

Clinical Geropsychology News

Society of Clinical Geropsychology

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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.

**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



November brings to mind two of my favorite events – American Thanksgiving and GSA! I have attended the GSA Annual Scientific Meeting for 21 consecutive years and I definitely missed having the meeting this November and seeing my geropsychology colleagues. I hope to see you in San Francisco for APA next August.

As we move into the holiday season and the close of 2017, I wanted to highlight a few items of interest: one concern and four “new” items.

1. **Membership matters.** SCG has seen a drop in membership the past few years. This is a concern for the SCG Board and we'd like to do whatever we can to continue to build SCG. If you have ideas, questions, or concerns, please reach out to me (b.mast@louisville.edu) or

President-elect, Doug Lane (dw_lane@hotmail.com). We have heard that the absence of a well-functioning website was part of the problem, so...(drum roll please)

- 2. **We have a new website!** Our new website (www.geropsychology.org) is up and running. The website serves as a central location for SCG including membership renewal, past newsletters, and other geropsychology resources. Please check it out and renew your membership today!
- 3. **We have a new listserv and it has new life!** If you aren't on our new listserv (now hosted by APA), you are missing out. In the last month, members have posted clinical consultation questions (e.g., role of ECT in treating older adults), referral requests, discussion of emerging research trends (e.g., prevention and treatment of Alzheimer's disease), and recommendations for clinical tools (e.g., cognitive screening). If you haven't already done so, please check it out. All SCG members are automatically added; if you have problems, please email me (b.mast@louisville.edu) or Christine Gould (gould.c@gmail.com).
- 4. **We have a new student rep!** Meghan McDarby is our newest SCG Student Representative. You can read all about her in the student column elsewhere in the newsletter. As we welcome Meghan, we also say our thanks to Allison Midden, our outgoing Student Representative, for her 2 years of service!
- 5. **We have a new incoming president!** Doug Lane will take over as President of SCG in January 2018. I am looking forward to working with Doug and seeing what he has planned for 2018. We also have a new President-elect and SCG Secretary. Nancy Pachana and Veronica Shead will fill these respective roles in 2018. You can read about Veronica in the Career Spotlight section of this newsletter.

Finally, I'd like to conclude by thanking you for your service to our field and to improving the lives of older people. I was reminded this summer how skilled and compassionate health care professionals can have a powerful impact on those who need care. On a trip to Europe just before APA, I had a biking accident, broke my hip, had orthopedic surgery, and began physical therapy all before making the long trip home. When I returned to the USA, many colleagues were quick to point out that a hip fracture would help me understand geriatric issues even more deeply. Maybe. I certainly felt the need for excellent care, the importance of clear communication (my surgeons did not speak much English), and the value of compassionate care (which somehow shines through, despite language barriers). It has been four months and I haven't been able to appropriately thank the people who put me back together again. Let me instead thank you on behalf of the people you serve. Though they may sometimes lack the ability to clearly understand what you are doing, they still need your compassionate and skilled care. Thank you for your service!

I was unable to travel to the APA Convention to deliver my presidential address. We have included it at the end of this edition of the newsletter for those who would like to read the text.

Our Website is Live!

The Society of Clinical Geropsychology website has undergone recent changes (spearheaded by Christine Gould!) and is now live! Please visit us at www.geropsychology.org to renew your membership, browse archived newsletters, view details on ABPP—Gero, and more!

Comments from the Editors: Brenna & Elissa

Welcome to the 2017 Fall/Winter edition of the Clinical Geropsychology News! Grab a hot beverage to combat the cold, and settle in to read this issue. Here are a few highlights to guide you:



- We love showcasing emerging geropsychologists! Look for a Research Roundup featuring the use of virtual reality for wayfinding in long-term care residents, written by graduate student Allison Walden on pp. 7.
- See pp. 11-14 for our Member Spotlights to “meet” two of your 12/II colleagues – both are new members of 12/II!
- If you missed APA, see below for pictures of your colleagues, and turn to pp. 23-27 for Ben Mast’s 12/II Presidential Address.

As always, if you have any ideas for special submissions or feedback on how we can improve the newsletter, we’d love to hear them! Email us at bnrenn@uw.edu or elk2020@med.cornell.edu.

12/II Business Meeting at the 2017 APA Annual Meeting



Back row: Andrea June, Kimberly Hiroto. *Middle row:* Jay Gregg, Amy Fiske, Allison Midden (Awardee), Brian Yochim, Margie Norris, Nicole Torrence, Brenna Renn. *Front, seated:* Sherry Beaudreau. *Front, far right:* Catherine Escher (Awardee)



Past Presidents of 12/II: Amy Fiske (2013), Brian Yochim (2014), Margie Norris (2015), Sherry Beaudreau (2016)



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



Catherine Escher, *Student Award for Excellence in Gerodiversity* (with mentor Rowena Gomez, left)

Career Pathways – Veronica L. Shead, PhD

Submitted by Benjamin Mast, PhD, ABPP



My 2017 SCG Presidential initiative is focused on career pathways in clinical geropsychology with particular focus on the people and experiences that have influenced career decisions. This edition features an interview with Dr. Veronica L. Shead.

Dr. Veronica L. Shead is a Clinical Psychologist in Palliative Care in the VA St. Louis Health Care System. She recently returned to her home of St. Louis after serving as the Psychologist in Geriatrics and Palliative Care at the Audie L. Murphy VA Medical Center in San Antonio, TX. Prior to serving in South Texas, she worked at the Memphis VA Medical Center as a pain psychologist after completing her fellowship in Medical Health Psychology with a focus on late life. She completed her internship training in Clinical Neuropsychology at the University of Arizona Medical Center and received her PhD from Washington University in St. Louis with a focus on Neuropsychology and Aging. In her present capacity, she cares for veterans in acute palliative consultation and outpatient palliative care settings. Within the community, she served on the Board of the San Antonio and South Texas Chapter of the Alzheimer's Association and has had the opportunity to advocate as a speaker, workshop leader, and panelist for a number of conferences and community events. Dr. Shead also maintains research interests in late life issues, including palliative care, integrated care, dementia assessment and treatment, caregiving, and health disparities and their effects on minorities and older adults. She has published on related topics and presented at numerous local, national, and international conferences. In her on-going pursuit of balance and self-care, Dr. Shead enjoys traveling around the world, running, concerts, vegetarian food, and spending time with her two dogs, Javier and Capri, along with the rest of her family.

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

Veronica: Currently I work as a clinical psychologist in Palliative care at the VA St. Louis Health Care System. I have the opportunity to serve Veterans and their families in the acute hospital setting and through palliative outpatient services. I serve as a member of an interdisciplinary palliative care team consisting of physicians, a nurse practitioner, social worker, and chaplain. Our team has a consultation service that sees veterans across the facility from the ED to medicine to ICU. In this capacity, we assist with symptom management, goals-of-care conversations, advance care planning, medical decision-making, communication and transitions of care. As a psychologist, I have the unique ability in this work to integrate mental health services in an area where they are often lacking. I support veterans and families by addressing new diagnoses, speaking to cognitive issues, informing staff about behavioral modification and management, conducting brief neuropsychological assessment, assisting with capacity assessments, and providing brief psychotherapeutic intervention, including health behavior intervention and caregiver support/bereavement services to families. Older adults make up the majority of my patient population and daily I advocate for understanding of aging issues and against stereotyping/assumptions made about the aging population. Within my position I have the opportunity to participate in training of interns and practicum students with interests in

Geropsychology and palliative care as well as have the opportunity to work with palliative medicine fellows. In addition, I serve on the national STAR-VA leadership team (a program to address dementia related behaviors) and I currently work as a co-lead implementing the life sustaining treatment initiative for our St. Louis VA Healthcare system (which includes training providers in how to manage goals-of care discussions). Within APA I am also a member of the APA End-of Life Workgroup, and am the incoming secretary for the Society of Geropsychology.

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

Veronica: I decided to pursue a career in aging when I graduated from college. I was a neuroscience major and I was very much interested in brain and behaviors. Moreover, I was interested in learning more about stroke and dementia and desired to make a difference in the lives of those with these issues. My initial focus was aging and neuropsychology. I wrote a paper my senior year in college titled “Old Men in Hats.” It was my first aging related work and it explored stereotyping in aging based on a stereotype I held myself growing up in an aging community where my cousins and I would avoid the older male drivers in my neighborhood.

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

Veronica: The initial learning experiences that influenced my work would be undergraduate courses: Biological Basis of Mental Disorder, Behavioral Neuroscience, and the Psychology of Death and Dying. These courses really expanded my thinking and considerations on this thought process.

Second was my practicum experience as a graduate student at the St. Louis VA in a CLC. This was life changing for me. I learned so much from my veterans—I was naturally drawn to my patient population and intrinsically motivated to enhance the quality of their lives. I very much had a sense of purpose in my work. The opportunity to learn from my practicum supervisor was invaluable, because I saw the research and practice intersect and produce great outcomes for patients as well as the value of psychology in the setting. This was my introduction to Palliative Care and Hospice and I will never forget one WWII Veteran in particular who through reminiscence allowed me to walk with him and discuss experiences he had not processed, which was very powerful and such a privilege.

Third was my Fellowship in Medical Health with a focus on late life at the Memphis VA. At this point, I knew that I wanted to work with older adults, but I was able to work on fully integrated interdisciplinary teams. I also was able to participate in program development and implementation so gained higher order understanding by working and helping develop a memory clinic from concept through patient care. This was powerful for me because as a clinician I now look toward process improvement and innovative methods for implementation of evidence based practices.

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

Veronica: The most influential people in my career have been my great-grand mother and my great-great aunt. They were sisters who lived together and cared for me as a small child. For a young child, I think that having octogenarians and nonagenarians as your favorite people has an impact on your connection to and respect for older adults. My great-grandmother was a caregiver

to all and a matriarch. Her passing was my first experience with death, which was very impactful. My great-great aunt lived to be 100+ (a lady never tells her true age, according to her) and in her final years I now understand that she likely had vascular dementia which resulted in her living in a facility. Her decline and extensive care needs were very difficult for me to understand and I remember distinctly as a teenager feeling helpless. Although they both passed prior to my deciding upon a career, I have always reflected upon the strong, bright and determined women they were and how amazingly they sustained their love and zest for life while growing older. When I work with my patients, I know that many may serve that role for others, and all deserve the same care and respect.

Professionally, I have to say my graduate school advisor Dr. Martha Storandt had the most impact on my path within geropsychology. To this day, I remain in awe of her efficiency and productivity. Her vast knowledge and study of Geropsychology speaks for itself, but she provided me with perspective and highlighted the importance and appreciation for healthy aging, which can be overlooked. Clinically, I have to say my fellowship supervisors Dr. Jennifer Jacobson and Dr. Karen Clark, who are clinicians in geriatrics and palliative care, respectively. I have modeled my approach to care and interprofessional practice after their style. I became a confident clinician who could not only walk the halls of a hospital with confidence but stand and lead in medical and interprofessional settings. I learned that by understanding my scope of practice I could speak directly to how my skillset and knowledge base as a psychologist could enhance patient care and clinical outcomes independently and through collaboration.

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

Veronica: I think a specialty in clinical geropsychology is important, because geropsychology is the psychological study of a distinct population with unique needs and considerations. I must advocate for my older adult patients almost daily in my practice. Factors as seemingly obvious as sensory deficits are often overlooked and misconstrued as a lack of understanding; orientation/mental status is generalized in a dementia patient as sufficient for decision-making capacity. In many instances, ageism and ageist ideology are rampant and sometimes accepted by the patients themselves. We need more research to understand aging and ways we can impact the psychological well-being of older adults. Most importantly, we need more people with the passion, knowledge and skillset to disseminate this information and provide education. Specialization not only provides a framework but also a platform.

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

Veronica: I am coming upon the end of my early career status and I would have to say that you must follow your passion. There is a great need for psychologists interested in Geropsychology and the practice is very fulfilling work. I look back on my experience and I say try many things and become involved. Often times psychologists wait to be asked to come to the table. I have made my way by showing up, taking notes, and speaking out when appropriate. When you show-up with something to offer in the way of knowledge, solutions, or simply a positive work ethic most are receptive. Do not be afraid to ask or go for opportunities that you would expect to be offered to a more seasoned psychologist or even leadership/admin positions usually held by other professionals. More often than not, other professionals are open to what you have and are willing to collaborate.

In Geropsychology, many times you find yourself in clinical practice positions where you are the only psychologist or you are in a medical setting where few expect you to be present. (Twice in the past week medical residents have called our team asking if palliative psychology is a thing and if so can I do XYZ.) For support, find your Geropsychology community and use them but also find your interdisciplinary team. I cannot tell you how I have continued to learn from my teams. There is nothing like having a geriatric pharmacist, a palliative CNS, and a board-certified geriatrician and palliative physician as true friends. I can call upon this team to connect with the larger geriatric/palliative community in ways that expand my reach and open the door to unexpected opportunity. One last thing, do not forget the community. Some of my most satisfying work has been as a volunteer speaker for non-profit organizations educating those who often do not have access to a geropsychologist—or even know we exist.

Research Roundup

Submitted by Allison Walden, MEd

It is well-known that the population of older adults is on the rise. With a greater population of older adults, diseases such as Alzheimer's disease (AD) and other forms of dementia will unfortunately impact the lives of more individuals. This in turn will lead to more people requiring nursing assistance and possibly long-term care (LTC). Making LTC facilities safer and increasing the quality of life for residents with dementia is of the utmost importance. As new forms of technology are being developed at rapid rates, technology (such as virtual reality [VR]) may hold answers for increasing the quality of life for dementia residents. One such study is presented below that studied wayfinding in a LTC facility using a VR simulation. VR research to improve LTC settings is a new and exciting developing area that has the potential to positively impact the lives of many.

Wayfinding, the ability to find one's way from one location to another, is a common, troublesome symptom experienced by individuals with AD (Golledge, 1999). It affects more than 50% of people with AD and limits one's ability to live and function independently. This in turn leads to high numbers of people with AD-related cognitive impairment living in LTC settings. One possible way to help improve wayfinding is by adding salient environmental cues (meaning cues that are prominent, distinct, and obvious; Caduff and Timpf, 2008). Davis, Ohman, and Weisbeck (2017) created a study to investigate the effects of salient cues on wayfinding for individuals with Alzheimer's disease or mild cognitive impairment (MCI) using a virtual senior residence.

They recruited a convenience sample of 88 participants, which included 38 participants with AD/MCI (50% female, $M_{age} = 77.26$) and 50 participants without AD/MCI for the control group (64% female, $M_{age} = 75.46$). Visual screening measures and the Clinical Dementia Rating (CDR) Scale were used to determine eligibility. A within-subjects, repeated measures design was used to evaluate participants' abilities to navigate a virtual senior living facility. Participants were exposed to two conditions; one contained standard cues (e.g. plain walls, muted carpet, equally spaced doors) and the other contained salient cues (e.g. bright, colorful wall hangings). They had to navigate the virtual facility to the goal location and were timed on how long it took to complete the task. Participants navigated the standard and salient cue conditions for two consecutive days, completing 10 trials each day (5 of each condition).

Results revealed that all participants were able to navigate the salient cue condition faster than in the standard condition. Additionally, as expected, participants with AD/MCI showed a significant diminished ability to navigate compared to controls, but were more capable with salient cues. Overall, Davis et al.'s (2017) results point to the importance of incorporating salient cues in LTC facilities to improve wayfinding. Their use of a virtual senior residence was a novel and effective way to measure wayfinding in older adults.

Allison Walden, MEd, is a doctoral student in the clinical geropsychology program at the University of Colorado Colorado Springs. She works under the research mentorship of Leilani Feliciano, PhD.

References

Caduff, D. & Timpf, S. (2008). On the assessment of landmark salience for human navigation. *Cognitive Processing, 9*, 249-267. doi: 10.1007/s10339-007-0199-2

Davis, R., Ohman, J.M., & Weisbeck, C. (2017) Salient cues and wayfinding in Alzheimer's disease within a virtual senior residence. *Environment and Behavior 49*(9): 1038-1065. doi: 10.1177/001391654667734

Davis, R. & Ohman, L. (2016). Wayfinding in ageing and Alzheimer's disease within a virtual senior residence: Study protocol. *Journal of Advanced Nursing, 72*(7), 1677-1688. doi: 10.1111/jan.12945

Golledge, R.G. (1999). Human wayfinding and cognitive maps. In R.G. Golledge (Ed.), *Wayfinding behavior: Cognitive mapping and other spatial processes* (pp. 5-45). Baltimore, MD: Johns Hopkins University Press.

Research Roundup is a * NEW * column designed to highlight exciting and recent empirical work relevant to the 12/II audience. We particularly welcome synopses submitted by students, interns, postdocs, and other emerging geropsychologists. Contact Brenna Renn bnrenn@uw.edu or Elissa Kozlov elk2020@med.cornell.edu if you would like to submit a brief piece to an upcoming newsletter.

Diversity Column

Assistance Animals and Older Adults
*Submitted by Katherine A. Johanson, BA, Charissa Hosseini, MS, Flora Ma, BSc,
& Nancy A. Pachana, PhD, FAPS, FASSA*

A disaster is generally defined as a "...major change to the physical and social environment with tragic human consequences" (Deeny, Vitale, Spelman, & Duggan, 2010, p. 78). Disasters may occur on a community level (e.g., floods, wildfires, cyclones, mass shootings) or an individual level (e.g., house fires, traffic or other accidents), yet all disasters share common features. In addition to potentially affecting many people, disasters also produce stressful circumstances, such as threats to a person or property, bereavement and loss, social and community disruption, and ongoing hardship. According to a report by the National Oceanic and Atmospheric Administration (2017), 15 natural disasters have occurred thus far this year, each causing at least \$1 billion in losses and

damages, with some costing close to \$580 billion. Collectively, these disasters (including a wildfire outbreak, drought, floods, freezes, cyclones, and damaging storms) have affected the lives of millions of people, affecting their psychological, biological, and social functioning and well-being.

Myriad adverse outcomes of disasters have been documented. In their review of 160 studies on disaster outcomes, Norris et al. (2002) identified the most common psychological consequences of disasters as post-traumatic stress disorder (PTSD; evident in 68% of the samples), depression (36% of the samples), and anxiety (20% of the samples). Moreover, the authors revealed a relationship between increased risk of suicidality and remorse and degree of exposure to the disaster. Physical and social consequences of disasters include elevated stress and psychosomatic symptoms, health problems and poor sleep, interpersonal conflict and decreased social support, financial stressors, and more practical concerns such as relocation, rebuilding, and replacing lost items (Norris et al.).

Impact on Older Adults

In light of the recent disasters impacting southeast Texas, Florida, and northern California, older adults may be particularly at risk during and after disasters—especially frail older adults, older adults living alone, and those with pre-existing health conditions. Not only do older adults face the barrage of the aforementioned consequences of disasters, but they may also experience difficulties with mobility and transportation, physical isolation, and access to medication, oxygen, good nutrition, and nursing care.

Disasters increase the vulnerability of older adults by impeding their level of daily functioning. The increased stress during and in the aftermath of disasters can exacerbate pre-existing conditions and increase risk of mental health issues and death. Biopsychosocial phenomena of disasters among older adults may include exhibiting specific psychological problems (e.g., PTSD, depression, and anxiety); having non-specific distress (i.e., elevated stress-related psychological and psychosomatic symptoms); developing chronic or acute health problems and concerns (e.g., somatic complaints, medical conditions, physiological indicators); creating daily living problems; and having psychosocial resource loss (Fernandez, Byard, Lin, Benson, & Barbera, 2002; Norris et al., 2002; Sakauye et al., 2009). On a practical level, the increased hassles of daily living may contribute to troubled interpersonal relationships, financial stress, and decreased availability of daily necessities (e.g., food, water, and shelter) and other basic needs (e.g., medication, transportation, and communication) (Norris et al.). Older adults are more vulnerable to isolation with the loss of social support. It is also important to be aware that poorer physical and/or cognitive abilities may be barriers to adaptive coping, caused by diminished levels of self-efficacy, optimism, and sense of control (Norris et al.). These various sources of disaster-related distress should be carefully identified to determine the appropriate assistance to best meet the needs of vulnerable older adults.

Psychological First Aid

In the advent of a disaster, there are a multitude of negative consequences and outcomes. With regard to mental health outcomes, this may include developing or exacerbating Acute Stress Disorder or PTSD. The National Center for PTSD and the National Child Traumatic Stress Network collaborated and developed Psychological First Aid (PFA) with the intention of reducing distress and increasing coping skills for those that experienced a disaster. PFA is defined as “...an evidence-informed modular approach for assisting children, adolescents, adults, and families in the aftermath of disaster and terrorism.” This modular approach consists of eight Core Actions to be

used by non-mental health professionals. The eight Core Actions consist of Contact and Engagement, Safety and Comfort, Stabilization, Information Gathering: Current Needs and Concerns, Practical Assistance, Connection with Social Supports, Information on Coping, and Linkage with Collaborative Services. However, the majority of PFA training does not discuss the specific challenges or barriers older adults face during a disaster. Researchers noted this gap within the training and addressed it by developing a PFA manual specific to Nursing Homes. The eight Core Actions remained the same; however, the content is specific to the needs of older adults living in care facilities. The manual provides examples of dialogue and culturally-informed language to use when communicating with an older adult patient, as well as covering issues such as working with older adults with dementia/cognitive impairment, end-of-life issues, and older adults coping with loss/change/trauma after a disaster. The general PFA and PFA for Nursing Homes manual provides mental health and non-mental health providers the opportunity to lessen and mitigate the potential negative consequences and effects of a disaster. A next step would be to develop a manual that addresses the needs of community-dwelling older persons (Brown & Hyer, 2008; Shultz & Forbes, 2014).

Conclusion

Disasters have the potential to affect the lives of millions of people and incur psychological, biological, and social hardships. Older adults may be especially vulnerable to the negative consequences of disasters, warranting our increased attention, awareness, and assistance. Psychological First Aid represents a means by which to help older adults, including those living in nursing homes, by reducing distress, strengthening coping skills, and equipping mental health and non-mental health providers with the ability to assist those in need. Further work on this approach will yield benefits in the future.

References

- Brown, L.M., & Hyer, K. (2008). Psychological First Aid: Field Operations Guide for Nursing Homes. Retrieved from <http://amh.fmhi.usf.edu/pfanh.pdf> on October 26 2017.
- Deeny, P., Vitale, C. T., Spelman, R., & Duggan, S. (2010). Addressing the imbalance: Empowering older people in disaster response and preparedness. *International Journal of Older People Nursing*, 5(1), 77-80.
- Fernandez, L. S., Byard, D., Lin, C. C., Benson, S., & Barbera, J. A. (2002). Frail elderly as disaster victims: emergency management strategies. *Prehospital and disaster medicine*, 17(2), 67-74.
- NOAA National Centers for Environmental Information (2017). U.S. Billion-Dollar Weather and Climate Disasters. Retrieved from <https://www.ncdc.noaa.gov/billions/>
- Norris, F. H., Friedman, M. J., Watson, P. J., Byrne, C. M., Diaz, E., & Kaniasty, K. (2002). 60,000 disaster victims speak: Part I. An empirical review of the empirical literature, 1981-2001. *Psychiatry: Interpersonal and Biological Processes*, 65(3), 207-239.
- Sakaue, K. M., Streim, J. E., Kennedy, G. J., Kirwin, P. D., Llorente, M. D., Schultz, S. K., & Srinivasan, S. (2009). AAGP position statement: Disaster preparedness for older Americans: Critical issues for the preservation of mental health. *The American Journal of Geriatric Psychiatry*, 17(11), 916-924.
- Shultz, J. M., & Forbes, D. (2014). Psychological First Aid: Rapid proliferation and the search for evidence. *Disaster Health*, 2(1), 3-12.

Member Spotlight



Full Member Spotlight: Elizabeth W. Hirschhorn, PhD

Year joined Society of Clinical Geropsychology: 2017

Hometown: Washington, DC

Current Professional Title and Affiliation: Staff Psychologist, Primary Care-Mental Health Integration (PCMHI), VA Puget Sound Health Care System, American Lake Division

Q: *Why did you join the Society for Clinical Geropsychology?* Throughout my training, I've valued membership in societies as a way to discuss shared interests/projects and build relationships with great people practicing in the same area. As someone who came to geropsychology a bit later than others, joining Division 12/II was an important step towards embracing the label of geropsychologist and feeling connected to a community of people with a wealth of knowledge (and who seem wonderful so far!).

Q: *How has membership in the SCG assisted you with your professional development?* I haven't been a member for too long yet, but I've really been enjoying the listserv discussions in my email inbox each day! It has given me some good ideas for ways to contribute to my clinic as the main geropsychology consultant for our team.

Q: *How did you get interested in the field of aging?* I was a practicum student at the Washington DC VA in my third year of graduate school when I was invited to stay on for the following year to train in a new outpatient MH team focused on older Veterans' needs. I had been gaining more experience in health psychology and understanding how medical status and mental health interact, and it seemed like an interesting new challenge. I had no idea I would love geropsychology so much, but that year totally changed the game for me.

Q: *What was your most memorable experience during your graduate studies?* Teaching my own section of Psychology 101 to undergraduates was one of my most memorable and favorite experiences in graduate school. Seeing students get their first taste of psychology (and getting hooked, of course) was so cool, especially when they started to understand complicated concepts like classical vs. operant conditioning and apply them in their daily lives.

Q: *Have you had an important mentor in your career? If so, how did he or she make a difference?* I have been fortunate to have incredible mentorship in my career thus far. The American Lake VA geropsychologists have been fantastic supervisors and preceptors—I'm so lucky to have had [12/II members] Doug Lane, Annie Mueller, and Kimberly Hiroto in my corner as I developed my skills and knowledge over the course of the year (and whom I'm so glad to call colleagues now!).

Q: *What is your current position and your key responsibilities?* I'm about one month into my first full-time position as a licensed psychologist—I'm currently the geropsychologist in Primary Care-Mental Health Integration at the American Lake VA in Tacoma, WA, where I also completed my postdoctoral fellowship in geropsychology. Our team provides population-based mental health care as part of interprofessional primary care teams comprised of MDs, ARNPs, RNs, LPNs,

pharmacists, medical support assistants, and mental/behavioral health providers. Along with conducting functional assessments and brief psychotherapy, I provide consultation and education for primary care team members about mental and behavioral health for older Veterans. I'm also a member of the Diversity Committee which focuses on providing training and education for psychology trainees/staff on cultural competency and advocacy for diversity-related issues.

Q: Tell us about your most recent activities. I've only been in this position for about a month, but so far, I've enjoyed providing gero-specific consultation for other psychologists about the team and receiving "warm handoffs" from primary care providers wanting to wrap mental health into the Veteran's treatment plan. Between the end of fellowship and beginning this position, I traveled through Vietnam for two weeks with my mom to better understand past experiences of Vietnam Veterans, who are rapidly becoming the largest segment of the geriatric population served by the VA.

Q: What has been your most memorable experience in gerontology and aging clinical practice and/or research? The most memorable experiences have been the quiet kernels of wisdom that clients have shared with me throughout my direct clinical work, especially those who have since passed away. I feel so fortunate to be able to learn and grow from their experiences and their willingness to be open with me about their journeys and challenges. It feels like a sneak peek of figuring out what is important in the end, which helps me sort things out in my own life.

Q: Do you have any tips for emerging geropsychologists? I'd encourage you to see as many different faces as you can in your clinical work—there are so many different ways to age and so many other factors (medical, cultural, geographical, family systems, etc.) that can affect how people grow older and the choices they make. It's pretty amazing.

Q: What keeps you busy when you are not working with older adults? What are your non-professional aspirations and hobbies? I'm still exploring the incredible outdoor offerings of the Pacific Northwest through hiking, camping, and going for long drives through the evergreen forests (and drinking great coffee). Weightlifting has been a great way to decompress after workdays, too. I prioritize spending time with friends and family—FaceTime through my phone is a regular part of my week to stay connected with loved ones across the country. I love corny jokes and puns, so if you have them, please send them my way!

Student Member Spotlight: Kathryn Phillips



Year joined Society of Clinical Geropsychology: 2017

Hometown: Lynden, WA

Current School/Affiliation: PGSP-Stanford PsyD Consortium

Q: Why did you join the Society for Clinical Geropsychology?

Shortly after entering graduate school, I realized a passion for working with older adults and sought out research and clinical experiences to focus my training in the field of aging. I joined SCG to access resources that support my clinical work in geropsychology, stay current issues and ongoing research in the field, and connect with others who are passionate about working with older adults.

Q: How has membership in the SCG assisted you with your professional development? SCG provides access to a wealth of information and resources for a young clinician, particularly as geropsychology is a specialty that we don't always have exposure to early in our training. In addition, SCG has helped me to refine my goals for internship. This has guided me towards sites that provide training and supervision in geropsychology and related areas, such as neuropsychological assessment. I also appreciate that being a member of this community allows me to observe the incredible developments in research and clinical advances in the field, and connect with students and professionals to discuss my own research and clinical work and interests.

Q: How did you get interested in the field of aging? I grew up having very important and special relationships with my grandparents and other meaningful older adults in my community, whether family friends or older mentors. In fact, my first job in high school was as a receptionist and activities coordinator at an RCFE (Residential Care Facility for the Elderly) in my hometown, where I loved connecting with seniors and hearing about their lives. Once in graduate school, I was unsure of where I might focus in my future career. I discovered a passion for learning about neurocognitive disorders and approaches to intervention and assessment. I began seeking out opportunities to work with older and disabled adults, through a research assistant position in neuropsychological assessment lab and volunteer work on a crisis line for seniors. These experiences led me to formal practicum positions in a neuropsychological assessment unit, and later in a PACE (Program for the All-Inclusive Care of the Elderly) program within a community mental health center. I learned through this journey that geropsychology is an area in which my lifelong passion for connecting with older adults intersects with my skills as a scholar-practitioner, through applying evidence based treatments and integrating new research findings.

Q: Have you had an important mentor in your career? If so, how did he or she make a difference? I have been fortunate to work with many supervisors and advisors who have shaped my career interests and training experiences. Two key influences in my career development include Dr. Harriet Zeiner and Dr. J. Kaci Fairchild. Their gentle guidance and high expectations of what I can contribute as a clinician, researcher, and academic have buoyed my ambition and confidence at multiple points in my development. They have enabled growth opportunities, fostered independence, and provided friendship during my graduate education. I will always cherish these relationships and what I have been able to learn from them. Watching their interactions with patients, colleagues, and students have been meaningful experiences that I will emulate someday in my future career.

Q: What has been your most memorable experience in gerontology and aging clinical practice and/or research? I think one of my favorite experiences in clinical work occurred while I was working in the PACE program within a community-based mental health center. I worked in a milieu setting in two Day Rooms, which hosted program participants living with varying levels of cognitive impairment. One of these participants, a 66-year-old Chinese-American woman living with frontotemporal dementia, was exhibiting challenging behaviors in the Day Room. In her past, she had dedicated significant time to earn money collecting bottles, cans, and other recyclables around the city. This participant was colliding with Day Room staff as she would frequently look through garbage and recycling bins throughout the center and her behavior was unfortunately violating health codes. Verbal and other redirections had been unsuccessful, and staff was unsure what to do, as she would become verbally or physically aggressive when blocked from participating

in this activity. We met as a team and brainstormed ways to "work in" her behavior, rather than attempting to block it. We eventually came up with a plan to have all staff in the building bring us their recyclables, which PACE staff would wash and sanitize. We then placed false 'recycling bins' around the center, which were made distinctive with signs in both Mandarin (her native language) and English, that identified them as recycling bins. This helped to obscure the real recycling bins and draw attention towards these false bins. Every day, the participant was permitted to move through the center as desired and collect her recyclables, and turn them in at the end of each day. Staff would clean and refill her bins, to be used for her the next day. This activity was a prime example of a team coming together to meet the participant where she's at. In addition, it was a lesson for me as to how psychology can provide a behavioral perspective and consult with an interdisciplinary team to work for a solution that engages for the participant.

Q: Tell us about your most recent activities. Currently I serve as a practicum student research assistant at the VA Palo Alto Healthcare System, where I am involved in three separate projects. The first study explores the effects of water-based exercise and cognitive skills training classes on veterans living with cognitive impairment. The second is a study that randomizes individuals living with mild cognitive impairment into one of two exercise programs to see the effects of various types of physical activity on cognition. The final study focuses on a demographically diverse sample of caregivers of persons living with dementia or traumatic brain injury. This study engages caregivers in skills training alongside participation in either of two exercise programs. For these three studies, I focus on administering neuropsychological and psychosocial assessments and providing individual skills training and psychosocial interventions to caregivers in the third study. In addition, I am second author on a book chapter ("Physical Activity in Late Life") for a text that will serve as a reference for health care professionals who work with older adult patients. This book is in progress and will be published through the APA.

Q: Looking forward, what are your plans post-graduation? I hope to continue practicing in geropsychology and related areas, such as behavioral medicine and neuropsychology, and work in interdisciplinary health care settings. I have been fortunate to be exposed to these team settings in multiple domains, including Veterans Affairs health care systems and community-based mental health centers, and plan to continue seeking out these opportunities. In addition, I hope to continue developing as a scholar-practitioner through consuming and applying research about new treatments and other issues.

Q: What keeps you busy when you are not working with older adults? What are your non-professional aspirations and hobbies? When not focused on the activities of graduate school and clinical work, I enjoy spending time with my partner, friends, and 22 lb. cat, Joey. I love exploring all of the culture and excitement that comes with living in San Francisco. I also like snowboarding, exercising, cooking, reading, and traveling around the country or the world to practice self-care.

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 Co-Editors Elissa Kozlov (elk2020@med.cornell.edu) or Brenna Renn (bnrenn@uw.edu).

Member News

Shane Bush, PhD, ABPP was recently honored with the 2017 ABPP Geropsychology Specialty Board Award. Dr. Bush is Board Certified in Geropsychology, Neuropsychology, Clinical Psychology, and Rehabilitation Psychology and is affiliated with the VA New York Harbor Healthcare System and University of Alabama, Department of Psychology.

Recent Member Publications

Fung, C. H., Martin, J. L., Hays, R. D., Patterson, E. S., Aysola, R., Col, N., Mitchell, M. N., Troung, C., **Dzierzewski, J. M.**, Jouldjian, S., Song, Y., Rodriguez, J. C., Josephson, K., & Alessi, C. (2017). Patient-reported usability of positive airway pressure equipment is associated with adherence in older adults. *SLEEP*, 40(3), doi: 10.1093/sleep/zsx007. PMID: 28364429

Kozlov, E., Egan, C., Moran, S., Herr, K., Reid, MC. (in press). Mental health in palliative care practices – Results from a national survey of palliative care providers. *American Journal of Hospice and Palliative Medicine*.

Martin, J.L., Song, Y., Jouldjian, S., **Dzierzewski, J.M.**, Fung, C.H., Rodriguez, J.C., Mitchell, M.N., & Alessi, C.A. (2017). A four-session sleep intervention program improves sleep for older adult day health care participants: Results of a randomized controlled trial. *SLEEP*, 40(8), doi: 10.1093/sleep/zsx079.

Molinari, V., & Ellis, M. (2017). Psychological interventions in long-term care settings. In N. Pachana (Ed.), *Encyclopedia of geropsychology* (pp. 1926-1931). New York: Springer.

Molinari, V., Hobday, J., Roker, R., Kunik, M. Kane, R. A., Kaas, M., Mehrotra, C., Williams, C., Robbins, J. C., & Dobbs, D. (2017). Impact of serious mental illness online training for certified nursing assistants in long term care. *Gerontology and geriatrics education*, 38(4), 359-374. <http://dx.doi.org/10.1080/02701960.2016.1188811>

Renn, B. N., & Feliciano, L. (2017). Biopsychosocial theoretical framework. In A. E. Wenzel (Ed.), *Encyclopedia of abnormal and clinical psychology* (pp. 497-499). Thousand Oaks, CA: SAGE Publications. doi: 10.4135/9781483365817.n188

Book Announcements

Bush, S.S. (Editor-in-Chief), Demakis, G.J., & Rohling, M.L. (Associate Editors) (2017). *APA Handbook of Forensic Neuropsychology*. Washington, DC: American Psychological Association Press.

Mast, B. T., & Yochim, B. P. (coming soon). *Alzheimer's disease and dementia*. Ashland, OH: Hogrefe Publishing. *Note:* A portion (2%) of the royalties will go to APA Division 12 (Society of Clinical Psychology). <https://us.hogrefe.com/shop/alzheimer-s-disease-and-dementia-84579.html>

Segal, D. L., Qualls, S. H., & Smyer, M. A. (coming soon). *Aging and mental health* (3rd ed.). West Sussex, UK: Wiley-Blackwell.
<http://www.wiley.com/WileyCDA/WileyTitle/productCd-1119133130.html>

The Student Voice

*Submitted by Meghan McDarby, BS
(Student Representatives: Meghan McDarby, BS & Kelly O'Malley, PhD)*



Hi everybody! My name is Meghan McDarby, and I am a second year clinical psychology graduate student at Washington University in St. Louis. I am thrilled to join SCG as the newest student representative and look forward to getting to know all of you over the next two years.

I started as a graduate student in Dr. Brian Carpenter's lab last fall. After working for two years as research coordinator on a VA Quality Improvement initiative related to inpatient care at end of life, I was eager to begin school and elaborate on my own, related research interests. Since college, I have been interested in improving access to excellent end of life care. My undergraduate honors thesis examined barriers to hospice utilization for rural older adults, and my work at Washington University continues to reflect strikingly similar goals. Some of my recent work includes a book chapter that I co-authored with Dr. Carpenter addressing ways to enhance communication and decision-making for individuals with life-limiting illnesses. I am specifically interested in ways to promote meaningful communication and collaboration between patients, providers, and family members to increase timely advance care planning. In addition to these interests, I am also currently pursuing research related to improving the delivery of palliative care. My master's project will examine facilitators and barriers to collaboration between palliative care teams and other care teams in the hospital, as well as factors that most meaningfully predict timely implementation of recommendations made by the palliative care team. I feel grateful for the opportunity to pursue my research passions here at Washington University over the next several years.

My goals as a student representative for SCG are two-fold. First, I hope to encourage my SCG student colleagues to become more involved with aging organizations in their local communities and aging awareness initiatives on their campuses. For example, I work as a bereavement volunteer

at one of St. Louis's local hospice organizations, which has been a meaningful and relevant way for me to give back to the local community. On campus, I am a teaching assistant for an interdisciplinary course offered to freshmen at Washington University entitled "When I'm 64: Transforming Your Future." In this course, students cover material related to what their lives will be like as older adults. Participating actively as a graduate student leader in weekly discussion sections has been extremely rewarding, as I am able to rally students around critical aging topics and encourage them to think more deeply about them as well. Due to the continued paucity of students pursuing careers in aging, it is critical for us as leaders in the field of gerontology to engage young minds whenever possible.

In addition to my goal of promoting service, I also hope to facilitate networking and collaboration between graduate students and professional members of SCG. Membership in organizations like SCG provides an incredible opportunity for networking and getting to know our colleagues, and I hope that as a student representative, I can help you take advantage of getting to know your fantastic geropsychology counterparts.

I am excited to serve as a SCG student representative, and I look forward to working with you over the next two years. Please don't hesitate to email me (mmcdarby@wustl.edu) with any questions you might have about how to get involved!

Committee Updates

Bylaws Committee Update

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

As many of you recall, this year's ballot asked members to vote on an amendment to allow non-APA members to join SCG. Though the inclusion of this amendment on the ballot had been evaluated through ongoing discussion of the Board, it was not until after the election that we discovered the amendment did not go through the required vetting process as outlined in the Bylaws. This process reads as follows:

"An amendment to these Bylaws may be proposed by a majority of the Board of Directors or by a petition signed by at least five percent (5%) of voting Section Members presented to the Board of Directors. After a proposed amendment has been reviewed by the Board of Directors, it shall be mailed within sixty (60) days to ... each Member. ... each proposed amendment... shall be accompanied by statements which specify the arguments for and against the proposed change. ... An affirmative vote of a majority of the votes cast shall be required to ratify the amendment, which shall then be effective immediately."

Outcome: After rigorous discussion, the Elections committee, Bylaws committee, and Board have concluded that this deviation from the Bylaws procedure nullifies the 2017 amendment votes. Going forward, the amendment change will go through the formal process outlined in the Bylaws for inclusion on the 2018 ballot. Specifically, 1) the Board will revisit whether a majority proposes

this amendment, and if so, 2) the 2018 ballot to vote on this Bylaws amendment will be accompanied by detailed pro and con statements for the proposed change.

The Bylaws committee will continue to supply updates regarding the status of this amendment on the upcoming ballot, as well as updates on other Bylaw changes for consideration during the course of our review.

Communication Committee Update

Submitted by Christine Gould, PhD

The Communications Committee is pleased to welcome a new website coordinator, Rachael Spalding. Rachael is a 1st year graduate student at West Virginia University. Additionally, we also are happy to announce that the updated website is complete. We hope that the changes made to the internal workings of the site will make for better user experience for SCG members. Instructions will be sent out to the listserv soon regarding membership renewals.

The Committee welcomes suggestions for information to be posted to Facebook and for content to be developed and added to the website.

- **Facebook:** Suggestions for content to post can be broad and may include announcements related to APA and GSA conferences, other APA related information, lay news related to the field of aging, announcements for scholarships and grant opportunities, etc. Please send suggestions to Patty Bamonti, PhD (Social Media Overseer) at patricia.bamonti@va.gov.
- **Website:** Please contact Rachael Spalding (Website Coordinator) at rls0046@mix.wvu.edu with suggestions for changes to our webpages. Ideas for new website content to be developed can be sent to Caroline Merz (Website Content Coordinator) at christinecarolinemerz@gmail.com.

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.

The IHC met in August prior to APA. 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. The American Diabetes Association collaborated with APA to develop a two-part workshop to credential psychologists to provide treatment for persons with diabetes. There was enormous interest in the workshop hosted at APA and reflects the growing recognition by other fields of the value added by psychology.
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 6mos 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

In late 2015, our committee (formerly the CE Committee), along with the Diversity and Communications Committees, sent out a survey to SCG members to learn more about how we could best serve the needs of the membership. We really appreciated everyone who responded to the survey and wanted to update you on how we've been using the information gathered:

- 1) We shared results from the survey in the Spring 2016 edition of the SCG newsletter.
- 2) Based on members' preferred methods for obtaining CEs (local seminars/conferences, online training, and regional/national conferences) and members' preferred method for learning about CE opportunities through professional organizations and listservs, we announced ways in which members could obtain CEs by attending the APA and GSA annual conventions in the SCG newsletter and on the listserv in 2016 and 2017.
- 3) Based on reported barriers to obtaining CEs (primarily high cost and time limitations), we highlighted opportunities for free CEs in the Spring 2017 edition of the SCG newsletter and on the listserv.
- 4) Based on the top domains for which respondents wanted more CE content (dementia/mild cognitive impairment, capacity issues/assessment, and adjustment to health problems), we identified APA convention CE workshops relevant to these domains and sent out messages through the listserv in 2016 and 2017.
- 5) Based on encouragement to focus equally on specialty competencies for geropsychologists and competency enhancements for general psychologists, we helped to schedule a Division 12 webinar focused on expanding one's practice to include work with older adults, currently planned for January 2018.

- 6) Finally, we recently shared the survey results with CONA to help guide their efforts to create CE opportunities at upcoming APA conventions.

Membership Committee Update

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

Membership Update

- Total Paid Members: 182
- Total Paid Regular Members (including Emeritus members): 156
- Total Paid Student Members: 26

We have published our new website (www.geropsychology.org) which should facilitate the membership joining and renewal process. Nonetheless, we appreciate everyone's patience as we work to standardize and streamline these processes. 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 encourage everyone to renew by the end of December. So, if you have not yet renewed your membership for 2018, 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

The mentoring committee is pleased to announce the addition of three new members: 1) Rebecca Allen, PhD, ABPP, Professor of Psychology at the University of Alabama and a Board-Certified Geropsychologist; 2) Brenna Renn, PhD, NRSA Postdoctoral Fellow in the Department of Psychiatry & Behavioral Sciences at University of Washington School of Medicine, and 3) Jarred V. Gallegos, MFT and current graduate student at West Virginia University. The committee, which was recently revived in March of this year, is meeting monthly to work towards a number of proposed committee goals including: submission for a special journal issue on mentoring in different career paths, submission of a GSA symposium on a similar topic, creation of a mentoring section/page of the new 12/2 website, and creative opportunities to link mentors to mentees.

Public Policy Committee (Joint committee with PLTC) Update

Submitted by Cecilia Poon, PhD

Advocacy regarding Medicare access and the leadership role of geropsychologists on interdisciplinary teams:

Cecilia Poon, PhD and Kelly Carney, PhD of the PPC committee drafted a letter to respond to CMMI's Request for Information (RFI) due November 20. The informal RFI is an attempt to solicit feedback on "a new direction to promote patient-centered care and test market-driven reforms that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, reduce costs, and improve outcomes." Our comment seeks to illustrate the value of

geropsychologists in care coordination and interdisciplinary leadership. We had a conference call with APAPO last month, as they were also working on their comment letter to CMMI.

Committee Membership:

We welcome Heather Noble, PhD, a member of Psychologists in Long Term Care (PLTC), to our committee. Heather is a clinical psychologist based in the Kansas City area. In addition to being a faculty member at Avila University, she also provides behavioral health services to several local long-term care facilities.

SCG Policy and Practice website:

We updated links to Medicare Local Coverage Determinations (LCDs) that impact psychological services earlier this year. The information will soon be updated on the SCG website, which has recently undergone major upgrades.

Society of Clinical Psychology (Division 12) Update

*Submitted by Victor Molinari, PhD, ABPP
Section 2 Representative*

A number of issues were discussed at the board meeting at the 2017 APA Meeting in Washington DC. Here are the highlights (thanks Tara Craighead):

- 1) SCG has been praised for its assistance with obtaining the authors for the volume *Alzheimer's Disease and Dementia*. Thanks to Ben Mast and Brian Yochim for writing this book, which has been very well received.
- 2) The editorship of both *Clinical Psychology: Science and Practice* and *Clinical Psychologist* will be opening.
- 3) Section reps to SCP have been canvassed and desire a 'tight' relationship with SCP.
- 4) Graduate Student summit has been rescheduled for March 18th, 2018.
- 5) SCP Fellowship Committee and SCP Early Career Psychology committee are seeking new members.
- 6) Recent decline in APA membership has leveled off.
- 7) SCP has conducted a diversity survey. Results will be circulated.

Committee on Aging (CONA) and Office on Aging Update

*Submitted by Margie Norris, PhD
CONA Chair*

NEW AND UPCOMING RESOURCES FOR YOU!

- Do you have a message to get out to a broad psychology audience? APAGENET has been established to bring together representatives from Divisions that share interests with CONA's mission. Twenty-nine [Divisions](#) are currently members (Divisions 1, 2, 3,

8, 12, 14, 15, 17, 19, 20, 21, 22, 24, 25, 29, 31, 33, 35, 36, 39, 40, 41, 43, 44, 45, 47, 52, 55 and 56). SCG members are encouraged to contact any of the APAGENET representatives to share postings on the APAGENET email distribution list. This is a great way to get the word out to psychologists who share interest with geropsychology!

- Are you training students interested in aging? Currently under development is a new web-based resource, *Exploring Careers in Aging: An Educational Roadmap for Every Step of The Way*. It will have multiple components including a Research Roadmap to explore options and prepare for a research or science-focused career pertaining to older adults; a Practice Roadmap to explore options and prepare for an applied career working with older adults; careers that intersect with aging such as engineering, business, law and policy, and biological sciences; and career profiles of psychologist researchers and practitioners who have embarked on age-related careers. For all levels of training (pre-college through post-doctoral), each Roadmap provides: questions to consider, training opportunities to undertake, and resources to help achieve one's educational and professional goals.

CONA UPDATES

- CONA is collaborating with the APA Advisory Committee on Colleague Assistance (ACCA) on the update of its [Tool kit](#) for the Colleague Assistance programs. CONA is working with them to include issues that may be salient to older psychologists including cumulative burnout, promoting cognitive health, a primer on cognitive aging, and preretirement planning.
- As a part of CONA's Priming The Pipeline efforts, CONA developed a poster, *What is the Psychology of Aging?* for use by the Committee on Teachers of Psychology in Secondary Schools (TOPSS) and the Committee on Associate and Baccalaureate Education (CABE) to encourage high school and undergraduate students to consider psychology and aging as a career focus. The poster is available for download here: <http://www.apa.org/pi/aging/aging-classroom-poster.pdf>
- CONA also provided guidance to TOPSS for their 2017 Student Essay Contest: An Aging World. Winning essays can be found here: <http://www.apa.org/ed/precollege/topss/student-competition.aspx?tab=5>
- This year, in collaboration with the APA Leadership Team, CONA nominated 16 psychologists with aging expertise to various APA boards and committees, including the Board for Scientific Affairs (BSA) and Board for Professional Affairs (BPA) awards. Success! Nominee, Cameron Camp, PhD was selected as the recipient of the APA Award for Distinguished Professional Contributions to Applied Research! Two additional nominees are on the slates to be voted on by Council.

If you have interest or questions about any of the above items, feel free to contact your colleagues and friends on CONA: Margaret Norris, PhD (Chair), Walter Boot, PhD, Vonetta Dotson, PhD, Erin Emery-Tiburcio, PhD, ABPP, Patricia Parmelee, PhD, & Maggie Syme, PhD, MPH.

Special Feature: 2017 APA Presidential Address

12/II Presidential Address (delivered at APA 2017, Washington DC)

Submitted by Benjamin Mast, PhD, ABPP

Each year, the president of the Society of Clinical Geropsychology focuses on an initiative to help move the field and SCG forward. I have chosen to focus my initiative on career pathways in geropsychology.

During my presidential year, I want to encourage clinical geropsychologists across career stages to share the stories of their careers and the people who inspired them. I would like to see the next generation of geropsychologists benefit from our collective experience and better understand the variety of career paths they can take. Through the stories of our careers and the people who inspired us, I hope we can communicate what makes clinical geropsychology special and continue to attract others into our growing field.

Last year at APA I had the pleasure of hearing our esteemed colleague Greg Hinrichsen talk about his career path. What I loved most about his talk was that he clearly demonstrated for us that his career and his efforts to care for older people is not just a product of his training and professional experiences but also of who he is as a person. Greg talked about his training, but also highlighted friendships, love, and people who influenced and inspired him. We are not just the product of our training experiences, but a unique blend of the personal and professional. Although this is true for all of us, but we don't often acknowledge it or collectively remember together.

When I tell people that I specialize in geropsychology, they often ask how I became interested in working with older people. Most people assume there must be a story behind this career choice and I believe for most of us there is. Today, I'd like to share a bit of my story and how it influenced me.

My family moved from Colorado Springs to western Michigan when I was four years old. I remember my first day in Michigan. Actually, it would be more accurate to say that I remember snippets of my first day in Michigan. That's usually how memory works. I remember wearing Wonderbread bags on my feet. In an effort to keep my feet dry, my mother pulled them onto my feet before I slid them into my green rubber boots, which I wore to walk across the wet, snow covered yard to meet our new neighbors. This breadbag method worked for about 10 yards, until I stepped into a snow covered drainage ditch and found my boots and the breadbags submerged in melting snow and icy water. Forty years later and I still remember my first experience of Michigan. Flashbulb memories – brief, vivid memories that stand out in the continuous recollection and reconstruction of our life stories. The brain holds onto these memories because of their emotional importance or perhaps due to incidental activation of the amygdala. I can't imagine why Wonderbread bags would be emotionally important, but there it is. Ask my amygdala.

The four of us adapted slowly to lake effect snow and bitter winters. We missed Colorado and waited in eager anticipation for our first return trip to visit our grandparents in Denver. Colorado is an easy sell for young boys who enjoy being outdoors, but my grandparents made it even more

appealing. They took us fishing in the mountains, climbing in the park, and helped us build chairs, tables, and other assorted wooden objects in the backyard under an old apple tree.

My recollections of these visits center around my grandfather. Grandpa was a strong man with gigantic hands, which he used effectively as a boxing champ in the Army and later as a plumber. Hands were important. He had the same routine that he repeated each year. "Hold up your hands!" he'd call out as we climbed out of the car. Pressing his rugged hands against ours, he'd declare "Getting pretty big!" This would inevitably be followed by shadowboxing and laughter. I also remember the smell of Camel cigarettes on his breath when he put us to bed at night and the way he occasionally switched into Dutch, muttering and laughing at jokes only he understood. Another flashbulb memory.

As we grew older and busier we lost interest in making the twenty-four hour drive to see my grandparents. The distance didn't seem reasonable to teenage boys or their increasingly worn out parents. On the other hand, my grandparents hadn't lost interest, and soon began a new tradition of making an annual trek to see us.

I forget when they first made the trip, but I remember standing with the family in our kitchen while we caught up. Grandpa asked my brother questions that he reluctantly answered. Where you working this summer? You got a girlfriend? You still playin' ball? This was typical grandparent interrogation and I was up next. He asked me a few short questions and soon returned to my brother. You have a job this summer? One more flashbulb memory.

Repetition is a normal part of life. We love repetition. We'll listen to a favorite song or poem many times over, sometimes several times in a row. We share stories with family or close friends over and over, and some stories feel like they'll never get old. Repetition forms habits, skills and leads to adaptation and efficiency in behavior and thought. Most of the time, repetition is welcome, necessary, and helpful. But, there are moments where repetition is unwelcome and strange. Misplaced repetition breaks up the rhythms of life and conversation that were established by years of well-placed, intentional repetition.

When grandpa started repeating himself, we weren't sure what to think but it didn't seem right or welcome. Maybe it was okay for grandpa to repeat the hand comparison routine each year when we met, but repeating something every five minutes felt odd, and even a little scary.

We looked to my father for cues, and in hushed voice he told us to speak up. He was our dad and grandpa was his dad, so we did what he said. Moreover, hearing problems were a reasonable explanation and grandpa sometimes wore hearing aids, so speaking clearer and louder made sense. We tried, but it didn't help. Repetition. Speaking even louder. Repetition. Almost yelling. More repetition.

We weren't holding his attention, or so my father said. Grandpa was asking the question and then getting distracted before we could answer, so we might try holding his attention before answering. The suggestion seems absurd now. I can't recall how we attempted to do this, but I remember it didn't work. He kept at it with the same questions, the same anecdotes, and the same confusion over and over.

As I look back now, I wonder whether my dad already understood that something else was happening with his father – something was looming that was more difficult than hearing loss or distractibility. But, the visit ended and we moved on. We didn't talk about grandpa's repetition again. The next summer brought a replay of the previous visit. We tried to speak up, we tried to be more engaging, but we encountered more repetition and confusion. Not much changed over the following years, except that my grandparents visited less often and we never returned to Colorado as a family.

I was sitting in a college literature class distracted by the tingling of frost bitten toes when someone interrupted with a knock at the door. The professor stepped out and then stuck his head back in asking me to come with him into the hallway.

“You need to call your Dad. Your grandfather has disappeared.” Yet another flashbulb memory.

Grandpa had been a union plumber for most of his working life. He never finished 8th grade, so he would never have used these terms, but being part of the union and working with his hands as a plumber was an important part of his identity and a central component of his self-concept. It mattered to him. Although he had recently retired, he continued to drive into downtown Denver each Tuesday to his union meeting to be with the other plumbers. I like to imagine him sitting there each week smoking a few Camels, repeating himself, and asking the younger plumbers to hold up their meager hands against his.

Whatever he did during those weekly meetings didn't matter on that day. What mattered most was that he didn't come home. He wasn't there at the usual time for dinner. My grandmother's annoyance turned to fear as the dark of night came. Police were called. Searches commenced. My father flew in from Michigan and his brother drove down from the mountains. As the sun rose the next morning, there was still no sign of him.

Anxious uncertainty hovered over the family throughout the morning until the phone rang at my grandparents' home. I imagine my grandmother rushing to the phone desperate to hear her husband's voice. Instead, it was the sheriff who spoke. You might wonder whether an urban metropolis like Denver has or needs a sheriff, but that is irrelevant because this man was the sheriff of Bird City, Kansas. Not much is known about Bird City in our family except that it is about 200 miles from Denver and this is where they found my grandfather.

We don't know what happened when grandpa left the house the day before. We aren't sure whether he made it to the union meeting, and the rest is even less clear. What we know is that on Wednesday, my grandfather drove his Chevy Citation to a small farmhouse, parked in the driveway and walked into the house. The old widow who lived in that house heard the door swing open and shut. As she peered around the corner, fearful of what she would find, she saw an old man already resting comfortably in the living room recliner. He must have been exhausted from driving, maybe circling most of the night. By the time she got up the courage to approach him, she found him already asleep.

The rest of the story is likely a familiar one to many of you. A battery of diagnostic tests, brain imaging, blood draws, and eventually an autopsy to confirm what we failed to recognize and accept – my grandfather had been living and eventually died with Alzheimer's disease.

We are a unique blend of the personal and professional. These experiences with my grandfather left a deep impression on me, and so two years later when I was offered the opportunity to work with people who had dementia at an adult day center, I eagerly accepted. As I look back, it was the people at this center who influenced me most powerfully and led to my career in geropsychology. I spent long days with people who were experiencing a wide variety of dementias. We did everything together, from trips to the bowling alley or Ryan's Steakhouse, all the way down to the most basic of activities of daily living. Although they had cognitive change in common, their individual life stories and the ways in which their individual psychology influenced the expression of their dementia was entirely unique to each person.

Charlie was the former executive consultant who taught me the value of entering into the subjective world of people, despite their confusion and forgetfulness.

Edith taught me about perseverance and unspoken grief, which emerged only when the demands of life exceeded her emotional capacity.

Ray asked 10-20 times per hour when his wife was coming to pick him up, which taught me something about short-term memory, but even more about his wife and his love for her.

Gertrude taught me patience and gentleness, and how words don't have to always be clearly articulated as long as they are genuine.

Willie had severe dementia, but he also couldn't see or walk. Despite his limitations, he taught me about faith, hope and love.

Carl gave me a right hook to the jaw and taught me how "problem behaviors" can be meaningful attempts to communicate unmet needs.

Working with and learning from these people led me to geropsychology as a career path and eventually to Wayne State University where I was influenced by my mentor and friend Peter Lichtenberg. Peter has had a decorated career as a scholar, leader, and mentor. In fact, tomorrow night he is receiving the APA Division 20 Powell Lawton Award for his contributions to the field. I won't take up your time explaining what many of you already know – that Peter is a wonderful colleague and leader in clinical geropsychology. I would like to simply add a more generalizable point as it pertains to career pathways and influence – there is nothing more valuable to students and emerging geropsychologists than having someone in the field who believes in you, invests time and energy into you, and who provides opportunity. Without Peter I'm not sure I would have remained in the field of geropsychology. My grandfather and adult day center friends with dementia gave me inspiration and motivation, but I needed mentoring.

Peter also introduced me to the broader community of geropsychologists at APA and GSA meetings. Cameron Camp, Jenny Moye, Victor Molinari, Sara Qualls, Barry Edelstein, Margie Norris, and Michele Karel were just a few examples. When I was a student, these geropsychologists checked in on me, talked with me about my research, and encouraged me in my development as a geropsychologist. There is something special about aging and the specialty of geropsychology. In my opinion, this is reflected in the people we serve and the colleagues we work with.

Many people have influenced who I am as a geropsychologist – my grandfather, people at the dementia day center, Peter, and many other colleagues who took time to invest in me - I can see the influence of these people in my research and scholarship, my approach to assessment and intervention, and in my teaching and mentoring.

Today, I encourage you to reflect on how you arrived to this point in your geropsychology career and ask you to share it with others who might need your investment and encouragement as they seek to find their way. This might mean speaking with a group of students, or spending time with an established colleague who would like to a geropsychological component to their practice. I hope SCG will continue to consider how we can invest in and inspire a new generation of geropsychologists. Our stories matter and when we share them with others, we can help them envision the way their stories and experiences might lead to meaningful work in the field of geropsychology.

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- That the Society is on Facebook?
 - Open to all members: <https://www.facebook.com/ClinicalGeropsychology>
- That all the archived newsletters are available on the Society website?
 - Current newsletter: <https://www.geropsychology.org/current-newsletter/>
 - Archives: <https://www.geropsychology.org/newsletter/>
- 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.

Note: Some content herein has been edited for brevity and clarity.

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