For example, people in later life may be suffering from hearing problems or cognitive deficits. Therefore, a therapist needs to pay more attention to communication through means other than speech.

Conversely, Norris says that her patients love to tell stories about themselves, as sometimes she is the only one who will listen to them. Rather than trivializing the seeming tangents, Norris often uses them as a springboard to generate behavioral change. When family members ask what they might do for an ill relative, Norris responds, "The best gift you can give is your time."

Indeed, therapists might benefit from the same advice. This group of patients is suffering devastating mental pain. And their bodies are not those of teens and therefore are less resilient to the ravages of starvation, bingeing and purging. Every person at every age needs to feel beautiful, not for appearances sake, but for their wisdom, experience and wealth of untold stories.

[1]Paul Cosford and Elaine Arnold, "Eating Disorders in Late Life: A Review," International Journal of Geriatric Psychiatry 7: 491-498, 1992.

[2] Ibid

[3] P.F. Sullivan, "Course and Outcome of Anorexia and Bulimia Nervosa," in C. Fairburn and K. Brownell, eds., Eating Disorders and Obesity: A Comprehensive Handbook, 2d ed. (New York: Guilford, 2002), 22. 226-232.

[4] Peter Dally. "Anorexia Tardive: Late Onset Marital Anorexia Nervosa," Journal of Psychosomatic Research 18: 423-428, 1984.

[5] U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

[6] John E. Morley. "Anorexia, Sarcopenia and Aging," Nutrition 17: 660-663, 2001.

[7] Edward Cumella, interview with the author, March 18, 2005; Cynthia M. Bulik and Nadine Taylor, Runaway Eating: The 8-Point Plan to Conquer Adult Food and Weight Obsessions (Emmaus, PA: Rodale, 2005)

[8] The Long-Term Course of Severe Anorexia Nervosa in Adolescents: Survival Analysis of Recovery, Relapse and Outcome Predictors over 10-15 years in a Prospective Study," International Journal of Eating Disorders 22: 339-360, 1992

[9] D. Reas et al., "Prognostic Value of Duration of Illness and Early Intervention in Bulimia Nervosa: A Systemic Review of the Outcome Literature," International Journal of Eating Disorders 30 1-10, 2001.

[10] P. Keel et al., "Long-Term Outcome of Bulimia Nervosa," Archives of General Psychiatry 56: 63-69, 1999.

[11] Sian Cocker, "Onset of Bulimia Nervosa in a 64-Year-Old Woman," International Journal of Eating Disorders 16: 89-91, 1994.

-References continued on page 18-

Profile On . . .
Suzanne Meeks, Ph.D.

Although I have always thought of myself as an organized, "planful" person, my career in geropsychology is marked by numerous fortuitous accidents that are probably more important than any intentional plan I have made in leading me to where I am today. As have most of us, I have also benefited from the generosity and guidance of numerous mentors, without whom I would be nowhere at all. I'll list the most important of these up front, more or less in chronological order: Wayne Meeks (my father), Dennis Turk, Carol Glass, Diane Arnkoff, Cliff Notarius, Tom Wright, Laura Carstensen, Stan Murrell, George Niederehe, and Linda Teri. There have been, and continue to be, many others who have advised and supported me; nobody goes far on her own.

As a daughter of a university professor, I grew up on college campuses, but when I entered graduate school in 1980 I had no expectation of ending up in academia. I also had never heard of geropsychology, and there was no one teaching in my doctoral program at Catholic University who worked in that area. My undergraduate thesis (at Yale) was on special education teachers, and my M.A. thesis was on relationship stress in two-career couples. As my training advanced, I found that the clinical work, while interesting and challenging, did not sufficiently tickle that part of my left brain that needed intellectual stimulation in the form of reading and writing. Research, on the other hand, was fun! So, by the end of my third year, I knew I wanted to keep doing research. During my fourth year I also had my first teaching experience and learned that, despite my habitual shyness, I could survive standing up in front of a class on a weekly basis (I do feel sorry for those students though –I taught a class of intro to psychology with no faculty supervision!). Meanwhile, while I was flailing around looking for an interesting dissertation topic in the general area of stress and coping, my maternal grandmother, who at age 80 was still running her own business and playing 18 holes of golf every Saturday, got sick and entered into what I now understand as the "disability cascade."

As I watched her struggle with the changes her illness caused in her life, I found my dissertation topic: coping with illness in late life. Fortunately my supportive mentors at CUA helped me to find an outside reader with some expertise in gerontology, and I managed to put together a somewhat credible dissertation. For this research, I interviewed 100 or so older adults, and that was it: love. A calling: geropsychology. I looked for clinical internships that offered training with geriatric populations and ended up at a Springfield State Hospital Center in Sykesville, Maryland for my internship year, a sprawling, ancient, rural state Hospital somewhere between D.C. and Baltimore. There, I spent 6 months on a geriatric inpatient unit and fell in love again, this time with severely mentally ill elders. I was also very drawn to clinical work in an institutional setting, which seemed to fit me much better than traditional outpatient psychotherapy settings. It was there that I encountered the limits of all the rules I had learned in graduate school about how to do therapy and assessment (e.g., if there is no quiet, private room, testing or therapy in a partly empty dining hall is better than not doing it at all).

At the end of my internship year, realizing that I had very little preparation for an academic career, I looked for post-doctoral fellowships and wound up taking an NIMH clinical scientist training fellowship at Indiana University, working with Laura Carstensen. It would be impossible to list the many things I learned from Laura and the other faculty at IU during the two years I spent there, so I will just highlight two career-changing opportunities. First, Laura organized a behavioral gerontology conference in Bloomington during my first year at IU. This conference opened my eyes to an entire network of scholars doing behavioral gerontology, including Margret Baltes, Richard Hussian, Elsie Pinkston, Linda Teri, and Pat Wisocki (and of course Laura herself, who has gone on to make such an important theoretical contribution to the field). It is possible George Niederehe was also there – this was more than 20 years ago and the faces and times begin to blur a little.

(George was later to be the program officer on the majority of grant proposals I have submitted to NIMH, and has been a constant and invaluable supporter and guide for me, as he has for countless others.) I can still feel the thrill I felt then to be able to sit at the table with people on the leading edge of our nascent field and learn about their work. Few conferences I have attended since have so stimulated and inspired me, and none has so definitively marked my thinking about clinical issues in gerontology and how to study them.

The second important opportunity Laura gave me was to introduce me to the world of grant writing (and getting). I had not had any education on grant writing, nor had I worked with anyone who had obtained significant grants, so I was very naïve about this process. I remember Laura telling me that I should "just apply," to things, which may seem pretty obvious now but at the time was inspirational advice. Under her tutelage I applied for, and received, a GSA summer fellowship to do a needs assessment at a senior center in Winnetka, IL, and the same year Laura and I collaborated on an AARP grant proposal to begin looking at the needs and characteristics of severely mentally ill elders in the community. The second study really launched my career, because it both allowed me to see how I could get funding to do the type of research I most wanted to do, and introduced me to the intricacies of clinical field research. I was very fortunate to have the guidance of Tom Oltmanns, who was also at IU at the time, and who gave me a crash course in diagnostic interviewing and assessment of severe psychopathology. With the assistance of a number of intrepid IU graduate and undergraduate students, I set out into the wilds of central Indiana to interview older adults who had been treated in community health centers 20 years prior. This was research-as-adventure, and I had a great time.

In 1987 I moved two hours south to take the Assistant Professor position at the University of Louisville in what was then just called the Department of Psychology (we have a longer, hipper name these days). Reinforcing the "just apply" philosophy, my new colleague Stan Murrell encouraged me to write a proposal for an NIMH FIRST (new investigator) award to study the adjustment of middle-aged and older adults with long-term mental illnesses.
That grant was awarded in 1989 (a corollary to "just apply" is "be persistent"), and the adventure continued, this time in the wilds of north-central Kentucky and southern Indiana. Because I was one of the primary interviewers for both of these early grants, I put in many face-to-face hours with the research participants, and I will always value the perspective this level of involvement with my "subjects" has given me. I continue to be a "hands on" researcher – I believe close interaction with participants and with one's data provides critical insight for interpreting data and helping with the translation from lab to clinic.

Needless to say, the five-year FIRST award was helpful in my quest for tenure, which I received in 1992. A glance at my C.V. shows that the years following could be described as career "dark years," or a publishing hiatus. A confluence of factors led to this hiccup in the linear progression of my career, including failure to procure funding for continuing the study of the SMI elderly from NIMH, accepting the Director of Clinical Training position for my program (a position I held from 1995 to 2000), and, last but not least, the arrival of my daughter in August 1994. Of course, these were not really "dark years" professionally, and certainly not personally. I accomplished many things, including nurturing some of the finest graduate students I've worked with and shepherding our doctoral program through many changes and an APA accreditation. But my name was not "out there" in terms of publications or service, resulting in a 2-year delay in my promotion to full professor. I share this for all the graduate students and early career psychologists who are struggling or will struggle with balancing the myriad commitments of a professional life with those of families of all kinds. It is hard to see in the midst of the struggle that the balance (or lack thereof) achieved at any 2- or 5-year period is only part of an ever-changing shift and flow of balancing and rebalancing. I have given up trying to predict what I'll be doing 5 years from now.

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Eye on Education and Training:
Training Directories Update Project
Steven David, Ph.D.

A few years ago Gregory A. Hinrichsen, Ph.D. and Norm O'Rourke, Ph.D put together directories of Clinical Internships and Postdoctoral Fellowships training programs who reported specialty training in geropsychology and/or available clinical placements with older adults. I noticed the web version of the directories would eventually become outdated and I thought it would make sense to have regularly updated directories.

With the approval of Greg Hinrichsen, Norm O'Rourke, and Forrest Scogin, and with the help of the society's website coordinator Rachel Rodriguez, we put what was already on the web site into directory documents for download and created blank forms for download so programs could update their listings regularly. As such, the previously created third edition of the Directory of Psychology Internships with Geropsychology Training Opportunities and the Directory of Clinical Geropsychology Postdoctoral Fellowships are now available for download on the 12/2 website. We are now in the process of updating these directories. If you would like your training site listed in the updated version of the directory or would like to update your existing entry on the site, please visit our website to download the official form. Programs should email their completed listing forms to Steven David, PhD at: sdavid@mednet.ucla.edu

To download the Internship Directory and/or the Internship Update Form go to:
http://geropsych.org/students.t1.html
To download the Post-doc Directory and/or the Post-doc Update Form go to:
http://geropsych.org/students.t2.html

The directories for download will be updated and posted approximately monthly (or as needed, depending on the volume of updates coming in). ***Again, programs are invited to add or update their listings by emailing completed update forms to Steven David, Ph.D. at: sdavid@mednet.ucla.edu

Student Voice: APA Convention
Kathryn Moss, M.A.
Student Representative

It's that time of year again – the APA Convention is right around the corner! I would like to take this opportunity to extend an invitation to all members of 12/2 to attend a special event hosted by the section: the Student Conversation Hour. This event will be held on Saturday, August 18, from 10:00 to 11:30am in the Division 12 Hospitality Suite and will be an excellent opportunity for student members to network with the professional members of the section as well as amongst themselves.

One of the most rewarding aspects of being involved in our society is having the opportunity to get to know fellow student members. Throughout my tenure as student representative, I have come to realize what an interesting and dynamic group of students we have in our organization. Our student members have been quite active this year in discussions focusing on how the section can better meet their needs. One of the themes that has frequently surfaced from these conversations is the desire to know more about senior members of the group in terms of research interests, clinical activities, and career paths.

Similarly, increased interaction with students is often requested by our senior and executive committee members, who are very much interested in the professional development and activities of geropsychologists in training. The Student Conversation Hour is one of several events planned over the coming years to promote open lines of communication among the entire 12/2 membership body.

Please feel free to contact me (moss024@bama.ua.edu) or my fellow student representative, Caitlin Holley (c.holley@louisville.edu) with any questions you have about the upcoming Student Conversation Hour. Please take note that information regarding the specific location of this event will be posted on the 12/2 Listserv. It is not too late to request issues to discuss at this gathering.

I look forward to seeing you all in San Francisco!

Profile On…
(Continued from page 16)

By 2000, when I gave up the DCT position, I also had realized that I needed to turn my attention to a new research focus. Since 1988, I had maintained a very small private practice in S. Indiana and Kentucky nursing homes, and it finally occurred to me to do research that tapped that area of interest and expertise. Most of the work I was doing was treating depression, and my frustrations with working against the institutional barriers to successful treatment led me to explore possible alternative models of treatment. My career-long admiration for Linda Teri's work (see paragraph #3 above) led me to ask her, at a chance encounter, whether she had ever tried out the pleasant events intervention she had developed (to use with families of elders with AD) in nursing homes. As I recall she replied something to the effect that no, nursing homes were too complicated, and I asked her whether she would help me to try it anyway. She generously allowed me to fly out to Seattle for a 2-day brainstorming session, at the end of which we had practically written a grant proposal for a pilot study to develop the intervention, now known as BE-ACTIV. With the generous support of Linda, Kimberly Van Haitsma, ace statistician Stephen Looney, and Ira Katz, I have successfully completed that pilot study and am now embarking on the 5-year clinical trial of BE-ACTIV in 28 nursing homes. Wish me luck. When this project is finished my daughter will be graduating from high school. Don't ask me what I think I will be doing next – even if I had an idea it would be wrong!

Consider This…
(Continued from Page 17)

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