Clinical Geropsychology News

Society of Clinical Geropsychology

APA Division 12, Section II Volume 24, Issue 2

July 11, 2017

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

Benjamin Mast, PhD, ABPP

This summer holds an exciting aging double header. Up first in late July (23-27) is the International Association of Gerontology and Geriatrics (IAGG) meeting co-hosted with the Gerontological Society of America in San Francisco, CA. Batting second is the American Psychological Association celebrating its 125th Anniversary in Washington DC at the Annual Convention (August 3-6). Two big events over two big weeks! The wealth of aging programs at these two conferences will certainly leave us enriched and inspired, even if the costs of back to back conferences might leave us with a little less wealth financially!

I would like to use this edition of the Presidential Column to (1) highlight programming sponsored by the Society of Clinical Geropsychology at the APA Convention and to (2) invite you to share your thoughts on SCG.

APA CONVENTION PROGRAMING SPONSORED BY SCG

Thursday – August 3
Presidential and M. Powell Lawton Awards Addresses (8:00am to 9:50am)
At 8:00am I will be delivering the Division 12, Section II Presidential Address. The focus of my presentation will be career pathways in clinical geropsychology, including a focus on the ways that we integrate the science and stories of aging. At 9:00am, Dr. Sara Qualls will give the SCG M. Powell Lawton Award address entitled, "Caregiving in Context: Implications for Intervention and Research."
Location: Convention Center Room 146C

Friday – August 4
SCG Board Meeting (8:00am)
SCG Business Meeting (9:00am) – open to all members and potential members
Location for both SCG meetings: Division 12 Hospitality Suite, Marriott, Room TBA

There are many more sessions at APA that address aging issues. Thankfully we aren't the only segment of APA interested in aging. A complete list of sessions on aging issues can be found at http://www.apa.org/convention/aging-sessions.pdf. Thanks to Debbie DiGilio and the Office on Aging for compiling this list! And, check out page 11 for information on joining SCG for dinner at APA!

MEMBERSHIP AND PARTICIPATION IN SCG – WHAT CAN WE DO FOR YOU?

Participation in SCG conveys not only an interest in the welfare of older adults but also a desire to promote of the field of geropsychology. Membership in SCG reflects commitment and investment.

SCG has experienced a recent decline in membership and we would like to better understand how we can better serve you as an individual member and the field of clinical geropsychology more broadly. What is most valuable to you as an individual member? Do you have ideas for initiatives or programs that you think we might be able to start? Do you think we should partner with other aging organizations more often? What would you like to see more or less of in SCG?

We would like to hear from you. If you have thoughts you'd like to share, send me an email (b.mast@louisville.edu) or better yet, stop by one of the SCG events I mentioned above. If you've forgotten to renew your membership for 2017, please contact Nicole Torrence, Chair of the 12/II Membership Committee (membership@geropsychology.org), or refer to the membership renewal form at the end of this newsletter.

Thank you and see you at IAGG and/or APA!

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Call for a Student Representative!

The Society of Clinical Geropsychology is looking for a new student representative to serve for two years starting in Fall 2017. We are interesting in hearing from graduate students with a strong commitment to aging and clinical geropsychology.

To learn more about what SCG student representatives do, please see the Student Representative column in this newsletter or contact Allison Midden (ajmidd02@louisville.edu). If interested in being considered for this role, please contact Benjamin Mast (b.mast@louisville.edu).

Comments from the Editors: Elissa & Brenna

Welcome to the 2017 Summer edition of the Clinical Geropsychology News! Those of you in university settings are easing out of the academic year and into the long days of summer. Hopefully everyone, regardless of setting, is taking some time to recuperate and reset before fall approaches. However, with two back-to-back conferences (IAGG and APA) coming up within the next month, you might find yourself busier than usual! We'd like to point out a few highlights in this issue of the newsletter:

- SCG welcomes two new elected board members (see below)!
- Congratulations to our SCG Award winners, featured on pg. 4.
- In lieu of our new Research Roundup column, we have featured the Student Research Paper Award winner and honorable mention. See winning abstracts from these emerging researchers on pgs 4-6.
- We have great member highlights, including a special submission by Dr. David Glenwick (pg. 16), two Member Spotlights (pg. 6), and news and announcements from your colleagues (pg. 9).
- Find conference-related events at IAGG and APA throughout!

As always, if you have any ideas for how we can improve the newsletter, we would love to hear them. Please feel free to email us at any point at Elk2020@med.cornell.edu or bnrenn@uw.edu.

New Board Members: Results of the 2017 SCG Election

Submitted by Sherry Ann Beaudreau, PhD, ABPP, SCG Elections Chair & Past President

Please join us in congratulating the winners of the SCG 2017 elections!

Secretary
Veronica Shead, PhD
St. Louis VA

President-Elect
Nancy Pachana, PhD, FAPS, FASSA
U-Queensland, Brisbane, Australia

We wish to express our gratitude to our other superb nominees who ran for Secretary (Drs. Erin Sakai and Sheri Gibson) and President (Dr. Shane Bush). SCG members expressed overwhelmingly enthusiastic support for all nominees in this year's race.

For updates regarding the 2017 vote on the Bylaws amendment to allow for non-APA members to join SCG, please refer to the newsletter section on "New Bylaws Committee."

Congratulations to our SCG Award Winners!

The Society of Clinical Geropsychology wants to congratulate this year's award winners:

Your colleagues applaud all of you, and sincerely thank you for all your eminent contributions that have advanced the profession of clinical geropsychology. We couldn't do it without you!!

Michele J. Karel, PhD *M. Powell Lawton Award for Distinguished Contributions to Clinical Geropsychology*

Daniel L. Segal, PhD *Distinguished Clinical Mentorship Award*

Nancy Pachana, PhD *Award for Excellence in Gerodiversity*

Catherine M. Escher, BA *Student Award for Excellence in Gerodiversity*

Elissa Kozlov, PhD *Student Research Paper Award*

Allison Midden, MS *Honorable Mention, Student Research Paper Award*

Student Research Awards

Congratulations to our 12/II Student Research Paper Award winner, Elissa Kozlov, PhD, and to Allison Midden, MS, for her Honorable Mention. See below for their abstracts.

Student Research Paper Award: Elissa Kozlov, PhD

Development and Validation of the Palliative Care Knowledge Scale (PaCKS)
Elissa Kozlov, PhD, Brian D. Carpenter, PhD, & Thomas L. Rodebaugh, PhD

Project background: *This paper is the published study from my dissertation at Washington University. I never intended to dive into scale development, but I was very interested in laypersons' knowledge deficits as a barrier to accessing palliative care, and there were no scales available to measure knowledge of palliative care in non-healthcare professionals. Thus, I believed I had no choice but to learn factor analysis and scale development techniques in order to study the phenomenon I was most interested in exploring. I'm really pleased with the end results: a scale that is psychometrically valid and internally consistent. Subsequent studies have demonstrated that layperson knowledge of palliative care is exceedingly low, and there is a great deal of misinformation regarding the differences between hospice (comfort care for people who are in the last six months of life) and palliative care (supportive care for people with advanced illness that can be added at any time throughout the illness trajectory). I hope that this study enables further research in how to increase access to and utilization of palliative care.*

ABSTRACT

Objective: The purpose of this study was to develop a reliable and valid scale that broadly measures knowledge about palliative care among non-healthcare professionals. **Method:** An initial item pool of 38 true/false questions was developed based on extensive qualitative and quantitative pilot research. The preliminary items were tested with a community sample of 614 adults aged 18–89 years as well as 30 palliative care professionals. The factor structure, reliability, stability, internal consistency, and validity of the 13-item Palliative Care Knowledge Scale (PaCKS) were assessed. **Results:** The results of our study indicate that the PaCKS meets or exceeds the standards for psychometric scale development. **Significance of Results:** Prior to this study, there were no psychometrically evaluated scales with which to assess knowledge of palliative care. Our study developed the PaCKS, which is valid for assessing knowledge about palliative services in the general population. With the successful development of this instrument, new research exploring how knowledge about palliative care influences access and utilization of the service is possible. Prior research in palliative care access and utilization has not assessed knowledge of palliative care, though many studies have suggested that knowledge deficits contribute to underutilization of these services. Creating a scale that measures knowledge about palliative care is a critical first step toward understanding and combating potential barriers to access and utilization of this life-improving service.

Honorable Mention: Allison J. Midden, MS

Differential Item Functioning Analysis of Items on the Geriatric Depression Scale-15 Based on Presence or Absence of Cognitive Impairment

Allison J. Midden, MS, & Benjamin T. Mast, PhD

Project background: *I (am a third year graduate student at University of Louisville working under Benjamin T. Mast, PhD doing research related to neuropsychology and aging. In both my research and clinical work, I have used the Geriatric Depression Scale-15 (GDS-15) several times while conducting dementia assessments. As many geropsychologists have noted, there is some concern as to whether some of the scale's items are truly screening for depression or if they are picking up on symptoms of cognitive impairment. I built upon my existing knowledge of item response theory to learn differential item functioning (DIF) analysis to try and answer that question. Fortunately, I learned that, for the most part, the scale functions comparably in older adults with and without cognitive impairment meaning that clinicians and research can continue to use the scale with confidence! If you are interested in information beyond the abstract included here, then you can find the article in Aging & Mental Health (PMID: 28612653).*

ABSTRACT

Objective. The Geriatric Depression Scale-15 (GDS-15; Sheikh & Yesavage, 1986) is used to screen older adults for symptoms of depression. The present study aims to investigate the differential item functioning (DIF) of the items on the GDS-15 to determine whether or not they are biased by the presence of cognitive impairment. ***Method.*** Data from 215 older patients referred for neuropsychological assessment were used to examine the GDS-15. Individuals were categorized as cognitively impaired if they earned a scaled score of 6 or less (<10th percentile) on the Mattis Dementia Rating Scale II. To evaluate DIF, configural invariance, metric invariance, scalar invariance, residual invariance, and factor variance were evaluated. Additional analyses were conducted to know the role identified DIF items play in the screening process. ***Results.*** Most levels of invariance indicated that items operated equivalently across groups ($p >$ .05). However, analysis of scalar invariance indicated worse model fit ($\chi^2(14) = 36.23$, $p = 0.001$), such that the threshold for Item 13 differed between the groups. Freeing this threshold resulted in scalar

invariance ($\chi^2(13) = 19.16$, $p = 0.12$). ***Conclusions.*** Results indicated that the GDS-15 items are generally not biased by the presence or absence of cognitive impairment and that the tool as a whole functions similarly for both groups. Thus, because partial measurement invariance was achieved, professionals can be confident that the GDS-15 screens for depression as well in individuals with cognitive impairment as those without.

Member Spotlight

Full Member Spotlight: Erin Woodhead, PhD

Year joined Society of Clinical Geropsychology: 2004

Hometown: State College, PA

Current professional title and affiliation: Assistant Professor, Department of Psychology, San José State University

Q: Why did you join the Society for Clinical Geropsychology? I joined during my first year of grad school because my advisor, Barry Edelstein, talked about how it was a good way to meet other students and to connect with other professionals in the field.

Q: How has membership in SCG assisted you with your professional activities? It turns out that Barry was right (he typically is!) and the greatest benefit has been meeting other members and learning about current developments in the field. I also was the newsletter editor for 3 years with Kaci Fairchild and that was a great opportunity to meet members and learn what everyone was up to.

Q: How did you get interested in the field of aging? I joined Steve Zarit's lab as an undergraduate at Penn State to help with the coding and data entry for his studies on caregiver burden. At the time, my grandfather had recently had a stroke and I was interested in the quality of long-term care settings for older adults. I worked in Dr. Zarit's lab for a couple of years and met his graduate students and postdocs, who helped me understand different options for grad school. I opted to go into clinical geropsychology because I wanted more flexibility with future career options.

Q: What was your most memorable experience during your graduate studies? We did a lot of social activities in grad school at West Virginia University. A couple of the memorable ones were Barry's yearly party at his house outside of town that we called "Barrywood," and the annual Chili fest with faculty and students. I'll also never forget going camping at Ohiopyle with a couple of other grad students and realizing that our tent had a leak in the middle of a flash flood watch in the area. We made it through the night with the help of duct tape and threw the tent in the dumpster on the way out the next morning!

Q: Have you had an important mentor in your career? If so, how did he or she make a difference? I've been fortunate to have had many important mentors in my career, some in clinical geropsychology and some in other areas of psychology. Early in my training, my mentors helped me develop skills in certain areas, navigate the transition from student to professional, develop relationships with other people in the field, and develop specific areas of interest. As I moved along in my training, my mentors

supported me in developing my own professional identity and interests. At this point in my career, my mentors are more like colleagues who I consult for professional development advice, collaborate with on projects, and who let me know about opportunities that I might be interested in.

Q: What is your current position? I'm about to start my 6th year in a tenure-track position at SJSU, which means that I have to submit my dossier this fall for tenure and promotion to Associate Professor. SJSU is first and foremost a teaching-focused university but there is also a lot of support for research. Right now I teach three classes a semester, serve on various committees at the department, college, and university level, and maintain an active line of research with students and colleagues at the VA Palo Alto. My main responsibilities are to do well and continue to improve at teaching, serve the department through my committee work, involve students in research, and ultimately publish about one paper a year.

Q: Tell us about your most recent activities. I have an ongoing collaboration with some of the researchers at the VA Palo Alto. I've been fortunate that they often share datasets with me so I can analyze topics that are relevant to mental health and aging. Their primary interests are in substance use disorders, so it's a great collaboration because they look at the substance use outcomes and then I look at the age-related factors that influence those outcomes. Right now I'm working with a dataset about rural methamphetamine users. We recently submitted one paper on age-related differences in health outcomes and treatment utilization over the course of the 3-year study and we're currently working on one looking at the association between barriers to treatment, stigma, health, and treatment utilization over the course of the study. It's been great to expand my interests into aging and substance use because I also teach a class on Addictions and Treatment, so my research can inform my teaching.

Q: What has been your most memorable experience in gerontology and aging clinical practice and/or research? I think it probably was when I taught my first Psychology of Aging class to 40 undergraduates when I started my position at SJSU. It was the first time I got to teach a course in my area of interest and it was a lot of fun to see how the undergrads changed their views of older adults and aging throughout the semester. I teach the course every semester and always ask the students to talk to older adults as part of their assignments. They ask them about their views on nursing homes, social relationships, health, and other topics to see how the theories that we read about translate to older adults' lives. They always really enjoy it and it's exciting to see them dispel some stereotypes about older adults!

Q: Do you have any tips for emerging geropsychologists? I think it's great if you can have multiple mentors that can meet different needs. I've had mentors that have been great for my clinical work and some that have been great for my research and professional development. I also think it's helpful to be honest with yourself about what you want to do in the future. I never saw myself doing full-time clinical work. I tried doing a research-based position with expectations of grant funding and that wasn't the right fit either. I love having some flexibility with my research and being able to try out different things in my classes each semester though I know there are many people who could never see themselves teaching (and grading!) as much as I do.

Q: What keeps you busy when you are not working with older adults? What are your non-professional aspirations and hobbies? I have two daughters who are ages 1 and 3 so they keep me busy and I really enjoy doing activities with them and my husband. I also enjoy reading fiction, exercising outside, trying new recipes, and working on craft and sewing projects.

Student Member Spotlight: Caitlin Foster, BSc, BA(Hons)

Year joined Society of Clinical Geropsychology: 2016

Hometown: Calgary, Alberta, Canada

Academic affiliation: University of Calgary alumna

Q: Why did you join the Society for Clinical Geropsychology? I joined the Society for Clinical Geropsychology in March of 2016 after I started volunteering as a research assistant in a substance abuse treatment program for older adults. At the time, I was conducting a systematic review of outcome measures for a program evaluation the clinicians were going to conduct in the future and I thought that Division 12, Section II might be a useful resource. I also knew that I wanted to pursue research with older adults when I entered graduate school and being part of this network would help keep me up to date with the latest Geropsychology material and allow me to network with others interested in similar research topics.

Q: How has membership in the SCG assisted you with your professional development? As a Canadian student, I may not be able to attend events and conferences in the United States; however, membership in the Society for Clinical Geropsychology has allowed me to keep connected with the discipline abroad. I am certain that as my career develops and I move into graduate school I will rely more on the resources afforded by membership in the Society for Clinical Geropsychology even more in the years to come.

Q: How did you get interested in the field of aging? I have been interested in Geropsychology ever since I took a course on the Social and Clinical Aspects of Aging with my honours supervisor, Dr. Candace Konnert. Her passion for this area of research was evident and she helped to show me the multitude of possibilities that exist when working with older adults. There is so much that can be explored with older adults and I would like to examine how different psychological disorders present in this population. So far this interest has manifested in the examination of substance abuse in older adults, however, I can think of so many areas of abnormal psychology to be explored within this population and through my volunteer work I am seeking to refine my research interests further.

Q: Have you had an important mentor in your career? If so, how did he or she make a difference? My supervisor, Dr. Candace Konnert, has been instrumental in fostering my understanding of the research process. With her guidance, I conducted an original research project, working from the ground up, collaborating with the clinical team to develop research questions and working with clients of the treatment program to answer them. Through her connections and guidance, I have been able to have research experiences at an undergraduate level that not all undergraduate students could attain. Through her recommendation, I applied for an undergraduate research award and was subsequently able to receive funding for my research last summer. I will always be grateful for what she has taught me and for helping me find my niche, working with older adults.

Q: What has been your most memorable experience in gerontology and aging clinical practice and/or research? As part of my undergraduate honours thesis I conducted in-depth interviews with clients of a substance abuse treatment program for adults over 60. We used a life course perspective in the interviews so I could gain an understanding and appreciation of these individuals' lives and understand the variety of factors involved that led them to where they are today. Young adults represent the largest subset of individuals with a substance abuse problem and perhaps this contributes to the laissez-faire attitude that

seems to exist towards older adult substance abuse, however, from the interviews I conducted I have learned the very real and devastating consequences of substance abuse in older adults, not just for these individuals but for their families as well. Conducting those interviews reaffirmed for me that Clinical Psychology is the right path for me and that working with older adults is always interesting as you never know what stories and rich life histories the next day may bring.

Q: Tell us about your most recent activities. I am currently completing analysis on the total set of interviews I conducted for my honours thesis examining substance abuse in older adults. Although our interviews included several subsets of questions concerning their life history, social relationships, substance abuse treatment experiences and their locus of control we are currently focusing on responses to inform an examination of age of onset in older adult substance abuse. Age of onset has long been explored as a predictor of treatment outcome in older adult substance abuse; however, studies to date have received mixed results. We seek to shed some light on the reasons for these mixed results and help reaffirm the importance of providing age-specific treatment programs for older adults with substance abuse problems.

Q: Looking forward, what are your plans post-graduation? Now that I have completed my honours thesis I am prepping for graduate school applications. I will be pursuing graduate studies in Clinical Psychology with a focus in aging. It is still early in my career and I am still in the process of refining my research interests but I know that a focus on working with older adults is in my future. I also have an interest in knowledge translation and hope to start working on the development of a website with the aim of disseminating psychological research to the public and first year undergraduate students in a form that is easily consumable by the average person. As Einstein put it, "If you can't explain it simply, you don't understand it well enough."

Q: What keeps you busy when you are not working with older adults? What are your non-professional aspirations and hobbies? I enjoy reading, art and walking my dog. I like to collect books from book fairs and yard sales and fill my walls with them. Nothing beats the smell, look and feel of an old book and I have always preferred reading from the real thing as opposed to the screen of my tablet. My artwork is mostly portraits and abstracts and I like to experiment with all mediums.

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).

Member News

Peter Kanaris, PhD was awarded Psychologist of the Year award by the Suffolk County Psychological Association. He also gave two presentations in June at the 80th annual New York State Psychological Convention: *How to Administer a Sexual History* and *Cyber Infidelity: A Treatment Model for the Great Challenge to Contemporary Relationships*. Dr. Kanaris is Director of Kanaris Psychological Services, PC a private group practice and is affiliated with the Northwell Health System as a consulting psychologist to both Long Island Jewish and North Shore Hospitals.

Meghan McDarby, BS, a graduate student at Washington University in St. Louis, recently won the 2017 A Place for Mom Senior Care Scholarship. There were five winning essays, and each person won $1000 in scholarship money.

Brenna N. Renn, PhD's review of deprescribing cholinesterase inhibitor medication in Alzheimer's disease was recently featured in Medscape Psychiatry (No Consensus for Discontinuing Mainstay Alzheimer's Drugs). She is currently a postdoctoral fellow at the University of Washington.

Roni Beth Tower, PhD, ABPP's memoir, *Miracle at Midlife: A Transatlantic Romance*, which was published last October, won a Gold Medal in the Independent Publishers Book Awards (Autobiography/Memoir: Celebrity/Political/Romance). Dr. Tower is a retired clinical psychologist.

Kim Van Orden, PhD, Assistant Professor at the University of Rochester School of Medicine, has received R01 funding from the National Institute on Aging to investigate a social volunteering program for older adults with regards to its effects on loneliness and quality of life. This RCT is a follow-up study from the completed study, The Senior Connection (ClinicalTrials.gov identifier: NCT01408654), which found that receiving peer companionship is associated with reduced depressive and anxiety symptoms, as well as reduced feelings of being a burden on others. In this new study, The Getting Active Project, lonely older adults will provide peer companionship to homebound older adults for one year.

Recent Member Publications

Betz, M. E., Arias, S. A., **Segal, D. L.**, Miller, I., Camargo, C. A., Jr., & Boudreaux, E. D. (2016). Screening for suicidal thoughts and behaviors in older adults in the emergency department. *Journal of the American Geriatrics Society, 64*, e72-e77.

Bush, S.S., & Schatz, P. (2017). Advanced technology and assessment: Ethical and methodological considerations. In T.D. Parsons & R. Kane (Eds.), *The Role of Technology in Clinical Neuropsychology* (pp. 457-469). New York: Oxford University Press.

Jahn, D. R. (2017). Suicide risk in older adults: The role and responsibility of primary care. *Journal of Clinical Outcomes Management, 24*, 181-192.

Meehan, M., Massavelli, B., & **Pachana, N.** (2017). Using attachment theory and social support theory to examine and measure pets as sources of social support and attachment figures. *Anthrozoös, 30*(2), 273-289.

Book Announcements

Bush, S., **Allen, R.**, & **Molinari. V.** (2017). *Ethical practice in geropsychology*. Washington DC: APA Press.

Stucky, K.J., & **Bush, S.S.** (2017). *The Neuropsychology Fact-Finding Casebook: A Training and Study Resource*. New York: Oxford University Press.

Oakes, H., Lovejoy, D., & **Bush, S.S.** (2017). *The Independent Neuropsychological Evaluation*. New York: Oxford University Press.

Member Presentations at IAGG

Jahn, D. R. (2017, July). Interactions with the healthcare system and suicide risk factors among older male veterans. In R. Cui (Chair), *Social, psychological, and health-related risk factors for late-life suicide.*

Jahn, D. R., & Crosby, E. S. (2017, July). Older male veterans' relationships, help-seeking attitudes, and suicide risk factors. In E. Thompson (Chair), *Older men's resilience and mental health.*

Lee, L., Castro-Costa, E., Petkus, A., & Hirst, R. (2017, July). In C. E. Gould (Chair), *Biomarkers and longitudinal trajectories of stress and neurocognitive disorders.*

Gould, C. E., Mashal, N., Zapata, A. M. L., Wetherell, J. L., Goldstein, M. K., Beaudreau, S. A., & O'Hara, R. (2017, July). *Older Veterans' Perceptions of Anxiety Symptoms*.

McDarby, M., Merz, C.C., & Carpenter, B.D. (2016) Fear of death and dying in self and others.

McDarby, M., Carpenter, J., Ersek, M.T., Thorpe, J., Smith, D., & Johnson, M. (2017). Associations between timing of palliative care consults and family evaluation of care among Veterans.

Member Presentations at APA

Goy, E., Carpenter, B., Allen, R., Gill, C., Kasl-Godley, J., Werth, J., Lyon, M., & Haley, W. *Psychologists and End of Life: Report from the APA Working Group on End of Life Issues and Care*. Thursday, 8/3, 10:00 - 11:50 am, Convention Center Room 208.

Haley, W. H., Roth, D. L., Jacobs, B. J., & Wray, L. In B. J. Jacobs (Chair) & D. A. King (Discussant), *Reap the Rewards: Increasing Family Caregiver Coping by Fostering the Benefits of Caregiving*. Friday, 8/4, 8:00-9:50 am, Convention Center Room 158.

Van Orden, K. A., & Hannum, A. *Workshop 125: Navigating Countertransference and Ethical Issues in Working with Suicidal Older Adults*. Friday, 8/4, 8:00-11:50 am, Renaissance Washington, DC Downton Hotel.

Join SCG at APA as we co-host a dinner with Division 20 and PLTC!

***Location**:* Sixth Engine, 438 Massachusetts Ave NW, Washington, DC 20001

***Date**:* Thursday August 3 at 6:30pm

***Cost**:* **Full members**: $47.50/person all inclusive (tax and tip) meal of: shareable appetizers, a choice of three entrees, dessert, as well as non-alcoholic drinks.
Link to pay: https://www.paypal.com/cgi-bin/webscr?cmd=_s-xclick&hosted_button_id=B6ZEX494PUMSS

Student members: Reduced to $20, thanks to a generous subsidy by SCG!
Link to pay: https://www.paypal.com/cgi-bin/webscr?cmd=_s-xclick&hosted_button_id=6HA2RJGZL7QP4

Space is limited!
Please RSVP to Douglas Lane (laned4@uw.edu) by July 24th.

The Student Voice

Benefits of Being a 12/II Student Member (or Even a Representative!)
Submitted by Allison Midden, MS & Kelly O'Malley, MA

What do you get out of being a 12/II student member? Or, perhaps better said, what *can* you get out of being a 12/II student member? Probably more than you think! We are going to endeavor to name all of the benefits available to you (though we will likely miss some because there are so many!), and in return, we hope that you will share this list with other emerging professionals in the field of geropsychology who are not yet members of 12/II. The more members we have, the greater the benefits for everyone!

What are these benefits that I keep mentioning? Networking is likely the main, overarching benefit that can lead to many desirable results, such as learning, consulting, collaboration, and career opportunities. Membership to an organization as specific as 12/II can be even more fruitful in reference to networking because we are all academically and/or clinically interested in geropsychology; this means that every contact that you make within 12/II is likely to be relevant in some way or another to your work! Additionally, as a member, you have access to the service and support of a national organization. Other members, via both the listserv and other forms of communication, are wonderful resources of updated information in the field. The listserv also provides a platform on which to ask for professional recommendations, referrals, or advice. There are few other ways to reach as many professionals at once!

Another benefit of being involved in 12/II as a student is the ability to take advantage of leadership opportunities and to work closely with successful professionals in geropsychology. There are many levels of student leadership within 12/II. You can be a student representative on one of our many committees, such as the diversity, membership, and mentorship committees. You can also, of course, be one of us – a student representative for the organization as a whole!

There are always two 12/II student representatives and each serves a two year term. I (Allison) am completing my two year term this fall and encourage you all to consider applying for the position! The student representatives participate in the 12/II board conference calls in order to provide a student perspective on any issues discussed and to also update the board regarding any student events or issues occurring within the organization. We also write a student voice column for the quarterly newsletter in which we try to discuss topics of particular relevance to our student members. Additionally, we are encouraged to attend GSA/IAGG and/or APA conferences to again provide a student presence at 12/II events and meetings. Along with attending the conferences, we plan our annual GSA/IAGG student networking event which is a great place to meet other emerging professionals, faculty members, and clinical supervisors in geropsychology.

Speaking of our GSA/IAGG networking event, we hope to see you there! It is being held at The Treasury (200 Bush St #101, San Francisco, CA 94104) on July 24th from 5-7 PM and light appetizers will be provided. **We will be giving away a door prize this year! If you arrive before 6 PM, are currently a graduate student, and bring a guest who is not a current member of 12/II, then you and your guest will each be entered to win a free 12/II student membership for 2018!** That means a free membership renewal for you and a free new membership for your guest all just for attending a fun and productive event – sounds like a win-win! Contact Kelly with any questions (Kelly.Omalley2017@gmail.com).

We hope to see you (and your guest!) on July 24th!

IAGG STUDENT SOCIAL

When: Monday July 24th from 5-7pm
Where: The Treasury
200 Bush St #101, San Francisco, CA 94104
What: Fun & networking! Light snacks provided.
Who: Current members of 12/II, and anyone interested in joining! Students, early career professionals, supervisors, faculty, etc.

RSVP for the IAGG Social:
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Career Pathways – Brian D. Carpenter, PhD

Submitted by Benjamin Mast, PhD, ABPP

My 2017 SCG Presidential initiative is focused on career pathways in clinical geropsychology with particularly focus on the people and experiences that have influenced career decisions. This edition includes an interview with Dr. Brian Carpenter.

Brian Carpenter is a Professor of Psychological & Brain Sciences at Washington University in St. Louis. He graduated with a BA in English and Psychology from Williams College and attended Case Western Reserve University for his doctorate in clinical psychology. He also completed postdoctoral fellowships at the Philadelphia Geriatric Center and the Portland Oregon VA Healthcare System. In addition to teaching undergraduate and graduate courses that focus on aging and the end of life, he directs a research laboratory that aims to improve communication between older adults, their family members, and their healthcare providers.

Ben: Tell us about your current work in clinical geropsychology.

Brian: I don't understand why everyone doesn't want to be a professor. It's the best job, and I have the good fortune to combine three things I love in my work – teaching, research, and clinical practice. I teach undergraduate and graduate courses related to aging and supervise a team of student therapists. At the moment, my favorite class is an interdisciplinary course I co-teach with colleagues from Social Work and Occupational Therapy. It's designed for first-year students and, surprisingly, we get 75 students to sign up each year. Our subversive goal is to get them interested in aging early and maybe steer more students into the field. My research, propelled in large part by great graduate student collaborators, focuses on family relationships later in life, particularly at the end of life. And I get to see a few older adult clients each week, mostly doing home visits for people who are no longer driving or too frail to travel to the office.

It's my favorite setting in which to see clients. They're comfortable in their own space, and you learn so much about a person. Do you know that research on "behavioral residue" by Sam Gosling, who demonstrated an association between NEO personality traits and dorm room environments? Home visits are less systematic than that, but you can generate some useful hypotheses based on photographs, knickknacks, etc. I love seeing how older adults create an environment that works for them.

Ben: When did you decide to pursue a career in aging?

Brian: I didn't know there was such a thing as a "career" in aging when I volunteered at a senior center in college. I just knew I liked talking with older adults. After college I worked at a computer software company doing corporate education. That's when I made the connection that I might be able to teach for a living, though I didn't necessarily want to do it for a for-profit company. Light bulb: oh, you mean I could be one of those professors? Like in college? That's a job? Wow. But wait: a person maybe could be a professor about old people? Wow-er. It took me awhile to figure out it might be possible to combine several of the things I enjoyed and make a contribution in my work that felt meaningful for me. I'll admit I wasn't particularly strategic about the whole enterprise at first, but it worked out. In retrospect, what I had going for me was that I was OK not knowing exactly what I wanted to do and open minded to possibilities. I also had the support of people to pursue what I loved, and the economic privilege to do it, even if my path to graduate training in geropsychology was a bit circuitous.

Ben: What were some key training experiences that influenced your current work as a geropsychologist?

Brian: My first clinical placement was at a state psychiatric hospital, and that was an important experience for setting my clinical "barometer" and introducing me to the many ways the mind can go awry. In some ways, talking with someone who is in the midst of a florid psychotic episode taught me as much about mental health as it did about mental illness. During internship, I did a six-month rotation in a rehabilitation and long-term care unit, which introduced me to a highly skilled and collaborative interprofessional team, where I came to appreciate the expertise of colleagues in OT, PT, nursing, pharmacy, speech-language pathology, and social work. Then I spent two incredible years as a postdoc at what was then the Philadelphia Geriatric Center, where I worked with colleagues who were superlative therapists and clinical supervisors. This was also one of the few places that had a research institute embedded within its congregate and residential housing for older adults. What a luxury to be at a place that really integrated research and practice! I think that solidified for me that I wanted any clinical research I pursued to have practical application.

After I had been teaching for a few years, on my first sabbatical I did a year-long interprofessional fellowship in palliative care at the Portland VA Healthcare System. I sought that out because I was interested in expanding my research in the direction of end-of-life care, but I didn't have any training in the clinical issues. So I was part of a palliative care team for a year, seeing inpatients and outpatients, working with interprofessional teams, and getting great supervision from Betsy Goy, the geropsychologist and palliative care specialist there. The end of life is such a rich clinical and ethical nexus, and psychology has so much to offer to help people at that ultimate time of life. Not that I think people should spend their whole life planning for their death! But it is the capstone of your life, everything leads up to it, so it's important to get it right. (Or at least as right as you can.)

Ben: Who has influenced you in your career in geropsychology?

Brian: I had an undergraduate clinical psychology professor at Williams College, Laurie Heatherington, who was open to my idea to volunteer with older adults in one of her clinical/community courses, while all my peers were seeking out placements with toddlers and kids. (Ick, they're so sticky!) Even though geropsychology was not her area, she supported me and really kicked off my career. I took a few classes at Boston University with Alice Cronin-Golomb who played a similar role, encouraging my interest in aging and showing me that geropsychology was "real" and introducing me to the community of geropsychologists, who really are the nicest people. My advisor in graduate school, Milton Strauss, while not a geropsychologist himself, found training opportunities for me, nurtured my curiosity, and helped me clarify in my own mind what was intellectually important to me. Along the way, I've had incredible clinical supervisors, whose sensitivity and expertise and respect for older adults has been inspiring. They include John Bolger, Bernadette Lauber, Jennifer Vasterling, Holly Ruckdeschel, and Betsy Goy. At the same time, I've had amazing research and professional collaborators, mentors who've generously shared their experience and wisdom. Too many to name, but they include Peter Lichtenberg, Michele Karel, Jenny Moye, Kimberly Van Haitsma, Katy Ruckdeschel, Powell Lawton, Debbie DiGilio, Martha Storandt, Nancy Morrow-Howell, and Susy Stark.

Two other groups have been critical as well. First are the students I've worked with, both undergraduate and graduate. I learn from them every day, as they tug me toward new questions and methods in the field. And of course the older adults themselves, whether I've encountered them in practice or research. They're the reason for the work, and they continue to inspire me with their creativity and resilience.

Ben: Why do you think a specialty in clinical geropsychology is important?

Brian: Specialists in clinical geropsychology understand that older adults are unique in many ways, and we can provide expert input on their physical and mental health needs, complementing the work of other specialists like geriatricians, geriatric social workers, and elder lawyers. At the same time, we also remind those other professionals to consider behavioral and mental health issues in their work. We also remind our psychologist colleagues, many of whom work (or will work) with older adults or aging issues in some way, that older adults are a distinctive group. So geropsychologists are important because we remind other psychologists about older adults, and we remind other professionals in geriatrics about behavioral and mental health.

Ben: Any advice for students and early career psychologists interested in geropsychology?

Brian:

1. **Read.** And read widely, both within psychology and outside our discipline. It's hard to keep up with even the new work in geropsychology, but some of the writing that's most influenced me has been in different disciplines (public health, design, bioethics) and other genres (blogs, fiction). Aging is a multidisciplinary experience, so to understand it broadly you need to embrace many different facets of living.

2. **Say Yes.** When an opportunity comes your way that's outside your comfort zone, beyond your skill set, with people you don't know, take the chance and see what happens. Your career may unfold in wonderfully unexpected directions.

3. **Say Hi.** Geropsychologists are the nicest people in the world, so try to meet them all. Every last one of them. In my experience, they'll be interested in you, willing to share their knowledge and give you any help they can.

Member Submission

Living with Lymphoma: Lessons for Clinical Geropsychology Practice
Submitted by David S. Glenwick, PhD

David S. Glenwick, PhD, is a professor of psychology at Fordham University, where he has also been director of clinical training and associate chair for graduate studies. His research interests focus on stress and coping in child and parent populations, developmental disabilities, and community-based interventions. Dr. Glenwick is a fellow of the American Psychological Association's Divisions of General Psychology, Teaching of Psychology, Clinical Psychology, Community Psychology, Child and Family Policy and Practice, Health Psychology, and Clinical Child and Adolescent Psychology. He received his PhD in clinical psychology from the University of Rochester.

This article discusses eight lessons learned from the writer's experiences as a person living with cancer for the past six and a half years. It is posited that these lessons have particular applicability to clinical work with elders, and especially to therapy conducted in the nursing home setting. Case examples illustrating this applicability are offered.

In January 2010 I was diagnosed with follicular lymphoma, a type of lymph system cancer. As I have never been in remission since then, I don't regard myself as a cancer "survivor" but, rather, an "endurer." Fortunately, treatment to date has kept the disease relatively stable, managing it as a chronic illness, as is increasingly the approach with refractory cases of cancer. I have been able to continue working as a psychologist, my primary role being that of teacher and researcher in a university setting. Until about two and a half years ago, I also continued in the role of therapist to nursing home residents. This is the role on which I will focus in this paper.

Through the past six and a half years of living with lymphoma, my experiences have led me to a number of "life lessons." Although I was 60 at the time of diagnosis (and thus would generally be thought of as being in late middle age), I've come to regard the period since then as a preview of coming attractions. Confronting a possibly terminal illness offers a glimpse of the issues that all who reach older age will eventually face (or try to avoid facing). The acquired life lessons have been, I believe, especially applicable to my therapy work with nursing home clients, elders in particular but also all residents living with ongoing challenging health conditions. It is this applicability that forms the core of this article.

Cognitive Behavior Therapy and Affect

One concern regarding cognitive behavior therapy (CBT) is that the uncovering and subsequent restructuring of cognitive schemas can be an overly intellectual process, with (if we think of, for example, Ellis's rational emotive therapy) too much emphasis on the rational/ cognitive and not enough on the emotive. CBT theorists and researchers, noting this potential limitation, have in recent years paid increasing attention to the role of affect in helping clients truly internalize and act upon the insights and cognitive modifications arrived at. Kendall (2011, p.16), for instance, discussing the implementation of CBT with children and adolescents (but pertinent to adult therapy as well), noted that "an emotionally significant event has greater impact on the development of a cognitive structure and on future thinking and action. One strives to design and implement therapy as an emotionally positive and involving experience, leading to coping and adaptive cognitive processing."

The life lessons enumerated below can, in the abstract, sound trite (an adult version of "all I really need to know I learned in kindergarten"). They assume their power, though, through the therapist's ability to make them emotionally and experientially vivid. In my work with older clients, I do not bring up these lessons didactically but, rather, capitalize on naturally occurring opportunities as clients relate affectively charged incidents in their lives. Such incidents become teachable moments, with the lessons hopefully having a greater likelihood of taking hold because of the emotionally impactful context and associations. For each of the life lessons presented in the next section, I will first describe how it has contributed to my adapting to living with cancer. I will then attempt to delineate its applicability to therapeutic work with nursing home residents.

Life Lessons for Elder Clients

1. Be more short-term focused in your planning, and choose how to spend your time. We are socialized to be future-oriented--to make long range plans, set goals, and delay gratification. For persons with a serious, possibly terminal illness, as in many cases of cancer, the time frame becomes foreshortened. One realizes that possibilities, and the time in which to realize them, are not limitless. As the 18th-century British writer Samuel Johnson wryly commented, "When a man knows that he is to be hanged in a fortnight, it concentrates his mind wonderfully. "One prioritizes. Since my diagnosis, I make more conscious choices about both professional and personal activities, attempting, where possible to, to do those things that (a) bring me pleasure or (b) contribute meaningfully to my significant others, the profession, or society. Thus, when I say "yes" to a request (e.g., taking on a new service activity or writing an article), it is a more thought-out decision than would previously have been the case. And I have learned to say "no" more often, typically regarding activities that are outside my central interests or would require expending excessive or taxing time and energy.

The same mind-set applies to my day-to-day activities. If today is Monday, how can I make it the best Monday possible, even if I'm not feeling great, without worrying about Tuesday, Wednesday, and the days thereafter? Thus, I may choose to spend an evening watching a televised NBA playoff game--a seemingly "frivolous" activity--but it is what I have chosen to bring me pleasure during that period, rather than doing it just to "kill time."

Applicability to therapy: Although hopes and goals should never be taken from elder (or any) clients, the lens becomes a compressed one. Nursing home residents can be aided in extracting pleasures from their current environment and forming realistic, implementable plans. The therapist can help them in engaging in activities (e.g., recreational, volunteering) that are doable and reinforcing in the present. Even within the restrictive setting of the nursing home, what can the resident control and what choices can he/she make? For example, the resident can decide whether or not to participate in a particular programmed activity, go outside to the facility's garden, walk in the corridor, etc., thereby achieving a sense of agency even within a confined environment. Additionally, the clinician can encourage the administration and staff to increase residents' options (e.g., related to food choices or times of arising).

2. Allow yourself to experience the present moment, to immerse yourself in it with focused intent and attention. In the words of a Talmudic saying, "What is most important? That which one is doing at that moment." Thus, in contrast to a previous tendency toward multitasking or passively engaging in an activity, I attempt, for example, to savor and appreciate my emotions while viewing a sports event, my body's physical sensations when working out in the gym, or the taste of a favorite but rarely eaten food.

Applicability to therapy: Nursing home residents can be encouraged and aided in mindfully engaging in activities (even "simple" activities of daily living) to the extent that they are cognitively and physically

capable, thereby deriving maximum enjoyment from them. What are the reactions that a resident experiences in hearing a decades-old melody played on the piano by a recreation therapist? What are a resident's feelings when putting on and wearing a preferred item of clothing?

3. Limit exposure to and the effects of toxic people and situations. By definition, these increase stress and produce negative affective reactions, such as anger and anxiety. For cancer patients, such persons and settings siphon off energy needed for productive coping and can have deleterious physiological effects (e.g., inflammation). I attempt to minimize the number of such interactions (e.g., by avoiding those who I know "push my buttons"), limit contact when they are unavoidable or unforeseen (e.g., by keeping such conversations brief and to the point), and consciously implement coping strategies (e.g., by using calming self-verbalizations when faced with a transportation delay or sticking to neutral or positive conversation topics to prevent possible contentiousness) aimed at reducing their harmful impact.

Applicability to therapy: Here we are referring to the resident's stimulus control of her/his environment and ability to engage in self-control. The resident can be encouraged to associate primarily with those persons (e.g., in the dining room or day room) and settings that are relatively positive and that enhance her/his mood. If, for instance, there is a fellow resident who is likely to set off one's client by a repetitive threatening or frightening utterance or by banging into her/him with a walker, the client can be guided in maintaining her/his distance from that person. It can be pointed out to the client that such a behavioral strategy is easier (and likely to be more successful) than trying to change the other person's verbal or motor behavior. Clients can also be instructed in simple self-verbalization (e.g., "Keep cool") and relaxation strategies to better handle such situations.

4. Express gratitude and appreciation; be positive. When one is living with the effects of cancer and the side effects of the treatment for cancer (and there are almost always side effects; only rarely is there such a thing as a free lunch), one learns not to take anything for granted. I have come to appreciate the relatively good quality of life that I have been able to maintain. When undergoing chemotherapy (where fatigue is a frequent side effect), I relish those periods of time during the day when I feel reasonably energized and can go to the gym or work on a paper. I also find myself expressing appreciation to (i.e., positively reinforcing) those who do things to make my life better. These can range from the large (e.g., my oncologist for his life-extending cutting-edge treatment plans) to the often-overlooked and seemingly mundane (e.g., the nurse who brings me a blanket during an intravenous infusion, the busboy who clears my table in a restaurant). Another quote from the Talmud: "Who is rich? He who rejoices in his portion."

Applicability to therapy: Residents can be encouraged to express gratitude for those abilities that remain, for those activities of daily living that they can (either independently or with assistance) continue to carry out, and for positive aspects of their physical and social environment. Such gratitude can be expressed to God, to fate, to whatever spiritual force one believes in, or to just plain luck, depending on a particular client's perspective. Nursing home staff engage in activities that are often physically and emotionally taxing, while being underappreciated by others (both residents and administration). Residents can be prompted to reinforce staff and fellow residents who perform activities that ease their burden or bring them pleasure (e.g., an aide who helps the resident dress, a transporter who takes the resident to physical therapy in a wheelchair). Likewise, we who are clinicians in nursing homes can praise staff for particular behaviors that they perform for residents. In the movie Bridge of Spies (Spielberg, Platt, & Krieger, 2015), the jailed spy Rudolf Abel, in a kind of running joke, repeatedly asks his attorney, "Would it help?" On one of these occasions, the attorney replies, "Well, it can't hurt." Nursing home residents discover that being "glass half-full" (or even one-quarter full) in one's outlook and reinforcing others usually leads to an improved mood state in oneself (affective change resulting from cognitive and

behavior change) and to increased frequency and positivity in the specific reinforced behavior and interactions in general. Those staff and fellow residents around the resident will respond better to him/her and will want to be around him/her more if the resident is not exuding negativity. This is yet another example of the above-mentioned idea of prompting the resident to control and influence that which he/she can.

5. Extract meaning from your experience. Although one would never wish a cancer diagnosis on oneself ("Would you like some lymphoma?" "No, thank you."), it can lead to the "benefit" of reflecting on one's life sooner and more deeply than one would otherwise do. Here we are in the realm of Viktor Frankl and the search for meaning and perspective. Within the grand scheme of the universe, each of us is insignificant, but each of us is also the center of our universe, the main character in our narrative. From the Talmud yet again: "For each of us, the world was created." So I ask myself: What have I done with that creation? What is my legacy? What have I transmitted to my son? What have I given to students and clients--either explicitly or by modelling? What has been transformative about my cancer experience and how has it hopefully caused me to be a better person? What life lessons can I extract from that experience?

Application to therapy: In a similar manner, a resident can be gently encouraged to reflect on her/his life, a process that hopefully results in a sense of wholeness, rightness, or Eriksonian integrity about it. In particular, reminiscence therapy (e.g., Korte, Bohlmeijer, Westerhof, & Pot, 2011) and, more generally, the use of oral narratives, photographs, written journal entries, drawings, and the like can be effective means of stimulating retrospection.

6. Forgive and seek forgiveness. Harboring resentments over others' past actions frequently leads to anger, and over one's own past actions to guilt, shame, and depression—affective reactions that are counterproductive physiologically, cognitively, and behaviorally for one with cancer. I feel more at peace with myself when forgiving others (even if unsolicited and even if only in my own mind) and myself and when seeking forgiveness from others. In so doing, I am acknowledging my own and others' fallibility and ability to let go of toxic emotions and to move forward. In reading Doris Kearn Goodwin's (2005) Team of Rivals, her portrait of Lincoln and his cabinet members, one is repeatedly struck by how forgiveness was, for him, both characterological and adaptive. His, Goodwin (p. 699) observed, was "a temperament that consistently displayed uncommon magnanimity." This is evident most famously in the phrase "with malice toward none; with charity for all" (p. 699) from his Second Inaugural Address, as well as by the following from that same address: "Let us judge not that we be not judged" (p. 698). Slights, wounds, and insults paled when subjected to Lincoln's realistic and generous perspective on his own and others' imperfections. And, not surprisingly, such a perspective typically led to mutually beneficial personal and political relationships.

Application to therapy: Residents can be guided in going easier on themselves and others (from both their present and their past). It can feel like the removal of a boulder for a resident to realize and accept that, in an incident occurring decades ago, he/she probably did the best that he/she could under the circumstances. Forgiving fellow residents for actual or perceived misdeeds and seeking forgiveness from them helps promote more positive relationships in the delimited community of the nursing home. In many cases, forgiving or seeking forgiveness may not be physically possible, as the other person has passed on. In such instances, the therapist can use the Gestalt empty-chair technique in aiding the resident in expressing his/her thoughts and feelings to others who, though absent in body, have continued to be present in their emotional hold on the resident. For those who can effectively engage in the guided scenario, the resulting release, relief, and acceptance can be powerful.

7. Use humor to help in coping. Humor, as has often been noted, is an excellent coping mechanism. As a cancer endurer, I have found it to be especially helpful in reframing situations, preventing negative reactions by me to others' comments, and improving my mood by reducing anger and depression. Both jokes and the humor inherent in situations can aid in accomplishing this. A frequently told joke among cancer patients is the following: "You've heard of bad hair days? Well, with chemo you have no-hair days." Several years ago, I encountered a former girlfriend who, when I told her of my recent lymphoma diagnosis, responded, "I'm sure the next time we run into each other we'll just look back on this and laugh about it." My unsaid reaction was, "I guess you know something about my PET scan results that I don't." A faculty colleague, commenting somewhat philosophically on the news of my diagnosis, remarked that "well, we all have to go sometime; it's really just a questions of when." My reply (this time stated): "Yeah, but I guess I'd prefer that it be later rather than sooner." Humor, either verbalized or just thought, can greatly defuse the arousal and annoyance one feels when faced with well-meaning but insensitive, not very empathic remarks. (For a cinematic portrayal of the cancer experience that deftly and realistically melds seriousness and humor, the reader is urged to view 50/50 [Goldberg, Rogen, Karlin, & Levine, 2011], a fictionalized treatment of the screenwriter's coping with schwannoma neurofibrosarcoma [a malignant spinal tumor].)

Application to therapy: In working with residents, the therapist can employ and reinforce humor to promote adaptive perspectives and behaviors. When I once asked a 92-year-old client how she felt about the fact that almost all of her friends and relatives had passed on, she replied, "Better them than me," to which we both chuckled. Another resident, when feeling anger toward a fellow resident or a staff member, would say loudly and repeatedly, "So-and-so (the other person's name) is dead," which typically provoked a verbal rebuke or the threat of aggression on the part of the recipient. I commented to my client how the other person might find it rather shocking and frightening to hear that she/he had died. This then led to a productive discussion of how the resident might express anger, hurt, and disappointment in a more socially appropriate manner.

8. Simplify your life. Life is inevitably complex and difficult--it's the human condition. For persons with cancer, it becomes even more so, due to effects of the disease itself, acute side effects of treatment, and cumulative effects (e.g., stemming from a compromised immune system) of successive treatment regimens. One becomes involved with numerous, often previously unfamiliar medical specialties (in my case, vascular surgery, pulmonology, endocrinology, and gastroenterology, among others). Much time becomes devoted to appointments with one's healthcare providers and to communications with one's third-party payers. Modifications, frequently major, in one's daily routines may be required. Thus, keeping life from becoming more complicated than it needs to be can greatly facilitate successful coping. Focusing on essential activities, not overscheduling myself, and trying to only minimally involve myself in intractable or conflict-laden situations are all ways that have served to reduce complexity and its attendant stresses for me. As Thoreau (1960, pp. 66, 215) observed in Walden, "Our life is frittered away by detail… Simplify, simplify…. In proportion as he simplifies his life, the laws of the universe will appear less complex."

Application to therapy: Therapists can assist residents in simplifying their lives behaviorally, emotionally, and materially. A resident can, for instance, be guided to realizing and accepting that it's OK to not be as "productive" or "busy" as one was in one's prime and that new baselines and criteria of self-evaluation might be appropriate. Another resident can be aided in not ruminating over familial issues that may be geographically or chronologically distant and not amenable to change or influence by the resident. A

third resident can be helped in decluttering her/his room by deciding which possessions are practically necessary or emotionally and aesthetically meaningful and letting go of the rest.

Conclusion

Decades ago, in my sophomore year in college, I mounted on my dorm room wall a poster exhorting, "If all you have are lemons, then make lemonade." (A drawing of a figure engaged in lemon squeezing accompanied the message.) In a similar, though more cynical, vein, Ben Franklin quipped that "Experience keeps a dear school, but fools will learn in no other." Cancer is certainly among the hardest experiences to be schooled in. However, through such adversity, and faced with the possibility of death, we may learn how to live a better life. The above eight lessons are illustrative of how my journey through Cancerland has affected my thinking and, I would like to believe, my behavior (although the latter remains a work in progress, an ongoing process of "becoming"). Additional such lessons could, if space permitted, be delineated. Among these would be: (a) Learn to live with ambiguity and uncertainty. (b) Be more patient with both others and yourself. (c) Listen to your body and act in rhythm with it. (d) Be tolerant and understanding of others' foibles and shortcomings (while being intolerant of injustice). Although presented discretely here, each life lesson is obviously intertwined with, and strengthens, the others.

Similarly, nursing home residents are faced with often-serious adversity and challenges--on a daily basis and extending over weeks, months, and possibly years. Thus, the lessons noted in this paper are applicable, I think, to our therapeutic interactions with clients in that setting (as well as, by extension, with elders in general). In bringing such lessons into our work, we can hopefully help others approach the ever-elusive balance and perspective that we seek for ourselves.

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Diversity Column

Assistance Animals and Older Adults

Submitted by Katie Johanson, Charissa Hosseini, Flora Ma, & Nancy A. Pachana, PhD, FAPS, FASSA

Introduction

Older adults may experience declines in sensory, cognitive, physical and emotional functioning for which assistance is required. Service animals and assistance animals play important roles in enhancing the psychological and physical well-being of older persons. Such animals have been most associated with sensory or way-finding functions, but recently have filled other niches, including meeting a variety of needs of those experiencing cognitive decline or dementia. Oftentimes, the full gamut of ethical and cultural considerations is not taken into account to appropriately utilize AAT to best meet the unique needs of each individual older adult.

Animal Assistance and Older Adults

Animals have been increasingly utilized as a component of therapy. Many older adults living in long-term care facilities may experience loneliness. Research has shown positive health benefits for older adults in animal assisted therapy (AAT), including reduced feelings of loneliness in long-term care contexts (Banks & Banks, 2002). Positive effects on social isolation also have been associated with interaction with either a living or a robotic dog (Banks & Banks, 2008). The amelioration of behavioral and psychological symptoms of dementia (Filan & Llewellyn-Jones, 2006), and decreases in agitated behaviors and increased social interactions for older adults with dementia have been shown with AAT (Richeson, 2003). However, other promising study results indicate moderate effect sizes in improving autism-spectrum symptoms, behavioral problems, and emotional well-being (Nimer & Lundahl, 2007). It may be helpful to further investigate factors such as the ownership of or attachment to a companion animal (Winefield, Black, & Chur-Hansen, 2008) in relation to the impact of interventions such as AAT on the general well-being of older adults.

Animal Assistance for Older Adults with Dementia

Although it is scant, research investigating the effects of AAT on psychological health in older adults with dementia has demonstrated positive findings. Past research has found evidence for decreased depressive symptoms in older adults with dementia following an AAT intervention, and additional research has demonstrated improvements in cognitive functioning following a year-long AAT program (Kawamura et al., 2007; Moretti et al., 2010). After implementing a therapy program with a robot named "Paro," Wada et al. (2004) found improved mood and decreased stress in a group of older women with dementia, indicating that robot therapy is a viable option for older adults facing barriers to traditional animal assistance (e.g., allergies). AAT has even demonstrated efficacy in a nursing home setting; Richeson and McCullough (2002) implemented a weekly AAT treatment and found that residents experienced increased life satisfaction and social interactions compared to no-treatment and student-visitor comparison groups. Despite these positive results, concern remains for the long-term efficacy of AAT. As reviewed by Bernabei et al. (2013), some studies found that the positive effects of AAT ceased after assistance was withdrawn, and others have found that AAT continues to improve symptoms for only a few weeks following an AAT intervention. Nevertheless, the benefits of AAT for older adults with dementia are promising and demand further investigation, especially considering the predicted increase in the prevalence of dementia and the subsequent need for effective treatment options.

The Role of Service Animals and the Intersection with Assistance Animals

With the advent of Title III of the Americans with Disabilities Act (ADA) individuals with disabilities have the right to be accompanied by a service animal into public places. Many older adults have acquired disabilities such as visual, hearing, and mobility impairments and the use of a service animal may be beneficial to increase functional independence. The literature distinguishes service animals from emotional support animals or therapy animals by identifying the legal differences, specifically that service animals are not pets (Duncan, 2000). Service animals may assist in a variety of ways for people with disabilities, including alerting an individual that is deaf or hard of hearing to the presence of sounds, as well as identifying the onset of seizures or episodes of hypoglycemia (Duncan, 2000). Additionally, service animals are trained to assist to diminish stressful situations and help individuals with mobility or visual impairments negotiate their environment as well as retrieve and carry items (Duncan, 2000). As such, service animals and the role of emotional support/animal therapy have shown to be helpful in meeting the needs of older adults with mental health and physical health needs.

Ethical & Cultural Considerations

As with all fields that provide clinical services for others, there are ethical considerations inherent in older adults' use of animal assistance. Clinicians may encounter ethical dilemmas including determining clients' needs for emotional support animals, 'counterfeit' emotional support animal vests, and pet allergies. More recently, clinicians have experienced situations in which their older adult clients request letters detailing a need for emotional support animals; this raises issues concerning conflicts of interest, as clinicians and clients may differ in how necessary they view an emotional support animal to a client's psychological health. As this difference could result in conflict and possible termination, some professionals recommend utilizing a third-party service to determine the need for an emotional support animal (Herzog, 2016). In a different vein, the practice of purchasing 'Emotional Support Animal' vests online as a means of bringing pets into public spaces raises concerns about diluting the credibility of genuine emotional support animals (which is not to say that pets in and of themselves don't act as our supports!) (Herzog, 2016). And lastly, it is possible for other clinic clients and a client's clinician to have pet allergies or phobias, which necessitates conversations about the need for a service animal during sessions and ideas for limiting contact with others with severe allergies or fears. As allergies can lead to serious consequences, attention must be paid to the practicalities of where the animal travels, including the waiting room, therapy rooms, hallways, and even stairs or elevators. However, clinicians should note that guide dogs are allowed in most public spaces, and accommodation for them is a necessity. (In other words, just because another client has a dog allergy does not mean the guide dog cannot be on the premises – careful negotiation, communication, and scheduling are required!) Flexibility in making decisions regarding the presence of emotional support animals is always to be encouraged.

Just as there are ethical considerations regarding the use of assistance animals, so too are there cultural considerations. Being mindful of clients' cultures and ethnic backgrounds is not only imperative to a strong therapeutic alliance, but it also aids in conversations surrounding animal assistance. For example, certain cultures do not have dogs as pets or allow them inside the home, so it may be damaging to recommend adopting an assistance dog to clients with such values. With regard to socioeconomic status, some clients may not have the means to afford or maintain an assistance dog, and it may be fruitful to discuss other, more affordable assistance animal options (such as cats) or non-animal options. Similarly, being sensitive to clients' geographic areas (e.g., rural vs urban) may impact possible assistance animals, as clients living in studio apartments in a large city may have different animal accommodation abilities from clients living in rural towns or on farms.

Conclusion

Animal assistance for older adults varies depending upon the individual's needs, impairments, and context. For example, an emotional support animal may benefit an older adult with a mood disorder or dementia, whereas a service animal's role is to increase the older adult's functionality within their everyday life. With that, there are ethical and cultural considerations for the clinician to consider regarding allergies, cultural norms around animals, and falsely claimed or counterfeit support animals. These considerations must be addressed prior to a health provider referring or suggesting animal assistance for older adults.

Dr. Nancy Pachana's work with RSPCA Australia (Royal Society for the Prevention of Cruelty to Animals) serves as her own animal therapy!

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Committee Updates

***NEW*: Bylaws Committee Update**

Submitted by Sherry Ann Beaudreau, PhD, ABPP (Chair), with members Alisa Hannum, PhD & Margie Norris, PhD

During her 2015 presidency, Dr. Margie Norris recommended that the SCG Board create a formal Bylaws Review committee. This would ensure a consistent annual review process of our bylaws to:

- Address inconsistencies;
- Enact a more expedient system for updating of information as organization processes change;
- Identify, as appropriate, substantive areas for change in the bylaws for discussion with the SCG Board, and with SCG Board support, to bring to a vote to our membership.

Drs. Margie Norris, Alisa Hannum, and Sherry Beaudreau (Chair) held the first Bylaws Committee meeting April 27, 2017.

- Overall, the committee plans to update sections of bylaws procedures to reflect our society's increased use of technology.
- SCG members recently voted on a bylaws amendment regarding APA membership to join SCG. The committee and SCG Board will be in touch with members soon on the outcome of this vote.

We will update our membership on this and other issues as the committee continues its work on the bylaws. If you have any questions or concerns, please contact Sherry Ann Beaudreau, Chair of the Bylaws Committee, at sherryb@stanford.edu.

Communication Committee Update

Submitted by Christine Gould, PhD

The Communication Committee consists of the two newsletter co-editors, webmaster, website content coordinator, and social media overseer. The Committee would like to recognize Vicky Liou-Johnson for her service as webmaster and Anne Mueller for her service as the social media overseer! As Vicky and Anne completed their tenure in their respective positions, we are now searching for a new webmaster and new social media overseer. The webmaster should be familiar with WordPress. The social media overseer is responsible for posting announcements and content to the Society for Clinical Geropsychology Facebook page. The society also has a Twitter account that could be used by the social media overseer as well. Please contact Christine Gould at Christine.Gould@va.gov if you are interested in either position. A formal announcement will be posted to the listserv in the next few weeks.

In addition to the transition in committee members, our website is faced with some technical issues that recently worsened. As you may have noticed, our website has been offline for a few weeks. We are troubleshooting the cause, while also transitioning to a new website. The new website (at the same domain/address) should be easier for our incoming webmaster to manage as it was built on the WordPress platform. We hope to unveil the new website in the next month. We also will be transitioning to an APA managed listserv when we unveil our new website. Be on the lookout for announcements on the listserv

about these changes. We appreciate your patience as we try to implement a long-term solution to address our Society's communication needs. Please contact me with questions, feedback, or comments.

Interdivisional Healthcare Committee (IHC) Update

Submitted by Kimberly Hiroto, PhD & Mary Lewis, 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.

Notes from the February 2017 meeting. Divisions represented include: 12/II, 17 (Counseling Psychology), 22 (Rehabilitation Psychology), 38 (Society for Health Psychology), 40 (Society of Clinical Neuropsychology), and 54 (Society of Pediatric Psychology). Additionally, representatives from the APA Practice Directorate, APA Center for Psychology and Health, APA Committee for the Advancement of Professional Practice (CAPP), and the APA Board of Professional Affairs. 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.
2. Efforts continue toward getting psychology included in collaborative care codes through the Center for Medicare & Medicaid Services (CMS) for integrated primary care services (e.g., psychological/neuropsychological testing).
3. The APA's Integrated Health Care Alliance developed the Integrative Care Training grant, funded through the APA and CMS. This grant aims to train 6000 psychologists in integrated care practice and follow them over 6 months to determine if/how their practice is changing. This program also affords participating psychologists to provide feedback to CMS about shifting their practice to alternative payment models. The training is free and provides CE credits. More information is available here: http://www.apapracticecentral.org/update/2017/06-15/integrated-health-care.aspx

Lifetime Learning Committee Update

Submitted by Meghan Marty, PhD

Continuing Education at IAGG

Up to 30 continuing education (CE) credits are available for psychologists at IAGG. When you register for the conference, make sure to check the box for "Psychology CEU," which will add a $60 fee to your registration total. To obtain CE credits, you must complete an on-line evaluation and credit request form. Directions and links for the CE forms will be available on-line and on-site at the registration desk. You will be able to claim your CE certificate for up to 30 days after the convention concludes.

Continuing Education at APA Annual Convention

There are two options for obtaining CE credits at the Annual Convention this year:

1. CE Sessions

- Over 300 convention sessions will be designated as CE sessions (look for the CES logo in the Convention Program)
- During the on-line registration process for the convention, be sure to click the box on the web-page titled "CE Sessions," which will add an extra flat fee to your registration total
- Obtain unlimited CE credits by attending as many of these 1-2 hour CE sessions as you'd like; be sure to wear your name badge as you enter and exit the session
- There are two ways to claim credit: (1) by cell phone or tablet or (2) by visiting the self-service kiosk located in the main APA Registration area. The deadline for claiming credit is 10/9/2017.

2. CE Workshops

- There are seven preconference workshops (Wednesday, 8/2) and 77 half- or full-day workshops during the convention (Thursday, 8/3 through Sunday 8/6)—several are being offered by SCG members!
- CE Workshops are priced separately from CE Sessions and the registration fee; however, you can enroll in CE Workshops and register for the convention at the same time
- You will receive an e-mail confirmation that will serve as your workshop ticket(s) on 7/12, if you enroll prior to 7/11. Attendance at each workshop will be verified by the e-mail confirmation, so you must print it out and bring it to convention
- If you enroll after 7/11, you will need to pick up your workshop ticket(s) at the Renaissance Washington DC Downtown Hotel

If you have any questions, you can contact the Office of Continuing Education in Psychology (CEP) office at 1-800-374-2721, ext. 5991, option 3, or find the CE information on-line at http://www.apa.org/convention/ce/index.aspx.

Membership Committee Update

Submitted by Nicole Torrence, PhD (Chair) & Kelly O'Malley, MA (student representative)

Membership Update

- Total Paid Members: 147
- Total Paid Regular Members (including Emeritus members): 128
- Total Paid Student Members: 19

We appreciate everyone's patience as we work to standardize and streamline our membership renewal process. We are making progress in that direction and hope the new process will be in place by the time membership renewals are due for 2018. As a reminder, we now have a standard timeline for membership dues. Annual memberships expire at the end of the year and membership dues should be paid by the end of December. There is a one month grace period, but we'd like to encourage everyone to renew by the end of December. If you haven't renewed your membership for 2017, please follow this link (https://www.surveymonkey.com/r/12II) and renew today! If renewing by mail, please make checks payable to Kimberly Hiroto, PhD, VA Hospice and Palliative Care Center, VA Palo Alto Health Care System (116B), 3801 Miranda Avenue, Palo Alto, CA 94304.

Mentoring Committee Update

Submitted by Jennifer Birdsall, PhD & Barry Edelstein, PhD

We are excited to announce that the 12-II Mentoring Committee will be revitalized this year!

The relevance and importance of quality mentoring opportunities in geropsychology continues to increase. The number of older adults in the U.S. will double from 46 to 89 million by 2060. According to the APA article: "Mental and Behavioral Health in Older Americans," 39% of all psychologists report delivering services to older adults each week, however, only 4.2% of psychologist identify geropsychology at their primary focus. This discrepancy emphasizes the need for additional training and mentoring opportunities to support the development of competent psychological practice in geriatric care.

Older adults are often biopsychosocially complex and require thoughtful and creative care planning to ensure best practice and treatment outcomes. Psychologists not only need to consider the impact of age itself as its own cultural and diversity factor, but also need to be culturally competent and aware of how all gerodiversity factors including: race, ethnicity, gender, socioeconomic status, disability status, sexual orientation, etc. impact our older adult clients. According to the Population Reference Bureau fact sheet on "Aging in the United States," the baby boomer generation is now between 53 and 71 years of age and is reshaping the U.S. older adult population. This population of elders is more racially and ethnically diverse, and includes notable economic and health disparities. This generation will see significant rises in older adults who are divorced, live alone, and require skilled nursing home care.

According to the APA Guidelines for Psychological Practice with Older Adults (2014), competently working with older adults requires a large knowledge base across numerous domains. Meeting these competency goals requires access to supportive, motivating mentoring relationships with psychologists specializing in working with older adults.

Psychologists working with older adults provide a breadth of clinical services, and with it, opportunities for mentoring in each domain. Geropsychologists provide individual, couples, family, and group psychotherapy, cognitive and neuropsychological evaluations, behavioral management, professional consultation and interdisciplinary support, research, teaching and in-service training, among other roles. Mentoring provides invaluable insights to clinicians striving to improve their mastery in these numerous professional activities. Opportunities for quality mentoring relationships will support the growing demands for psychologist trained to competently work with older adults in diverse settings (e.g. outpatient, in-patient, skilled nursing and rehabilitation centers, home-based care, etc.).

Mentoring relationships provide numerous benefits for both the mentor and mentee. Benefits to the mentee include: knowledge development, clinical and professional skill development, wisdom learned from the mentor's past experiences, opportunities for contacts and networking in the field, a sounding board for difficult clinical cases and professional concerns, and modeling of how to be a great mentor. Benefits for the mentor include: being able to "give back," improving one's own skill set and expertise through critical thinking and teaching, improved professional satisfaction, opportunity to re-energize oneself about one's career and profession, encouragement of self-reflection on one's own practice, improved self-confidence, and enhanced peer recognition.

The 12-II Mentoring Committee is committed to developing creative opportunities for formal and informal mentoring relationships among 12-II members and other gero-community members. We are also currently discussing creative writing projects and conference presentation opportunities for 2017.

Public Policy Committee (Joint committee with PLTC) Update

Submitted by Cecilia Poon, PhD

The Public Policy Committee (PPC) has updated links to Medicare Local Coverage Determinations (LCDs) that impact psychological services. These links are posted on the SCG, PLTC, and GeroCentral websites. PPC members Cecilia Poon and Kelly Carney, APA CONA Chair Margie Norris, as well as Jennifer Birdsall and Bill Whitely from CHE Health Services have been discussing shared advocacy goals for psychologists in long term care settings. We recently reached out to a few psychologists from related settings to identify empirical evidence that supports psychologists' role as "leaders" on interdisciplinary treatment teams and its positive impact on various behavioral and physical health outcomes. Thank you to those of you who have provided us with valuable information. If you have any first-hand experience, ideas, references, or suggestions to share, please email Cecilia at cepoon@nebraskamed.com.

Society of Clinical Psychology (Division 12) Update

Submitted by Victor Molinari, PhD, ABPP
Section 2 Representative

I want to acknowledge Shane Bush who substituted for me on the May Division 12 conference call and who is the source of the information for this column.

1. One of the continued areas of Div 12 concern relates to the pressing need for increased collaboration among sections, and different sections have been encouraged to present together at APA. Please think about this for the 2018 APA convention. With this collaborative theme in mind, a listserv for section representatives is just now up and running.
2. It was asked that student representatives from each Div 12 section connect with Section 10 (Graduate Student and Early Psychologists) to discuss issues of mutual concern.
3. It was also noted that a new Trends section in the APA Monitor spotlights the activities of sections. Please contact Sarah Martin at APA for more information or to submit an article (SMartin@apa.org), or submit an article to her via Tara Craighead (division12apa@gmail.com)
4. It was announced that Div 12 needs members for its Fellows Committee. To serve on this committee, one must be a fellow of Div 12. Contact Tara Craighead (division12apa@gmail.com) or Michael Otto (mwotto@bu.edu).

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.

ENJOY YOUR SUMMER!

THURS, AUGUST 3RD 6:30PM

DIVISIONS 20, 12-SECTION 2 AND PLTC DINNER @ APA 2017 IN WASHINGTON, D. C.

Division 20 (Adult Development & Aging), Division 12-Section II (Society of Clinical Geropsychology), and Psychologists in Long Term Care invite you to attend our group dinner at the 2017 meeting of the American Psychological Association in Washington, DC.

Sixth Engine restaurant is located in a historic firehouse with many of the original touches dating back to 1855. Dinner includes shared appetizers, a choice of three entrees, dessert, and non-alcoholic drinks (including soda, lemonade, tea, coffee) for $47.50 (includes tax and tip). Space is limited, so don't wait to confirm your attendance! Payment is due in advance – Contact for info.

20 DIVISION | Adult Development and Aging

Reserve your place now, space is limited!!!

Division 20 Contact:
Allison Bielak
Allison.Bielak@colostate.edu

Division 12-Section II Contact:
Douglas Lane
laned4@uw.edu

PLTC Contact:
Craig Schweon
chsphd@gmail.com

LOCATION

Sixth Engine
438 Massachusetts Ave NW,
Washington, DC 20001
11 min walk from W.E. W. Convention Center

https://www.sixthengine.com/#

APA Division 12, Section II: The Society of Clinical Geropsychology
MEMBERSHIP DUES FORM

Name (Print)	**Degree**	**Membership Status** (Please check one) **_____New Member _____Renewal**
APA Member No. (Required)_____ You must be a member of APA to join Section II (unless you are a student)		
Street Address		
City	**State**	**Zip Code**
Phone **( )**	**Fax** **( )**	**Cell** **( )**
Email:_____ Note: Your email address is crucial for our records and, therefore, strongly encouraged **_____ Check here to OPT OUT of the LISTSERV** **_____ Check here to OPT OUT of the membership directory**		
Are you a member of APA Division 12 (The Society of Clinical Psychology) **_____Yes _____Yes—student member _____ No**		
Please list other Divisions and Societies you are affiliated with:		
Please list your special interests within geropsychology:		
Please list your primary emphasis as a geropsychologist (defined as 51% or greater) **_____ Clinical Practice _____ Research _____ Teaching _____Administration**		
Payment of Dues (USD) Please select one: **____$35—one year membership ____$10—one year student membership** **____$100—three year membership ____Emeritus members are dues exempt**		**$_____**
Added contributions to Section II: Donations are strictly voluntary but greatly appreciated		**$_____**
Total amount enclosed: Please make checks in US dollars payable to APA Division 12, Section II		**$_____**
Signature	**Date**	
Faculty Endorser (if joining as a student):	**Signature**	**Date**
Make your check payable to: "APA Division 12/II" Mail this form to Kimberly Hiroto, PhD, VA Hospice and Palliative Care Center, VA Palo Alto Health Care System (116B), 3801 Miranda Avenue, Palo Alto, CA 94304.		