# Clinical Geropsychology News

## Society of Clinical Geropsychology

APA Division 12, Section II Volume 17, Number 1
March 17, 2010

## INSIDE*



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Please contact Sherry Beaudreau at sherry.beaudreau@gmail.com or Brian Yochim at byochim@uccs.edu if you wish to comment on the contents of this Newsletter.

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

## President's Column

David Powers, Ph.D.

*H*ello everyone. First, I would like to recognize the service of the Past President, Jon Rose. In the small world that is clinical geropsychology, Jon served as a supervisor on one of my internship rotations at the Palo Alto VA fifteen years ago, and it is great to have the opportunity to work with him again. Second, I must say what an honor it is for me to have the opportunity to serve as President of the Society for Clinical Geropsychology. Over the past 15 years, SCG (also known as Division 12 Section II) has developed into my primary professional organization, because of both the focus of and the

people in the society. It has been very rewarding for me to be a member of the society, and I will do my best to serve this organization and the membership.

As president this year, I plan to focus on growth and action, particularly advocacy. I believe that organizational growth and organizational activity interact with each other to create an "upward spiral" of progress toward the goals we have for our profession and the older adults we serve.

Toward that end, I would like each of us to add "One Plus One" to what we're doing with the society. The first "one" is one additional organizational activity, be it a visit to a state or national representative, joining a committee, contributing to the newsletter, or supporting. One more thing, something that will be exciting and new for you and that will help our profession move forward in optimizing mental health for older adults.

The second "one" is to reach out to someone whom you believe should join the Society for Clinical Geropsychology. Many of us are in contact with fellow clinical geropsychologists who are not (yet!) SCG members. Perhaps you have told someone about something valuable you learned from the listserv, or about some activity the society is engaged in, and they seemed interested to learn more. Reach out and ask them to join, explain what you get out of being in this organization, and encourage them to meet us at the APA Convention.

The APA Convention is always a great opportunity for clinical geropsychologists to gather and share our research and clinical experiences, but this year that will be exceptionally true. The convention will be August 12-15 in sunny San Diego. APA President, Carol Goodheart, has chosen caregiving as a Presidential theme for the convention, and one of the Society's programming hours will be devoted to caregiver intervention research.

I hope to see many of you at APA in August, and hear about your "One Plus One." Together we can make great strides for older adults in our communities across the country.

## 2009 Student Research Award Recipient

**Katherine D. Kane, MA**
**University of Colorado, Colorado Springs**
**Mentor: Brian Yochim, PhD, ABPP**

### "Depressive Symptoms and Cognitive Impairment Predict All-Cause Mortality in Long-Term Care Residents"

*I* want to thank 12-II again for the great honor of the Student Research Award. Below is a synopsis of the work that earned this honor (with the help of my co-authors, Drs. Brian Yochim and Peter Lichtenberg) and is currently in press with *Psychology & Aging*.

This study investigated whether depressive and cognitive dysfunction symptoms were predictive of 12-month, all-cause mortality for new residents in a long-term care (LTC) facility. Participants were 171 adults over age 60 consecutively admitted to a Midwest urban LTC facility. They had a mean age of 77.1 (SD = 8.8), with 10.6 years of education (SD = 3.3), and 61.4% were female. African Americans comprised 50.9% of the sample, and 49.1% were European American.

Participants were administered the Geriatric Depression Scale (GDS) and the Dementia Rating Scale, 2nd edition (DRS-2), and had data collected for the Comorbidity Index on average 12 days following admission. Using Cox regression analyses, increased symptoms of depression and cognitive dysfunction and European American ethnicity were significant predictors of 12-month, all-cause mortality. These results suggest that in LTC settings, the pairing of depression and cognitive dysfunction may heighten the risk of 12-month, all-cause mortality.

## Cultural Diversity Committee

**Yvette Tazeau, PhD, Section Chair**

*M*y name is Yvette Tazeau and I'm a Hispanic, bilingual (Spanish/English) neuropsychologist and management consultant in Silicon Valley, California. I succeed Angela Lau as the Section's Chair for the Cultural Diversity Committee.

The Committee is staying tuned for when the new website is launched as this group will be helping by adding content for the Section regarding multicultural resources. Currently, we are at work writing several papers for an upcoming special issue on the topic of "Diversity, Mental Health, and Aging." We are very thankful to Dolores Gallagher-Thompson and Larry Thompson, Co-Editors in Chief of Clinical Gerontologist, for extending to the Committee the opportunity to submit papers for the journal.

The Committee currently has sixteen members and just about everyone is involved in this exciting project. We are hoping that more members of the Section will join the Committee to help us plan for other projects and ways in which to further disseminate information about the important intersection of cultural diversity and older adults! For those of you who would like to join or have your students join, please contact me via e-mail at ytazeau@ix.netcom.com

## Federal Advocacy Update

**Donna Rasin-Waters, PhD**
**Division 12 Federal Advocacy Coordinator**

### The APA Public Policy Advocacy Network

*I*t is crucial for psychologists to become active in advocacy at the federal level simply because legislation that is passed by Congress affects each and every one of us. The Public Policy Advocacy Network (PPAN) of the American Psychological Association offers information to enhance understanding about current public policy initiatives that are critical to psychology. The APA Government Relations Office has a simple sign-up process that enables one to receive legislative updates and take action on major policy issues being followed by the Education, Public Interest and Science Directorates. Please join the Public Policy Advocacy Network by direct link at http://www.apa.org/ppo/ppan/aboutppan.html or by logging onto www.apa.org and searching for Public Policy Advocacy Network.

In addition to receiving periodic legislative alerts and news from PPAN, there is a wealth of information to assist psychologists in understanding Federal Advocacy at the PPAN site. Under the heading *Capitol Hill Basics* one can find a summary of how the legislative process works. Tips are also provided regarding the most effective way to communicate with one's U.S. Senator and Representative. Other helpful resources are *Advancing Psychology in the Public Interest: A Psychologist's Guide to Participating in Federal Policymaking* and *Advancing Psychology Education and Training: A Psychologist's Guide to Federal Advocacy*. For those who want to become even more active and possibly visit representatives, APA can offer information and assistance to make your visit as successful as possible.

In addition to legislative updates and important news that is relevant to psychology one can also follow links to make contact with Representatives on a variety of issues important to psychology. Sample letters are available making it fast and easy to respond to your Representatives on an issue. However, please take a moment to personalize letters as it increases the effectiveness.

Collectively we all need to take part by informing Congress about psychology and how it is relevant to federal policy-making, particularly as healthcare reform moves forward. While APA advocates for psychology regularly, the most important aspect of advocacy comes down to us, the constituents. So let me encourage each and every psychologist to exercise the right and privilege as citizens to impact

public policymaking related to our field. Please mark time on your busy calendar to visit the PPAN site.
drrasinwaters@aol.com

## APA Committee on Aging (CONA) and Office on Aging Update

### Deborah DiGilio, MPH, Director, APA Office on Aging

As mentioned in the last newsletter, I am honored to be staffing the APA 2010 Presidential Task Force on Caregivers convened by President Carol Goodheart, EdD. The Task Force will develop an online "Family Caregiver Briefcase for Psychologists" that will organize available information and resources in a way that is most useful for psychologists as they work with family caregivers. Caregiving will also be a central theme of the 2010 Convention in San Diego. Many divisions are offering programming that will be highlighted in the Convention Program with a special Caregiver Initiative logo.

Another Task Force I staff, the Task Force to Update the Guidelines for the Evaluation of Dementia and Age-Related Cognitive Decline (1998) has just completed its task. Before being adopted as APA Policy, the 2010 Guidelines will be vetted through the Cross Cutting Agenda process at the APA Spring Consolidated Meetings in March followed by a 90-day public comment period. I will notify the list serve when they are posted for comment.

CONA welcomes its newest members - Adam Brickman, PhD and Neil Charness, PhD who began their 3-year terms on CONA in January. Dr. Charness is the William G. Chase Professor of Psychology at Florida State University and Dr. Brickman is an Assistant Professor of Neuropsychology at the Taub Institute for Research on Alzheimer's Disease and the Aging Brain at Columbia University. They join Chandra Mehrotra, PhD (Chair), Patricia A. Areán, PhD, Dolores Gallagher-Thompson, PhD, ABPP and Sara Honn Qualls, PhD as CONA 2010. The standard two meeting per year schedule has been reinstated for 2010.

As you may know, both my Office and CONA spend a good amount of time keeping abreast of proposed APA initiatives, plans and reports to assure that they are informed by geropsychology research and practice and that the implications for older adults are considered. We also have made an effort to nominate individuals with aging expertise to other APA Boards and Committees with the goal of infusing an understanding and appreciation of aging broadly throughout APA. Building upon our success of having more "aging" individuals named to these groups, we have just launched a new list serve, GeroGov, for these individuals, Council of Representatives members with expertise in aging, and the Presidents of Divisions 12-2 and 20 in order to coordinate our education and advocacy efforts across governance groups. As APA is developing its first strategic plan, it seems like a particularly good time to do this. We are starting with 23 members and hope to expand as we identify more folks. If you know anyone who is involved in APA Governance, a strong supporter of aging issues, and has not heard from me, please give them my contact information. I want to thank Peter Lichtenberg, PhD, ABPP, President of Division 20 and past CONA chair for raising this idea!

In closing, I ask you to take a moment to visit the new APA Office on Aging webpage, http://www.apa.org/pi/aging/index.aspx. All of our materials including *Multicultural Competency in Geropsychology* (2009), *Assessment of Older Adults with Diminished Capacity: A Handbook for psychologists* (2008) and *Blueprint for Change: Integrated Health Care for an Aging Population* (2007) and many others can be found there. As always, please direct your ideas and questions to me at ddigilio@apa.org.

# Student Voice

**Joseph Dzierzewski, MS**
**Student Representative**

## Doctoral Candidate, University of Florida—Gainesville

Greetings from Florida! As your new junior student representative I wanted to share a little bit about myself. I am currently in my 5th year of graduate studies in clinical psychology at the University of Florida. In addition to the Ph.D., I am also working towards completion of Graduate Certificates in Gerontology and Methodology / Statistics. This coming fall, I will be applying for clinical psychology internships around the country.

I have come to find that a great deal of individuals in the field of clinical geropsychology have been attracted to it through personal experience. For me that experience was watching my grandmother's physical and cognitive health deteriorate rapidly during my undergraduate sophomore year of college. It may have been coincidental, but that same semester I was enrolled in a cognitive aging seminar at the University of Nevada, Las Vegas (UNLV). Though my grandmother passed away before the end of the semester, the thoughts of her decline did not. I found myself wanting to learn more about when and why the human brain experiences cognitive difficulties as a result of the aging process. After the semester ended, I promptly approached the seminar's professor and began working in her lab as a research assistant. Following my time at UNLV, I applied to clinical psychology doctoral programs across the country and was lucky enough to be offered admission to the University of Florida (UF).

While at UF, I have been fortunate enough to work on several different collaborative projects, which have examined different aspects of the aging process. Thus far, I have been involved in interventions aimed at improving sleep, physical activity, and cognitive functioning in late-life. In general, my main research interests involve: age-related changes in health behaviors and their relation to late-life cognitive functioning, short-term cognitive change processes and intraindividual variability, and statistical techniques for modeling change. I have participated in various clinical practica involving care of older adults. These experiences include rotations in neuropsychology of aging, health psychology of aging, psychotherapy with older adults, and primary care psychology of older adults. Following my Ph.D., I wish to obtain an academic position that will allow me to continue pursuing both my research and clinical interests in aging. On a more personal note, I am an avid Green Bay Packers fan and absolutely love Gator football.

As your student representatives, Shannon and I are here to make your 12-II experience the best possible. Please do not hesitate to e-mail either of us (see contact information below) with questions, comments, or suggestions! If you have ideas about future installments of The Student Voice or regarding possible future symposia at conferences, please drop us a line. As always, we encourage you to use the Facebook Group to network with your student colleagues. I look forward to serving as your student representative.

Joseph Dzierzewski: joedz@phhp.ufl.edu
Shannon Foster: sfoster2@uccs.edu
Facebook group:
http://www.facebook.com/group.php?gid=53793187809

## CALL FOR ARTICLES

***The 12/II Editors are currently seeking:***

- **Editorials**
- **Opinion pieces on current issues in geropsychology today**
- **Professional development articles for budding geropsychologists**
- **Summaries of your geropsychology research**

**If you have an idea about something you'd like to contribute, run it by us today! We'd love to hear from you!**

## Quote Unquote

### A New Section Brought to You by Your 12/II Newsletter Co-Editors

*"Aging is not for the weak. Think about it: with all the losses we go through, if we were weak to begin with we'd have nothing to lose!"*

Palisades Senior Living Resident
(submitted by Lindsay Anderson, MA)

Thanks for your submission, Lindsay! If other 12/II members have an aging related quote to share, please contact Sherry Beaudreau at sherry.beaudreau@gmail.com or Brian Yochim at byochim@uccs.edu

## A Synopsis of the 2009 12/II Presidential Address

**Jon Rose, PhD**
**2009 12/II President**

### "Integration of Wisdom and Science in Psychotherapy with Older Adults"

Thompson et al. in 2001 published a well-known comparison of desipramine and CBT for treatment of older adults with mild to moderate depression. CBT and combined CBT/pharmacotherapy groups performed best, though the difference between CBT alone and desiprimine was marginal. Less known is a sub-analysis performed by Gradman et al. (1991). Patients meeting DSM-III criteria for a co-morbid personality disorder at intake had significantly worse outcomes if treated using medication alone than if assigned to CBT or combined therapy. Also significant, most patients no longer met criteria for personality disorders at the conclusion of 16-20 weeks of CBT, indicating that defenses may be highly exaggerated during acute Axis I episodes, creating a false impression of a personality disorder.

Expanding this research, Stanley, Beck & Glassco (1996) found that CBT and non-directive, supportive psychotherapy were both effective in treating carefully diagnosed older adults. Time-limited CBT groups tend to work best for older adults with uncomplicated mild to moderate depression. Those with more chronic or severe forms of depression are more likely to need further treatment, according to a study by Leung & Orrell (1993). In their meta-analysis of empirically supported treatments (ESTs), Scogin & McElreath (1994) found that ESTs for older adults with diagnosed and sub-clinical depression were just as effective as medications and that results were similar to findings in studies of cognitive-behavioral therapy with younger adults. Scoggin et al. (2001) found that psychotherapy was effective and appropriate for treating those symptoms of depression that persisted after completion of pharmacotherapy. Later, Scogin et al. (2005) found several treatment modalities demonstrated effectiveness, and even more were promising but needed replication studies. Older adults appeared to prefer psychotherapy over medication, and may prefer combination therapies for severe depression. However, study participants tend to be White, with higher than average education, and that may affect the generalizability of many psychotherapy outcome studies.

Gatz et al. (1991) reviewed behavioral and environmental ESTs for people with dementia. "Probably efficacious therapies for older adults included cognitive behavioral treatment of sleep disorders and psychodynamic, cognitive, and behavioral treatments for clinical depression. For nonsyndromal problems of aging, …life review and reminiscence… are probably efficacious in improvement of depressive symptoms or in producing higher life satisfaction." (http://www.APA.org/pi/aging/psychotherapy.html, downloaded 8/4/09). Bruce Rybarczek has demonstrated that reminiscence is effective in improving patient satisfaction with heart surgery (Rybarczyk & Auerbach, 1990; Rybarczek et al., 1993).

Riley et al. (2007) have created TherapyAdvisor.org, an on-line resource that provides both practitioners and consumers with information on ESTs that is organized by DSM-IV disorders. Another bibliography of ESTs for older adults can be found on the APA Public Interest website prepared by Bob Knight at http://www.APA.org/pi/aging/psychotherapy.html.
Some proponents of ESTs have advocated their use in favor of evidence-based practices that have heretofore dominated clinical psychology. However, Wampold & Bhati (2004) point out that studies generally compare two or more time-limited manualized therapies for specific disorders, while meta-analyses of well-established or EST psychotherapies have consistently demonstrated "that no particular treatment or approach is demonstrably superior to another, across disorders or within disorders" (p. 566). In the general psychotherapy literature, there is persuasive evidence that therapeutic alliance and perceived empathy (Horvath & Symonds 1991), along with other general factors, are robust predictors of outcome regardless of the specific intervention or technique (Martin, Garske & Davis, 2000; Crits-Christoph et al., 1991; Wampold, 2001; Kim, Wampold & Boldt, 2005) and maintainence of gains at follow-up (Klein et al., 2003).
Another important consideration in evaluating the literature on EST is that for practical reasons of time to complete and ease of measurement, experiments emphasize the use of treatment manuals, specific treatments for particular DSM-IV disorders and the use of comparison interventions. This methodology favors cognitive, behavioral and time-limited psychotherapies. These are the treatments that predominate the list of ESTs (Wampold & Bhati). Outcomes such as love and work, existential meaning, and self confidence are difficult to measure, particularly over decades. My colleague Steve Katz has said "you can't count what counts."

The APA Presidential Taskforce on Evidence-Based Practice (2006) recommended an integration of knowledge gleaned from "best research evidence with clinical expertise and in the context of patient characteristics, culture, and preferences" (p. 273). Evidence-based practice (EBP) includes analysis of available qualitative data from case reports and the patient at hand. EBP, by virtue of its hypothesis-testing approach to each therapy session, can encompass a wide range of treatment goals that need not be directed by symptom clusters.
So, what have experts told us about enhancing our effectiveness with older adults? Knight (1996) created a formalized system for employing the EBP principals recommended by the APA Presidential Task Force. He describes it as a way of adapting any therapy system to work with older adults. It reminds geropsychologists to be mindful of the context that the older client lives in. Powell Lawton was a pioneer in adapting treatment to the environment and culture of older adults. Examples of cohort effects would be survivors of the Great Depression, or more recently, the Vietnam generation. Earlier born cohorts "have different skills, different values, and different life experiences than later born cohorts," Knight, APA, p. 2). Their expectations and openness to psychotherapy also reflect those group experiences. Geropsychologists must also have knowledge of the specific challenges of later life, such as social role change, death of family and friends, and biological changes that can affect the experience and meaning of self and life. Specific challenges include hormonal changes, cognitive changes and chronic illness.

Specific challenges can also enhance the therapy process. In informing research participants that they would receive 20 sessions of therapy, one older adult told me "Twenty sessions! I'm 85 years old. I haven't got that long!" Nemiroff & Colarusso (1985) also observed that nearness to death can accelerate change in older adults receiving therapy.

Harry Berman boiled Freud's legacy down to three words: "The past matters." Older adults have long histories. Whether we are behaviorists dealing with a lack of extinction or psychoanalytic therapists interpreting the current meaning of past experiences, geropsychologists must be open to considering data from all of the client's past experience. Auerhahn, Laub & Peskin (1993) said

that we reconstruct our past in the service of our current psychological needs. Jerry Gruiness taught us that the future matters as well. Gero-psychologists can learn a lot about the severity of late-life depression and the older adult's sense of hope by examining the client's relationships with grandchildren.

The therapist's awareness of client's strengths, and the therapist's ability to communicate respect for the client's wisdom and experience can make the difference between life and death in working with older patients who are suicidal, according to Rechman (1994). Thornstam (1989) has shown that mature older adults' capacity to see their life in the context of humanity, and an openness to spirituality, a concept he labeled gero-transcendence, gives some older adults the capacity to accept loss and limited potential with strength. Solitary philosophy can facilitate more effective social activity. Awareness of this developmental potential can enhance our effectiveness as clinical geropsychologists.

Returning to Freud's legacy, I would add that Freud's conceptualization of symbolism and free association as qualitative data available to help psychotherapists form hypotheses about patients' unconscious developmental conflicts is an invaluable theoretical construct for gero-psychologists, and suggests specific skills that are essential in training competent therapists. I also believe that this is a trans-theoretical skill. In operant conditioning, for example, many clients cannot readily identify what is reinforcing. Careful listening will often reveal not only what reinforces a behavior, but why, even with clients who have dementia.

Kasl-Godley & Gatz (2000), in their review of the literature on interventions for people with dementia, show the value of considering the symbolic meaning of symptoms and behaviors by these patients. Their results were consistent with the theoretical underpinnings of six intervention types. Psychodynamic approaches allowed therapists to understand intrapsychic concerns that influenced symptoms and problematic behaviors. Support groups and CBT helped patients with mild dementia cope. Reminiscence and life review therapy helped patients with mild to moderate stage dementia connect with others. Behavioral and cognitive rehabilitation strategies helped improve current functioning.

Another pearl of wisdom to be used by effective geropsychologists is to be aware of age-bias in our counter-transference. For example, Altschuler & Katz (1996) looked at how therapists' counter-transference sometimes blinded them to older women's desire to explore sexual concerns. Hillman & Strickler (2001) point out that exploration of "sexualized dynamics can provide valuable information regarding an elderly patient's sense of intrinsic value, beliefs about power and agency, and difficulties with or desires for emotional intimacy," (APA, 2009). Similarly, I have found that in my own work with older adults in physical rehabilitation settings, I need to be open to men's need to find a sense of accomplishment through competitive sports, despite the limitations of age and physical disability. One former VA inpatient told reporters that he felt alive after winning a gold medal in swimming at age 101, even though there were no other competitors in his age class.

A disturbing trend I've observed in the past few years is that graduate schools are so focused on teaching technical skills from manualized therapies that many of our new interns do not know how to think and listen like psychologists. Moreover, they have not had the opportunity to collaborate with other disciplines and family members in their psychotherapy practice. While treatment manuals provide reassuring structure to the novice therapist, we must not forget to teach our students to use the essential common predictors of successful outcomes in delivering those treatments, and we must also remember to teach them to think outside the book.

Arguments for and against the use of ESTs are often analogous to choosing between finding a destination by using a map or learning from someone who has been there. ECTs can provide a

helpful structure, like a roadmap, keeping therapy focused. Therapists who stick to the map deprive themselves of learning from the journey. By not attending to the client, the therapist may drive to the wrong destination. Learning from theory and case studies provides guidance, though theories can also blind us the evidence in the room. By collecting new evidence in each encounter and learning about pitfalls and special attractions from those who have been there, the evidence-based therapist can paraphrase John Lennon: therapy is what happens along the way.

**(Editors note: References for Dr. Rose's address can be found on p. 11)**

## Meeting of the Division 12 Board of Directors
## January 7-8, 2010
## San Francisco, CA

**Brian D. Carpenter, Ph.D.**
**Section II Representative**

*B*elow is a summary of selected topics discussed during the recent Division 12 Board Meeting.

**Section Caucus**
Section representatives discussed their common interest in growing their memberships, particularly among students and early career psychologists. This conversation presaged themes that arose throughout the Board meeting regarding the importance of articulating and communicating the multiple benefits of section (and division) membership.

**Presidential Updates**
*President Marvin Goldfried* opened the meeting and welcomed Board members. Dr. Goldfried discussed his interest in creating two-way bridges between science and practice. Part of his effort during his presidential term is to focus programming at the APA convention on this theme. He discussed a variety of presentations and program offerings that would encourage dialogue between scientists developing treatments and the practitioners who implement them. Beyond the convention, Dr. Goldfried is developing mechanisms by which practitioners can provide feedback to researchers about what works and what doesn't in empirically supported treatments. As an example, starting with CBT for panic disorder, he has developed a scale to ask clinicians about their experience with actual clients, results from which can be shared with treatment developers.

Dr. Goldfried also discussed the continued importance of making the Division relevant to a wide spectrum of members. To help clarify how the Division can be useful to its members, Dr. Goldfried proposed that the October Board meeting in Chicago include regular business along with an invitation to local students and early career psychologists to meet with Board members and offer input about how the Division could be beneficial to their professional development. The Board discussed the value of offering a series of brief presentations by Board members, followed by small focus groups to help the Board learn how to maximize the Division's relevance to new members.

The Board had a lengthy discussion about the Division's position on evidence-based treatments. In light of rapidly emerging legal and clinical standards of care, Board members, led by *Past President John Norcross* and *Larry Beutler,* drafted a position statement that emphasized the importance of an inclusive consideration of scientific methods that can provide information about effective treatments. This position statement, once ratified by the Board, will appear on the Division's website in its section on empirically-supported treatments.

**Strategic Planning**
As it continues its strategic planning initiative, the Board discussed broad themes including the identity of the Division; benefits of Division membership; the relevance of the Division to early career psychologists, who may identify with other more narrow professional organizations or even disciplines; the role of Divisions and their

relationship with one another; and nurturing philanthropy to support special projects. This effort at strategic planning is ongoing, and division members who would like to share their input are invited to contact any Board representative.

**Finance and Treasurer's Report**
*Treasurer David Rudd* reported that the Division operated under a deficit for 2009, which will likely continue through 2010, primarily due to a continuing decline in membership, which is happening in nearly all APA divisions. Dr. Rudd reviewed proposals made by the Finance Committee to reduce spending and raise revenue. In this effort, the Board chose to reduce the number of Board meetings in 2011, relying instead on conference calls when necessary. The Board also granted the Investment Subcommittee the ability to invest in more moderately aggressive products.

**Membership Committee**
*Past President John Norcross* reported that *Membership Chair Tony Cellucci* has undertaken a broad and successful effort to enhance recruitment and retention, bringing the current Division membership to 3,281. Membership efforts have included targeted letters to new students and graduates, diligent follow up on renewals, and exit letters to people who have not renewed. Student representatives have been aggressive in recruiting new students, though a large number of students continue to leave the Division after one year. Dr. Norcross discussed the upcoming membership survey in 2010. This survey goes to about 1/3 of the membership, and results will be back in time to help guide strategic planning for the Division.

**Program Committee**
Dr. Goldfried reported for *Program Committee Chair Chris Muran* that successful programs from last year, including the "Section Showcase" and "Croissants and Conversations" will make encore appearances in 2010. The Division will also host a hospitality suite for additional programming.

**Nominations and Elections Committee**
*Dr. Norcross* shared the current slate for the positions of President, Secretary, and two APA Council Representatives.

**Awards Committee**
*Dr. Norcross* reported that last year's efforts to streamline the nomination process were very successful, and the Committee received a significant increase in the number of qualified candidates this year. *President-Elect Danny Wedding* discussed the creation of a Division 12 Early Career Summer Fellowship to foster the career of psychologists 1-7 years out of their training. The format of these fellowships would be support to a young investigator during the summer months, during which they could travel to work with a Division 12 mentor on a focused project. The focus of these fellowships is on researchers and research that integrate science and practice. The Fellowship will start in the summer of 2010. *David Rudd* is spearheading the first round of fellowships. Investigators who are interested in supporting a fellow are invited to contact Dr. Wedding.

**Governance Committee**
*Chair Lynn Collins* reminded Board members that serving on an APA committee is an excellent way to promote the visibility of the Division, while influencing APA policy. Each year there are multiple opportunities to serve, and self-nominations are welcome.

**Committee on Science and Practice**
Dr. Goldfried reported for *Chair Barry Wolfe,* who is assembling panel presentations for the APA program that will focus on bridging research and practice (see Presidential Updates earlier).

**Publications Committee**
Dr. Goldfried reported for *Chair George Stricker* that *Edward Craighead* is the incoming editor for *Clinical Psychology: Science and Practice,* while *Milton Strauss* will edit *The Clinical Psychologist,* with designs to move to an electronic-only version. *Danny Wedding* reported on the continuing popularity of the *Advances in Psychotherapy* series.

Each year four volumes are published, with Division members receiving a substantial discount on the price. Volumes to be released in 2010 will focus on elimination disorders and sexual violence, to name two. Finally, the Division has a growing Facebook presence, and members are encouraged to become a fan of the Division as an additional opportunity for news and networking.

**Education and Training Committee**
The Board approved a motion supporting a statement that emphasized the expectation that programs accredited by APA should publicize on their websites a 5-year history of program characteristics, including details about internship match rates. This statement will be sent to APA's Committee on Accreditation in an effort to promote compliance on this valuable information for students who are investigating programs.

**Task Force on Evidence-Based Psychotherapy Relationships**
This interdivisional taskforce (which includes members of Division 29, Psychotherapy) is preparing chapters for an upcoming book that will focus on key elements in successful psychotherapeutic relationships, client-therapist matching, and meta-analyses of research on psychotherapy relationships, among other topics.

**APA Council**
The Council was pleased to report an unexpected source of income from the release of the new Publication Manual. In other developments, APA launched a redesigned website, which has been garnering attention and positive comments. Strategic planning has been another focus, with Council starting to update APA's mission statement.

**Highlights of Section Activities**
The Section II (Geropsychology) report included an update on new officers and committee chairs, treasurer's report, membership update, information on the Geropsychology Respecialization Program, details on the newly published volume, "Multicultural Competency in Geropsychology: A Report of the APA Committee on Aging," and concern that psychology was missing from the recent Institute of Medicine report, "Retooling for an Aging America: Building the Health Care Workforce." Section III (Society for a Science of Clinical Psychology) reported that its web page for students includes an updated on-line Internship Directory which emphasizes research opportunities available at internship sites. The Section IV (Clinical Psychology of Women) report included an update on its electronic newsletter and updated website. The new President of Section VI (Clinical Psychology of Ethnic Minorities) is focusing on leadership development, and the Section is developing a 5-year strategic plan to enhance the mission of the section and leadership opportunities for ethnic minority psychologists. Section VII (Clinical Emergencies and Crises) collaborated with the APA Practice Directorate Advisory Committee on Colleague Assistance to produce a fact sheet on preventing violence against psychologists. These groups are also researching cases of psychologist suicide with the aim of developing guidelines for prevention and postvention. Section IX (Assessment) is examining the continued relevance of psychological assessment in legal cases. Section X (Graduate Students and Early Career Psychologists) reported on its recently launched website, convention programming focused on how to apply and obtain a postdoctoral position, the development of its mentoring program, and a new Communications Chair position to coordinate its newsletter and website.

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## A synopsis of the 2009 12/II Presidential Address
**Jon Rose, PhD**

References

Altschuler, J., & Katz, A. (1996). Sexual secrets of older women: Countertransference in clinical practice, *17*(2), 51-67.

Auerhahn, N. C., Laub, D. & Peskin, H. (1993). Psychotherapy with holocaust survivors. *Psychotherapy, 30* (3), 434-441.

Bortolotti, B., Menchetti, M., Bellini, F., Montaguti, M. B., & Berardi, D. (2008). Psychological interventions for major depression in primary care: a meta-analytic review of randomized controlled trials. *General*

*Hospital Psychiatry*, *30*, 293-302.

Butler, R., & Birren, J. (1963). (Life review and reminiscence).

Crits-Christoph, P., & Mintz, J. (1991). Implications of therapist effects for the design and analysis of comparative studies of psychotherapies. *Journal of Consulting and Clinical Psychology*, *59*(1), 20-26.

Felton, J. L. (1984). Inter-assessor agreement on hypothesized controlling variables and treatment proposals. *Behavioral Assessment*, *6*(3), 199-208.

Gatz, M., Fiske, A., Fox, L., Kaskie, B., Kasl-Godley, J., & McCallum, T. (1999). Empirically validated psychological treatments for older adults. *Journal of Mental Health and Aging*, *4*(1), 9-46.

Gradman, T., Thompson, L. W. & Gallagher-Thompson, D. (1991, November). MCMI personality assessment and outcome in the treatment of depressed elders. Paper presented to the 44th Annual Scientific Meeting of the Gerontological Society of America, San Francisco, CA.

Hillman, J., & Stricker, G. (2001). The management of sexualized transference and countertransference with older adult patients: Implications for practice. *Professional Psychology: Research and Practice*, *32*(3), 272-277.

Horvath, A., & Symonds, D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, *38*(2), 139-149.

Kasl-Godley, J., & Gatz, M. (2000). Psychosocial interventions for individuals with dementia: An integration of theory, therapy, and a clinical understanding of dementia. *Clinical Psychology Review*, *20*(6), 755-782.

Kim, D., Wampold, B. E., & Bolt, D. M. (2006). Therapist effects in psychotherapy: A random-effects modeling of the National Institute of Mental Health Treatment of Depression Collaborative Research Program data. *Psychotherapy Research*, *16*(2), 161.

Klein, D. N., Schwartz, J. E., Santiago, N. J., Vivian, D., Vocisano, C., Castonguay, L. G., et al. (2003). Therapeutic alliance in depression treatment: Controlling for prior change and patient characteristics. *Journal of Consulting and Clinical Psychology*, *71*(6), 997-1006.

Knight, B. G. (1996). Overview of psychotherapy with the elderly: The contextual, cohort-based, maturity-specific-challenge model. In *A guide to psychotherapy and aging: Effective clinical interventions in a life-stage context* (pp. 17-34). Washington, DC, US: American Psychological Association.

Leung, S., & Orrell, M. (1993). A brief cognitive behavioural therapy group for the elderly: Who benefits? *International Journal of Geriatric Psychiatry*, *8*(7), 593-598.

Martin, D., Garske, J., & Davis, M. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *68*(3), 438-450.

Nemiroff, R. A. & Colarusso, C. A. (1985). *The race against time: Psychotherapy and psychoanalysis in the second half of life*. Secaucus, NJ: Springer.

Riley, W., Schumann, M., Forman-Hoffman, V., Mihm, P., Applegate, B., & Asif, O. (2007). Responses of practicing psychologists to a web site developed to promote empirically supported treatments. *Professional Psychology: Research and Practice*, *38*(1), 44-53.

Rybarczyk, B., & Auerbach, S. (1990). Reminiscence interviews as stress management interventions for older patients undergoing surgery. *The Gerontologist*, *30*, 522-528.

Rybarczyk, B., Auerbach, S., Jorn, M. L., Lofland, K. R., & Perlman, M. (1993). Using volunteers and reminiscence to help older patients cope with an invasive medical procedure: A follow-up study. *Behavior, Health, and Aging*, *3*(3), 147-162.

Scogin, F., & McElreath, L. (1994). Efficacy of psychosocial treatmeants for geriatric depression: A quantitative review. *Journal of Consulting and Clinical Psychology*, *62*(1), 69-73.

Scogin, F., Shackelford, J., Rohen, N., Floyd, M., McKendree-Smith, N., & Jamison, C. (2001). Residual geriatric depression symptoms: A place for psychotherapy. *Journal of Clinical Geropsychology*, *7*(4), 271-283.

Scogin, F., Welsh, D., Hanson, A., Stump, J., & Coates, A. (2005). Evidence-based psychotherapies for depression in older adults. *Clinical Psychology: Science and Practice*, *12*(3), 222-233.

Stanley, M., Beck, J., & Glassco, J. (1996). Treatment of generalized anxiety in older adults: A preliminary comparison of cognitive-behavioral and supportive approaches. *Behavior Therapy*, *27*(4), 565-581.

Thompson, L., Coon, D., Gallagher-Thompson, D., Sommer, B., & Koin, D. (n.d.). Comparison of desipramine and cognitive/behavioral therapy in the treatment of elderly outpatients with mild-to-moderate depression. *American Journal of Geriatric Psychiatry*, *9*(3), 225-240.

Thornstam, L. (1989). Gerotranscendence – A theoretical and empirical exploration. In: L. E. Thomas & S. A. Eisenhandler (Eds.), *Aging and the religious dimension.* Westport, CT: Greenwood Publishing Co.

Wampold, B., & Bhati, K. (2004). Attending to the omissions: A historical examination of evidence-based practice movements. *Professional Psychology: Research and Practice*, *35*(6), 563-570.

Wampold, B. E. (2001). Contextualizing psychotherapy as a healing practice: Culture, history, and methods. *Applied and Preventive Psychology*, *10*(2), 69-86.

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