Clinical Geropsychology News

Section 2 of the Society of Clinical Psychology

APA Division 12, Section 2 **Volume 11, Number 3**

INSIDE

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President's Address: Geropsychology Practice, Advocacy, and Research: One Psychologist's Journey

Paula Hartman-Stein, Ph.D.

Thanks to all of you who have given me the opportunity to play a leadership role in this organization within APA; one that represents psychologists who work with older adults. Although I have been a member of Division 12, Section 2 for over ten years, I felt like an outsider until Sara Qualls and Bill Haley encouraged me to run for office. Now I feel accepted, valued, and have a deeper commitment to help advance the profession of Clinical Geropsychology. I struggled with the topic of this address. Then on June 25th an email message from Bob Knight with the heading of

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Public Policy Committee: Update

Donna Rasin-Waters, Ph.D.
PPC Chair

Our Public Policy Committee has moved forward with the Public Education Media Campaign by beginning to collect Expert Profiles from our members. I hope many of you will join the effort to reach the public with our research findings and clinical expertise. What better way to impact the field of geropsychology than to educate the public through local and national newspapers, television and radio shows! Please join the effort by becoming a media volunteer. Peter Kanaris, PhD has been regularly posting the media volunteer profile sheet with guidelines for how to fill out the form. If you are not on the listserv and would like a copy emailed or faxed to you, please contact Peter at DrPit1@aol.com. Angela Toia, PhD can be contacted to assist with editing and wording the information on your profile. She can be reached at AMToia@aol.com. Keep the profiles coming! We are aiming to have the project connected to our media service by the beginning of 2005.

In order to get ready for our public education media campaign I have arranged a workshop at the Gerontological Society of America's 57th Annual Scientific Meeting. It is important to note that the workshop content will cover all aspects of the media, including how to have contact with journalists who are writing articles on older adults. Please join us during the GSA Conference at the Marriott, Balcony B. for the *Media Training Workshop: Preparing for the Media Interview* with Rhea Farberman, APR, Executive Director for Public and Member Communications, APA. The workshop is being held on Friday, November 19, 2004 at 4:30-7 pm at the Marriott, Balcony B. Please RSVP to DrRasinWaters@aol.com or by phone 718.623.6291.

This workshop is designed to help psychologists, whether clinicians, researchers, educators or consultants succeed as spokespersons for psychology and their own work. The program begins with a classroom style discussion about how news media work and what media outlets want from news sources. Also covered will be the best way to prepare for an interview and how to develop message points for news interviews.

Interviews from national news programs will be reviewed and a select number of attendees will have the opportunity to participate in an on-camera "practice" interview. The interviews will then be discussed (gently critiqued) with the larger group.

Rhea Farberman, APR, the Executive Director for Public and Member Communications at APA, conducts the training. Ms. Farberman has worked as a media relations professional for 20 years representing academic, Federal government and non-profit entities to the news media. She is frequently quoted in the news media on psychology topics as APA's national spokesperson. Ms. Farberman earned a BA degree in Communications from the American University in Washington, DC and completed graduate studies at the George Washington University. She is an accredited member of the Public Relations Society of America.

In addition to our public education project, we hope to begin assisting members with information about Medicare regulations. Information, helpful resources and regulatory updates will be posted on our website. This will be a joint effort with 12/2 and PLTC. If you have resources in your Medicare region to tell us about or would

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APA's Committee on Aging and Office on Aging: Update

Gregory Hinrichsen, Ph.D., CONA Chair-elect

Committee on Aging (CONA) facilitated events went off smoothly at the APA convention in Honolulu. Geropsychologist Jennifer Moye and lawyer Charles Sabatino lead a well attended Conversation Hour on issues related to assessment of capacity in older adults. A companion symposium, *Assessment of Capacity in Older Adults: An APA-ABA Collaboration*, drew an especially interested and enthusiastic audience which snapped up all available copies of a draft, *Assessment of older adults with diminished capacity: A handbook for attorneys.*

This author and Leonard Poon convened the symposium which included Jennifer Moye, David Powers, and Charles Sabatino. We were especially pleased to have Robert Kinshcerff, chair of APA's Committee on Legal Issues, as a discussant. Some past and current members of CONA also had an opportunity to gather to discuss past and future directions for the Committee. Members discussed CRSPP's disapproval of an application by a group of geropsychologists for recognition of geropsychology as a specialty.

The ABA-APA Collaboration is moving full steam ahead. Jennifer Moye is doing final edits on the *Attorney Handbook* following review of the document by a focus group of practicing lawyers in a gathering at the American Bar Association this summer. Jennifer Moye received funding from the Borchard Center Foundation on Law and Aging to develop a related Handbook document for judges. There are current discussions among members of the ABA-APA project to submit presentations for 2005 APA and ABA conventions as well as find ways to bring to fruition other collaborative endeavors.

George Niederehe has been selected for this year's CONA Award for the Advancement of Psychology and Aging which recognizes psychologists and friends of psychology who have made significant contributions to the mission of CONA. The CONA award was presented to Dr. Niederehe at the October APA Fall Consolidated Meetings. The award was given to Dr. Niederehe in recognition of his critical role in the development of the field of geropsychology. He is commended for his creative leadership at the National Institute of Mental Health and his mentorship of students, fellows, and junior colleagues. The award also applauds his leadership role for the recognition of clinical geropsychology within APA including the establishment of APA Division 12, Section 2 and his tenacious advocacy in the development of the Guidelines for Psychological Practice with Older Adults. His broad perspective on scientific, clinical, and educational issues has enriched geropsychology.

CONA member Toni Antonucci has taken the lead on a new project, *Roadmap to Aging*. The goal of the project would be to offer middle-aged and older adults guidance in planning for late life including psychological, social, health, housing, work retirement, spiritual and legal concerns. CONA staff officer Deborah DiGilio crafted an application for foundation funding to support this project. There are hopes that the *Roadmap to Aging* project and Diane Halpern's Presidential Initiative on Retiring Psychologists can find avenues of collaboration to strengthen each of these projects.

As noted in prior columns, APA has been host to the National Coalition on Mental Health and Aging. The Coalition is beginning preparations for the 2005 White House Conference on Aging (WHCoA) which might include a mini-convention on

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Section 2 Executive Board Meeting Minutes, July 30, 2004

Forrest Scogin, Secretary

The meeting was held in conjunction with the 2004 American Psychological Association Conference. The meeting was called to order by Paula Hartman-Stein at 8:13 am. In attendance were Molinari, Arnold, Edelstein, Intrieri, Hartman-Stein, Raisin-Waters, O'Rourke, King, Norris, and Scogin.

Introductions - Paula Hartman-Stein. Norm O'Rourke was introduced as the new Website Coordinator and Merla Arnold as the new 12/2 Liaison to the Committee on Aging. It was determined that Merla would be reimbursed for costs associated with her trip to the Consolidated meetings (this is a new policy). The questions arose as to whether we need a liaison to the Mental Health and Aging Coalition?

Elections - Victor Molinari. Vic announced that Bob Intrieri was elected the new President-elect. Jon Rose was elected Treasurer. Vic noted poor voter response, only 37 members voted. How can we increase response?

Membership Committee - Bob Intrieri. Bob distributed a report. This report indicated 332 members. This is an increase in 91 from last year. The terrific efforts of Bob and others were applauded by the board. Bob indicated he will now focus on student recruitment. One way to do so will be by mailing recruitment material to pre-doctoral training programs. The membership database is in the process of being converted to Access. A membership directory will be made available by early 2005 in PDF format. The directory will be sorted by state, name, and interest area. Paula noted a problem with folks joining section but not getting services. Barry and Bob will investigate and remedy.

Program Chair - Barry Edelstein. Barry noted that 12/2 sponsored presentations are being well attended. Thanks also goes to Toni Zeiss for facilitating aging content as Program Chair for Division 12. Barry reported that the 12/2 dinner is a sellout. The section will pay for student members attending the dinner given the expense of attending APA. For future meetings, 50% cost sharing by students was suggested.

Treasurer Report - Margie Norris. Margie distributed a report. The current balance is $8,775. We have saved money by publishing the Newsletter electronically, but are still experiencing a decline in the overall balance over the past several years. Do we need to be concerned? Margie noted that a $7,000 balance might be a good minimum, as this represents approximately one year's expenditure.

Newsletter - Merla Arnold. Merla indicated that the ad placed in the newsletter generated a small income. Merla noted September 9th as submission deadline for next issue and distributed tentative outline. It was decided that Award Winners will get the Newsletter for one year and stay on the 12/2 listserv. Book publishers and health care industries will be approached about placing ads. Merla was applauded for her excellent work as Newsletter editor.

Secretary Report - Forrest Scogin. Minutes from the November, 2003 Executive Board meeting were submitted, reviewed and approved.

Division 12 Board Representative Report - Deborah King. Three new Graduate Student Awards have been announced by Division 12. Where possible, Section 2 awardees will be nominated for these and other Division Awards. Section 2 will be reciprocally linked to the Division 12 website. Deborah noted that our various efforts make it easy for her to make reports

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Meeting of the Div 12 Board of Directors, Las Vegas, Nevada, June 26-27, 2004

Deborah King, Ph.D., Section 2 Representative to Div 12

The following is an abbreviated summary of selected topics:

Nadine Kaslow's Presidential Theme and Activities (*Embracing the Diversity of Clinical Psychology*). The previously reported Presidential Announce-Only Listserv has been a vehicle for increasing communication within the Division and conveying a sense of inclusiveness for all psychologists and graduate students who identify as clinical psychologists. As announced on the listserv, Dr. Kaslow also made some changes to welcome/acknowledge student members with the development of three new graduate student awards: *The Distinguished Student Practice Award*; *The Distinguished Student Research Award*; *Distinguished Student Service Award.*

Winners receive a plaque, $200 (donated jointly by D12 and the Journal of Clinical Psychology) and complementary two-year subscriptions to both CPSP and JCLP. The deadline for receipt of nominations each year is July 1st. Awards are presented at the D12 Awards Ceremony at the annual APA meeting. Nominations should include a copy of the nominees' CV and two letters of support testifying to the nominee's accomplishments in practice, research or service. These should be sent to the Chair of the D12 Education and Training Committee, Beverly Thorn, via email: bthorn@bama.ua.edu or post: Beverly Thorn, Ph.D., University of Alabama, Dept. of Psychology, PO Box 870348, Tuscaloosa, AL 35487-0348.

It was decided at this meeting that the Division would sponsor a fund to support student activities, such as travel or additional awards. The D12 Education and Training Committee will be charged with developing the source and nature of this funding.

The Division is also interested in publishing a description of each of the students receiving awards from the sections. These will be put on the website and/or in *The Clinical Psychologist.*

Division Finances. Due to the reduction in the annual number of Division BoD meetings (from three to two) and fiscal restraint measures, the Division deficit is expected to be much smaller than in recent years.

Division Election Results. President: Gerald Davison; Secretary: Linda Knauss; Council Reps: Barry Hong and Annette Brodsky.

Division Membership. It was reported at the Division Leadership Conference that only four APA Divisions increased membership this year (all others lost members). It was suggested that retention of existing members is a greater challenge that recruitment of new members. Divisions were encouraged to stay in active communication with their members, soliciting input and reminding them of the benefits of membership. The Division was informed of the online survey conducted by Section 2 under the leadership of Paula Hartman-Stein. There was great interest in the results of this survey (especially regarding attitudes toward D12 membership). Nadine Kaslow indicated an interest in surveying all Sections to determine their views regarding membership in Division 12. The question was raised whether the Sections would consider having a link on their websites to allow members to join the Division.

Division Public Policy Workgroup. The formation of the Division Public Policy Workgroup was discussed and the Board expressed appreciation for the leadership

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Section 2 Sponsored Symposia at the 2004 APA Convention.

Barry Edelstein, Program Chair

Bill Haley chaired a symposium entitled *Bereavement and Grief Therapy: Beyond Conventional Wisdom and Clinical Lore.* The symposium provided state-of-the-art updates on bereavement research. The first presentation by George Bonanno, was entitled *Loss and Human Resilience.* He summarized recent research on trajectories of bereavement, utilizing studies that have followed older married couples prospectively through the process of bereavement.

The second presentation by, Robert Neimeyer, was entitled *Does Grief Therapy Work? A Cautionary Reply.* He reviewed recent evidence suggesting that psychosocial interventions for most bereaved people are far less effective than are most forms of treatment for a broad range of psychological problems, and might in fact be detrimental for many. Dolores Gallagher-Thompson commented on the presentations.

The second symposium, chaired by Barry Edelstein, was entitled *Suicide in Older Adults: Contemporary Considerations.* The first presentation, by Sylvia Canetto, was entitled *Cultural Factors in Older Adults' Risk and Resilience to Suicide.* She challenged the traditional theories of suicide among older European American men and discussed cultural factors associated with risk and resilience to suicide.

The second presentation, by James Werth, was entitled *What To Do When Clients Desire Death.* He addressed the complicated issue of how to consider the desire of older adults to hasten death through means other than what is traditionally considered "suicide." Methods were also presented for assessing client and situation variables that respect individual autonomy and permit the clinician to intervene if a client is deemed suicidal in the traditional sense.

The third presentation, by Paul Duberstein, was entitled *Suicide in Older Adults: How Risk Factor Research Can Inform Interventions.* He reviewed studies of late-life suicides and discussed reasons for inadequate treatment and prevention. An empirically informed conceptual model of suicide prevention was then offered. Marsha Linehan commented on the presentations.

Section 2 also co-sponsored a symposium with Division 22 (Rehabilitation Psychology) that was co-chaired by Cheryl Shigaki and Barry Edelstein. The symposium title was *Capacity Assessment Issues: From the Perspectives of Geropsychology and Rehabilitation Psychology.*

The first presentation, by Jennifer Moye and Michele Karel, was entitled *Evaluating Competency in the Complex Older Patient: Conceptual Models and Sticking Points.* The presenters provided an overview of conceptual issues, legal standards, and practice guidelines with a focus on the role of the psychologist. General strategies for using neuropsychological testing, specific capacity instruments, and clinical interviewing was discussed.

The second presentation, by Stacy Wood, was entitled *Presenting the Complex Capacity Client in Court.* She discussed the complex client in guardianship proceedings using two case examples. Topics addressed included the role of the psychologist in court, options for the client (limited versus full guardianship) and the type of information sought by the judge in these cases.

The third presentation was by Martin Zehr, entitled *Consulting with Attorneys About Capacity.* He addressed issues

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Value of Belonging to Clinical Geropsychology, APA's Division 12, Section 2: Online Survey Results.

Paula Hartman-Stein, James Luther, and Zachary Steiner

In the winter of 2004, Division 12, Section 2 (Clinical Geropsychology) of the American Psychological Association (APA) conducted a survey to get feedback from grassroots psychologists, who work with older adults, in order to evaluate what is currently beneficial about being a member of this professional organization and to help guide the future initiatives of the Section.

Survey methodology and description of sample. The survey was distributed over the Internet through approximately 10 to 12 listservs including state psychological associations, divisions, and sections of the APA as well as through one non-APA organization, Psychologists in Long Term Care. The survey, which was online for one month, received a total of 470 responses. However, 325 respondents completed the entire questionnaire. About 60% of the membership of 12/2 at the time of the survey responded to it, representing 44% of those who completed the questionnaire. Approximately 40% of the respondents were members of Division 12 of APA (Clinical Psychology).

Of the 470 respondents, 60% were female, 40% male, with the average age of 47. More than half of the respondents were doctorally-trained, licensed clinicians who provide direct service to older adults, with students comprising 14% of the sample. Almost equal numbers of the respondents work in universities, hospitals, and private practice. Twenty-five percent of the respondents worked exclusively in academic settings; most provided direct clinical services as well. More than half (56%) of the respondents were Medicare providers. One third of the sample are involved with gerontological research.

Clinical services offered by respondents. Forty-seven percent of the respondents conduct psychotherapy services, 41 % offer consultations to family or caregivers, 37% conduct cognitive screening, 27% provide health and behavior interventions, 24% engage in neuropsychological testing, and 11% conduct forensic evaluations involving older adults. Most of the participants who provided direct care services worked either in out-patient settings (31%) or long term care facilities (24%).

Current benefits of membership. Almost half of those surveyed (49%) found the opportunity to know other psychologists who provide clinical services or conduct research with older adults a current valuable benefit. The second most highly rated benefit was the listserv, rating it useful for information in several areas including clinical problems (47%), research citations (39%), and information about Medicare (35%). The third most highly ranked benefit of membership (44%) was the synthesis of evidence-based research for mental health treatment of older adults provided by a sub-committee of 12/2. The next most valued benefit, rated by 41% of the respondents, was the Newsletter. Many participants felt that membership offered them networking opportunities for ideas about clinical practice (38%), with an equal number of respondents (38%) perceiving membership valuable for public policy advocacy conducted on behalf of the Section for improved mental health services for older adults. One third of the respondents (33%) rated a decrease in professional isolation as a member benefit valuable to them, and about one third of the respondents value the effort 12/2 makes to network and combine efforts for advocacy with other sections of APA. At the time the survey was

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Profile on... Norman Abeles

About 15 years ago, when Norm was Director of Clinical Training and Director of the Psychological Clinic at Michigan State University, he decided on a new focus for his research and clinical training efforts. Prior to that, he was involved in process and outcome research in psychotherapy with an additional interest in clinical neuropsychology. It occurred to him that clinical neuropsychology and gero-psychology go very well together and he began involving his graduate students in mood and memory studies in community dwelling older adults, with an initial focus on subjective memory complaints.

Previously, he had established a Neuropsychological Specialty Clinic within the Psychological Clinic and he later started on a Memory Disorder Clinic. At that time, Norm was able to get a contract for all the geropsychological assessments at a local geriatric unit in a hospital. At the time, his students completed two geropsychological assessments per week for a total of about 70 during the academic year. Soon afterwards, he and his students were asked to look at the assessment needs of the State Veteran's Home in Grand Rapids Michigan. That facility houses about 600 veterans within a very attractive facility. We recommended that assessments be provided for the Veterans and the Social Workers made referrals to our psychological clinic. We have been doing these assessments for about 12 years or so and they are still continuing.

In the meantime, the clinical faculty encouraged the development of a neuropsychological track with emphasis on older adults. A number of students have received their doctorates in this and have gone on to postdoctoral training, and some have gone on to faculty positions. Among them are Natalie Denburg, a research scientist at the Department of Neurology at the University of Iowa and Phil Fastenau, who is a tenured faculty member at Indiana University-Purdue University Indianapolis.

In 1995, Norm was appointed as a delegate to the White House Conference on Aging by his congressperson. In 1997, Norm served as President of the American Psychological Association and his major focus was on aging. During his Presidency APA's Council of Representatives passed *Guidelines on the Assessment of Dementia and Other Cognitive Disorders* (this was prior to all the fuss there is nowadays about any kind of guidelines). During his Presidency, Norm appointed a task force to develop a brochure, *What the Practitioner Should Know About Aging.* 5,000 copies were published initially and another several thousand copies were published subsequently. Additionally, it was during Norm's Presidency that the Committee on Aging (CONA) was established. Recently Norm was recognized with that committee's first award for the Advancement of Aging.

While Norm was President of APA, he appointed Sara Qualls to chair the program efforts. Her very astute and successful selection of participants in various symposia and other presentations resulted in an edited book by Sara Qualls and Norm titled The Aging Revolution: How we adapt to longer life. This book was published by the American Psychological Association. In addition, Norm published an edited book on the Aging Revolution.

More recently, Norm was appointed to the Geriatric and Gerontology Advisory Committee to the Secretary of Veteran's Affairs. He is the only psychologist serving on that group. One of the activities of this committee is to review and evaluate Geriatric Research and Education Centers in Veteran's Administration facilities.

Norm has also been active on the International Scene where he is a member of

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Eye on Education and Training: Improved Quality of Life in Nursing Home Settings

Nanette A. Kramer, Ph.D. and Michael C. Smith, Ph.D.

A major objective of psychologists who work in nursing homes is to improve quality of life for the residents who live there. Most commonly, psychologists attain this objective by providing direct service to nursing home residents themselves, and sometimes to their families, in face-to-face psychotherapy. There is growing recognition of the importance of this work in both the clinical and research geropsychology literatures.

In addition to providing direct services, nursing home-based psychologists are uniquely able to offer valuable indirect services, such as consultation with staff, program development and in-service training, to help improve the lives of residents. To date, the value of these indirect services has been little recognized by potential funding sources (e.g., nursing home administrations, insurance companies) though it could be argued that they compare favorably in terms of long-run benefits and cost-effectiveness with individual psychotherapy. One possible reason for this lack of support is that there is not enough information available explaining their potential positive impact both on quality of life for residents and on practical benefits for the nursing home. Another possible obstacle may be the challenge of adding new programs into an environment in which staff are already stretched to the limit. Proposed changes in an institutional setting must also deal with the skepticism and inertia that are often prevalent there.

In this article, we describe a training program we developed, which aims to help nursing assistants deliver quality care to residents, and which incorporates elements to increase the likelihood of its utilization and success. The basic idea for the training program stemmed both from our years of observing nursing home settings and from a series of research studies we conducted with nursing assistants to learn more about how they feel about and manage the work-related challenges they face. The training program was based on our understanding that (1) nursing assistants provide the great bulk of face-to-face care to nursing home residents, more than all other disciplines combined, (2) the care they provide includes a large psychosocial component, which is greatly under-addressed in standard training or in-service programs and (3) nursing assistants are likely to deal better with the psychosocial challenges of their work when given an opportunity to discuss such issues with their peers and give as well as receive guidance and support.

The program comes in the form of a kit called *Working Together: Nursing Assistants Help One Another Manage Stress in the Workplace.* It is intended to provide training to nursing assistants to help minimize job-related stress so that quality of care can be maximized. The kit is intended primarily for those individuals (e.g., in-service directors) who will be carrying out the training and contains four booklets, each targeting a different source of stress on the job (stress of working with residents, stress of relating with family members, stress of interacting with co-workers and stress of handling personal problems while at work). Each booklet provides instructions for leading group discussions and has a number of training exercises as well as handouts for participants. Training is to be conducted in groups comprised of nursing assistants and a facilitator.

There were three major considerations in making this training program viable. First was relevance.

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The Student Voice: Gaining a New Perspective

Laura Phillips, M.A.
Student Representative

This last year, my school (University of Alabama) was chosen for a GPE grant to train students to provide services for older adults in interdisciplinary settings. The grant, directed by Forrest Scogin, Department of Psychology, has allowed my school to offer a special class educating students about caring for the older adult in various settings and training us to work with a variety of health care professionals. During the course of this class I learned about the many obstacles in helping those who were of lower socioeconomic status, chronically ill, or in rural communities (just to name a few!).

During this course, Dr. Zeiss, a consultant to the grant, presented a special seminar discussing the different types of multidisciplinary teams, and what the "true" meaning of interdisciplinary was. Dr. Zeiss explained that a truly interdisciplinary team only existed when the team had the final decision and decisions were not deferred to one person. Through this discussion she encouraged us to challenge our conceptualizations of interdisciplinary teams while helping us to identify specific ways psychologists can provide insight to the team, ultimately providing better care for the patient.

This led to the realization that truly interdisciplinary teams are rare, and though desirable, a multidisciplinary team was more likely. Multidisciplinary teams include a variety of specialists but the team, as a whole, does NOT make the ultimate decision regarding patient care.

Having given the students sufficient background for the setting and clients we would work with we (the nine students in the class) began our practicum experiences. I was fortunate enough to work at an urban health clinic and a rural health clinic both serving predominately low socioeconomic status patients. Although both settings were primary care, the types of patients encountered as well as the difficulties in navigating a multidisciplinary working environment were very different.

The urban clinic in which I worked was a large facility with several physicians, nurses and support staff. This clinic saw a broad spectrum of illnesses, though the patients were predominately African American, and among the older adults, chronically ill. Despite the large number of clients seen daily, the doctors were remarkably familiar with individual patients, and were able to provide good medical care.

However, when it came to making referrals for psychological services, or seeing that patients followed orders (especially psychological services), there was little follow through. This was largely due to the high volume of patients, although it was clear to me that efforts were made to achieve this gold standard of care. One major advantage this clinic had was its location. The clinic itself was within a short walk of publicly funded housing, the bus system, and had an additional shuttle service set up with the senior centers in the area, thus enabling the clinic to overcome the basic barrier to treatment – getting to the health center.

The next challenge was helping clients to see the value of treatment – for both physical and mental health. Clients were frequently noncompliant with medication regimens often due to monetary concerns but also because they "felt better." Overcoming the clients' perception of taking a pill to get better, or in other cases their refusal to take medications at all, was one of the largest challenges. A few clients did open up and agree to engage in psychotherapy with the psychology students and eventually word of mouth helped other

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Consider This: Evidence-Based Treatments and the Older Adult – Part 2

Adriana Coates, B.A. and Forrest Scogin, Ph.D.

A symposium at APA's 2004 Annual Conference provided participants with an overview of the work of the Division 12, Section 2's Taskforce on Evidence-based Psychological Treatments for Older Adults. The symposium covered the methods used to categorize treatments and the results from three of the work groups--depression, memory training, and caregiver stress.

The primary task involved was identifying relevant studies. Relevant studies included not only those showing beneficial effects of the tested treatment, but also any study showing that the treatment has harmful or null effects. For a particular study to be regarded as showing beneficial treatment effects, over 50% of the target problem post-treatment outcome measures must show both statistically significant treatment effects and between-group effect sizes (ES's) of at least .20.

Treatments were considered beneficial if there were at least two between-group design studies (studies comparing two or more separate groups of subjects) with a minimum of 30 participants across studies, representing the same age group, receiving the same treatment for the same target problem, with a prospective design (decisions about which treatment and control groups to compare, how participants are to be assigned to groups, and how outcomes will be assessed, must have been made prior to the onset of treatment and control conditions for any participant) and random assignment to conditions.

Additionally, findings must have shown the treatment to be better than the control or comparison condition or equivalent to an already-established evidence-based treatment (EBT) or, at least two within-subject or single-case design studies, with a minimum of 30 participants across studies, representing the same age group, receiving the same treatment for the same target problem, and with a prospective design.

Findings must show the treatment to be better than the control or comparison condition or, a combination of one or more between-group and one or more within-subject or single-case studies, with a minimum of 30 participants across studies, representing the same age group and receiving the same treatment for the same target problem. And, the majority of applicable studies support the treatment.

Further, the treatment procedures must show acceptable adherence to the treatment manual. A coding manual provided detailed explanations for terms used in the above criteria. This manual was developed by John Weisz, Ph.D. and colleagues under the auspices of Division 12.

The University of Alabama's group, led by Forrest Scogin, focused on the treatment of depression in older adults. Several types of interventions were deemed evidence-based, according to the coding criteria, including behavioral therapy, cognitive bibliotherapy, cognitive-behavioral therapy, problem-solving therapy, brief psychodynamic therapy, and reminiscence therapy. Several other treatments were found to need more research supporting their efficacies to be labeled as evidence-based (personal construct therapy, Coping Together, interpersonal therapy, behavioral bibliotherapy).

The Stanford University's School of Medicine group, led by Dolores Gallagher-Thompson, reviewed articles to identify EBTs for family caregivers of older adults. Psycho-educational interventions were found to be the most heavily supported

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CONGRATULATIONS SECTION 2 AWARD WINNERS!!

Sara Qualls, Awards and Recognition Committee Chair

Dr. Larry W. Thompson was the 2004 recipient of the M. Powell Lawton Award for ***Distinguished Contributions to Clinical Geropsychology***, and delivered an invited address on his research. Dr. Thompson currently holds positions as The Goldman Family Professor of Psychology at the Pacific Graduate School of Psychology, Professor (Emeritus) at Stanford University, and Staff Clinical Psychologist, VA Medical Center, Palo Alto. Dr. Thompson has made many contributions to the field of clinical geropsychology, including his pioneering work (in collaboration with Dr. Dolores Gallagher-Thompson) conducting randomized trials of the efficacy of cognitive-behavioral treatment of depression in older adults. In his comments introducing the invited address, Dr. Bill Haley noted that Dr. Thompson had also made major contributions to the success of geropsychology programs at Duke, the University of Southern California, and the Palo Alto VA, and that Dr. Thompson merits recognition as the "father of research on evidence-based practice for older adults."

Dr. Antonette (Toni) Zeiss was awarded the MENTORSHIP AWARD at the Division 12 Awards ceremony. Dr. Zeiss serves as Training Director for the Psychology Service at the VA Palo Alto Health System where she has overseen geropsychology internship programs for over 20 years. Many clinical geropsychologists have benefited from the exceptional training environment she fosters. Her nominators lauded her exceptional training and clinical skill as well as her personal involvement in their careers and lives. They noted that guidance begun during internship has continued throughout their lives. Dr. Sara Qualls who presented the award noted that an informal conversation with several colleagues revealed that when in tough political or clinical situations, they discovered that they all turned to the internal question, "What would Toni do?"

Amanda Schafer, a student at the Wayne State University's Institute of Gerontology, was presented The ***Student Research Award*** for her work under mentor Peter Lichtenberg on a project entitled, *The Dementia Screening Battery is More Accurate than Other Traditional Dementia Screening Devices.* A summary of this important work begins on page 13 of this Newsletter.

Section 2 2005 Election Results
Victor Molinari, Nominations/Election Committee Chair

Congratulations are extended to Bob Intrieri and Jonathon Rose. Bob will begin his one year service as President of Section 2 in January, 2006. Jon will begin his 3 year term as Treasurer in January, 2005.

We would like to extend our gratitude for the work and efforts of Section 2's current President and Treasurer, Drs. Paula Hartman-Stein and Margaret Norris.

Presidents Past & Future. APA 2004 Section 2 Dinner. Back row Drs: Knight, Haley, Molinari, Hinrichsen, Edelstein, Intrieri; Front row Drs: Hartman-Stein, Qualls, and Zeiss. Photo courtesy of Dr. Hartman-Stein

The Dementia Screening Battery is More Accurate than Traditional Screening Devices

Schafer, A., Lichtenberg, P., Maddents, M., Erlanger, D., Barth, J., & Webbe, F.

Considering the problems with traditional screening devices, particularly the Mini-Mental State Examination (for a review, see Tombaugh & McIntyre, 1992) and the growing skepticism about screening in general (U.S. Preventative Service Task Force, 2003), there is definitely a need for more accurate dementia screening tests. In this study, we examined the utility of an Internet-based dementia screening device, the Dementia Screening Battery (DSB).

The DSB takes roughly 15 minutes to administer, can be correctly administered by a medical or nursing assistant and requires no interpretation. As part of the DSB battery, patients are administered a memory test in which they are asked to identify the locations of nine objects in a virtual cabinet (immediate and delayed recall trials are involved), and also complete a task in which they must respond to certain numbers on the screen and inhibit response to other numbers. In order to determine a patient's outcome on the DSB, normative data were employed to determine which demographic variables made significant contributions to each subtest. The beta weights for each variable, along with a patient's score, were plugged into a GLM equation to derive a z-score. Z-scores less than two standard deviations below the mean are typically considered pathological indicators, and multiple scores below this point will lead to a "probable impairment" classification.

We compared this method of dementia detection to other established dementia screening devices, namely the MMSE and CLOX (Royall, Cordes & Polk, 1998). Our sample was taken from a geriatric primary care clinic in suburban Detroit. After several days of physical testing and, frequently, neuropsychological referral by geriatric specialists, the diagnosis arrived at by their PCP was considered the gold standard. This gold standard was compared to dementia screeners through a series of alpha-corrected t-tests. Using a cut-score of 23/24, MMSE was found to have perfect specificity but misclassified more than half of those who were actually cognitively impaired. On the other hand, the DSB had sensitivity, specificity, positive and negative predictive power ranging from 83-86%. Further analyses were done with a slightly smaller group who had been administered the DSB, MMSE and the CLOX (cut off was either lower than 10 on CLOX 1 or lower than 12 on CLOX 2; see Royall, et al., 1999), and determined that the DSB's and MMSE's accuracy remained roughly the same, while CLOX' accuracy was significantly lower, ranging from 56-62% (due to time constraints, not all patients were administered all measures). Furthermore, when the MMSE and CLOX were put together (i.e., considered probably impaired when either the MMSE was below 24 or below 10/12 on CLOX 1 and 2) their predictive validity still did not match that of DSB (range=56-70%). See Table 1.

While the Dementia Screening Battery needs further validation with minority populations and those with less education, it has thus far shown better utility than other screening measures in use. It's ability to accurately predict is largely based on the fact that it takes into account demographic characteristics that have been shown to influence test performance, such as age, education, ethnicity and gender.

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"disappointing news" caught my attention. He explained that the APA Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP) turned down the application for specialty recognition of Geropsychology. Most of us thought the process would be a "slam dunk." Not so.

In light of this recent setback, I decided to give a practitioner's perspective about specialty status, provide some cautionary notes, and describe some pathways to attract more practitioners to our field.

One argument against specialty status is that Geropsychology does not have sufficiently different skill sets compared to health psych or neuropsychology. A second and more salient argument perhaps is that we have not described in detail how our skills are acquired. Aspects of my own professional journey illustrate the invalidity of the first argument and possibly help to illustrate one pathway for acquiring the necessary content and skills. This address describes aspects of my personal pathway of becoming a geropsychologist.

The year is 1978, two years after I received my "terminal" master's degree from WVU in psychology. I work in a community-based 500-bed teaching hospital on the psychiatric consultation-liaison team. Each morning the psychiatrist assigned to this service and I make in-patient rounds on units where patients with chronic illness or somatization disorder are receiving medical evaluation and treatment. Many of the patients are older adults, triggering the beginning of my interest in clinical geropsychology.

My plan had been to work a few years and then pursue a doctoral degree. Where could I find such training locally? The University of Akron has the Institute for Life Span Development and Gerontology, but it did not offer a clinical degree. So I audited Dr. Harvey Sterns' course, the Psychology of Adulthood and Aging, which provided a solid beginning base. In the fall of 1979, I entered Kent State's clinical psychology program. There were no older adult or health psychology tracks, but I was able to work part time at the same hospital, getting more healthcare experience. Both my internship and post-doctoral year were spent in a health psychology program designed by Dr. Jeanette Reuter from Kent State. I rotated through specialty units such as endocrine, neurology, rheumatology, and cardiology. I saw many older adult patients, deepening my exposure and interest in geropsychology.

Fast forward to 1988 nine years later. I am now 5 years past receipt of my clinical psychology license. My position is an instructor in two departments: Internal Medicine and Surgery. The job is to teach the basics of health psychology to residents in both specialties. The Chairman of Surgery, Dr. Doug Evans, a wonderfully funny and humane general surgeon, told me bluntly he had no idea what I did when I saw patients. "You could be roasting chestnuts with your patients, Paula, and I would not know the difference," he quipped. Although Dr. Evans did not understand the techniques of my professional work, he respected and supported my initiatives. However, his statement illustrates the educational work ahead of health psychologists.

Fast forward to 1989. A series of converging events occurred that steered me in the path of seeking proficiency in geropsychology. Mary Ann Stephens from Kent State asked me to be a discussant for a presentation by Steve Zarit on caregiving. He emphasized how self-talk can change the stress level of caregivers, interesting, radical ideas. I became motivated to know more.

At almost the same time, the hospital

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where I taught, was about to open an out-patient geriatric assessment center. The chairman of Family Medicine invited me to be part of this venture. Here was a great opportunity–after all, I had didactic course work from Harvey Sterns, years earlier and over 10 years working in healthcare settings. And, both West Virginia University and Kent State taught me a thing or two about measuring behavior and providing psychotherapy.

I quickly discovered that the challenges of this new work setting left me feeling inadequate, under prepared. Why? The problems of the older adults who came through the doors of the geriatric center were highly complex. They had multiple medical morbidities impacting their cognitive functioning and capacity to benefit from psychotherapy. And the referral questions were plain tough. Was it safe for the older adult to stay at home without supervision? How much supervision was needed? Was a guardian necessary? What is the least restrictive living environment for my Dad?

Such challenging questions triggered my interest in conducting applied research in this area. I linked up with Dr. Jeanette Reuter from KSU, and together we created the Behavioral Competence Inventory, a 106-item caregiver inventory that focuses on remaining behavioral competencies rather than behavioral problems of frail elders.

I felt I needed more specialized knowledge to do this job well. Local options were limited. I heard about a program at Case Western Reserve University that sounded promising, the Geriatric Clinician Development Award program. Set up primarily for physicians, no psychologists had gone through it yet. But the director was interested in my request, and together we designed a curriculum that focused on neuropsychology, psychotherapy, and basic psychopharmacology of older adults. For approximately the next three years I spent one day a week either observing technicians administer neuropsychological tests at the Alzheimer's Center at University Hospital, going on rounds with a geriatric psychiatrist, or attending CE lectures in geriatric medicine or geriatric psychiatry. The requirements took 4 years to complete because it included a "capstone experience." Under the auspices of Dr. Boaz Kahana, I designed and taught a graduate course, "Pragmatics of a geropsychology practice" offered through the master's program at Cleveland State.

Around the same time, I began consulting in long-term care settings, an aspect of my part time private practice. There I encountered yet another challenging area, how to modify the behavioral problems of dementia patients. The curriculum at Case Western had nothing to offer. Linda Teri's research and writing on this topic proved to be helpful. I read her work and was able to arrange for her to do a presentation in Akron.

Subsequently, she invited me to participate in the 1992 APA Geropsychology Training Conference in Washington, D.C. During that meeting, I entered the world of advocacy without intention to do so. During one session about Medicare regulations and reimbursement issues, I asked the audience why reimbursement for testing codes had dropped precipitously, from $99 an hour to less than $60 an hour, over the last four months. I remember the hush that fell over the room. Not one of the mainly academic based geropsychologists knew anything about that.

Now it is 1993. I had just completed all requirements of the Interdisciplinary Geriatric Clinician Development award.

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I felt proficient in geropsychology practice at that point. But now several primary care physicians began referring increasingly challenging diagnostic cases. Still more to learn. Enter Drs. Peter Lichtenberg and Al Kaszniak. Not shy about asking for help, I sought them out for consultation on my toughest cases. I met Peter through the organization, Psychologists in Long Term Care. He graciously reviewed and critiqued my neuropsychological reports on several occasions, helping me to learn about pragmatic issues of neuropsychological functioning. In 2001, I took Al Kaszniak's course on differential diagnosis of dementing illness. Al has subsequently allowed me to consult with him from time to time. I am grateful to both of these knowledgeable and highly skilled professionals. In addition, there is a geriatric neurologist with whom I consult, Dr. John Morris, from Washington University in St. Louis. So I have plenty of people to thank who have helped me gain clinical expertise with tough cases. As Hilary Clinton wrote about the raising of children, "It takes a village;" in raising a clinical geropsychology specialist, it takes a team.

But there is yet another important area of knowledge needed for competence in geropsychology, i.e., correct coding and documentation procedures. It is 1993, about three years after psychologists became independent providers under Medicare, George Taylor nominated me to the APA Practice Directorate as one of 33 names given to Dr. William Hsiao's research team at Harvard, who had the task of examining the work value of three professional groups whose work was not yet assigned numeric value in the Medicare system; these were Podiatry, Optometry, and Clinical Psychology. From the 33 names, Hsiao's group chose seven, and I was among them.

What an experience it was, to learn how Medicare reimbursement is determined. During the weekends at Harvard, I met Dr. Jim Georgoulakis, the APA's representative to the Relative Update Committee of the AMA, the group that determines what CPT codes are developed and reimbursed. Through my association with Jim over the last 11 years I have learned about coding, billing procedures, and Medicare compliance. Without knowledge of those areas, you can risk having to pay back money, pay extra fines, lose your Medicare provider status, or even risk a criminal conviction. Obviously these are fairly hefty consequences not to be ignored, yet not taught in any course I had ever seen.

In the 1990s, as I studied methods of improving skills in cognitive assessment, the country was changing its focus from one in which the clinician could see patients almost indefinitely, with little required documentation, to the world of industrialized health care that required clinicians to work quickly, explain the necessity of treatment, and document that progress is occurring. No longer would third party payors simply take our word that we know best what the patient needs.

The era of managed care had arrived. How could I best learn about this? In 1998, I attended an eight-day intensive training program for experienced therapists conducted by Dr. Nick Cummings. The training was not focused on older adult care, but I was able to apply many of the concepts and techniques to older adult out-patients and long- term care patients. Cummings emphasized the value of client homework, how every session including the diagnostic session could be therapeutic, and how we must work quickly and efficiently. He recommended we offer group therapy whenever feasible, and he predicted

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psycho-educational programs would be the wave of the future for improving our efficacy with patients with chronic medical problems. In his usual visionary way, Nick taught concepts that were realized with the development of the Health and Behavior codes introduced a few years after his seminar. Add Nick Cummings to the growing list of professionals who further shaped my clinical skills.

My personal journey or pathway to become a psychologist who primarily works with older adults illustrates how good generalist psychology graduate school training followed by an internship in health psychology is insufficient. Why? Because the knowledge we need as geropsychologists are not found within health psychology or neuropsychology training and textbooks, although both of these areas are wonderfully appropriate starting grounds. The guidelines published in the May-June 2004 *American Psychologist* elucidate the information and skill sets recommended for psychological practice with older adults.

The growing numbers of older adults who need psychological services is well documented. So how do we add more geropsychologists to meet this public health demand? Creating more post doctoral programs in geropsychology is one pathway. The latest event in my professional journey and commitment to the future of the field is my appointment as Director of Geriatric Psychology at Summa Health System. I am currently working on developing a curriculum to train a new psychologist to work competently with older adults.

Training new psychologists through full-time post doctoral programs is only one small way to help meet the growing needs of this field. A more realistic answer is to tap into the talents of already licensed clinicians. There are many practicing psychologists who have begun working with older adults in long term care facilities for example, who are motivated to become more proficient in the field. The creation of more CE or certificate programs with a progression of curriculum of assessment, therapy, and Medicare compliance information seems a logical path to increasing proficiency of seasoned clinicians who want to add geropsychology as a proficiency area. This is one of Sara Qualls' ideas about to be realized in 2005. But simply attending such programs is insufficient. To quote Dr. Nick Cummings, past APA president, who succinctly put it, "A certificate, if based on poor training and conceptualization is even worse than no certificate as it only gives the idiot credibility." This is not a criticism of any existing or planned program. It points to the need also for more consultation and peer review opportunities available for fledgling geropsychologists.

Here are my recommendations. As an organization, we need to strive to offer CE programming regionally and online, covering the distinct areas described by the principles already outlined in the article by the *Interdivisional Task Force on Practice in Clinical Geropsychology*. The results of the online survey our group conducted in the winter of 2004 showed there is definite interest in such programming.

In the published practice guidelines one area blatantly missing from the recommended, comprehensive skill set is training in coding, documentation, and Medicare compliance. Our CE programs need to offer this content area much more than we already do. The American Medical Association does a far better job emphasizing the importance of this information to their members. We must stop lagging behind in teaching this and approaching the billing and coding area as though it is tainted by materialism and

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greed. Psychologists who are employed by hospitals, community agencies, or large practice groups all need to know these principles, as they cannot hide behind their employers. It is the individual clinician's license that is on the line in an audit. It is absolutely shameful to our profession that psychologists are one of the top three erroneous billers in the nation, based upon audits authorized from the federal government.

In states that require CEU's, a certain percentage of these programs each year in geropsychology should be required. California has already taken the lead on this. Those of us in influential positions with the state boards need to push this forward thinking initiative.

In order to become proficient in geropsychology, attendance at didactic courses at universities or CE programming is insufficient. Periodic and ongoing consultation with another professional should be mandated. We as an organization within APA have the resources to set up such a panel of experts to review our work. Regarding Medicare audits, the best insurance is to have yearly reviews of our charts. Why can't we have yearly reviews of our chart documentation, our compliance with regulations, and just as importantly, how we assess and treat our most challenging cases?

To organize such proposed efforts will take dedication of members in our professional organizations. I propose there be more discussion of these ideas, and I intend to appoint an ad hoc committee within 12/2.

It is equally imperative that those of us in leadership positions in the field not be exclusive and elitist. Although I am arguing Clinical Geropsychology is a specialty in its own right, it is absurd to require all psychologists who treat an occasional older adult in their practice to need an extra credential in geropsychology. I will once again quote Dr. Cummings, "In a successful practice colleagues gravitate to the kinds of work they do best or have the greatest expertise. This narrows their practices to seeing a preponderance of two, sometimes three kinds of patients. I can understand the need for expertise.... However, in his keynote address at the 2003 Competencies conference, Cummings said "Psychology is well on its way to becoming the most credentialed and lowest paid doctoral health profession in America."

I am therefore proposing that leaders in organized geropsychology strive to offer appropriate CE programs and consultation panels of experts. However, we must guard against counterproductive turf wars within the profession that propose exclusivity as to the type of graduate and post doctoral training necessary to allow clinicians to work with the growing older adult population.

Back to the original question: is clinical geropsychology a specialty? My own professional journey since 1982 illustrates how it is indeed a specialty area. And why is it important that it be recognized as such by APA? Legislation in which our geriatric psychiatry colleagues can participate currently excludes us because we have no defined equivalent of geriatric psychiatry. This is ridiculous for our profession.

One last thought in closing -- let us not forget about teaching and reaching the general public and other healthcare professionals. Remember the roasting chestnuts story! We need to be out of our offices and our academic settings in order to let the public, the medical profession, and legislators know more about what we know and what we can do. To date, there is no Dr. Phil for the older adult set. Maybe it is time... if we want to reach the American public in a major way.

Section 2 Board Meeting Minutes

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for the Division 12 meetings. The Federal Aduvocacy Coordinator position was discussed. It was agreed that it would be nice to have a person with geropsychology interests in this position. Peter Kanaris was a person mentioned as someone the Section could put forward.

Webpage - Norm O'Rourke. Norm gave an online presentation of new website. It appeared a sleeker, more user friendly site. Credit card payment for dues will be an option via website. The page location is: www.geropsych.org . Listings of pre-doctoral, internships, and postdocs will be available as will many links. A Member's Only section will also be available. Voting, for example, can be done via the website. Norm's work was applauded.

Specialty application for clinical geropsychology. CRSPP denied our application for specialty status. One of the reasons was the lack of a coherent training model. Plans are now underway for having a conference on training. Bob Knight will begin to explore the feasibility of conducting a conference aimed towards refining a model of training in clinical geropsychology.

Public Policy Committee - Donna Raisin-Waters. Donna reviewed Media Campaign efforts. Expert Profiles are being developed that will be used in the campaign. Media leads will be distributed with hopes of increasing the visibility of aging. A Media Training Workshop will be held at GSA by Rhea Faberman of APA. Several public policy initiatives were reviewed, including Medicare and multicultural issues.

Dues increase. Our dues are currently $15. Should this be increased? Those members currently on the fence about renewing might be deterred. Would an increase have to be voted on by the membership? The President's Conference call in September will explore this topic further with more available data.

The meeting was adjourned. Respectfully submitted, Forrest Scogin

Division 12 Board Meeting

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that Section 2 has taken in this arena. The mission and agenda of the workgroup will be developed at the APA meeting in Honolulu, on Thursday July 29th at 8:00. Donna Raisin-Waters has agreed to lead the workgroup and all Section Advocacy Reps are expected to attend the meeting.

Section 2 Public Education Media Campaign. The activities and initiatives of the Section 2 Public Policy Committee were discussed and praised by the Board. The Board suggested that Section 2 formally request $300 from the Division (an amount available to Sections on an annual basis for special projects) to support the purchase of Profnet. They further suggested that Section 2 consider nominating members of the Public Policy Committee for the APA Heiser Award to acknowledge their efforts.

Committee on Science and Practice. There was discussion of the need to review the current state of the field regarding empirically-supported treatments (ESTs) since previous reports spearheaded by D12 are now out of date. The S & P Committee and Section 3 (Sheila Woody) will consider this issue and invite the participation of prominent leaders in this field.

Publications. The contract with Oxford to produce the Division journal will end in approximately 18 months. Ed Craighead, Chair of the D12 Publications Committee, is reviewing the options of changing publishers or bringing the journal

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Division 12 Board Meeting

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'in house' in order to increase circulation and revenue. He will make a full report to the BoD at the Midwinter meeting and a decision will be made at that time.

Book Series. Through the initiative of Danny Wedding (Section 8), a book series is being developed that will include concise, evidence-based volumes on various clinical topics targeted for practitioners. Four volumes are underway. Although geropsychology is not currently a topic area, proposals for work in this area would be welcomed and should be discussed with Dr. Wedding.

Special Issue of Clinical Psychology Science and Practice (CPSP). Progress on the special issue on *Assessment and Treatment of Depression in Older Adults* was discussed. Invited authors submitted outlines for eight papers on various aspects of this topic. Manuscripts were due August 1st and have been sent out for review. The Board thanked Section 2 for taking leadership in this important project.

The Midwinter Board meeting will be held in Alexandria, Virginia February 11-13th.

Public Policy Update

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like to join this effort please contact Margie Norris, PhD at MargieNorris@hotmail.com.

Another project underway is the development of a professional education outreach strategy for the invisible gays and lesbians in nursing homes and assisted living settings. Any members who would like to join this effort are welcome. Please contact Vicki Passman, PhD at vpass@nyc.rr.com.

As always, the Public Policy Committee welcomes your ideas and thoughts. If you would like to volunteer on a project or develop one on your own please contact me at DrRasinWaters@aol.com or by phone at 718.623.6291.

APA Committee on Aging and APA Office on Aging Update

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mental health and aging (as was done at the last Conference). The WHCoA takes place once a decade to make policy recommendations to the President and Congress related to aging issues. APA will work independently and in cooperation with the National Coalition to promote inclusion of mental health issues at the conference and to secure representation of psychology at the Conference.

The brochure, *Psychologists Make a Significant Contribution: Psychology and Aging* and the fact sheet, *Geropsychology: It's Your Future!* was distributed this summer. The materials were funded by the Retirement Research Foundation. The brochure offers documentation of psychology's contributions to aging and is intended for policy makers and health care organizations. The fact sheet (and accompanying poster) promote psychology as a career option to undergraduates.

Finally, members of CONA and other members of the geropsychology community met with congressional representatives this summer to support the Positive Aging Act. The Act would enhance mental health services for older adults through mental health outreach to primary care and community-based settings. Informal reports from those who participated in this effort found a receptive audience in congressmen, senators, and their staff.

Section 2 at APA 2004

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concerning the use of scientific data such as psychometrics, while dealing with the underlying issue of providing assistance to the hiring lawyer.

The fourth presentation, by Robert Ruchinskas and was entitled *Risk Assessment as an Integral Aspect of Capacity Evaluations.* He reviewed the intrinsic difficulties in performing capacity assessments in the context of risk assessment, and other issues often faced by rehabilitation psychologists. He highlighted his research that suggests that rehabilitation clinicians are quite susceptible to common errors in clinical judgment when predicting future risk. He provided psychologists with an appreciation of some of the pragmatic concerns inevitably encountered by professionals who work with attorneys dealing with capacity issues in formal legal settings. Important matters discussed included the relationship between psychological evidence and legal conclusions and the common pitfalls of psychological practice when legal questions, such as capacity to make informed decisions, are dealt with in the course of work in geriatric and rehabilitation settings.

The next presentation, by James Pasino and Aida Saldivar, was entitled *Assessment of Medical Decision Making.* The presenters discussed the issue of capacity assessment within the context of survival of seriously brain injured patients, risk management concerns of the institution, emphasis on patient autonomy, financial pressure toward shorter lengths of stay, and aggressive discharge planning. A comprehensive system for capacity evaluation within a medical rehabilitation was presented. The presentations were discussed by Stephen Anderer.

Well done members of Section 2!

Profile On... Norman Abeles

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the US International Committee of the International Union of Scientific Psychology Societies (IuPsyS). He is the President-elect of Section 7 (Applied Gerontology) of the International Union of Applied Psychology and will become President of that Section in Athens in 2006.

In July 2004, Norm returned to research and teaching after having directed the MSU Psychological Clinic for 26 years. He continues to teach courses on Neuropsychological Assessment, Personality Assessment and Scientific and Professional Ethics. His most recent publication, not in the area of aging, is a paper by Tara Victor and Norm on coaching clients to take psychological and neuropsychological tests. This was published in the August 2004 issue of *Professional Psychology: Research and Practice.*

Currently, Norm is working on getting invited to the 2005 White House Conference on Aging. He continues to be active in APA and serves as the Division 12 (Clinical) Council Representative. He is also the President of Section IX (Assessment) of that Division.

What about the future? Norm plans to continue to be active in the area of aging and hopes to continue his work in this area even after he retires in a few years.

The *Clinical Geropsychology News* welcomes readers' thoughts and opinions.
Please send these to ma159@columbia.edu

Eye on Education and Training

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Obvious as it may seem, many nursing assistants interviewed as part of our research complained that the training they typically received did not relate to the work they did and the problems they faced. Therefore, we tried to make this training as close to the reality of their workdays as possible. For example, we decided to make stress management the central theme of the training because that was so frequently cited as a problem by nursing assistants. Similarly, exercises in the training program were created to stimulate group discussion of actual (vs. hypothetical) situations the nursing assistants struggled with in their daily work.

A second consideration was empowerment of the nursing assistants. As a group, nursing assistants are often treated with less respect than they should be. Sometimes they are demeaned, insulted or subjected to prejudice; any training they receive needs to recognize and help them deal with this reality. To address this, we designed the training so that emphasis would be on the nursing assistants' perspectives rather than on the perspectives of outsiders or non-nursing assistants; we call this a "peer-oriented" approach to training. While a facilitator is present during training, her (or his) primary role is to encourage participants to share their concerns, issues, experiences, knowledge and suggestions with one another and to assure the maintenance of respect for one another throughout the training (rather than to tell them how to do their work). Additionally, the information nursing assistants receive during training provides them with suggested tools for handling job-related stress while maintaining their dignity. Also, handouts the participants receive contain numerous depictions of nursing assistants engaged in a variety of work tasks which were rendered to convey both the complexities they face and the skill and sensitivity they possess.

Third, the program was designed to be practical, user-friendly and appealing for facilitators. For example, the program was designed to fit in the standard 45-50 minute allotment usually given to in-service classes and to fall within the acceptable range of topics for these classes; thus, no extra staff time needs to be set aside to carry this training out. Also the kit contains everything needed to conduct training sessions with a minimum of advance preparation. Instructions for facilitators were written to be as straightforward, clear and easy to follow as possible. Also, the kit is portable, contained in an easily transportable shell. As much flexibility as possible for facilitators was built in. This includes being able to choose to focus on any among the four sources of stress and to decide how much emphasis to put on discussion of causes of, reactions to or interventions for managing stress. Facilitators also have a choice of following the dialog in the kit as closely or loosely as desired and of selecting among the suggested exercises based on the needs of particular groups of nursing assistants. Additionally, the training program can be carried out by a qualified in-house staff person, such as an in-service director or a social worker. A psychologist with expertise in long-term care issues would also make an excellent facilitator or consultant for this type of training program.

We were fortunate to receive financial support from the New York State Department of Health to develop the kit and conduct the research that underlies it. This support also enabled us to send copies of the kit to every nursing home in New York State. Additional copies are available at no charge by contacting the first author of this article at nk105@columbia.edu . It can also be downloaded online at www.sephardichome.org .

The Student Voice

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clients to consider services as well. This demonstrated to me the relatively small impact health care professionals have on patient care and the large influence significant others in their lives have, in terms of compliance with medical care.

The rural clinic faced many of these same problems, but had additional challenges for the clinician. Because of the rural setting there was a close-knit community, so close that the nurse practitioner was related to some of the patients. Due to this circumstance, a limited amount of confidentiality could be guaranteed to a potential client, and after reviewing the potential risks of this situation and insuring both parties were well informed of the circumstances, the client elected to seek treatment despite her familial relationship with the primary care provider.

Another barrier for treatment was the distance to the clinic, and the lack of public transportation to assist clients in getting to the clinic. Because of physical disability, some students agreed to see clients in their homes, while other clients tried to strategically plan appointments. Though the income level was just as low as the other site, the rural clinic required greater commitment on the behalf of the client to come for services due to transportation difficulties. Further, this clinic was much smaller than the urban clinic, and only had one nurse practitioner available. Between the difficulties coming to the clinic for appointments and the availability of paid staff, this clinic was stretched to its maximum capacity. Yet, the follow through and dedication to providing a gold standard of care was amazing.

These two sites showed the differences a seemingly similar placement (primary care clinic) can reveal. In one realm, I served as a clinician and part-time case manager ensuring all the T's were crossed and I's dotted, while, in the other realm, I was a clinician working nonstop to solve the barriers to treatment (medication or psychotherapy) to help improve the client's quality of life.

In sum, these experiences over the last year have made me realize that there is much perspective to be gained by working around professionals in other fields and opportunities to gain unique experiences when working in a primary care setting.

Consider This: EBTs, Part 2

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while multi-component and environmental treatments were also regarded as evidence-based.

The University of California, San Diego's group, led by Julie Wetherell, identified 2 EBTs for geriatric anxiety: relaxation training and cognitive-behavioral therapy.

The group from John's Hopkins Bloomberg School of Public Health, led by George Rebok, examined the memory training literature. They identified the teaching of mnemonic techniques as being the only EBT for normally aging older adults. Several treatment techniques, such as visual memory support and the method of loci, were found to need more support before being considered evidence-based. For non-normally aging older adults, there were no treatments considered to be evidence based in terms of improving memory. Several needing more support include procedural memory training, external memory aids, and cognitive remediation.

There is still a question today regarding the degree to which psychological interventions for older adults work. Based on the committee's findings, it can be said

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Consider This: EBTs, Part 2

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that such interventions do appear to work for a number of problems facing older adults and their families, and that, in several cases, practitioners and clients have several treatment options to choose from. Identifying such treatments may help remedy the apparent under-use of psychological interventions for older adults.

Online Survey Results

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conducted, less than 25% of the respondents checked the Section's website as a benefit.

Potential future directions for the organization. Another question probed participants' (n=470) interest in potential future membership benefits. Equal numbers of members (39%) would like to see regional and internet continuing education (CE) programs offered by 12/2, as well as having a part of the organization's website inform them about these programs (38%). Topics suggested for continuing education programs included treatment of older adults, reimbursement/documentation issues, assessment/testing, death and bereavement issues, and psychopharmacology.

About one third of the participants (30%) would like to be listed in network of experts to be consulted on clinical, business, and research issues. Also, close to one third of the participants (29%) wanted to see efforts on the part of the Section to create closer ties with professional multi-disciplinary or political organizations, outside of APA, that are involved with aging.

Participants were also interested in opportunities for private consultations with other Geropsychologists. Twenty-eight percent expressed interest in consultation about challenging cases or clinical problems and 25% rated consultation about business issues such as documentation, coding clinical services, and Medicare compliance to be areas for which they would like consultation available.

Some participants (26%) were interested in regional geropsychology interest groups, and others (19%) were interested in informal networking sessions at APA conferences regarding geropsychology topics. Some (23%) were interested in organization networks for research. Sponsorship of a geropsychology journal was also checked as a possible new benefit by 22 % of the respondents. But, in the free response section, a few individuals wrote they are unable to keep up with reading the journals they now have. Smaller but equal numbers were interested in the section getting involved with more grass roots public policy work (17%), and the same number (17%) wanted opportunities for private consultation about marketing their practice.

In the free response section of the survey, the idea surfaced that older retired psychologists should serve as an advisory panel to 12/2.

New added benefits. Since the time this survey was conducted in early 2004, several initiatives have begun that are responsive to suggestions garnered from the online survey data. For example, a new website is being created that is easier to navigate, has a Members' Only section, and a listing of CE programs across the country of interest to geropsychologists. The Public Policy Committee is well on its way to creating a panel of experts who are available to the media and potentially to other psychologists for consultation. Recently, following advocacy efforts by the current leadership of 12/2, the Interdivisional Healthcare Committee, an informal advocacy group formed in 1996 of healthcare psychologists within APA, has

Continues on next page

Online Survey Results

Continued from previous page

invited the Section to participate in this forum that helped to write new CPT codes involving health and behavior and is currently investigating the utility of a functional rating system used by the World Health Organization. In September 2004, APA's Division 20, Adult Development and Aging, has asked Division 12, Section 2 to co-sponsor a grant proposal to create a website for opportunities for retired psychologists.

We believe these initiatives are a great start toward implementing several new projects of interest and value to our members. But there is obviously much more work to be done. It is one thing to conduct a survey and review the results, but quite another to keep the momentum going of working out details regarding suggestions from our members so they can come to fruition. Therefore, the current President has appointed an ad hoc committee chair, with the challenging task of working with the executive board and committee chairs to explore how ideas from the survey data can be implemented in the future.

In a time when professional groups are losing numbers because of the perception that their organization does not listen to them or have anything valuable to offer, the Executive Board of 12/2 wants to strive toward a flexible organizational culture that can respond positively and proactively to the ever changing work demands of our profession.

Dementia Screening Battery is More Accurate than Traditional Screening Devices

Continued from page 13

Royall, D.R., Mulroy, A.R., Chiodo, L.K., & Polk, M.J. (1999). Clock drawing is sensitive to executive control: A comparison of six methods. *Journal of Gerontological Psychology, 54(B)*, P328-P333.

Tombaugh, T.N., & McIntyre, N.J. (1992) The Mini-Mental State Examination: A comprehensive review. *Journal of the American Geriatric Society, 4*, 922-935.

U.S. Preventative Service Task Force. Screening for Dementia: Recommendations and Rationale. Guide to Clinical Preventive Services, Third Edition: Periodic Updates; 2003.

Table 1.

Accuracy statistics comparing the DSB with other dementia screening devices.

	n	Sensitivity	Specificity	PPP	NPP
DSB	65	.86	.83	.86	.83
MMSE	65	.44	1.00	1.00	.59
DSB	54	.86	.84	.86	.84
MMSE	54	.46	1.00	1.00	.58
CLOX	54	.62	.56	.62	.56
MMSE or CLOX	54	.70	.56	.65	.61

Give the Section II Membership Application on page 29 to a colleague!
- Share the Experience -

Section 2 Members at the 2004 Annual Meeting of the Gerontological Society of America

Note: The following information was provided by Section 2 Members. You may confirm days, times and places by going to the GSA website: www.geron.org .

FRIDAY, November 19, 2004

4:30 pm – 7:00 pm

Media Training Workshop: Preparing for the Media Interview. Rhea Farberman, Executive Director for Public & Member Communications, APA
Workshop; Marriott, Balcony B

SATURDAY, November 20, 2004

8:30 am – 10:00 am

Depression as a Function of Demographic Status and Assessment Strategy. Martha R. Crowther, Forrest Scogin, Shannon Hauser, Patricia Baker, and Richard Allman.
Paper, #2564; Maryland A

10:30 am – 12:00 pm

Association Between Reported Alcohol Intake and Changes in Cognition: The Women's Health Initiative Memory Study (WHIMS). Stephen Rapp.
Session #1753; Marriott Balcony D

Family Caregivers of Aged Persons with Dementia Living in Rural Alabama. Jordan I. Kosberg, Allan V. Kaufman, Louis D. Burgio, and James D. Leeper.
Session #1247; Roosevelt

Encouraging Behavioral Care Strategy Use and Teamwork in the Nursing Home. Alan Stevens (Chair), Angela Hochhalter, Louis Burgio, and Linda Davis
Symposium; Maryland A

Improving Mental Health in End-of-Life Care (Mental Health and Aging Formal Interest Group). Rebecca S. Allen (Co-chair), Dean Blevins (Co-chair), Joan Teno (Discussant), Presenters: Bill Haley, Lisa Gwyther, Diane Meier, and Virginia Tilden.
Session #3165; Harding

Assessment and Treatment of Pain in Nursing Home Residents with Dementia. L. Miller, K. Talerico, D. Meier; *Successes and Challenges in Managing Pain in Elders with Dementia*: Miller, Rader, Sloane, and Talerico; *Recruitment Challenges in a Pilot Study of Pain in Nursing Home Residents with Dementia*: Hiatt, Miller and Talerico; *Effects of the Serial Trial Protocol on Discomfort and Tenacity*: Kovach, Logan, Noonan, Schlidt, Simpaon, Smerez; *A Training Program for Improving Pain Assessment Skills in the Nursing Home*: Susan E. Fisher, L.D. Burgio and A. Lynn Snow; *Pain Screening in Persons with Severe Dementia*: Ashton, Beck, Bruera, Cody, Kunik, O'Malley, and Snow
Session #3236; Coolidge

1:30 pm – 3:00 pm

Assessing Values for Advance Care Planning in Older Adults With and Without Dementia. M.J. Karel, J. Moye, A.L. Bank, A. Azar.
Poster; Exhibit Hall B North

Preparation of Social Workers for End-of-Life Care Practice in an Aging Society. Ellen Csikai
Poster, #2678; Exhibit Hall

Continues on next page

Physical Performance Tests to Identify Assisted Living Residents Who are at Risk for Adverse Health Outcomes. Carol Giuliani, Ann Gruber-Baldini, Nan S. Park, Lori Schrodt, Philip D. Sloane, and Sheryl Zimmerman.
Paper, #1986; Hoover

3:30 pm – 5:00 pm

How Do Long Distance Caregivers Share Parent Care Responsibilities with Siblings? Lucinda L. Roff, Lisa K. Jennings, and Michael W. Parker
Poster, #1833; Exhibit Hall B North

SUNDAY, November 21, 2004

8:30 am – 10:00 am

Mild Cognitive Impairment in a Sample of Community-Dwelling Older Adults. Rachel L. Rodriguez, Kristine L. Lokken, and Martha R. Crowther.
Paper, #2261; Marriot Balcony A

Psychological Interventions in Long-term Care: Perspective on What Works. Lee Hyer (Chair); Victor Molinari (Discussant). C.J. Camp, M. L. Malone, M. J. Skrajner: *Dissemination of Montessori-Based Dementia Programming TM in Long-Term Care*; Lynn Snow and David Powers: *Cognitive-Behavioral Therapy for Long-Term Care Patients*; Jiska Cohen-Mansfield and Aleksandra Parpura-Gill: *Self-Identity Roles: Utilization for Design of Psychosocial Interventions for Persons with Dementia*; Lee Hyer and Peter Aupperle: *Use of Psychiatric Medication in LTC: Role of Psychosocial Intervention.*
Session #3093; Marriott Balcony B

The Impact of Disasters on the Lives of Older Persons: Applied Implications. Barbara L. Torgusen, Jordan I. Kosberg, and Areila Lowenstein
Poster, #2359; Exhibit Hall B North

10:30 am – 12 pm

Assessment of Depressive Symptomatology in Older Adults: Self-Report and Informant Report. Lisa M. Brown, John A. Schinka and Lawrence Schonfeld,
Poster, #1217; Exhibit Hall B North

MONDAY, November 22, 2004

8:30 am – 10:00 am

Meeting the Challenges of Conducting Clinical Gerontological Mental Health Research in Rural Communities. Martin P. Morthland, Forrest R. Scogin, Louis D. Burgio, and Allan V. Kaufman.
Poster, #1434; Exhibit Hall B North

Recognizing Early Symptoms of Alzheimer's Disease. S. H. Qualls, K. Berryman, A. Williams, and M. Rogers
Session #2371; Capitol Room (Omni)

10:30 am – 12:00 pm

Mental Health Care Utilization by Community-Dwelling Elderly: Identifying Service Use and Predictors of Care. Bradley E. Karlin, Michael Duffy, and David H. Gleaves.
Session #1791; Virginia A

Assisted Living Facilities' Response to Residents' Mental Health Needs: A Study in Two States. Sherry M. Cummings, Rosemary K. Chapin, Deborah Dobbs, and Jeanne Hayes.
Paper, #1105; Virginia A

Family-household Structure and Access to Care among Midlife Women. Jacqueline C. Wiltshire, Maureen Smith, and Michael Hardin.
Poster, #1688; Exhibit Hall A

Continues on next page

Career in Behavioral Research in Aging: Opportunities for Under-represented Minorities and Use of Ancillary Studies. Martha R. Crowther
Symposium; Harding

3:15 pm – 4:45 pm

Gender Differences in Positive Aspects of Caregiving. Daniel W. Durkin, Lucinda L. Roff, David L. Klemmack, Laura Gitlin, Linda Nichols, & Louis D. Burgio
Poster, #1487; Exhibit Hall B North

Spirituality vs. Religiosity: Perceptions of Elderly Iranian Immigrants. Shadi Martin
Poster, #1294; Exhibit Hall B North

Quality of Life Ratings in Medically Frail Elders in Rural Alabama: Sex and Race Differences. Louis D. Burgio
Paper, #2156; Marriot Balcony A

Improving Care Delivery at the End of Life: A Focus on Public Policy. Dean Blevins (Co-chair), Rebecca S. Allen (Co-chair), and Brian DeVries (Discussant)
Symposium; Virginia A

Men as Caregivers to the Elderly. Edward H. Thompson & Jordan Kosberg
Symposium, #3112; Virginia C

TUESDAY, November 23, 2004

8:30 am – 10:00 am

Family-based Care for Frail Older Persons: Treatment Implementation (TI) of PREP. Patricia G. Archbold, GSAF, & Louis D. Burgio (Discussant)
Symposium, #3231; Coolidge

Spiritual, Disease, and Disability Profiles. David L. Klemmack, Lucinda L. Roff, Harold G. Koenig, Patsy Baker, Michael W. Parker, and Richard M. Allman
Symposium; Maryland A

Many Thanks to Section 2 Contributors!!

On behalf of the Board and members of the APA Clinical Geropsychology Section, we extend a huge round of applauds and thanks to the following colleagues who have generously made contributions to the Section this past year!

Norm Abeles
Daniel Bruzzone
Martha Crowther
Susan Cooley
Helen DeVries
Paul Duberstein
Larry Dupree
Erin Emery
John Epperson
Stanley Friedland
Jerome Gabis
Michael Gilewski
Linda Gonzales
Amber Gum
Mary Harper
Paula Hartman-Stein
Gregory Hinrichsen
Robert Intrieri
Peter Kanaris
Brian Kaskie
Deborah King
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Bob Knight
Elizabeth Kolin
Nancy LeBlanc
Rocco Marino
Gregory Martino
Molly Maxfield
Elizabeth Midlarsky
Victor Molinari
Ann Morgan
Suzanne Norman
Margie Norris
Alisa O'Riley
David Powers
Sara Qualls
Pamela Ridgway
Michael Salamon
L. Shuman
Daniel Segal
Catherine Strong
Peg Thompson
Tara Victor

All Section 2 members are invited to write to Merla Arnold at ma159@columbia.edu with *Member News* (your own, or someone you know) which can be included in a subsequent *Clinical Geropsychology News.*

APA Division 12, Section 2: *Clinical Geropsychology*
NEW MEMBER APPLICATION – 2004

Please complete the following information (print clearly or type):

Name: _____ **Degree**: _____
Address: _____
_____
_____

Phone: _____ **Fax**: _____
E-mail: _____
(Note: The Section maintains an e-mail listserv that notifies members of policy updates, job opportunities, and is a resource for communicating with colleagues. New members are automatically added to the listserve. However, if you do NOT wish to be on this e-mail group, please check here_____).

APA Membership Status:
(You must be a member of APA to join Section 2. Section 2 membership may be Divisional – for Division 12 members – or Affiliate – for non-Division 12 members. Applicants for Student Member status must have their application endorsed by a faculty advisor who is an APA member)

What is your APA membership status? Please check one:
___Fellow ___Member ___Associate ___Emeritus (retired member of APA)
___Student Member (at graduate, internship, or postdoctoral level)
___Student, not a Member of APA ___Non-APA Member

Are you a member of Division 12 (The Society of Clinical Psychology)?
___Yes ___Yes, as a student ___No

Special Interests within Geropsychology: (We update our membership directory every few years and we include members' primary areas of interest within geropsychology, as a resource for networking and mentoring.)

_____

_____

PAYMENT OF DUES:

Divisional and Affiliate Member Dues are $15.00 (U.S.); Student Dues are $5.00 (U.S.)
Emeritus Members are dues exempt.

2004 Membership Dues enclosed $_____ (Make your check – in U.S. dollars - **payable to APA Division 12, Section 2)**

Signature:_____ **Date**: _____

If student, Faculty name (print):_____

Faculty signature:_____ **Date**: _____

Detach (or copy) and mail this form, along with your check, to:
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email: mfrci@wiu.edu ; Phone: (309) 298-1336; Fax: (309) 298-2179

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