Clinical Geropsychology News

Society of Clinical Geropsychology

APA Division 12, Section II Volume 25, Issue 3

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INSIDE*

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Please contact Elissa Kozlov Elk2020@med.cornell.edu or Brenna Renn, at BNRenn@uw.edu if you wish to comment on the contents of this Newsletter.

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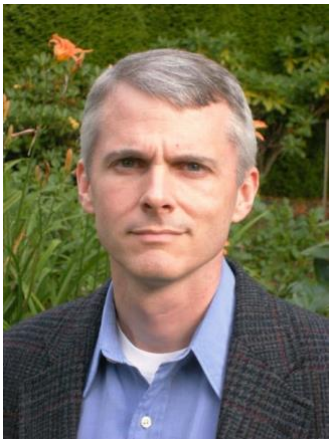
*Published articles do not necessarily represent the official views of Society for Clinical Geropsychology (Section II), Division 12, or APA

President's Column

Doug Lane, PhD, ABPP



Colleagues,

As this is my last column, I wanted to thank you for giving me the opportunity to serve as our Society's President this year (2018). My overall goals have been to engage our members at a "grass roots" level and develop ways for us to share what we know with the "grass roots" members in other APA divisions. I plan to continue nurturing these in the next year as Past-President. We cannot be a "We" without all of us.

Summarizing specific efforts in this regard for 2018:

1). We developed and submitted a position statement on behalf of 12/2 addressing scope of practice claims pertinent to Geropsychology, made by Neuropsychology in their application for re-accreditation as a specialty by APA. We are very grateful to Brian Yochim for his guidance on the submission.

2). We also developed and submitted a position

statement on behalf of 12/2 addressing the APA proposed practice guidelines for treating depression. Our gratitude goes to Ann Steffen for her work coordinating this.

3). We formed a group of 12/2 members who are willing to serve as peer-to-peer contacts with the ground-level membership of other divisions around shared interests in aging. Thank you all for your willingness to serve.

We had excellent programming at the APA conference in San Francisco and were joined by a member of the British Psychological Society/Faculty for the Psychology of Older People as a liaison. I look ahead to serving under the leadership of Nancy Pachana as our President in 2019, whose efforts in making connections with geropsychologists in other countries are well known.

Lastly, as many of you know, the 12/2 website has experienced its challenges. We thought that these were resolved but they reemerged over the past summer. In response, we have engaged the services of a new developer and the website is undergoing significant renovation at this time. Once completed, the website should be much easier and more reliable to use. We thank you all for your patience with this.

So, in conclusion, I'll close with a favorite quote about aging, one that matters more and more to me as I age myself:

"Aging is an extraordinary process where you become the person you always should have been" -David Bowie

Again, thank you all for a great year.

Douglas W. Lane, Ph.D., ABPP, C. Psychol. (UK)
President
Society for Clinical Geropsychology
American Psychological Association

Comments from the Editors: Elissa & Brenna

Hello SCG! We are so excited for the fall newsletter this year – in this issue, you will see special columns including the full text of Michele Karel's M. Powell Lawton Address for those who missed her compelling speech at APA over the summer. We also have Doug Lane's farewell address in his last President's Column of his term. We cannot thank Dr. Lane enough for his commitment to serving SCG during his presidency. Andrea June provided some exceptionally sage wisdom to aspiring and junior geropsychologists in her Member Spotlight that should not be missed! Thank you, Dr. June!

We are also very excited to see everyone at GSA next week! The newsletter highlights the various ways you can support your fellow SCG members, whether by attending a talk or poster session or showing up at the Student Social on Thursday night at Back Bay Social at 5pm at 867 Boylston St. Many thanks to Meghan McDarby for organizing the event this year!

As always, we are interested in hearing from you about how this newsletter can better serve the SCG community. If you have any suggestions ore recommendations, please feel free to email us at any point at ELK2020@med.cornell.edu or BNRENN@uw.edu

Member Spotlight

Full Member Spotlight: Andrea June, PhD,

Year joined Society of Clinical Geropsychology: *2007*

Hometown: Menomonee Falls, WI

Current Professional title and affiliation: Associate Professor, Department of Psychological Science, Central Connecticut State University

Q: Why did you join the Society for Clinical Geropsychology (Division 12, Section II)?

I joined the Society in graduate school because it was the professional home of my future career. My mentors and future colleagues were members.

Q: How has membership in the Society for Clinical Geropsychology assisted you with your professional activities?

Membership in the Society keeps me connected to the mental health side of geropsychology. In my current position, I am very focused on gerontology education at the undergraduate level. Membership keeps me close to my specialty roots and how I might use my clinical skillset, in addition to my knowledge about aging, to the betterment of the various individuals and systems in my professional sphere.

Q: How did you get interested in the field of aging?

I found the field of aging when I was an undergraduate student looking for a research project for my methods class. I paired up with another student who wanted to do a project related to aging. Through the process of interacting with those vibrant older adults, a professional lightbulb went on. My undergraduate mentor, Dr. Susan McFadden, helped turn that lightbulb into a professional path.

Q: What was your most memorable experience during your graduate studies?

One of my most memorable experiences during graduate school was the first time I was actually helpful to one of my clients – I could connect something we did in therapy to a positive change in her life. You know that "woah, I might just be able to do this" moment where some of the imposter syndrome lessens just a bit.

Q: Have you had an important mentor in your career? If so, how did he or she make a difference?

I have had so many wonderful mentors throughout my career! And this is what I LOVE about our geropsychology profession; we are surrounded by supportive colleagues. Sometimes a mentor made a big difference in my career; other times the mentor made a small but meaningful difference. As such, I try very hard to pay forward their generosity by helping others navigate their way.

Q: What is your current position and what are your key responsibilities?

I am an Associate Professor in the Department of Psychological Science at Central Connecticut State University. I teach at the undergraduate level and at the graduate level in our master's program in psychology. I also teach the Psychology of Aging course in our graduate certificate in gerontology. I am the co-chair of our undergraduate gerontology minor and help to coordinate that program. I am also a leader in furthering Age-Friendly University initiatives on our campus.

Q: Tell us about your most recent activities.

My campus became a member of the Age-Friendly University global network in May 2017 and my most recent activities with my colleagues have been focused on assessing and growing the initiatives in our campus as well as contributing to the expansion of the global network. At GSA, I am a co-presenter on the GSA-AGHE Presidential Symposium, Age-Friendly University (AFU) Initiative—Higher Education Meeting the Needs of Aging Populations. I am also involved in an AGHE-AFU webinar series made possible through a grant from the Retirement Research Foundation to AGHE The Founders 3.0 Project. Those will launch in January, February and March of next year.

Finally, a Special Issue of Journal of Gerontology & Geriatrics Education on Age-Friendly Universities is scheduled for publication in 2019 and I hope to have a co-authored paper included regarding our efforts on my campus.

Q: What has been your most memorable experience in gerontology and aging clinical practice and/or research?

My most memorable experiences continue to be watching the lightbulb go on for other students who discover that working with older adults can be a viable and meaningful career. I have watched several of our gerontology minors graduate and find jobs in local communities. I have several students who are now applying for PhD programs who have added an aging perspective to their focus of study.

Q: Do you have any tips for emerging geropsychologists?

Keep walking- the path will continue to unfold in front of you. As you are facing decisions, make the best one with the knowledge you have and keep going. As I've reflected on my own path and payed attention to others, many of us would not have been able to predict where we have ended up or the types of activities we've found ourselves most engaged in. If you start to feel the pressure of having it all figured out, pick a direction and see where that goes for a bit.

Q: What keeps you busy when you are not working with older adults? What are your non-professional aspirations and hobbies?

In a state where I don't have family, I have created community through volleyball. The physical activity keeps me busy 3-4 times/week between leagues and recreational pick-up. It's a social activity which is great for my extraverted personality, but it is also meditative in that my focus has to be completely on the current moment or I risk getting hit by the ball! Outside of volleyball, I enjoy camping and hiking and board games and movies and skiing with these friends. I just bought a house and filling it with people laughing and smiling makes my heart swell.

Student Member Spotlight: Christina D Caso

Year joined: 2017

Hometown: Seattle, WA

Current academic affiliation: University of Washington

Q: Why did you join the Society for Clinical Geropsychology (Division 12, Section II)?

I joined 12/2 in order to gain more exposure to the field. When I began thinking about graduate school, I wasn't aware that some institutions had dedicated Geropsychology programs. Joining 12/2 seemed like a great way to keep up with the literature and the academic opportunities that are available. What I didn't realize is that joining 12/2 would also connect me to a welcoming community of professionals who are eager to help out one another.

Q: How has membership in the Society for Clinical Geropsychology assisted you with your professional development?

I wasn't as confident in my ability to navigate the graduate school application process before joining 12/2. Connecting with other members has given me the confidence and knowledge that I need in order to be a more competitive applicant. I now have a much better understanding of how to identify potential mentors, how to highlight my accomplishments more effectively, and what qualities lead to the success of an incoming graduate student. I've also gained a lot of insight by learning about the experiences of other 12/2 members.

Q: How did you get interested in the field of aging?

Getting involved in aging research was an easy choice for me since I've always gravitated towards older adults. Having thoroughly enjoyed my experience with neuropsychometric testing, I was certain that clinical neuropsychology was the most suitable career for me. However, it wasn't until very recently that I realized I am just as passionate about other aspects of aging, including quality of life, family communication and planning, end of life care, barriers to clinical care, and disease literacy.

Q: Have you had an important mentor in your career? If so, how did he or she make a difference?

It's difficult for me to identify just one mentor. There have been so many people invested in my career growth over the years. Most recently, Drs. Kimiko Domoto-Reilly and Kristoffer Rhoads have served as my primary mentors. Both are natural teachers and turn just about everything into a learning opportunity.

They also give me the space to share my observations and ideas. In preparation for graduate school, Dr. Domoto-Reilly is mentoring me through my first independent publication and speaking engagement.

Q: What has been your most memorable experience in gerontology and aging clinical practice and/or research?

While I was a Research Coordinator at the Frontotemporal Disorders Unit at the Massachusetts General Hospital, our team planned an inaugural fundraising gala. It was so much fun to get dressed up and spend the evening with the patients and care partners that I had come to know so well over the years. Everything about that evening was deeply heartwarming and reinforced my intuition that I had chosen the right career path.

Q: Tell us about your most recent activities.

I'm currently working as a Research Coordinator in the Alzheimer's Disease Research Center (ADRC) at the University of Washington (UW), where I administer a variety of neuropsychometric testing batteries to healthy older adults and those with cognitive impairment. I'm also helping to build the Frontotemporal Disorders (FTD) cohort within the UW ADRC in collaboration with Dr. Kimiko-Domoto Reilly. She and I are the go-to people for anything FTD related.

Q: Looking forward, what are your plans post-graduation?

I'm planning to earn my Masters in Public Health at the University of Washington before applying to Geropsychology programs. I feel this is an excellent point of convergence for my interests in aging, neurodegeneration, and the social determinants of health. I'm particularly interested in studying disease literacy and barriers to clinical care in Washington state.

Q: What keeps you busy when you are not working with older adults? What are your non-professional aspirations and hobbies?

I love to learn in my spare time. I'm an avid reader, traveler, documentary watcher, and social justice enthusiast. Having moved to Seattle from Boston just over two years ago, I'm still completely enamored by the Pacific Northwest. Walking around the city and spending time in the arboretum are my favorite ways to unwind.

Announcements and Member News

This section of the newsletter highlights announcements relevant to the membership and the accomplishments of the Section's members. If you have received any local or national awards, or want to let the Section know about recently accepted publications, or recently published books, please email updates to Elissa Kozlov (ELK2020@med.cornell.edu) or Brenna Renn (bnrenn@uw.edu).

Drs. Michelle Hilgeman, Becky Allen, and colleagues received the *Journal of Gerontological Nursing's* Edna Stilwell Writing Award for the top article published in JGN each year, for their paper entitled, "Enabling Advance Directive Completion: Feasibility of a New Nurse-Supported Advance Care

Planning Intervention." They will be presented with a plaque and a $500 award at the JGN Editorial Board Meeting during GSA in Boston. The article was also featured on the cover of the journal in July 2018; the citation and abstract are copied below:

Hilgeman, M., Uphold, C., Collins, A., Davis, L., Olsen, D., Burgio, K., DeCoster, J., Gay, W., & Allen, R. (2018). Enabling Advance Directive Completion: Feasibility of a New Nurse-Supported Advance Care Planning Intervention. *Journal of Gerontological Nursing, 44(7)*, 31-42.
https://doi.org/10.3928/00989134-20180614-06

ABSTRACT: Adults who complete an advance directive (AD) are not consistently offered information about the risks, benefits, or alternatives (RBA) of the life-sustaining medical procedures addressed on standardized forms. The current article describes a new patient-centered nurse-supported advance care planning (NSACP) intervention focused on providing information about RBA of life-sustaining procedures. Fifty participants (mean age = 50.26 years) at a Veterans Affairs medical center were randomized to the NSACP intervention or a comparison condition. Before randomization, 78% (n = 39) expressed interest in RBA information. Of participants in the NSACP group, 94% (n = 30) completed an AD. Participants who received NSACP made more decisions to decline life-sustaining treatment than those who were randomized to the comparison group. Promising feasibility data include brevity (mean = 46 minutes), high patient satisfaction, participant retention, and treatment fidelity. The NSACP holds promise as a brief, educational intervention to support patients in completing an AD. [*Journal of Gerontological Nursing, 44*(7), 31–42.]

Kimberly Van Orden did an NPR interview on suicide prevention in later life: September 30, 2018. Radio interview for *Take Care* on WRVO (NPR affiliate). "Suicide prevention: A public health approach and a focus on vulnerable populations." http://www.wrvo.org/post/suicide-prevention-public-health-approach-and-focus-vulnerable-populations

Recent Member Books & Publications

Carone, D.A., & Bush, S.S. (2018). *Validity Assessment in Rehabilitation Psychology and Settings*. New York: Oxford University Press.

Bush, S.S. (2018). *Ethical Decision Making in Clinical Neuropsychology, 2nd Edition*. New York: Oxford University Press.

Jon Rose & Marypat Kelly (2015) Reversing dementia. Complications when Alzheimer's, stroke and spinal cord injury combine. Presented at the International Spinal Cord Society conference in Sydney, Australia, Oct. 13, 2018.

Van Orden, K. A., & *Deming, C. (2017). Late-Life Suicide Prevention Strategies: Current Status and Future Directions. *Current Opinion in Psychology, 22*, 79-83. doi: 10.1016/j.copsyc.2017.08.033. PMC5843499

Wiktorsson, S., Sterner, T. R., Fassberg, M. M., Skoog, I., Berg, A. I., Duberstein, P., **Van Orden, K. A.**, & Waern, M. (2018). "Few Sex Differences in Hospitalized Suicide Attempters Aged 70 and

Above." *International journal of environmental research and public health*, *15*(141). doi:10.3390/ijerph15010141.

Kandasamy D., Platts-Mills, T. F., Shah, M. N., **Van Orden, K. A.**, & Betz, M.E. (2018). Social Disconnection among Older Adults Receiving Care in the Emergency Department. *West J Emerg Med.*

Van Orden, K. A. (2018). The Interpersonal Context of Suicide and Self-Harm in Later Life. *American Journal of Geriatric Psychiatry.* doi.org/10.1016/j.jagp.2018.05.012

Lambden, J., Chamberlin, P., **Kozlov, E**…Prigerson, H. Association of clinician burnout with perceived provision of futile or potentially inappropriate care. *Am J Hosp Palliat Med.* (In Press)

Kozlov, E, Cai, A, Sirey, JA, Ghesquiere, A, & Reid, MC. Identifying palliative care needs among older adults in a non-clinical setting. *Am J Hosp Palliat Med.* (In Press)

GSA Meetings, Posters and Talks

Michele Karel, Symposium: Wednesday, November 14th, 2:30pm – 4:00pm. "Meeting Behavioral Health Needs of Older Veterans: Evaluating Programs Across the Continuum of Care"

Elissa Kozlov, Symposium: Wednesday, November 14th, 4:30pm – 6:00pm. "Barriers and Facilitators to Providing Mental Health Care Within Palliative Care"

Caroline Merz, Poster: Saturday, November 17, 1:00pm - 3:00pm session. "Attitudes of Licensed Psychologists Toward Medical Aid in Dying"

Brian Carpenter & Elissa Kozlov, Symposium: Sunday, November 18th. 8:00a, – 9:30am. "Challenges to Engaging in End-of-Life Care Discussions and Advanced Care Planning"

Society of Clinical Geropsychology Student Social! Thursday, November 15th from 5-7pm at Back Bay Social located at 867 Boylston St. Many thanks to Meghan McDarby for organizing the event this year!

Look out for special interest group meetings including the Mental Health and Practice Special Interest Group and the Hospice and Palliative Care Special Interest Group!

The Student Voice - Turning the Page on Ageism

Submitted by Meghan McDarby

We often associate November with celebrations of Alzheimer Disease awareness. However, November is also *National Hospice and Palliative Care Month*. This year, the National Hospice and Palliative Care Organization (NHPCO) is celebrating over 35 years of the Medicare hospice benefit, which helps provide meaningful end-of-life care to individuals with life-limiting illness.

Palliative care (which can be provided to individuals with serious illness at any time during that chronic illness trajectory) and hospice care (a specific subset of palliative care that can be provided to individuals with serious illness who have a prognosis of six months or less) both provide state-of-the-art pain and

symptom management; emotional support; spiritual support; and assistance with end-of-life communication to patients and their care partners. Palliative and hospice care have instrumentally changed the level of patient-centered care we can provide in the final years, months, days, and hours of life.

To celebrate National Hospice and Palliative Care Month, we've developed a list of activities that you can consider for yourself, your clients, your friends, and any other important people in your lives. Depending on where you (or your clients) are in the process of making decisions about your end-of-life care, some of these celebratory opportunities may seem a bit too daunting—but that's ok. Consider choosing an activity that matches your readiness to engage with hospice and palliative care this year.

1. *Educate*. Healthcare providers, patients, and care partners are frequently confused about the differences between hospice and palliative care. Oftentimes, providers think that palliative care equates to "giving up" on treatment, and patients think that it signals impending death. Inform important people in your life—including family members, friends, clients, and colleagues—about the differences between hospice and palliative care and the utility of both at end of life.
2. *Volunteer*. Hospice agencies are always seeking volunteers to help with patient visits, bereavement support, and even simple office tasks like mailings. Connect with a hospice in your area and see if there is a way that you can get involved.
3. *Have a conversation*. Talk to your friends and family members about your goals for end-of-life care. With the holidays approaching, it can be a great time to use articles you've read (like this!) to start a conversation that can lead to important exchange of information about preferences and hopes for future care. *The Conversation Project* has some great tools and resources and can be a great place to start http://theconversationproject.org/.
4. *Think about your end-of-life care preferences independently*. Sometimes starting the conversation with friends and loved ones is difficult, so spend some time thinking about your end-of-life care preferences on your own. Consider using tools like *Five Wishes* to think about the aspects of care that are important to you and the types of choices that would be concordant with your preferences at end of life.

As a reminder, please join us for the 2018 SCG Student Social at GSA in Boston at Back Bay Social (867 Boylston St.) on Thursday, November 15 from 5-7 PM. Light appetizers will be provided, and drinks will be available for purchase. This event is open to any and all students (graduate and undergraduate), psychologists, faculty members, and supervisors. Contact Meghan with any questions (mmcdarby@wustl.edu), and please RSVP at the following link if you plan to attend https://www.surveymonkey.com/r/HY3N6SL. We hope to see you on November 15th!

Committee Updates

Diversity Committee

Submitted by Nancy Pachana, PhD

Our committee had our first successful meet and greet event at APA this year. Many ideas were raised during a productive and fun hour. We are going to focus on promoting the diversity award within SCG outward within APA, and hopefully will attract more folks to consider applying for the award.

I'd like to thank the members of the committee for their work over 2018: Charissa Hosseini, Katie Johanson, Flora Ma and Daniel Parker.

Mentoring Committee Update

Submitted by Jennifer Birdsall, PhD & Barry Edelestein, PhD

The 12-II Mentoring Committee continues to meet monthly to work on current committee initiatives. The committee's current focus is on the development and implementation of a brief survey aimed at better understanding how clinicians who work with (or want to work with) older adults locate and select specific jobs with this population. There are two versions of the survey--one for trainees, and one for career-level/established psychologists. In our committee discussions on supporting the mentoring process, we realized many budding psychologists are often aware of general career path categories that will lead to a focus in aging (e.g., professor/academic work, VA psychologist opportunities, research with older adults) but are often unaware of more specific job opportunities with older adults and where to locate these different positions. The ultimate goal of this survey is to better understand what information and resources are most helpful to job seeking, job selection, and career decisions. The information could also be used to advise the mentoring committee on opportunities to create and disseminate resources highlighting specific jobs available to psychologists interested in working with older clients. Our survey research proposal has been submitted to an IRB for approval. We hope to have our research proposal accepted in the near future and to begin survey dissemination and data collection.

Committee on Aging (CONA) Update

Walter R. Boot, PhD., Chair-Elect of CONA and Erin Emergy-Tiburcio, PhD, CONA Chair

CONA has been busy with developing educational materials and advocating for important aging policy!

CONA developed, tested with undergraduate and graduate students, and disseminated the Careers in Aging Roadmaps to promote and provide step-by-step guides for undergraduate and graduate students interested in aging careers. Within just the first six months after going live, it has been viewed more than 2,500 times, and is already being used by university career centers. CONA members also promoted the Roadmaps during two sessions at the 2018 Convention: *Skill-Building Session: Introducing a New Tool to Help Mentors Guide Students to Critical Careers in Aging* and *APA psycCareers LIVE: Exploring Careers in Aging*.

CONA collaborated with Teachers of Psychology in Secondary Schools (TOPSS) to encourage interest among high school students in aging issues. Collaborative activities included: "An Aging World" essay contest for high school students; conducting follow-up interviews with four essay winners and publishing an PI-Education blog, "What High School Students Told Us About the Future of Healthy Aging"; and developing a "What is Psychology and Aging?" poster.

CONA members and their trainees recently participated in in-district advocacy visits with lawmakers, advocating for $2 million funding for S. 2070, Kevin and Avonte's Law. The legislation, which became law in March of 2018, has no current funding. The bill helps to reduce the risk of injury and death relating to wandering, adds grant program support for individuals with autism, dementia and other developmental disabilities, safeguards the well-being of individuals with disabilities during interactions with law enforcement, and provides education and resources to law enforcement agencies, schools, and clinicians.

CONA has created, maintained, updated, and disseminated a library of online and print educational materials for older adults, psychologists, health and aging service providers, and policymakers including *Elder Abuse and Neglect: In Search of Solutions*; *Prolonging Vitality Society's Grand Challenges: Insights from Psychological Science*; *What Mental Health Practitioners Should Know about Working with Older Adults*; *Older Adults Health and Age-related Change: Reality versus Myth; and, Life Plan for the Lifespan* which are all available on the APA Office on Aging webpage. In the period between 2015 to the present, these documents were viewed 250,000 times.

SCG/PLTC Public Policy Committee Updates

Submitted by Cecilia Poon, PhD

Members: Kelly Carney, PhD, Perri Navarro, PhD, Heather Noble, PhD

1. Website Updates
PLTC is currently updating their website. The PPC made suggestions to make policy and advocacy issues more accessible online. We are hoping to do the same with the SCG website in the next few months.

2. CY 2019 Medicare Physician Fee Schedule
The Centers for Medicare and Medicaid Services (CMS) published its 2019 PFS final rule in the Federal Register on November 1, 2018. Most relevant to geropsychologists are new CPT codes for psychological and neuropsychological testing that go into effect on January 1, 2019. APA Practice Organization recently hosted a free one-hour webinar (https://youtu.be/Q1kAZEgih2w)
They will be hosting another webinar on December 5, 2018
(https://register.gotowebinar.com/register/8120135656674082306)

3. In early March, the APA Office on Aging reached out to the PPC and other groups to see if we were aware of any pending legislation that would be important for the APA Committee on Aging to advocate for. Since then CONA members and students have been advocating for a $2 million funding to the S.2070 Kevin and Avonte's Law of 2017, one of the 2 bills mentioned by the PPC. This bill seeks to help individuals who wander. Deborah DiGilio, director of APA Office on Aging, recently posted an update on the SCG listserv about this. While the PPC was not directly involved, we are excited to learn about the advocacy effort. In addition to the listserv, SCG members are always encouraged to refer to APA's Federal Action Network for monthly legislative updates (https://cqrcengage.com/apapolicy/)

Thank you!
Cecilia

Lifetime Learning Update

Submitted by Andrea June, Erin Emery-Tiburcio, PhD, ABPP

The Lifetime Learning Committee would like to remind SCG members that Continuing Education (CE) credits are available at the upcoming Gerontological Society of America (GSA) meeting on November 14-18 in Boston. To earn CE credits, you must add the continuing education option to your registration. Within 30 days of the event, simply complete the online evaluation forms and credit claiming, and your certificates will be available for download. The cost for psychologists is $60 for unlimited CEs based on full attendance at eligible sessions.

The Lifetime Learning Committee also encourages those who are attending the conference to consider identifying learning goals for the conference—with or without CE. Whether you plan to attend many conference sessions, come to the conference to network, have lots of GSA business to attend to, or are also hoping to enjoy a little of the city, consider what you'd like to learn while you're in Boston.

Interdivisional Health Care Committee Update

Submitted by Kimberly Hiroto, PhD

What is the IHC?

The Interdivisional Healthcare Committee (IHC) comprises representatives of APA divisions that have investment in clinical healthcare. The IHC offers a way for clinically specialized psychologists to work collaboratively and act on common issues and concerns. While the IHC is not formally affiliated with APA, the committee works closely with APAs Practice Directorate.

The IHC met in August prior to the APA convention for our annual summer meeting. Divisions represented included: 12/II, 17 (Counseling Psychology), 22 (Rehabilitation Psychology), 38 (Society for Health Psychology), 40 (Society of Clinical Neuropsychology), 43 (Couple and Family Psychology), and 54 (Society of Pediatric Psychology). Additionally, representatives also attended from the APA Practice Directorate, APA Center for Psychology and Health, and the APA Board of Professional Affairs, and the APA Public Interest Directorate. The IHC addresses multiple topics related to psychology's role in healthcare. Summarized here are some key points related to Clinical Geropsychology:

1. Ongoing efforts toward developing biopsychosocial models of health care highlighting the value added of psychologists for relevant issues including opioid use, disability/functioning, and chronic pain. APA is taking efforts to collaborate with medical organizations to this end. Stakeholders seem to appreciate that Medicaid recipients and patients with complex needs contribute to the minority of the population accounting for the majority of health care costs. The IHC continues promoting interprofessional, function-based care to help with non-opioid approaches to management of chronic pain across the lifespan.
2. The IHC continues supporting the American Diabetes Association's partnership with APA to certify psychologists to deliver diabetes treatment.
3. IHC continues collaborating with and supporting APA's Center for Psychology and Health on projects to train psychologists on integrated care and help psychology increase its foothold as healthcare providers. Geropsychology, in addition to other specialties, are far more familiar with this process than psychologists in other specializations, and continue being leaders in the field and offering models of care for others to emulate.

Membership Committee Update

Submitted by Nicole Torrence, PhD & Anne Schwabenbauer, PhD

- Total Paid members: 183
- Total Paid Regular Members (including Emeritus members): 150
- Total Paid Student Members: 33

We are delighted to announce that we have significantly increased our membership over the last quarter and would like to thank all of our members for their continued support. For all of our current members, a reminder that your

SCG memberships expire at the end of the calendar year so please renew to avoid losing your SCG benefits! This is also a great time to invite potential members to join so that they are able to enjoy a full year of SCG! We currently updating our website and hope it will be fully functional in the near future. Stay tuned for updates!

Communications Committee Update

Submitted by Christine Gould, PhD

Communication Committee Update

The SCG Communication Committee has worked closely with the SCG Board to correct the website issues we have experienced over the past year. We thank all our members for their patience while these technical issues are ironed out. Bonnie Palmer, who has worked on the COPTGP website, has successfully restored our website, geropsychology.org, so that members will be able to renew via the website. She is just waiting on a few minor fixes prior to declaring the website fix officially "completed." Rachael Spalding, SCG website coordinator, has updated the newsletter and newsletter archives. SCG have also been placed on Bonnie's annual maintenance plan to ensure that technical difficulties like this are avoided.

Opening for new committee chair for the Society for Clinical Geropsychology Communication Committee!

The Communication Committee aims to increase psychologists' awareness of the function, activity, and mission of the Society and promote public knowledge of Geropsychology. The Committee includes the Chair, Newsletter Editors, Social Media Overseer, Website Content Coordinator, and Website Coordinator. The Chair would be responsible for bringing the committee together for approximately 1-3 meetings per year by phone. The Chair also is responsible for managing the 12/2 APA Listserv.

Questions about the position can be directed to Christine Gould at Christine.Gould@va.gov. If you are interested, please submit your statement of interest and a brief CV to Doug Lane at dw_lane@hotmail.com.

Research Round-up - Self-harm among older primary care patients is undertreated

Submitted by Emily Bower, PhD
Postdoctoral Fellow
VISN 2 Center of Excellence for Suicide Prevention, Canandaigua VAMC
Department of Psychiatry, University of Rochester Medical Center
Supported by the Office of Academic Affiliations, Advanced Fellowship Program in Mental Illness Research and Treatment, Department of Veteran Affairs

Research Roundup: Self-harm among older primary care patients is undertreated

Suicide in later life is a complex and understudied issue. A constellation of psychiatric, physical, and social factors contributes to suicide risk in later life, emphasizing the need for a collaborative and multi-faceted public health approach to prevention (Conwell, Van Orden, & Caine, 2011).
The accurate identification and clinical management of self-harm is particularly important to late life suicide prevention efforts given high rates of repeat suicidal behavior and suicide following emergency treatment for self-harm (Cheung et al., 2017). Motivated by findings that a significant number of people who die of suicide presented to their primary care provider within the months and weeks preceding their death (Ahmedani et al., 2014; Conwell et al., 2000), recent research has strived to improve suicide prevention efforts within primary care clinics (Lapierre et al., 2011); however, relatively little is known about the incidence and management of self-harm in primary care.

In a study reported in the November issue of *The Lancet Psychiatry,* Morgan and colleagues (2018) responded to this gap in the literature with a data linkage approach to explore the incidence and outcomes of self-harm using one of the world's largest primary health care datasets, the Clinical Practice Research Datalink. Risk of mental health, physical illness, and mortality were further explored using a matched cohort design. The authors identified 4124 cases of self-harm among older adults registered with a primary care provider in the UK during 2001-2014. Incidence rates were highest among the oldest age group (85+ years) and clinics located in low socioeconomic regions. Older adults who self-harmed had higher documented rates of mental illness, dementia, and medical comorbidity compared to the matched cohort. Perhaps the most striking findings were with regards to clinical management and mortality outcomes. Contrary to national practice guidelines, referral to mental health services in the year after self-harm was low (12%) and referral rates were marked by significant disparities, with the lowest referral rates reported for men (10%) and patients in lower socioeconomic locations (8%). Tricyclic antidepressants (TCAs) were prescribed in 12% of self-harm cases despite practice guidelines warning against TCAs due to their potential toxicity (Morgan et al., 2018). These rates are particularly alarming in view of the finding that older adults with self-harm were at increased risk of suicide and all-cause mortality in the years following the index event, and were 20 times more likely to die by unnatural causes within the first year after self-harm (HR=19.65, 95% CI 11.69-33.05).

In a commentary on the study, Mitchell (2018) emphasized that the findings point to the need for improved clinical management of self-harm among older adults within primary care. Taking a public health perspective, findings also point to the broader need for selective prevention programs that target older adults with mental illness, medical multimorbidity, and dementia to reduce incident self-harm and rates of unnatural death in this high-risk group. Geropsychologists are uniquely positioned to contribute to these efforts through the development and dissemination of educational tools, prevention programs, and evidence-based co-located behavioral health services.

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M. Powell Lawton Award Address

American Psychological Association Convention
August 9, 2018

Submitted by Michele J. Karel, PhD, ABPP

Foundational Skills for Professional Geropsychology Practice: Exploration and Reflections

Hello newsletter readers:

I was so very honored to receive SCG's M. Powell Lawton award in 2017, and to have the opportunity to reflect on my career in preparation to give this address at the APA meeting in San Francisco this past August. Thanks to those of you able to attend the session – it always helps one's nerves to see so many friendly faces in the room! I had not written out my entire address word for word. Rather, I had a slide presentation with visuals, bullet points, and screen shots of articles I have written; I spoke to the material in the slides with the help of my notes. I will do my best here to re-create my comments without benefit of the visuals. I would be happy to share the slides separately for anyone who is interested.

Thank you to the Society of Clinical Geropsychology for this recognition and to all of you for joining this session today. This award is in honor of Dr. M Powell Lawton, as are several other major awards in our field. Unfortunately, I did not have a chance to know Dr. Lawton but I know he was beloved by many. He was a pioneer in our field, known in large part for his work the relationship between the environment and the aging individual, with implications for the design of residential care settings for older adults.
M. Powell Lawton, PhD (1923-2001), known as the "Elder Statesman of Gerontology," served many professional and leadership roles, including: Director Emeritus, Polisher Research Institute; Professor of Psychiatry, Temple University; Adjunct Professor of Human Development, Penn State University; Past President, GSA; Past President, APA Division 20; and beloved mentor. He received awards galore. Quotations from two who knew him well include: *Through his research, writings and teachings, Dr.*

Lawton provided a beacon that has guided and influenced public policy to enhance the quality of life of seniors (Frank Podietz). *Powell Lawton was a giant. The whole field of aging stands on his shoulders and the lives of older people are better for it. He was also personally responsible for the development of a whole generation of research investigators, clinicians, and educators dedicated to improving the lives of older people* (Barry Lebowitz). And, Dr. Lawton shared a sentiment that I believe many of us share: "*What I do for a living excites me, motivates me. I've been fortunate to be in a situation where personal goals can be fulfilled at work.*" Thanks to Dr. Lawton and, again, I am honored to receive this award in his honor.

On a personal note, I am grateful to have been trained, supervised, coached, and provided exciting professional opportunities by some of the most remarkable people in our field. I wish I had time to explain just how each of the people pictured here has supported me, but much thanks to (shown in photos): Margy Gatz, Bob Knight, Greg Hinrichsen, Rick Zweig, Suzann Ogland-Hand, Jenny Moye, Sara Qualls, Victor Molinari, Toni Zeiss, Brad Karlin, and Marsden McGuire. And, thanks to so many others of you with whom I've collaborated, served, trained, mentored, and/or otherwise befriended.

Professional Geropsychology: An Abbreviated History

Geropsychology has come into its own as a specialty are of professional psychology practice over the past 40 years. Two conferences set the stage: Older Boulder I, in Boulder, Colorado, in 1981, focused on the knowledge base in geropsychology and began the discussion of how this knowledge base could be taught to new geropsychologists. Older Boulder II, which met in Washington, DC, in 1992, continued this discussion, but with a greater focus on skills training and more attention to the various levels of clinical training. Based in part on that earlier work, the APA guidelines for Psychological Practice with Older Adults were first published in 2003, with an update in 2013.

As Bob Knight and others worked to have geropsychology recognized as a proficiency, and then specialty, area of practice by the APA Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP), feedback was that the field really needed an explicit training model. How does one develop specialization in this field? Thus, the Peak Conference was organized in 2006, hosted in Colorado Springs by Sara Qualls and colleagues, and I had the honor to co-chair that conference with Bob Knight. The following year, the Council of Professional Geropsychology Training Programs (CoPGTP) was established, and currently has approximately 45 training program or affiliate members. With establishment of the Pikes Peak competency-based training model, and lots of hard work, geropsychology was recognized as a specialty in 2010. Then, lots of hard work by Victor Molinari and others led to establishment of the American Board of Geropsychology (ABGERO) and opportunity for psychologists to become board certified in Geropsychology through the American Board of Professional Psychology (ABPP). As of today (8/9/18), there are 64 psychologists with board certification in Geropsychology.

The introduction to the CRSPP definition of the specialty of geropsychology reads as follows:

> *Professional Geropsychology is a specialty in professional psychology that applies the knowledge and methods of psychology to understanding and helping older persons and their families to maintain well-being, overcome problems and achieve maximum potential during later life.* ***Professional geropsychology appreciates the wide diversity among older adults, the complex***

ethical issues that can arise in geriatric practice and the importance of interdisciplinary models of care. (See http://www.apa.org/ed/graduate/specialize/gero.aspx)

The sentence that I've put in bold font are some of the foundations of geropsychology practice which I will address today. The full CRSPPP definition includes information about specialized knowledge base, common problems addressed, populations served, and skills and procedures utilized in geropsychology practice.

Reflecting on My Geropsychology Career: What's it all About?

Before moving on to the focus of this talk, I thought it might help to provide a brief bio of my professional development and how I decided on the theme of foundational skills for geropsychology practice for this talk. I developed an early interest in geropsychology as an undergraduate, when I did a senior thesis on family caregiving in late life, influenced in part by my family's experience caring for my father's mother who I only realized years later clearly had Alzheimer's disease. I completed my PhD at the University of Southern California (1989-1994), where I was in the clinical-aging track. I worked with Margy Gatz, Bob Knight, and others, and, in my research, explored interests in late life depression, and ethical issues related to, and the family context of, end-of-life care decision making. After a community mental health center internship at Yale (1993-1994), I completed a geropsychology fellowship at Hillside Hospital, working with Greg Hinrichsen, Rick Zweig, and others, where my love of clinical geropsychology was reinforced. The summer of that fellowship I participated in the NIA Summer Institute on Research on Aging, which was a great experience, and among other things, introduced me to remarkable colleagues including Suzann Ogland-Hand and Becky Allen.

In September 1995, I started my VA career at the Brockton VA Medical Center, now part of VA Boston Healthcare System, recruited by my dear colleague Jenny Moye and others, where I spent 16 years working in an interdisciplinary geriatric mental health clinic, coordinating geropsychology internship and fellowship training, and collaborating in research and other academic and professional service activities. Thanks to Brad Karlin and Toni Zeiss for bringing me on to VA Central Office in 2011, when the position for Program Coordinator of the Home Based Primary Care Mental Health Initiative opened up. Since that time, I've had the chance to become involved in many important initiatives to address mental health of aging Veterans. Over these years, I've been fortunate to be engaged in so many different professional activities, in such a wide range of areas, that I feel I don't have a strong specialty within geropsychology. But, one theme running through much of my work is our profession's foundational skills, which I'll focus on in this talk.

Foundational Skills and the Pikes Peak Model

To discuss foundational skills for geropsychology, I need to take a step back and provide brief overview of the Pikes Peak model for training in professional geropsychology, with which many of you are familiar. Attitude, knowledge, and skill competencies for professional geropsychology practice were delineated in the Pikes Peak model (Knight et al., 2009; Karel et al., 2010). The range of knowledge and skills delineated were geared towards an entry-level psychologist who practiced extensively with older adults. The model worked to balance high standards for competent practice but also inclusivity – the goal is to invite people to develop competencies, not exclude people. The model acknowledged that there are multiple pathways to geropsychology competence – not everyone who ends up with geropsychology

competencies will do so through a graduate program and/or internship and/or fellowship. People may develop skills at the post-licensure level as well.

Th Pikes Peak competencies were modeled after the "Cube Model" for psychology competency development (published by Emil Rudolfa and colleagues in 2005), that considers the development of both foundational and functional competencies across a psychologist's training career. While functional competencies are the major professional activities we do (e.g., assessment, intervention, supervision, teaching, research, administration), the foundational competencies are the underpinnings of all our professional activities. Foundational competencies are similar across all psychology specialties, but adapted to the particular populations or care settings. In addition to foundational competencies of ethical/legal standards, individual diversity, interdisciplinary collaboration, self-reflection, relational skills, and application of scientific knowledge, the Pikes Peak conferees also viewed appropriate documentation and billing procedures and advocacy/care management to be foundational to competent geropsychology practice.

I will highlight my work and thinking in the areas of ethics, interdisciplinary care, and self-reflection through the lens of training/supervision. In this limited time, I will not be reviewing great work by others in this area, apart from direct collaborators, but my work has, of course, been influenced by many others working in these areas.

Ethics in Geropsychology Practice

The Pikes Peak competency reads that geropsychologists should be able to: Understand and apply ethical and legal standards, with particular attention to aging-specific issues, such as informed consent, confidentiality, capacity/competency, end-of-life decision making, and elder abuse and neglect. What are some ethical dilemmas common in your geropsychology practice? Ethical concerns or dilemmas are essentially uncertainties or conflicts about values, where different people of good faith may have different opinions about what is the right thing to do and there may not be one "right answer". [The audience shared some ideas, and then I shared some examples.] Common ethical dilemmas regard: Values conflicts, e.g., promoting safety vs autonomy; gray areas of decision-making capacity, and eliciting values/goals; engaging family members and others in assessment/treatment: when and how; surrogate decision making; addressing privacy and confidentiality in team-based and congregate living settings; defining boundaries, e.g., home care, sharing of gifts; reporting suspected elder abuse.

In my experience in practice and providing supervision and consultation to trainees and colleagues, working primarily in VA medical center team–based care settings, these are normative, everyday struggles we encounter and often pose the greatest challenge for many of us. Learning to assert concerns in team-based settings and support teams in resolution are important skills for geropsychologists. Thanks to the editors of the books pictured here for the opportunity to contribute chapters on ethics, helping me to develop and clarify my thinking (see citations for Karel, 2011; Karel, 2009; Karel & Moye, 2006). I've always wondered why, in these and other textbooks, ethics is commonly the last or 2nd to last chapter in the book? I think it's the bedrock of everything we do and might come earlier! I'd also like to give a shout out to a book published last year, *Ethical practice in geropsychology*, by Shane Bush, Rebecca Allen, and Victor Molinari.

In reviewing many articles and frameworks for ethical decision making in geriatric healthcare contexts, these five steps (borrowed and adapted from others, see reference list) have been helpful for me in

thinking about situations where different people have different ideas about what is the right thing to do and, likewise, to help teams. I don't have time to illustrate this framework with a case but, essentially, it can really help a team talk through:

Step 1: Clarifying the ethical issue – what is the dilemma? This step can often help folks realize they share many goals.

Step 2: Clarify who are the relevant stakeholders and each of their **values, goals, and interests**. This issue has been a longstanding interest of mine, that is, how best to understand, elicit, and help communicate values and goals, particularly of vulnerable older adults with marginal decision-making capacity. I will focus on some of my work in that area in a moment.

Step 3: Clarify decision-making authority. Who has the right to make the decision in a particular situation? A lot does have to do with decision making capacity; a competent adult has right to make decisions about his/her own life, within limits, i.e., that don't pose harm to others, and/or to decide to delegate decision-making authority to trusted others.

Step 4: Consider all ethically justifiable options. Often there are multiple ethically justifiable options – lay those out.

Step 5: Implement, evaluate, and re-evaluate. Choose one option, see how it goes, and evaluate, particularly as circumstances may change.

I will share some collaborative research in this area. Ethical dilemmas in geriatric care often boil down to questions of decision making capacity and, from my perspective, really understanding and respecting individual diversity in life values, goals, and preferences. I've been honored to collaborate for years with Jenny Moye, and others, in studies related to evaluation of decision making capacity. As many of you are aware, decision making capacity depends on four core abilities – understanding, appreciation, reasoning, and choice. I don't have time to define all the terms but an important ability is reasoning, weighing pros and cons of different options, or, as stated in the APA/ABA Handbook for Psychologists, on the Assessment of Older Adults with Diminished Capacity, reasoning "involves the ability to state rational explanations or to process information in a logically or rationally consistent manner (APA/ABA, p. 52)."

But, we know it's not always so rational/logical… reasoning also depends on being able to weigh options based on one's long-held values, beliefs, goals, relational considerations, emotional factors – fears, desires, dreams, and so forth. We need to understand how to help people communicate their values and evaluate whether decisions are consistent with an individual's values/beliefs, even if we don't agree with their decisions.

In the study referenced on this slide (see Karel, Hicken, Gurrera, & Moye, 2010), older individuals with schizophrenia, mild dementia, or primary care controls (~20 in each group) engaged in rational and values-based reasoning about a hypothetical treatment decision. While both people with schizophrenia and dementia had more trouble than primary care controls in the rational reasoning questions, those "with dementia were as able as the controls…to explain their hypothetical treatment choice in terms of valued abilities and activities." We need to ensure that, in our evaluations of clinical capacity, we work to elicit individual's values and describe decisions in context of those values. (Also see Moye, Karel, Edelstein, Hicken, Armesto, & Gurrera, 2008).

I've also been interested in the extent to which we can engage people in earlier stages of dementia in sharing their values and goals for the future. In this project (see Karel, Moye, Bank, & Azar, 2007), men and women aged 60 and older completed three values assessment tools—open-ended questions, forced-choice (which of these is more true for you?), and rating scale questions—and named a preferred

surrogate decision maker. Half (N=81) had dementia and half (N=84) did not. Adults with and without early dementia were able to respond meaningfully to questions about values regarding quality of life and health care decisions. They were equally able to report consistent values and a preferred surrogate after 9 months. Certainly, as we all know, a diagnosis of dementia does not indicate decisional incapacity and, even if a person with dementia has difficulty making complex decisions, they may be well able to express long-held values and beliefs. Back to ethics, people with dementia can be engaged in planning for their futures, if they wish to participate.

Jenny Moye and Aanand Naik, a geriatrician researcher at the Houston VA, have lead a very rich longitudinal study of older Veterans diagnosed and treated for GI cancers – oral through rectal (chosen due to the often very significant impact on quality of life of these cancers) - to understand the course of functional disability, psychological distress, meaning making, resilience, and other adaptation over time. At one of the three points in time of this study, there was a section called "Planning for the future," the interview included these open-ended questions: *Now that you have had cancer and may face ongoing decisions about medical care in the future, what would you want your family, friends, and doctors to know about you, in terms of what is most important to you in your life? If your cancer were to recur, is there anything you'd want to be sure your loved ones knew about you and your goals of care?* An interdisciplinary team conducted thematic analyses of 146 participants' responses. Five domains emerged, for which – in this paper (see Naik, Martin, Moye, & Karel, 2016), we suggested questions that could be used in a clinical interview to help elicit individuals' values in these areas: (1) Self-sufficiency, (2) Life Enjoyment, (3) Connectedness and Legacy, (4) Balancing Quality and Length of life, and (5) Engagement in Care.

Team Work in Geropsychology Practice

I will now shift to discussing team work as a foundational competency for geropsychology practice. The Pikes Peak competency reads that geropsychologists should be able to: Address complex biopsychosocial issues among many older adults by collaborating with other disciplines in multi- and inter-disciplinary teams. What are some of the challenges you face in working as part of a multi or interdisciplinary team, or simply collaborating with professionals across disciplines, in your practice? [The audience shared some ideas, and then I shared some examples.] Examples include: Different professional values, priorities, or approaches to care; overlapping roles and responsibilities; misunderstanding of psychologist's role; team conflict, ethical dilemmas; ineffective or toxic team leadership.
In my experience, a critical role for psychologists in general, and geropsychologists in particular, is to help facilitate team functioning, communication, and conflict resolution. For trainees, and at times for all of us, it can be intimidating and take courage and practice to learn how to speak up in team settings. We can model active listening; ask questions to help team members, especially those reluctant to speak up, share their perspectives and to clarify issues at hand; validate emotional reactions or differences in opinion; and help the team work through conflict. Trainees work to find their voices as advocates, facilitators, and leaders in teamwork.

I want to thank Ann Steffen and Toni Zeiss for including me in this chapter in the Oxford Handbook of Clinical Geropsychology, another great chance to think about teams and psychologists' participation and contributions (see Steffen, Zeiss, & Karel, 2014). Not all older adults with behavioral/mental health concerns need care by a full interdisciplinary care team but, to the extent that there are multiple biopsychosocial problems with increased complexity, the more helpful care will be if overseen by an interdisciplinary team. In this chapter, we reviewed research on teams in geriatric care, presented an

international model of healthcare team performance, growing out of Toni Zeiss' original work on teams in the VA, and implications for practice for geropsychologists.

We are fortunate in the VA Healthcare System to have teams as the core structure for healthcare delivery. Over the past decade, VA has worked to integrate mental health professionals not only in primary care teams but also into Geriatrics and Extended Care teams in programs including Home Based Primary Care (HBPC), Geriatric Primary Care, Community Living Centers (or skilled nursing home care settings), and Hospice and Palliative Care. We have been building communities of practice for these mental health professionals, mostly psychologists, via listservs, on-line resources, webinars, community meetings, peer mentorship programs, and more. Many of you here are members of these teams, and communities of practice.

A note about Home Based Primary Care in VA: Thanks to Brad Karlin, Toni Zeiss, and Jocelyn McGee for their leadership in advocating for and supporting the integration of mental health professionals in HBPC teams. I have been involved since 2011 in supporting this remarkable community of providers. HBPC is a phenomenal program that provides longitudinal primary care for Veterans who are not able to access clinic based services due to complexity of their needs. The interdisciplinary team goes to the home. HBPC has been demonstrated to reduce overall costs of care, with decreased hospitalizations, ER use, and delay of nursing home placement, with high levels of satisfaction by patients and families. Psychologists are integrated members of the team and, in this generally stepped model of care, support the team in addressing behavioral concerns and provide home-based specialized mental health evaluation and treatment when indicated. (See Karlin & Karel, 2013; Gordon & Karel, 2014).

In VA Community Living Centers, we have been training teams to better understand and manage behavioral concerns among residents with dementia, with an interdisciplinary team-based behavioral intervention based on Dr. Linda Teri's STAR program (Staff Training in Assisted Living Residences) adapted to the CLC context and called STAR-VA. Brad Karlin and others took the lead in developing and piloting this program starting about 10 years ago. In STAR-VA, we train a mental health professional (usually a psychologist) and a registered nurse to partner in training and supporting the rest of the team in behavioral assessment and care planning. We have demonstrated significant decreases in severity and frequency of target behaviors, and decreased symptoms of depression, anxiety, and agitation (see Karel, Teri, McConnell, Visnic, & Karlin, 2016). Thanks to Kim Curyto, PI of an ongoing evaluation project and many evaluation partners, we are now examining the impact of STAR-VA on overall rates of disruptive behaviors in CLCs, psychotropic prescribing, staff injuries, and, transitions to acute care settings. Stay tuned for those evaluation results. We are focusing now on how best to help teams sustain this approach to care, integrating it into usual care, in the face of many challenges, including staff turnover.

Self-reflection, Self-awareness…and Training in Geropsychology

The next and final Pikes Peak foundational competency I will discuss, in context of training and consultation, is that geropsychologists: Practice self-reflection, self-assessment (e.g., self-awareness of ageist assumptions/biases; recognition of boundaries of competence and when/how to refer elsewhere). Of course, this competency is not specific to geropsychology. Ethical professional practice depends on all of us knowing the limits of our competence, when we need to consult or refer elsewhere, as well as to have some awareness of our own needs, emotional states, motivations, and styles of self-presentation and whether those may be interfering with best meeting patients' needs. It is so important to have trusted team members/colleagues to help us be aware of our own lack of insight at times.

What are some challenges you have faced in addressing possible gaps in self-awareness (e.g., of biases, competencies, self-presentation) among trainees or colleagues? [The audience shared some ideas, and then I shared some examples.] Examples include that people may not: Know what they don't know (metacompetence); accurately self-report interactions with patients; recognize styles of interacting with older adults; appreciate countertransference. For example, I have observed a lovely and loving person being very stern with an older adult in an initial evaluation or, on the other hand, speaking to older adult as a child (elderspeak); a trainee using humor to avoid painful discussion of grief; or trainees displaying a "know it all" or angry demeanor towards team members. As a supervisor, it can be difficult to pick up on these issues unless you have a chance to observe trainees in action, via videotaping, co-assessment or co-treatment, or participating together in team meetings. Direct observation of geropsychologists-in-training is important, acknowledging strengths and supporting collaborative reflection to help increase self-awareness.

Related to the foundations of self-awareness and building meta-competence, and overall competence, supervising and mentoring people has been my favorite part of my career. I have done collaborative research and writing in this area. Thanks to Drs. Abby Altman, a postdoctoral fellow at VA Boston at the time, Greg Hinrichsen, and Rick Zweig, for collaborating, and to many of you for responding to the request for input from geropsychology supervisors and supervisees, for this project supported by CoPGTP (see Karel, Altman, Zweig, & Hinrichsen, 2013). In this study, 32 post-licensure geropsychologists and 18 doctoral graduate students, six of whom were on internship, responded to an online survey. To highlight a few findings: Not surprisingly, geropsychology supervisors perceived supervisees to struggle more than supervisees did; it takes time to develop meta-competence. Areas of relative struggle per both groups: working with challenging/complex family systems; personality disorders; institutional/systemic challenges; and assessment/ treatment with cognitively impaired older adults. Supervisors and supervisees value observation of both supervisor and supervisee clinical work (approaches that we do not always utilize).

Mentoring can be integrated into supervision or, per Dr. Brad Johnson, providing "transformational supervision" for those interested. Per Dr. Johnson's language, I needed to learn how to be an "intentional" versus an "accidental" mentor during my years as a clinical supervisor at VA Boston. Thanks to Carolyn Stead, prior VA Boston postdoctoral fellow, for working with me on this project, where we shared tips for supervisors/mentors and supervisees/mentees at internship and fellowship levels of geropsychology training, based on our mutual experiences (see Karel & Stead, 2011). Supervisor-mentors: Support competency self-evaluation; provide challenge and validation; respect diversity; serve as professional role model; provide professional socialization; and are genuine/humble. Interns/fellow learn that mentoring relationships are reciprocal and, developmentally, interns and fellows are at a point to actively help set the agenda for their supervision and mentoring needs.

Peer mentorship is another approach for helping to build professional competencies in our field. Many people who start VA HBPC or CLC jobs are new to home-based or nursing home care, as well as to geropsychology and/or team-based care in a medically oriented program. How can we help to support their professional growth in these positions? One part of the solution has been peer mentorship. In the HBPC program, 89 psychologist peer mentor pairs were established between 2012 and August, 2018. Thanks to Danielle Terry, Heath Gordon, and Pam Steadman-Wood for helping to support an evaluation of this program in HBPC between May 2012 and January 2015, at which time 57 mentorship pairs had been established (see Terry, Gordon, Steadman-Wood, & Karel, 2017). During that time, about 50% of established HBPC psychologists volunteered as virtual mentors, and 50-60% of newly hired psychologists

sought a peer mentor. Mentoring generally entailed monthly phone calls and email correspondence, with discussion of clinical, team, and professional issues. We received generally positive feedback from those serving both as mentors and mentees. Psychologists who were mentees reported their peer mentorship relationships provided acceptance, support, encouragement and positive role modeling. Mentors reported feeling very positive about the ability to "give back" and provide guidance to others navigating the novel HBPC psychologist role and perceived the opportunity as a satisfying aspect of their professional endeavors.

Final Thoughts

- Effective geropsychology practice builds upon these foundational skills
- What a remarkable field we get to work in: Let's do all we can to inspire others to "Come, Join, Lead" (See Moye et al., 2017)
- Collaborative work, mentoring, professional service and leadership are fun!
- Thank you to a remarkable community of colleagues and students in professional geropsychology and in VA
- Again, I agree with M. Powell Lawton: *"What I do for a living excites me, motivates me. I've been fortunate to be in a situation where personal goals can be fulfilled at work."*

(I ended this presentation by sharing some photos of me and my husband at our home and hiking in Vermont and thanked everyone for participating).

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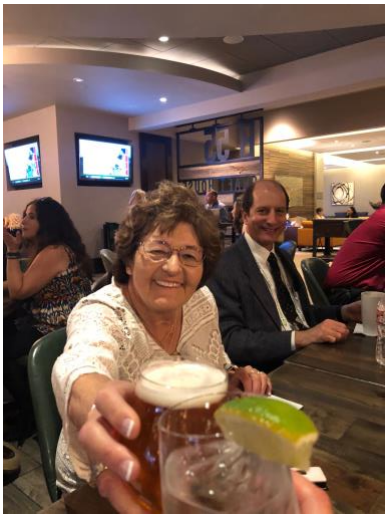

Did You Know…

- That the Society has two Facebook pages?
  - One is for all members: https://www.facebook.com/#!/ClinicalGeropsychology
  - The second is for student members: https://www.facebook.com/groups/53793187809/
- That all the archived newsletters are available on the Society website?
  - http://www.geropsychology.org
- That board meeting minutes are available on the Website? As part of our efforts to increase member awareness of and promote involvement in our Division, the official minutes of each Executive Board meeting are now available in the Member's area of our Division's website.
- That you should encourage your colleagues and students to join the Society? Please distribute the membership form on the next page to encourage others to join!
- We publish announcements of recent members' achievements in research (publications, grants, awards), clinical work (awards, recognition), teaching, and public policy. Please send information concerning your own achievements or those of a colleague to either Elissa or Brenna.

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