Clinical Geropsychology News

Winter/Spring 2003 *APA Division 12, Section II* Volume 10, Number 1

President's Comments:

Victor Molinari, Ph.D.
University of South Florida

As the new president for Section II, I hope I can continue my predecessors' tradition of strong and educated leadership. We will need it to transform the significant challenges we face as an organization into opportunities for professional growth. We were recently apprised that clinical geropsychology has been denied approval by the APA College to develop a certificate of proficiency due to what appears to be 'marketing' concerns. Our organization must determine how to proceed - whether to seek specialty status via the American Board of Professional Psychology, to develop a 'vanity board' to certify ourselves, or perhaps to issue geropsychology certifications after a certain number of APA-approved CE credits have been completed, etc.

Although we have some committed staff members in APA and professionals in CONA tirelessly promoting an aging agenda, it is clear that it will be up to Section II to propel ourselves forward. Whether this task will be accomplished by remaining a section or becoming a separate division is a question that will require open debate by all constituencies of the clinical geropsychology community.

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

Society of Clinical Psychology (Division 12): Fall Board Meeting Summary

Deborah King, Ph.D., Section II Representative

The meeting was held in St. Louis, October 19th & 20th. Selected points of interest are summarized below:

Divisions, Sections, and APA Relationships: Guests Kurt Salzinger, Ph.D. and James McHugh, J.D. discussed with the Board the issue of Section III advocating against the bill for prescription privileges for New Mexico. The major point emerging from the lengthy discussion was that advocating against prescription privileges outside of APA is not permitted. The Council of Representatives voted in favor of prescription privileges for psychologists making it an APA policy. It was clarified that divisions and sections are not separate entities from APA and that all of APA is liable for whatever happens in its divisions and sections. Groups can dissent only within the structure of APA (i.e., through their own boards and the Council of Representatives).

Membership: 2002 membership of Division 12 was 5004, representing a net loss of 500 members. Larry Beutler sent out a letter to new APA members pointing out the advantages of membership for both practitioners and scholars. As the Section II representative, I suggested that the Board develop a strategy for engaging students more actively in Division 12 committees (a strategy that has worked well in Section II).

2003 Convention Program: Some "big star" sessions at the 2002 convention were well attended, although the Presidential address, business meetings and section addresses were less well attended. There was discussion about the impact of Cluster Programming, as well as inconvenient hotel locations on the low turnout at some meetings and presentations. Section representatives pressed for increased programming and asked to have Section program hours (including business meetings) published in the Program. Dan McNeil, the new Division 12 Program Chair, indicated his intention to be responsive to these concerns (and since this discussion Section program hours have been increased modestly from 2 to 3 substantive hours).

Budget: Consistent with budget difficulties across APA, the Division 12 budget will go into reserves this year and projections for subsequent years reveal dwindling revenues. There was considerable discussion of potential cost cutting measures (e.g., changing Division publications to electronic format, having fewer Board meetings) and means of increasing revenue (e.g., raising dues). These issues were not resolved but moved to committees or future board meetings for further thoughtful consideration.

APPIC Liaison: Nadine Kaslow encouraged members of the Board and Sections to nominate clinical psychologists to serve on the APPIC Board and committees.

Clinical Psychology in Schools: Division 12 has a list of individuals who are interested in forming a Section on Clinical Psychology in the Schools. Those on the list will be contacted to determine if someone is willing to assume leadership in this effort.

New Leadership: Larry Beutler thanked the Board for the "memorable experience" of his presidency and turned the gavel over to Diane Willis, who announced that the theme for her presidency would be "Best Practices for Special Populations."

Next Meeting: January 10th-12th in Sante Fe, NM.

APA Committee on Aging & Office on Aging Update

Deborah DiGilio, MPH, APA Aging Issues Officer

I would like to update you on a sample of the activities we have been involved with during the past year:

Local Medical Review Policies (LMRPs) Tool Kit: It is in its final revision stage and should be available on the Aging Issues web page in early spring. Components will include an explanation of Medicare LMRPs and their development process, opportunities for advocacy, and tools such as samples of correspondence with insurance intermediaries, "pro-psychology" LMRP provisions, and empirical evidence to support incorporation of such provisions.

Graduate Training in Geropsychology (GTG) Appropriations Initiative: The goal of this initiative, which is a collaborative effort of the Education Policy Office and the Office on Aging, is to secure the allocation of funding in the FY 2003 Labor, HHS and Education Appropriations bill for the Graduate Psychology Education (GPE) Program in the Bureau of Health Professions, with a $3 million set aside for training in geropsychology. This past fall, the Senate did include $5 million in its appropriations bill with $3 million allocated to support geropsychology. Unfortunately, the final deliberations for the FY 2003 Federal appropriations were postponed until the 108th Congress in 2003.

Promoting The Contributions of Geropsychology: This year, we have secured the representation of geropsychology (mostly members of 12-2) in a variety of important efforts including:

- Suicide Prevention in Later Life: An NIH Scientific Consensus Process
- The Aging of America: Implications for the Health Workforce sponsored by the Bureau of Health Profession at HRSA and the Center for Health Workforce.
- The National Institute of Mental Health's Workshop on Career Development and Training in Geriatric Mental Health - focusing on the need for researchers in geriatric mental health
- *American Geriatrics Society* - Improving the Quality of Mental Health Care in America's Long-term Care Facilities: Management of Treatment of Depression and Behavioral Disorders Associated with Dementia. We are currently seeking APA endorsement of the consensus statement.
- President's New Freedom Commission on Mental Health: APA's initial statement to the Commission was substantially modified in its draft phase to more fully include the mental health needs of older adults. I also presented APA comments to the Commission at its meeting that focused specifically on mental health and older adults.

The APA Committee on Aging welcomes new members: John Cavanaugh and Greg Hinrichsen. Their terms are from 2003-2005. We say a fond farewell to Bob Knight and Martita Lopez. CONA's chair for 2003 is Forrest Scogin.

It continues to be a pleasure working with you all. For more information on any of the above, or to share your thoughts, please contact me at (202) 336-6135 or ddigilio@apa.org.

Profile On...*Dolores Gallagher-Thompson, Ph.D., ABPP*

Professor of Research, Department of Psychiatry and Behavioral Sciences
Stanford University School of Medicine; Director, Older Adult & Family Center,
VA Palo Alto Health Care System

I began my career as a practicing geropsychologist, having obtained my Ph.D. degree in clinical psychology (with a minor in Adult Development and Aging) from the University of Southern California in 1979. I became licensed in 1981 and moved to northern CA at that time, as the first coordinator of an interdisciplinary team training program in geriatrics and gerontology at the GRECC (Geriatric Research, Education and Clinical Center) of the Palo Alto Veterans Administration (VA) medical center. That was a very exciting job -- one of the first of its kind in the VA system -- which enabled me to develop the role of psychology (and illustrate the various contributions to diagnosis and treatment that psychologists can make) in a medical setting where team treatment of elderly patients was just beginning. At the same time, my husband, Larry W. Thompson, Ph.D., joined the Stanford faculty and the same VA and established the Center for the Study of Psychotherapy and Aging there. For the next 10 years we collaborated on a series of clinical research programs designed to test the efficacy of various forms of time-limited psychotherapy for the treatment of late-life depression. Over that period

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Division 12, Section II (Clinical Geropsychology) Distinguished Clinical Mentorship Award

*N*ominations are sought for the Division 12, Section II:Distinguished Clinical Mentorship Award. The purpose of the award is to recognize clinical geropsychologists who have played important roles in the clinical supervision of psychology graduate students, interns, and/or postdoctoral fellows who provide services to older adults. It also recognizes individuals who have played mentoring roles for graduate students, interns, and fellows interested in a career in clinical geropsychology. Nominations can be made by members and student members of Section II. Nominees must be a member of Section II. Nominations should be accompanied by letters from at least three current/former supervisees attesting to the abilities of the nominee as a supervisor/mentor. Previously submitted nominations will remain active for a total of three years but materials may be updated at the discretion of nominators.

Nominations must be received no later than March 31, 2003 and may be sent to:

William E. Haley, Ph.D., Chair, 12/2 Awards and Recognition Committee, Department of Gerontology, SOC 107, University of South Florida, Tampa, FL 33620. Email: whaley@chuma1.cas.usf.edu

*Congratulations! to member *Dr. Julia Kasl-Godley*, who will be receiving the Theodore Blau Award at the 2003 APA Convention in Toronto. More to come in the Summer 2003 issue.

Psychological Health Care

Ronald F. Levant, Ed.D., M.B.A., A.B.P.P.
Nova Southeastern University
APA Recording Secretary

From my current vantage point as both a dean of a graduate school of psychology and an officer of the American Psychological Association, I have a unique opportunity to reflect on the evolution of professional psychology. The scope of psychological practice is expanding and diversifying into new areas -- areas where the distinction between applied scientist and professional practitioner begins to blur -- such as geropsychology, health psychology, neuropsychology, rehabilitation psychology, forensic psychology, child and family psychology, multicultural psychology, business and industry consultation, and psychopharmacology. It cannot be emphasized enough that the future evolution of professional psychology will entail the development of roles that do not now exist - in health care, public sector care, the courts, the correctional system, schools, businesses, etc. - in the numbers that psychologists entered the role of outpatient therapists in the 1970s and 80s.

In this column I want to highlight the new opportunities for expanding the roles of professional psychologists in psychological health care.

One of the most important aspects of the evolving nature of professional practice is the redefinition of psychology from specialty mental health care to primary health care. As a

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Division 12, Section II (Clinical Geropsychology) Student Research Award

Graduate and post-doctoral students may submit a completed project relevant to clinical geropsychology for the Division 12, Section II Student Research Award. The award ($250 and a plaque) will be presented at the 2003 APA meeting in Toronto during the Section II business meeting. The award recipient also will be invited to appear at the Division 12 awards ceremony. Submissions will be accepted from student members of Section II and from students of members of Section II. Manuscripts should be up to 30 pages of text, plus tables and references. The manuscript should include contact information for the student as an Author Note, including email, telephone, and mailing address. Manuscripts that are being presented as posters or in symposia at the APA convention will be accepted and are encouraged; please let us know if the manuscript you submit is being presented.

Deadline for receipt of submission is March 31, 2003. Send the manuscript as an email attachment (preferred), or mail three copies, to:

William E. Haley, Ph.D., Chair, 12/2 Awards and Recognition Committee, Department of Gerontology, SOC 107, University of South Florida, Tampa, FL 33620. Email: whaley@chumal.cas.usf.edu

The Student Voice

Laura Lee Phillips M.A.

As your new junior student representative I wanted to introduce myself and tell you a little bit about how I became interested in geropsychology. I began my college career as a psychology major with aspirations of getting my doctorate in clinical psychology and working with children and families in private practice. I finished my bachelor's degree at the University of Evansville in Indiana in fall of 1999. I returned home to Colorado Springs, Colorado and began working full time as a mental health technician at a residential sex offense treatment program. This one experience, if nothing else, convinced me to continue my education so that I could do something more with my degree in psychology and make a "real" difference in the lives of others.

In the fall of 2000, I began working on my Masters degree at the University of Colorado in Colorado Springs. I began to work with Sara Qualls because of her interest in families. At that time, I was still intent on working with families and children. My interest in studying the problems facing older families grew. I then decided to take a practicum placement working strictly with older adults. My practicum lasted a full year, in which time I discovered how much I loved working with older adults and decided that I wanted to work exclusively with this population.

I then applied to graduate school, with the goal of becoming an applied clinical researcher, instead of a clinician. This change was almost 180 degrees from where I started two short years ago. Since I have made this change, I couldn't be happier. Currently I am pursuing a Doctorate in Clinical Psychology, in the Adult Program at the University of Alabama with a specialization in geropsychology. As Becky Allen's student, I have been working on end-of-life issues and I am pursuing research regarding end-of-life issues within the prison system. As Dr. Allen's student, I have been involved with updating the Section II website and gladly welcome any suggestions for improving the site! In addition to being a research assistant, I have been working at the newly developed Center for Mental Health and Aging (CMHA) at the University of Alabama developing seminars to teach caregivers skills to ease the burden of caregiving for older family members.

Now that you know a little more about me personally, let me catch you up on the progress of Section II from the student's perspective. The two meetings of the Board that I have attended (APA & GSA) have focused on long-term planning for Section II and what goals are important to members. Beyond this large focus, there has been a lot of discussion about membership – both how to retain and attract new members. As a student, I would like to see an increase in student membership. Although student membership in Section II is growing, there is a constant effort to invite new students to join. In the past, listserves have been the primary means of getting the word out to students. But, new ideas are needed for helping students find Section II. After talking with other students at APA and GSA, I realized how few students know about the field of geropsychology when they are undergraduates or even in their first year of graduate school. As a result, I would like to try to advertise Section II to undergraduates who show promise and who are interested in pursuing graduate school. The mechanics of how to find these students are being worked out. I would welcome any new ideas you may have!

In closing, I would like to ask everyone to consider what it is they would like from Section II, what would make it better for you as a student and what you would like to give back to the Section. Please do not hesitate to contact me (phil1094@bama.ua.edu) or Sherry Beaudreau (sbeaudreau@hotmail.com) with ideas, questions or just to introduce yourself!

President's Comments, continued from page 1

We are all aware of the statistics reflecting the aging of the population and the critical need for mental health services by trained providers, particularly for the oldest-old in long term care settings. Although there is a growing number of internships and post-doctoral programs offering geropsychology rotations, there are still few graduate programs that offer geropsychology specialization. At a time when this Section has been trying to encourage professional psychologists to become involved in working with older adults, there remain limited APA-sponsored continuing education offerings in geropsychology. There seems a consensus opinion that switching some of our efforts away from the national level towards state association venues may yield dividends in terms of satisfying geropsychology CE needs (particularly for non-APA member practitioners not originally trained in geropsychology who we want to return to the fold).

At our last meeting, past-president Sara Qualls invited board members to set short and long term goals for this organization. What should we be doing now to accomplish those things that we would like to be doing in the future? One of the issues discussed relates to a plateau in membership rolls. Although I certainly do not think that growing numbers are invariably yoked to the success of an organization, I think it is all too clear that APA, Division 12, and Section II should have far more members than we currently do. It is obvious that many practice-oriented psychologists working with older adults are not joining APA (and may not even be aware of our section). We need to determine a way that Section II publicizes our work outside of APA, makes research findings relevant for practitioners in the field, and draws clinicians into active participation. I think the Public Policy efforts of treasurer Margie Norris and president-elect Paula Hartman-Stein, and the LISTSERVE Webmastery of Barry Edelstein have been effective ways of reaching out to our membership to assist in the ever-evolving definition of our mission, and perhaps of informing Division 12 of the important policy agendas facing geropsychology practitioners.

I ask all members to work with the Board in forging our future rather than being passive spectators to an APA spectacle that at times appears submerged in arcane bureaucracy and unresponsive to the needs of a proficiency/specialty poised to emerge. I thank Sara Qualls for her judicious leadership in the past year. Although the challenges are both chronic and systemic, we are equipped to manage the task. Our strength is a remarkably well-informed and conscientious executive board and membership rolls that include the very best in geropsychology education, research, and practice.

Remember.....
Renew your membership for 2003.
Look for your dues renewal notice *in the mail* January 2003.

Profile On...*Dolores Gallagher-Thompson, Ph.D., ABPP,* continued from page 4

three separate randomized clinical trials were conducted with significantly depressed geriatric outpatients which indicated the superiority of cognitive-behavioral therapy (CBT) over other forms of treatment to which it was compared (e.g., time limited psychodynamic therapy). Not only were short-term improvements greater, but gains were maintained longer, with fewer relapses into major depression, among those treated with CBT. The most recent study was a comparison of CBT alone, an antidepressant medication (desipramine) alone, and both in combination. Results, with close to 100 depressed outpatients, indicated that CBT alone was superior to the drug alone, and there were no significant differences between CBT alone and the combination treatment, again supporting the efficacy of CBT with the elderly. At the same time, I was developing my teaching career at Stanford, having taught the first undergraduate course in Aging there (for the Program in Human Biology) for several years and then serving for 3 years as a Visiting Associate Professor in the doctoral level Counseling Psychology Program at Stanford's School of Education. I really enjoyed these teaching opportunities and have mentored many undergraduate and graduate students throughout the years as a result of these opportunities.

At the same time, I continued as a psychologist for the Palo Alto VA, with a primary focus on developing educational programs in geriatrics and gerontology for the GRECC, as well as providing direct patient care to depressed older adults and their families. I became the GRECC Associate Director for Education -- a position which I held until my retirement from the VA in June, 2002. In that role, I was fortunate to be able to allocate a considerable amount of time to my own research as well. By then my own line of research was clearly emerging: namely, intervention studies with family caregivers. For the past decade that has been my main focus -- based on my personal experience trying to provide long-distance care to my mother who was disabled from several strokes and who needed far more help than either I or the "system" could give at that time. This spurred my desire to study how to provide psychotherapeutic services to distressed caregivers in a manner that would be acceptable to them and allow them to participate in treatment. This led to the development of a variety of psychoeducational programs that have been effective in accomplishing those goals. In fact, I have been the recipient of a number of grants from the National Institute on Aging and the national office of the Alzheimer's Association to study the efficacy of this approach. The psychoeducational programs we developed were based on CBT principles and techniques but were created by our research group (at the Older Adult and Family Center of Stanford Univ. and the Palo Alto VA) to address the specific psychological problems common in caregivers, such as depression, guilt, anxiety, and frustration. A series of treatment manuals were written (based on findings from these studies) that are in use in other caregiver research centers both in the US and in Scotland and Japan as well. We then took the most successful stress reduction methods from the earlier work and modified our approach in various ways so that our newer psychoeducational programs are tailored to meet the needs of ethnically diverse caregivers, and can be delivered in several different languages. For the past five years or so, these intervention studies have included non-Caucasian caregivers (e.g., Hispanic/Latino, Chinese, and African American individuals). Results with Hispanic/Latino caregivers (the only group for which we have a sizeable N at this time) are very encouraging. In fact, in our most recent investigation, Latina caregivers benefited more from the psychoeducational program we offered than did their Caucasian counterparts -- a

finding for which there is no immediately obvious explanation. This then led to the generation of new research designed to study various mediators and moderators of stress in ethnically diverse caregivers -- on both physiological and psychological levels. In this latest project I am part of a group of investigators, led by David Spiegel, M.D., who are studying HPA axis dysregulation in individuals undergoing chronic stress. It is anticipated that this study will provide valuable information about the "mind-body connection" as it pertains to family caregiving among various ethnic and cultural groups, and will generate many other ideas to guide future research.

Recently, I was promoted to full Professor (Research) in the Department of Psychiatry and Behavioral Sciences at the Stanford University School of Medicine. In this capacity my principal duties are to conduct the various research programs that are currently ongoing, as well as to generate new research inquiries. I am also very fortunate to be able to continue training psychology interns and post-doctoral fellows, as well as psychiatry residents, in CBT and in the design and implementation of clinical research with diverse populations. I have been privileged to co-author a recent book (with Castleman & Naythons) entitled: "There's Still a Person in There" which is a lay person's guide to dementing disorders and to caregiving stress and well-being. I've also co-edited (with Coon & Thompson) a new release entitled: "Innovative Interventions to Reduce Dementia Caregiver Distress: A Clinical Guide" which has received very good reviews from those who have already begun to use it. I am also co-author (with Laidlaw, Thompson & Dick-Siskin) of a forthcoming volume on CBT and the elderly, which will be published by Wiley in the next month or so. I have been asked to edit a book on caregiving among various Asian American groups and intend to make that my next writing project for the new year!

In addition to these scholarly activities, I find time to pursue my interest in physical fitness and wellness -- I am a (very) part time fitness instructor and make it a point to exercise every day (to preserve my sanity!) and to encourage other "older adults" (i.e. those over the age of 50) to do the same. I believe that by promoting physical, mental, and spiritual well-being, we can live long, productive, happy, and healthy lives - and I'd like to be one of those who succeeds in achieving that goal!

Anyone interested in learning more about the ongoing research briefly mentioned above should feel free to contact me by email or phone: delorest@stanford.edu, or, 650-493-5000 ext. 22005. I would also be glad to hear from any potential students, interns, or post-doctoral fellows who would like to contact me about opportunities in the future. We are always seeking qualified, competent, and, when possible, bilingual/bicultural individuals to join our research teams.

Psychological Health Care, continued from page 5

specialty profession of mental health care, we deal primarily with the people who self-identify as having psychological problems and who have access to a mental health specialist, which is just a fraction of those who need psychological services. As a primary health care profession we would be able to serve the much larger group of people who do not have access to mental health care or who do not identify their problem as psychological. To grasp this potential, please consider a few facts about health care:

1. The U.S. Department of Health and Human services has pointed out the seven top health risk factors - tobacco use, diet, alcohol, unintentional injuries, suicide, violence, and unsafe sex - are behavioral
2. Seven out of the nine leading causes of death have significant behavioral components.
3. At least 50% (and maybe as much as 75%) of all visits to primary care medical personnel are for problems with a psychological origin (including those who present with frank mental health problems and those who somaticize) or psychological component (including those with unhealthy lifestyle habits such as smoking, those with chronic illnesses, and those with medical compliance issues).
4. There is a growing body of empirical evidence supporting the effectiveness of psychological interventions in ameliorating a wide range of physical health problems, including both acute and chronic disease affecting literally every organ system and encompassing pediatric, adult and geriatric populations. In addition to being clinically effective, these interventions are dramatically less expensive than alternative somatic interventions across a wide variety of illnesses and disorders, including cardiovascular disease, diabetes, traumatic brain injury, etc.
5. The vast majority of people receiving mental health treatment are cared for by medical professionals with minimal specific training in mental health.

The Cartesian world view, which separates mental health from physical health, is breaking down, and as a result psychology has a tremendous opportunity to evolve into a premier primary health care profession. At the very least this would put psychologists on the front lines of health care, working collaboratively with physicians and nurses. The more visionary perspective is that health care should be reorganized so that psychologists serve as primary caregivers at the gateway to the health care system, functioning to diagnose and treat the more prevalent psychological problems, and referring to medical physicians when indicated.

All of this suggests a huge potential market for psychological services in health care systems. In order to access these opportunities, however, psychology must define itself as a health profession rather than as a mental health profession. In fact, an APA Board of Professional Affairs Workgroup has recently called for a "figure-ground reversal" in professional psychology (APA, 2000). That is, rather than viewing itself as a mental health profession with health psychology representing a subset of its expertise, the group advocated a view of psychology as a health profession, with mental health as a subset of its expertise.

A serious limitation on psychologists' ability to participate in integrated care has been the absence of payment mechanisms to reimburse psychological services within general health care settings. Psychologists have not been permitted to bill under procedure codes such as evaluation and management of medical disorders, patient education, and preventative services. As a consequence, they were forced to bill under mental health codes, which are often inappropriate. Moreover, psychologists frequently do not have access to reimbursement for services provided to patients related to non-psychiatric diagnoses, even when these services are well accepted clinically and are strongly supported by the empirical literature. However, the recent approval of the Health and Behavior codes for psychologists will begin to address these problems.

As always, I welcome your thoughts on this article. You can most easily contact me via email: Rlevant@aol.com.

PROPOSITION:

IT IS PROPOSED THAT NON-APA AND/OR NON-DIVISION 12 MEMBERS BE ALLOWED TO BECOME SECTION II MEMBERS, IF THEY MEET ALL OTHER SECTION II QUALIFICATIONS.

This proposal was discussed by the Executive Committee and is seen as a means to broaden and strengthen Section II membership roles. There will be a formal ballot vote by Section II members after a comment period. Please address your comments concerning this *Proposition* to Victor Molinari, Ph.D. at: vmolinari@fmhi.usf.edu and/or on the listserv at: WVUGER-L@LISTSERV.WVU.EDU

TO SEEK OR NOT TO SEEK ABPP STATUS

Would you seek ABPP clinical geropsychology specialty status if one were available? Please address your comments concerning this Proposition to Victor Molinari, Ph.D. at: vmolinari@fmhi.usf.edu and/or on the listserve at: WVUGER-L@LISTSERV.WVU.EDU

Editors' Comments:

Michelle Gagnon, Psy.D.
Merla Arnold, R.N., Ph.D.

This is the first issue of a two-issue transformation of editorship from Michelle (Shelley) Gagnon to Merla Arnold. We will be working collaboratively on this and the Summer 2003 issues. Please forward any comments or suggestions to either Shelley (Mgagnon123@aol.com) or Merla (ma159@columbia.edu). As always, we appreciate the input of Section II members.

Prior to becoming Coeditor of Clinical Geropsychology News, Merla served as a Student Representative for Section II. The position provided a wonderful opportunity to participate in the work of the Section, on behalf of student members, while learning about the many issues that impact the work of clinical geropsychologists and students in clinical geropsychology. It is both a challenging and exciting time for the Section and the profession at large, as the articles within this issue attest. In this complicated health care environment, the sharing of ideas and information is as important as ever. As such, there is a strong commitment to maintain the Clinical Geropsychology News as an effective communication tool among Section II members.

Membership *renewal* notices will be mailed to Section II members in January. If you have any concerns, please contact Michele Karel (Michele.Karel@med.va.gov). *New Membership* applications will be included in this mailing. Please encourage students and colleagues to join Section II. As it has been said, there is strength in numbers.

OPPORTUNITY: If you would like to present your clinical geropsychology training site/educational program to Section II members via this Newsletter contact Merla Arnold, R.N., Ph.D. at: ma159@columbia.edu

Clinical Geropsychology News
Newsletter of Section II, Division 12, APA
Michelle Gagnon, Psy.D., Editor
Nova Southeastern University Geriatric Institute
4800 North State Road 7, Suite #F102
Lauderhill Lakes, FL 33319

Gregory A. Hinrichsen, Ph.D.
Psychological Services, Kaufman Bldg.
Hillside Hospital
75-59 263 Street
Glen Oaks, NY 11004-0038

11004+1150 33

Did you know....

- If you need to change your address for the newsletter, please contact Forrest Scogin, Ph.D. at e-mail: Fscogin@gp.as.ua.edu.
- Stay connected with your colleagues in clinical geropsychology by joining our e-mail network. Simply send an e-mail to Barry Edelstein, Ph.D. at barry.edelstein@mail.wvu.edu (Be sure to include your name, e-mail address, and express your interest in joining the 12/2 e-mail network).
- Division 12, Section 2 has a website, maintained by Becky Allen, Ph.D. Check in out at http://bama.ua.edu/~appgero/apadiv12.htm.
- Encourage your colleagues and students to join Division 12, Section II. Contact Michele Karel, Ph.D., Psychology Service, 3-5-C, Brockton VAMC, 940 Belmont Street, Brockton, MA 02301; e-mail: Michele.Karel@med.va.gov; or phone: (508) 583-4500, ext. 3725 regarding membership.