CLINICAL GEROPSYCHOLOGY NEWS

APA DIV. 12 SECTION II — MAY, 1998 VOL. 5, NO. 1

Aging at APA: We Are Not Alone

Steven H. Zarit, Ph.D. (President, Section II)

Many exciting developments have been taking place, which put aging in a better focus at APA. First and foremost, the proposal for Geropsychology to be recognized as a proficiency in professional psychology, which had been held up in August by the APA Council of Representatives, has now been approved. The creation of a geropsychology proficiency represents an important step within APA, highlighting that there is a need for special training to work with older people. It is my hope that the establishment of the proficiency will lead to more continuing education efforts in geropsychology, as well as to the incorporation of adult development and aging into the curriculum of more graduate training programs.

The success of this proposal is due to the efforts of many people. I want to thank all the members of the joint task force of Division 20 and Section II, which developed the proposal and saw it through to completion. I particularly want to note the efforts of George Niederehe, who provided leadership and perseverance in the development of the proficiency. George deserves all our thanks.

APA's Committee on Aging (CONA--everyone has an acronym at APA) had its first meeting at the March APA Consolidated meetings. Committee members are myself, Michael Duffy, Margaret Gatz, Jacqueline Goodchilds, Manuel Miranda and Anderson Smith. The committee is currently staffed by Jacquelyn Gentry, until a new staff person is hired. The committee provides a visible focus for APA staff to refer issues on aging. In turn, members can express their concerns to CONA. I believe that the committee will make a difference in improving coordination of aging issues within APA, and in helping APA take a more proactive approach on aging issues with other organizations and agencies.

A standing committee on aging at APA has been a long time in the making. We owe a great debt to the leadership that Norman Abeles provided during his term as President of APA, who finally brought this project to a successful conclusion. I also want to thank M. Powell Lawton, who ably chaired the ad hoc committee that developed the proposal that subsequently was approved by the Council of Representatives.

Beginning next year, current members of CONA will begin rotating off the committee, and there will be nominations for people to replace them. If you would be interested in serving on this committee, look for the call for nominations next year. (continued on p. 5)

APA Convention Program for Clinical Geropsychology

Antonette Zeiss, Ph.D.

SATURDAY

Student Discussion Hour: Student perspectives on Clinical Geropsychology: A conversation with Section II Board members (8- 9 am), Division 12 Hospitality Suite

Symposium: Training in Professional Geropsychology (1- 2:50 pm) Moscone Center-South Building Room 252/254/256; Organizers: Victor Molinari, Ph.D. & Greg Henrichsen, Ph.D.

Graduate training in Geropsychology, Michael Duffy, Ph.D.; *Internship training in Geropsychology*, Greg Henrichsen, Ph.D.& Diane Myers, Ph.D.; *Post-doctoral training in Geropsychology*, Michele Karel, Ph.D. & Dolores Gallagher-Thompson, Ph.D.; *Continuing education in Geropsychology*, Sara Honn Qualls, Ph.D & Nanette Kramer, Ph.D., Discussant: George Niederehe, Ph.D.

Social Hour: Division 12, Sections 1-6 Award Reception (6- 7:50 pm) San Francisco Marriott Hotel Golden Gate Salon A1/A2; Steve Zarit, Ph.D. (co-host)

SUNDAY

Conversation Hour: Student Forum-Selecting a Clinical Psychology Internship (8- 8:50 am) San Francisco Mariott Hotel Golden Gate Salon A2

Presidential address : The Final Frontier: Perspectives on the Oldest Old, Steven Zarit, Ph.D. (2- 2:50 pm) Moscone Center South Building Room 252/254/256

Business meeting: Division 12, Section II (3- 3:50 pm) at the Moscone Center, South Building Room 252/254/256

MONDAY

Symposium: Teaching Clinical Geropsychology to Traditional and Nontraditional Populations (11-11:50 AM) Moscone Center-South Building Room 224 Organizer: David Glenwick, Ph.D.

TUESDAY

Symposium: Opportunities and Pitfalls in Adult and Older Adult Prevention Research (9- 10:50 am) at the Moscone Center-South Building, Room 305

Organizers: Jane L. Pearson, PhD & Mary C. Blehar, PhD

Symposium: Death and Dying: Diverse Settings and Diverse Perspective (11- 11:50 am) Moscone Center-South Building Room 301 Organizer: David V. Powers, Ph.D.

Cognitive-Behavioral Psychology in a Hospice Setting, David V. Powers, Ph.D.; *Understanding and Approaching Dying and Death Issues Affecting Older Medical Patients, Nursing Home Residents and Community-Dwelling Adults: A Cognitive-Behavioral, Mind/Body/Spirit Perspective*, Sue C. Jacobs, Ph.D.; *Dying and Death: A Mind/Body/Spirit Approach for Cancer and HIV+/AIDS*, Ann Webster, Ph.D.; *Suicide in Later Life: Update from the APA Special Committee on Assisted Suicide*, Dolores Gallagher-Thompson, Ph.D.

Symposium: Diversity in Care giving to Individuals with Memory Impairment (1- 1:50 pm) Moscone Center-South Building Room 252/254/25

Organizers: Dolores Gallagher-Thompson, Ph.D. & Ana Menedez

Progress on Proficiency and Certification in Geropsychology

George Niederehe, Ph.D.

In February 1997, Section II and APA Division 20 (Adult Development and Aging) jointly submitted a petition to APA's Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP), requesting that Clinical Geropsychology be formally recognized as a proficiency. As defined by APA, proficiency areas of practice require some degree of special expertise, training and clinical experience, but are more circumscribed in scope and degree than subfields designated as specialties (such as clinical or counseling psychology). The petition was prepared by the Interdivisional Task Force on Qualifications for Practice in Clinical and Applied Geropsychology, which Section II and Division 20 had earlier established. Last October, CRSPPP unanimously voted to recommend approval of the petition.

Meanwhile, last summer the APA Council of Representatives placed a moratorium on considering any further specialties or proficiencies with the word "Clinical" in their title until controversy within APA over the use of this term can be resolved. Thus, CRSPPP suggested that we shorten the proficiency's title to simply "Geropsychology" if we wanted it to be considered by the Council at this time. Because proficiencies, by definition, apply only to licensed practitioners, a modifying adjective like "clinical" is not technically necessary, but those involved with the Clinical Geropsychology petition felt strongly that a modifier is important for conveying the meaning of this proficiency to other professionals and the general public. However, there was general consensus that the foremost priority should be to keep up the momentum toward gaining increased recognition for geropsychology. Accordingly, the Task Force and the boards of Section II and Division 20 reluctantly agreed to shorten the proficiency title to Geropsychology, but indicated a desire to revisit the title once the controversies over "clinical" have been resolved and reinsert an appropriate modifying term. Given this feedback, CRSPPP forwarded our petition to the Council of Representatives with their positive recommendation, and the recognition of Geropsychology as a proficiency won easy approval at the February 1998 Council meeting.

Subsequently, the Task Force has received an inquiry from the APA College of Professional Psychology about whether certification in Geropsychology is needed and feasible. As of the end of March, the Task Force sent a series of responses, and will continue to communicate with the College as it decides whether to develop a certificate in Geropsychology -- which may be a lengthy process. A key issue is likely to be whether there are adequate numbers of psychologists who will apply for a certificate in Geropsychology and pay an annual fee to make this financially feasible for the College.

In late 1986, the Task Force distributed a draft report on qualifications for practice in clinical geropsychology to all Section II members, as well as to various APA boards, committees, divisions, directorates, and outside organizations. The report was also posted on the Division 20 home page. Subsequently, a Task Force subcommittee headed by Peter Lichtenberg reviewed the comments received about the draft (generally very positive) and made recommendations for certain revisions. Most of the changes entail strengthening the report's discussion of areas in which greater emphasis was needed, but do not alter the basic consensus recommendations that the Task Force had reached on the types of training and experience that psychologists should have for practicing responsibly with older adult clients. The Task Force is presently pursuing further steps in obtaining official clearance of the report as an APA guidelines document, which involves additional circulation, comments, review by the APA legal office and Council, etc. Though the process is lengthy, securing clearance of the report may prove to be quite significant. In particular, if the APA College does decide to develop a certificate in (continued on p.9)

International Geropsychology: The Second Chapter

Bob G. Knight, Ph.D. (Editor)

What follows is the second in a three part series on international geropsychology. These brief descriptions provide a glimpse of clinical geropsychology in Korea and Norway. The next edition of the newsletter will describe geropsychology in Sweden, the United Kingdom and will end with a few observations on comparisons among countries. Looking at the development of the field in other nations can give us some insights into issues that we face here in the U.S. I have inserted a few comments or points of information in brackets in the individual pieces.

Geropsychology in Korea

Gahyun Youn
Department of Psychology, Chonnam National University
Kwangju, Korea 500-757

The Korean Psychological Association was founded over fifty years ago. The current membership is less than 1,000, in a total population of around 45 million. There are very few clinical psychologists who have an interest in geropsychology. In addition, there is a small number of developmental psychologists who have been working on the second half of life. Most clinical or developmental psychologists in Korea have worked on the areas of children and adolescence. Some Korean psychologists, irrespective of their major areas, have shown an interest in geropsychology as they have grown older.

Why is geropsychology not emerging as a specific area in Korea yet? First of all, the aged population in Korea remains small although increasing with industrialization from 3.2% in 1960 to 5.0% in 1990. Secondly, Westernization and urbanization of the Korean society began in the early 1960's. Consequently, the traditional extended family system has rapidly changed into a nuclear family system or a modified extended family system. The duty or role of the elderly Koreans in the past was to protect and govern their offspring while their position in the contemporary extended family system as aging parents has been altered to that of being protected and governed by their offspring.

Contemporary aging Koreans have been in conflict with their current situation, but have never complained about it. They have learned to restrain their needs and to suppress frustrations, traditionally considered a virtue. Over 90% of the contemporary aging Koreans were farmers when they were young. Moreover, more than 75% of the population was female.

Due to this traditional way of thinking, the elderly persons do not express their conflicts to other people clearly because they might consider it admitting that they were not good parents. The adult children also do not express conflicts with their elderly parents because they might consider it admitting that they were not good children.

However, it can be expected that the aging Koreans of 10 or 20 years hence will be greatly different from the contemporary aging Koreans. The future aging Koreans who were born between the late 1930s and the early 1950s were better educated and have lesser expectations of being cared for by their children than the current aging Koreans. That is to say, the current middle-aged Koreans might express their needs when they are old. Therefore, I am sure that geropsychology will be one of the primary areas in psychology within the next decade or so.

Clinical Geropsychology in Norway
Inger Hilde Nordhus

U of Bergen, Norway

In the Nordic countries, the number of clinical psychologists with training to serve the elderly is relatively small - about 50 psychologists in Norway [Note: this is from a total population of just over 4 million]. It is possible to identify settings in which psychologists offer services to older adults, despite lack of training to work with this population. Such is the case of many mental health clinics, private practices, psychiatric and general hospitals. These are settings in which university programs have an opportunity to offer supervised training.

Clinical geropsychology has been slowly emerging as a specialty area within clinical psychology. The Norwegian Psychological Association (NPF) has for some years offered a training program in clinical geropsychology, as a subspecialty of applied clinical psychology. The first seven candidates were graduated in 1992. About 20 psychologists have been enrolled in this program. Through an organized sequence of educational courses and supervised internship, appropriate areas of applied psychological practice with older adults are addressed. Most psychologists working within geropsychology have general clinical specialty training with more or less formalized geropsychology training as a supplement. It should be remembered that clinical psychology has a strong position in Norway. There are relatively few geropsychologists working at the university level. The University of Bergen is the only university in Norway with an outpatient psychology clinic offering supervised clinical graduate training as well as a didactic curriculum training.

The recognition of geropsychologists working as reimbursable providers of mental health care for older adults has been an important development in increasing the accessibility and use of psychological services for this segment of the population. But in spite of the relatively autonomous (in terms of professional status) position that psychologists have in Norway, we play a minor role within the primary community care system. Major cities are likely to have psychologists offering services to nursing homes (especially within dementia care), but primarily on a consultation basis. As specialists then, we are consulted in relation to neuropsychological assessment and in supervising health care personnel, and organizing/supervising various therapeutic interventions. As dementia care has recently developed, psychology as a profession within this area has become more explicit (both research and training programs have been created), employing psychologists working full time with a specified occupational title.

Aging at APA, continued from p. 1

I would like to encourage all of you to be sure that graduate students, psychology interns and postdocs who are interested in clinical aging join Section II. We have done well in building up membership, but need to do better in attracting student members. We will have a special discussion hour at the APA conference for students (see the APA program, p. 2). I hope you will encourage all your students and postdocs to attend.

Finally, on behalf of the entire Board of Section II, I want to extend an invitation to the membership to communicate your concerns to us. Please join us at the annual business meeting at APA, or contact us directly about issues you believe Section II should be considering. I look forward to hearing from you.

Report on Division 12 Board Activities

William E. Haley, Ph.D.

The Division 12 Board of Directors meeting held January 9-11 in New Orleans was my first as the newly-elected representative of our Section. It was a positive experience for me in every respect. First, it was clear that Barry Edelstein had very ably represented Clinical Geropsychology in his years as our representative, making other members of the Board sympathetic to our concerns. Second, I must admit, going to the Big Easy to represent our Division was a rather cushy assignment, other than the fact that I got too little sleep on this trip...

The Board discussed one item of great interest to Section II members. Our application for specialty recognition by the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP) had been placed on hold because of the use of the term "clinical" in the application. Section II, and Division 20 (which had cosponsored the proposal) proposed to proceed for approval under the term "geropsychology", dropping the controversial "c" word for now, but retaining the right to reconsider this at a later date. Fortunately, the Board supported this compromise position and the representatives to APA Council from Division 12 subsequently successfully supported our application. (Further information on this issue is presented elsewhere in this newsletter).

In other important news, the Division approved a deficit budget of about $60,000 for 1998. The Division still has substantial reserves but clearly cannot continue this type of deficit spending. Alternatives such as raising dues, working to increase membership, and decreasing the number of board meetings from three to two per year were considered. Some economies were adopted, including decreasing the numbers of individuals attending some of the board meetings.

Sections I (Clinical Child Psychology) and V (Society of Pediatric Psychology) are considering forming a new division. A task force was established to pursue this issue. While some psychologists might choose to retain Division 12 membership under such a scenario, this move clearly could weaken Division 12 as a unified force for the interests of clinical psychologists as a whole.

The Division 12 Newsletter, The Clinical Psychologist, has a new Editor, Paul Rokke. The newsletter will have a new look including color in the next issue.

President-elect Tom Ollendick noted that he is especially interested in developing two areas through special task forces. One will be "Reducing violence: Treatment methods and prevention strategies", and the other is "Upgrading the science and technology of assessment and diagnosis". Any Section II members with special interest and expertise in these areas should contact Steve Zarit concerning possible appointment to one of these task forces.

The Board also approved a motion encouraging ethnic and gender diversity in all sections, committees, and task forces of Division 12. With this reminder from the Board, we should do all that we can to be sure that women and ethnic minority psychologists are well represented in our section membership and in our elected officers.

Response To Prescription Privileges Debate- Against

Victor Molinari, Ph.D.

I would like to comment on three aspects of the prescription privileges debate that were not addressed in the otherwise fine presentation of the issues by Drs. Sexton, Zeiss, and Knight (previously published in this newsletter). One, there seems to be an underlying assumption in the pro camp that "expansion" of the scope of the practice of psychology is always a positive thing. I for one do not believe that more is necessarily better. Indeed, we need to take a good hard look at the recent problems caused by the increasing numbers of clinical and counseling graduate students who are dwarfing the limited internship training slots. To assert that we should widen the boundaries of our practice is to put the cart before the horse, and quantity above quality.

Two, the challenge of adequately training a scientist-practitioner who is well-grounded in research methodology, personality theory, psychological assessment, and capable in clinical practice across a variety of settings and ages is a daunting one. To add on psychopharmacological expertise is both overwhelming and misguided. What currently required graduate courses or clinical practica will be replaced by prescription privileges 101? There are still far too few programs which provide the training necessary to achieve proficiency status in clinical geropsychology. The recent draft report of the APA interdisciplinary task force on the training of practicing geropsychologists documents the extensive didactic knowledge and clinical training required for capable practice in this specialty area. Let us remedy the deficiencies in our current models of training which allow psychologists to graduate without a hint of gerontological expertise before taking on a far more difficult enterprise of "medicalizing" psychologists.

Three, our frequent insidious comparisons with psychiatrists are undergirded with the highly questionable presumption that we have somehow discovered a prescription training method which demands less education. As Dr. Zeiss suggested, such psychological hubris and disregard for the valuable expertise of our psychiatric colleagues (and PA's and nurse practitioners I may add) is at gross variance with the atmosphere of collegial respect so necessary for multidisciplinary teamwork in geriatric settings. Although it is true that you can become an MD with "just" four years of medical school, we all know that to be accepted into medical school almost always requires years of course work in pre-med programs, and that to be licensed as a psychiatrist demands a six-month medical internship and a psychiatric residency that takes an additional three and one-half years. Clinical geropsychologists working in hospital or long-term care settings are aware of the mind-numbing diagnostic and pharmacological dilemmas faced by professionals treating the psychiatric problems of older patients. Our unit recently admitted a man with COPD, diabetes, and a seizure disorder, who was status post multiple CVA's and who had an acute behavioral change just PTA. There was a need to evaluate for psychosis and/or depression to determine which of the many medications he was currently taking for his medical problems could be contributing to his symptomatology, and to select which psychiatric medication might be effective in remitting his symptoms. If he were a close relative of mine, I would hope that it was a full-fledged geropsychiatrist making the difficult medical decisions and referrals by working in close consultation with other physicians. I would also hope that there was an adequately trained geropsychologist competently addressing the myriad of psychological features so frequently encountered in older adult patients. Just because certain professions allow some members to practice beyond the scope of their gerontological expertise, does not mean that psychologists should follow suit.

Resources of the Coalition of Mental Health and Aging

Jiska Cohen-Mansfield, Ph.D.

The following resources were publicized in the latest meeting of the coalition of mental health and aging.

AARP: http://www.aarp.org
- AARP published a booklet: "9 ways to get the most from your managed health care plan."
- AARP Federal Health Update

- Newsletter: Dimensions Quarterly, of the mental health and aging network of the American Society on Aging.
- Recruitment brochure: Join the leaders. Mental Health and Aging Network

National Technical Assistance Center for State Mental Health Planning: http://www.nasmhpd.org/ntac
e-mail: ntac@nasmhpd.org
- Report: Planting the seeds of change: Developing mental health and aging coalitions to improve services for older persons with mental illness.

University of Pennsylvania, Center for Mental Health Policy and Services Research:
http://www.med.upenn.edu/cmhpsr
Reports: Managed care initiative panel reports:
- Adults with serious mental illness
- Children and adolescents with mental illness
- Older adults with mental illness
- African-American persons with mental illness
- Asian-American persons with mental illness
- Hispanic-American persons with mental illness

The reports are listed under: Publications and Presentations. Click on: Managed Care Consensus Reports.

CMHS - SAMHSA, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration: http://www.samhsa.gov
- Status report: Mental Health Managed Care and Workforce/Training Project. A 3-year plan (FY 1995-1997) and status report.

Department of Veterans Affairs (VA): http://www.va.gov
- Guidelines: Assessment of competency and capacity of older adults: a practice guideline for psychologists. Available at VA Medical Systems libraries, and from National Technical Information, U.S. Department of Commerce, 5285 Port Royal Road, Springfield, VA 22161, telephone (703) 487-4650. Expedited requests may be made to 1 (800) 553-NTIS. Request publication #PB 97-147904.

National Coalition on Mental Health and Aging: http://www.mentalhealth.org/resource/how2.htm
- Overhead handouts: State Coalition study and report - Willard Mays.

Mental Health and Aging, continued from previous page

American Geriatrics Society, American Association for Geriatric Psychiatry and the Alzheimer's Association: http://www.americangeriatrics.org
- Consensus statements: Diagnosis and treatment of Alzheimer's disease and related disorders. JAMA, October 1997, 278 (16), 1363-1371.

American Occupational Therapy Association: http://www.aota.org
- Paper: Occupational therapy for independently living older adults. JAMA October 1997, 278 (16) 1321-1326.
- Guidelines: Occupational therapy practice guidelines for substance use disorders.

Proficiency in Geropsychology, continued from p. 3

(clinical) Geropsychology, we hope that the Task Force's recommendations will strongly influence the specific qualifying criteria that are established for applicants.

Established in 1994 as a collaborative initiative of Section II and Division 20, the Task Force is chaired by George Niederehe (for Section II) and Linda Teri (for Division 20). Other members include Michael Duffy, Barry Edelstein, Dolores Gallagher-Thompson, Margaret Gatz, Paula Hartman-Stein, Gregory Hinrichsen, Asenath LaRue, Peter Lichtenberg, and George Taylor.

Editor's Comments

Suzanne Norman, Ph.D.

Greetings! As I finish out my first year as newsletter editor, I wanted to update our readership on some new developments in the year ahead. First of all, I would like to thank all those who have contributed to the newsletter this year. This is an exciting time in geropsychology and the newsletter provides an opportunity for all of us to stay abreast of new developments within our field.

In the year ahead our newsletter will expand from 2 to 3 issues per year. As part of this growth we would like to include a regular column entitled "Clinical Geropsychology Exchange". This column will be similar to the CGX updates which were disseminated via e-mail in the past. Articles featured in the exchange might cover a wide variety of topics generally of interest to our readers. This could include, but is not limited to, pieces focusing on various aspects of clinical practice/ consultation, new research developments, public policy issues, "hot topics" in geropsychology, etc. I would like to see this column used as an exchange of ideas and information which would include the opinions and questions of students as well as experts in the field. Feel free to send submissions for this column to me by e-mail at: Normans@Xavier.xu.edu or by mail at the address listed below.

Did you know that Division 12, Section 2 has an e-mail network? I would like to encourage all of you to take advantage of this opportunity to stay connected with your colleagues in clinical geropsychology by joining! Any member of this section may join by simply sending a note expressing your interest in the e-mail network to Barry Edelstein at u21b4@wvnvm.wvnet.edu. Please include your name and e-mail address.

Finally, just a few reminders. If you need to change your address for the newsletter please contact Kathy Riley at e-mail: kriley@aging.coa.uky.edu or by phone: (606) 257-3921. If you would like a new member application form, contact Bernice Marcopulos at e-mail: bam8@virginia.edu or by phone: (540) 332- 8391. Have a great summer!

Clinical Geropsychology News
Newsletter of Section II, Div. 12, APA
Suzanne Norman, Ph.D., Editor
Department of Psychology
Xavier University
3800 Victory Parkway
Cincinnati, Ohio 45207-6511

Gregory A. Hinrichsen, Ph.D.
Research Building
Hillside Hospital
75-59 263rd Street
Glen Oaks, NY 11004-0038