# CLINICAL GEROPSYCHOLOGY NEWS

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# APA Div. 12/2 Presidential Address

## The Final Frontier: Perspectives on the Oldest Old

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

The oldest old, people aged 80 and over, is the fastest growing segment of the population, yet relatively little is known about their functioning. What does it mean to reach very late life? Is decline and disability all that we can expect, or can some people function independently, despite advanced age? And if so, what factors might promote independence and delay disability? These are important questions for researchers and clinicians alike. As psychologists, we need to know if the same principles of assessment and treatment developed and standardized with the young old work as effectively with the oldest old, or if there are special characteristics or challenges in very late life. From a larger social perspective, a growing dependent population of very old would place enormous cost pressure on Medicare and Medicaid and on society as a whole.

In this paper, I report on studies conducted over the past decade with colleagues at the Institute of Gerontology at the University College of Health Sciences in Jönköping, Sweden, Boo Johansson who introduced me to this research and with whom I have worked closely on several studies, Stig Berg, Bo Malmberg and Gerdt Sundström. We have also been assisted by several colleagues and doctoral students in the U.S.

Besides being a scenic and friendly country to visit, Sweden offers unique opportunities for studying the oldest old. It is possible to recruit select samples, such as people aged 80 or 85 and older, with greater ease in Sweden than in the U.S. Sweden is also more advanced in the aging of its population than the U.S. The proportion of people 65 and older in Sweden is 17 percent, or about what the U.S. will reach in the next 10 to 20 years. Finally, Sweden has a comprehensive and affordable system of long term care for its older people, which makes an interesting contrast with our own pattern of services and benefits.

I want to begin by examining the prevalence and pattern of disabilities in very late life, which will suggest what is typical or normative at advanced ages. I will then examine models of disabilities, including what factors may be associated with continued independence. I will then consider patterns of help to disabled elders in Sweden compared to the U.S. Finally, I will discuss the implications of these findings.
(continued on p.6)

# Training in Professional Psychology

Gregory A. Hinrichsen, Ph.D., Michele J. Karel, Ph.D. and Victor Molinari, Ph.D.

At the APA annual meeting in San Francisco several members of the Section discussed issues in geropsychology education and training from the graduate to the post-graduate years in a symposium organized by Victor Molinari, Ph.D. and Gregory Hinrichsen, Ph.D. With recent recognition of clinical geropsychology as a proficiency area, it appeared critical to identify core educational training experiences that are necessary to competently work with older adults. Michael Duffy, Ph.D. noted that historically graduate school training has primarily focused on general or academic aspects of the aging process. He characterized graduates of programs with these offerings as generalists "trained in knowledge about aging but with few specific skills in actually helping older adults." In part,this has reflected the undervaluing of applied work within academic circles. This is beginning to change and there are more opportunities for graduate students to obtain clinical training in work with the aged. Dr. Duffy described his own program in Counseling Psychology at Texas A & M which awards a speciality certificate in clinical geropsychology. This program provides organized field practica in geriatric settings with grand rounds, intensive supervision, coordinated with a curriculum in research, assessment, psychotherapy, family therapy and consultation.

Gregory Hinrichsen, Ph.D. Diane Myers, Ph.D. and Douglas Stewart presented results of a summary of data collected through the *Directory of Predoctoral Internships in Clinical Geropsychology Training Opportunities and Postdoctoral Geropsychology Fellowships*. The Directory was an effort by the presenters, in collaboration with Section II, to develop a listing of clinical training opportunities in geropsychology. The presentation focused on internship training opportunities. Psychology internships are seen as an important tool for recruitment of beginning professionals into geropsychology. Sixty-five psychology internships self-identified as offering substantive clinical geropsychology training. VA's dominated as the most common training site. One-third of the internships offered speciality training slots in clinical geropsychology with a sum of 40 slots nationally. The majority of other internships -- without speciality slots but which offered training opportunities in work with older adults -- offered two or more non-specialty training slots with a total of 207 nationally. The most common types of clinical placements are in nursing homes (45.1%) and psychiatric inpatient units (35%). Services provided by interns in these placements were quite varied. Cognitive/neuropsychological, behavioral, diagnostic/personality and functional assessments were available in the majority of settings. Individual, group, and family therapies were also noted by the majority of sites. Empirically supported treatments were mentioned by only about one-third of sites. Notably, 80% of internships listed in the Directory indicated that their supervisory staff had specific clinical and/or research interests in aging.

Michele Karel, Ph.D., Victor Molinari, Ph.D., Dolores Gallagher-Thompson, Ph.D., and Stephanie Hillman, M.S. described the results and implications of a survey of psychologists who completed clinical geropsychology postdoctoral training during the past five years. Eighty of 109 graduates from 14 post-doctoral programs responded to a mailed survey, representing a 73.4% response rate. Respondents to the survey were 64% female, 91% Caucasian, and ranging in age from 27 to 56 (mean = 37.5). Most held Ph.D. degrees (91%) granted mainly from clinical psychology graduate programs (75%); 90% completed their postdoctoral training after 1990, 56% of respondents completed VAMC-based postdoctoral programs and 73% completed VAMC-based internship programs. The questionnaire asked respondents to rate themselves as poor, some, or a firm sense of competence in each of 40 competency areas. Respondents reported having "some competence" or "a firm sense of competence" in almost every area.

(continued on p. 9)

# President's Comments

Steven H. Zarit, Ph.D.

If you are reacting to all the news out of Washington as I am, you have probably concluded there is nothing worthwhile in the newspapers anymore. Then, of course, you have more time to read the valuable and important articles in our newsletter. I would like to call your attention to two matters: encouraging students to join Section II, and activities of APA's Committee on Aging.

**Student Membership**

For those of us who teach or who supervise interns and postdocs, we need to remind students to join Section II and to participate in our activities. Benefits of membership include the receipt of the Section's newsletter three times a year, access to geropsychology faculty and practitioners for advice and mentoring, exchanges with other clinical geropsychology students, and a chance to get involved in a professional organization. Students can learn about career opportunities as well as cutting edge research and clinical programs. [An informational page for students entitled, APA Division 12 Section II (Clinical Geropsychology) and an application form have been included in the center of this newsletter. Please pass these along to your students.] We had a very productive discussion at the APA meetings in August between student members and the Section II Board, and hope to hold similar meetings in the future.

**APA Committee on Aging**

The APA Committee on Aging (CONA) just finished its second meeting. It has begun to serve the purpose many of us hoped for, that is, getting APA's various committees, boards and directorates to think about aging as they develop programs or policies.

The committee meets at APA's consolidated meetings, where other committees and task forces are holding their sessions. CONA has the opportunity to review the activities and proposed actions of other committees and to comment on them. This review assures that aging perspectives will be appropriately taken into account. As an example, the Committee on Women developed a laudable resolution that will be proposed to APA Council about violence against women. CONA proposed additional language to supporting materials for the resolution that appropriately took into account the types of violence that can be suffered by older women.

In a similar way, other committees and boards in the past have developed initiatives that involved aging issues, but did not bring in experts from Section II or Division 20, who knew something about these issues. In future activities of that sort, CONA would take the lead, or would collaborate with other groups, and would make sure that psychologists from Section II or Division 20 who are knowledgeable about the issue being discussed would get involved.

Another important way that CONA can have an influence is by opening up lines of communication with APA's directorates: Science, Education, Practice, and Public Interest (of which CONA is a part). Of particular interest to Section II is to make sure that the Practice Directorate is aware of the reimbursement problems that clinical geropsychologists have encountered. After a discussion with a representative from Practice, I was reassured that they were aware and actively engaged on the issues that members were bringing to my attention, namely, dealing with "incident to" services and Medicare carriers that are making it difficult to get reimbursement for appropriate psychological services. These discussions, however, were very preliminary, indeed, occurring right at the end of the CONA meeting. What I hope is that the discussions will continue and there will be good lines of communication between CONA and the Practice Directorate, so that the concerns of clinical geropsychologists can be heard.

# International Geropsychology: The Final Chapter

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

What follows is the final piece in a three part series on international geropsychology. These brief descriptions provide a glimpse of clinical geropsychology in Sweden and The United Kingdom. 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 Sweden

Boo Johansson
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In Sweden, interest in geropsychology became manifest in the late 1960's and early 1970's. The prevailing medical perspective on aging and the elderly was slowly supplemented by an incorporation of behavioral aspects to achieve a better understanding of aging and age related changes.

A few psychologists announced their interest in gerontological research and a few were offered clinical positions in the health care system in the early 70s. Since these early days of geropsychology, approximately 100 positions are now available in the comprehensive health care system, mainly for assessments in hospital-based geriatrics and at psychogeriatric clinics. More recently positions are offered as consultants and supervisors to staff working in community-based aging programs. More such positions are expected to become available. In Sweden, counties are responsible for the medical part of old age care, while the municipalities organize social services, including sheltered housing, long-term care, home-help, and other programs to support independent living.

The first national meeting for geropsychologist was organized in 1980; then followed by annual meetings for an increasing number of psychologists partly or exclusively working with the elderly. A geropsychology interest group was formed in 1986 and became the embryo to the Swedish Society for Geropsychologists (SGF), now a section within the Swedish Psychological Association. SGF was founded in 1995 with a current membership list of about 60 persons [Ed. Note: The population of Sweden is about 8.3 million]. The need for a close relationship between researchers in geropsychology and those in clinical practice was early emphasized.

A problem in the recruitment of psychologists for work with the elderly has been the "lack of aging" in the basic curriculum for psychologist (5-years, followed by one-year of internship/residency). Initiatives to include more aging in the curriculum have come from SGF and was addressed by a task force within the Nordic Gerontological Society. Post-graduate programs in geropsychology have been offered on an irregular basis since 1982. Better educational opportunities, from the undergraduate level to post-graduate courses, is currently a high priority issue for SGF. A collaboration between the Scandinavian countries is discussed here. SGF is currently working to achieve an approval of geropsychology as a sub-specialty, according to the recent "specialist format" that now includes the fields of clinical psychology, educational psychology, neuropsychology, and organization-/work psychology.

Geropsychology has slowly become an established field for psychologists' in Sweden. However, much work remains to improve and integrate geropsychology in the educational system. The demands for qualified geropsychological practice from an increasing number of elderly people, as well as from other professions who are knowledgeable about psychologists' expertise in assessment, treatment, consultation, and research, is promising for the future.

(continued on p. 10)

# Editor's Comments

Suzanne Norman, Ph.D.

Greetings! With the addition of a Fall installment of the newsletter we bring to you some of the highlights from the APA convention program for clinical geropsychology held in San Francisco last August. Included in this newsletter are Steve Zarit's presidential address offering insights into the needs of the oldest old in the U.S. and Sweden and a synopsis of the symposium on training in professional geropsychology. Many thanks to Steve Zarit, Greg Hinrichsen, Michelle Karel, and Victor Molinari for their contributions to the newsletter and Toni Zeiss who did an excellent job of planning our program.

It seems hard to believe but it's already time to start thinking about APA in 1999, keeping in mind the December 2 deadline for submissions. Greg Hinrichsen is hard at work planning our division's program for next August. Dick Suinn, as president of APA, plans to focus on addressing cancer and minority issues. Certainly these are relevant issues for clinical geropsychologists and I encourage our members to submit articles on cancer or minority issues in aging for presentation at APA in August, 1999.

Special thanks to Bob Knight for his series of articles focusing on International Geropsychology which ran in the December, 1997, May & October, 1998 newsletters. Reading about the involvement of geropsychologists around the world was very interesting and put the U.S. efforts in a new context.

I would like to encourage our members (especially students) to send submissions for the "Clinical Geropsychology Exchange" (CGX) column which will be a new newsletter feature. Dolores Gallagher-Thompson has graciously agreed to discuss her involvement in the End of Life Task Force, an important topic which I hope will generate some discussion amongst our members. As a reminder, articles featured in the CGX column 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 or suggestions for possible topics to me by e-mail at: Normans@Xavier.xu.edu or on disc by mail at: Psychology Dept., Xavier University, 3800 Victory Parkway, Cincinnati, OH 45207-6511.

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. To join the 12/2 e-mail network contact Barry Edelstein at u21b4@wvnvm.wvnet.edu. Please include your name and e-mail address.

**The Final Frontier**, continued from p.1

Prevalence and Pattern of Disabilities

Findings on the prevalence and pattern of disabilities comes primarily from the OCTO study, a population-based, longitudinal study of the oldest old (Johansson & Zarit, 1995; Zarit, Johansson & Berg, 1993; Zarit, Johansson & Malmberg, 1995). The sample for this study was initially aged 84 to 90, and was assessed at two-year intervals for 6 years.

Looking first at prevalence of disabilities, not surprisingly, people were most likely to report problems in carrying out instrumental activities of daily living (IADL). Seventy-four percent of the sample had some difficulty carrying out IADLs. Fewer people had difficulties with basic activities of daily living (ADL) or with mobility (44% and 47%, respectively). In turn, 31 percent of the sample had cognitive impairment consistent with a diagnosis of dementia, which is a considerable amount, but certainly not universal. This prevalence of dementia is similar to most other reports on people over 85.

Disabilities, of course, do not occur in isolation. As we examined patterns of co-disability, some interesting findings emerged. First, 38% of participants had no significiant disabilities. This group could certainly be characterized as "successful agers". Another sizable group (29%) had difficulties with IADLs only. This group would be able to function well with relatively small amounts of help, such as assistance with housekeeping, shopping, or meals, although those are types of services that are being cut back even in Sweden, and can be very difficult to arrange in the U.S. A relatively small group (3%) had IADL and ADL disabilities. Finally, a large group (31%) had dementia and problems carrying out various IADLs and/or ADLs. In other words, relatively few people without cognitive impairment had heavy care needs, while a considerable proportion of those people who required assistance also had cognitive difficulties. This means, of course, that care systems for the oldest old have to accommodate people with dementia.

We next examined changes in functioning over time. Focusing just on dementia, we found that people initially classified as having dementia had a higher mortality rate between each round of assessments than did people without evidence of cognitive deficits (Johansson & Zarit, 1997). Despite this higher mortality, incident cases of dementia more than fully replaced those people who had died. Reflecting these changes, prevalence of dementia cases rose slightly from 31 percent to 42 percent across the 6 year period. Cumulative risk of developing dementia at some point before dying was estimated at 53 percent.

An important caveat is that our determination of dementia used DSM IV criteria, but was not confirmed at autopsy. It may be that at advanced ages cognitive impairment is due to other causes than a progressive dementia, for example, cardiovascular disease, multiple medications, or a process of terminal decline. From a functional perspective, however, the implications are the same, that care of the oldest old will frequently be complicated by cognitive deficits.

An important comorbidity for functional decline is depression. Using a short form of the CES-D, we found that rates of depressive symptoms were somewhat higher in the OCTO sample of oldest old than reported among the young old (Zarit, Femia, Gatz, & Johansson, 1998). One quarter of the sample had clinically-significant levels of depression at baseline, a proportion that stayed about the same over the course of the study. Between assessments, we found new, incident cases of depression, but also people who recovered. While we had no information regarding what treatment people might have received, these results suggest that depressive symptoms remain modifiable even at these late ages.

(continued on p. 7)

**The Final Frontier**, continued from p.6

Predicting Stability and Decline

I want to turn next to two study conducted by Elia Femia which examined predictors of stability and decline in very late life (Femia, Zarit, & Johansson, 1997; Femia, Zarit, & Johansson, 1998). The first used data from the OCTO study, comparing people who declined in functioning from Wave 1 to Wave 2 to people who remained stable. Three domains of functioning were examined: IADLs, ADLs and Mobility. Predictors were sociodemographic variables, measures of physical vitality (e.g., lung function, grip strength), and psychological variables (e.g., mastery, subjective health ratings). The results showed that psychological variables, particularly mastery, consistently differentiated people who remained stable from those who declined, even after taking into account physical vitality. People with a greater perceived sense of mastery were more likely to be stable in all three domains of functioning.

This approach to examining disabilities was extended to a second sample, OCTO Twin. This study recruited intact same-sex twin pairs aged 80 and over throughout Sweden, using the unique Swedish twin registry, and was designed to examine genetic and environmental contributions to functioning in later life. For these analyses, we did a more traditional gerontological study of individual differences by selecting one twin randomly from each pair. The study had a slightly larger sample size than OCTO (N = 351 at Wave 1), and used some different measures.

Using Verbrugge and Jette's disablement process as a guide, a model was tested which viewed disability as the outcome of a process by which the impact of chronic illness and its subsequent functional impairments were mediated by psychosocial factors. The results of a cross-sectional test that used Structural Equation Modeling confirmed this model. Psychological variables, including poorer subjective health, being depressed, and lower social integration, were associated with more severe disability. The effects of functional impairments (e.g., vision loss, grip strength) and functional limitations (e.g., upper and lower body limitations, cognitive deficits) were mediated by these psychosocial variables. These findings indicate that while 95 percent of the sample had one or more chronic disease, these conditions do not directly translate into disability. Rather, disability is the outcome of a complex process in which the consequences of chronic disease are mediated by psychological resources.

Of course, a major limitation of these analyses is that they were cross-sectional. We attempted to extend the analysis to a longitudinal panel but found there were too few individuals who declined during the first two-year follow up in order to model change. While further testing of possible mediators of decline is needed, the results of these two studies suggest that psychological interventions that enhance personal resources such as mastery and/or reduce depression may contain the effects of chronic illness of everyday functioning.

Patterns of Help in the U.S. and Sweden

The last set of studies I want to discuss examine how much help people get in the U.S. and Sweden and the sources of that help (Zarit, Shea, Berg Sundström, Davey, & Femia, 1998). This comparison is potentially informative because Sweden has an extensive system of community-based long term care services that is affordable and accessible, while the U.S. has a more patchwork system of services that are not consistently covered by Medicare or most other insurance (private long-term care insurance being the exception).

We were interested in determining if families in Sweden provided less help and formal services provided more help than in the U.S. We used data from a U.S. national survey (1994 National Medical Expenditure Study--NMES) and a Swedish national survey (På Älder D'ar--Aging at Home) that asked comparable questions about IADL and ADL performance and assistance (continued on p. 8)

**The Final Frontier**, continued from p. 7

received from informal and formal sources. The samples were people aged 75 and older living in ordinary housing. After adjusting for the need for assistance (i.e., needing help with one or more IADL and/or ADL), we found that older Swedes were more likely to get formal help, but there was no difference in the amount of help provided by families between the two countries. There was also much less unmet need in Sweden (1%) compared to the U.S. (29%). These differences were most pronounced among the oldest old and people living alone. Thus, despite the greater availability of formal services, families in Sweden participate as much in assisting older family members as in the U.S.

These findings have important implications for estimating the cost of a comprehensive long-term care system in the U.S. On the one hand, families will not recede into the background if formal services are covered more consistently by Medicare. On the other hand, there is a large group of older adults in the U.S. who are not getting the help they need with ADLs and IADLs . These people ought naturally to be the target of any new system of community based long-term care. In particular, the very old (85+) and those living alone seem most vulnerable under the current U.S. system. As experienced geropsychologists already know, they often have to be advocates for their clients to get needed services because of the fragmented care system in the U.S. Opportunities for clinical intervention will improve if supportive services to help older people and their families are more readily accessible.

Conclusions

Very late life remains a largely unexplored area, despite the growing number of people aged 80 and over. An important role for geropsychologists is to develop an understanding of the needs and potential of this age group, and to implement appropriate methods of assessment and treatment. The findings from the studies reviewed here emphasize the high rates of need, particular for people with cognitive disabilities, but also the potential that psychological interventions might lower rates of ADL and IADL disabilities, and allow people in very late life to function at their highest potential.

References

Femia, E. E., Zarit, S. H., & Johansson, B. (1997). Predicting change in activities of daily living: A longitudinal study of the oldest old. Journal of Gerontology: Psychological Sciences, 52B, P294-P302.

Femia, E. E., Zarit, S. H., & Johansson, B. (1998, May). The disablement process in very late life. Paper presented at the Nordic Gerontology Congress. Trondheim, Norway.

Johansson, B., & Zarit, S. H. (1997). Cognitive predictors of the incidence of dementia and mortality in a representative sample of oldest old. International Journal of Geriatric Psychiatry, 12,53 -59.

Johansson, B., & Zarit, S. H. (1995). Prevalence and incidence of dementia in the oldest old: A study of a population based sample of 84-90 year olds in Sweden. International Journal of Geriatric Psychiatry, 10, 359-366.

Zarit, S. H., Johansson, B., & Malmberg, B. (1995). Changes in functional competency of the oldest old: A longitudinal study. Journal of Aging and Health, 7, 3-23.

Zarit, S.H., Johansson, B., & Berg, S. (1993). Functional impairment and co-disability in the oldest old. Journal of Aging and Health, 3, 291-305.

Zarit, S.H., Femia, E.E., Gatz, M., & Johansson, B. (1998). Prevalence, incidence and correlates of depression in the oldest old: The OCTO study. Unpublished paper.

Zarit, S. H., Shea, D. G., Berg, S., Sundström, G., Davey, A., & Femia, E. E. (1998, May). Patterns of formal and informal long term care in the United States and Sweden. Report to the AARP-Andrus Foundation. Gerontology Center, Penn State University, University Park, PA.

**Training in Professional Psychology**, continued from p.2

Areas that had relatively less consistent ratings of competence included: providing couple's, family, and group psychotherapies, knowledge of diversity issues with respect to gender, race/ethnicity, and sexual orientation, and skills in program management and program evaluation. While post-doctoral training prepares highly qualified specialists, the current health care system may not adequately make use of these specialists. A significant minority of the respondents expressed concerns about being able to find a full-time job in the field. Common concerns were inadequate pay and wish for better integration of research and clinical training. The majority of respondents (90%) reported spending at least some of their professional time devoted to geropsychology activity. On average, they spend at least half of their professional time in geropsychology activities including: clinical service, training, research, and administration. Most respondents have published and are affiliated with aging-related professional organizations.

Sara Honn Qualls, Ph.D. and Nan Kramer, Ph.D. noted that two large training conferences have outlined needed academic and practica training for persons interested in providing services to older adults. They said that the report by the (Division 20, Section II) Interdivisional Task Force on Qualifications for Practice in Clinical and Applied Geropsychology further fleshes out requisite skills needed by practicing geropsychologists. Recognition of clinical geropsychology as a proficiency area by APA underscores the need for continuing education opportunities for psychologists who work with older adults but who have not received formal training as well as for those who want to expand their practice to include the elderly. Dr. Qualls summarized the experience of Division 20 and Section II in promoting CE offerings for psychologists which have primarily taken place as APA pre-conference workshops. Participants in 1994-1996 workshops practiced, in order of frequency, in: nursing homes, outpatient settings, hospitals, clients' homes, private offices, and day care centers. Almost all of them wanted to expand their practice with older persons. Dr. Qualls noted that Division 20 has changed the focus of its CE-accredited activities to encourage and accredit regional CE conferences at varied institutions throughout the country.

Steven Zarit, Ph.D concluded the sessions with an integrative summary of the presented papers and encouraged the authors to continue to do creative thinking and empirical research on geropsychology training. He discussed APA and national public policies that support or impede geropsychology. Despite significant advances in the numbers of undergraduate, graduate, internship, and post-doctoral geriatric educational experiences now offered, psychology training output is still lagging behind demand. The need across a variety of geriatrics settings for psychologists who have expertise in geropsychology is still outstripping the supply. He concluded that continuing education workshops may be the most efficient avenue to assist psychologists in gaining proficiency status so that older adults received competent mental health care.

**International Geropsychology**, continued from p.3

Clinical Geropsychology in the UK
Bob Woods
U of Wales, Bangor, United Kingdom

Clinical psychology with older people is one of the four major areas of clinical practice in the UK, alongside adult mental health, work with children and work with people with learning difficulties. These are the four areas in which all students in clinical psychology must gain practical experience, under the supervision of a senior clinical psychologist.

Most clinical psychologists working in this area belong to 'PSIGE' the most organized and cohesive of the 'Special Interest Groups' of the British Psychological Society Division of Clinical Psychology. This group has a regular Newsletter, a lively, well-attended Annual Conference and regional group meetings for its 300 plus members [Note: U.K. population about 57 million]. It is regularly consulted on government documents on ageing, and produces briefing papers on matters of policy relevance.

PSIGE was formed in 1980, following a slightly earlier initiative in Scotland. It was in the mid-1970's that recognition grew of a broader role for clinical psychology with older people beyond developing and administering cognitive tests for dementia. Therapeutic approaches to dementia began to be discussed, and as a variety of roles emerged the speciality became more popular, at a time when care of older people became a recognized priority for the NHS.

In virtually every part of the country, a National Health Service (NHS) post has been created for a clinical psychologist to work with older adults. In a few well-established centers, as many as 5 or 6 qualified clinical psychologists may work in this speciality; a group of 2 or 3 would be more usual. Growth of numbers has been steady and continues, but a key issue remains the difficulty in providing sufficient training placements for all those who require them. This relates to the second key issue - filling the numerous vacant posts, so that the potential of clinical psychology services can be delivered. [Note: It's difficult to imagine having a problem with filling vacant job openings in clinical geropsychology in the U.S.] There is at times a Catch-22 situation: to fill vacant posts we need to train more people; we cannot train more people because of the lack of qualified psychologists to supervise placements, reflected in the vacant posts.

Virtually all psychologists working with older people are employed in the NHS. It would be usual for some of this work to be carried out in homes, day-centers etc. managed by other health and social care providers. It would be rare for other health and social care providers to directly employ a clinical psychologist in this area, and the scope for private practice with older people is perceived to be limited. A small, but growing, number have a part-time attachment to one of the clinical psychology training courses (typically University-based, offering a three-year doctorate program), reflecting the requirement on the courses to provide teaching and organize clinical placements in this area. A few are employed in a University context, having primarily a research focus.

Although clinical psychologists draw heavily on initiatives and research from the USA in their work, the NHS context has enabled a more consistent pattern of growth and service than in the USA. Academic developments have tended to be secondary to service development. (continued on p.11)

**International Geropsychology**, continued from p.10

Concluding Comments
Bob G. Knight, Ph.D.

With regard to clinical geropsychology in these nations and the U.S., it strikes me that we all see ourselves as both new and small. In some ways the relative size (at least in Norway, Sweden, and the U.K.) and the rate of growth seem larger elsewhere than here: Section 2 has just over 300 members, the U.S. population base is about 260 million. One could wonder why clinical geropsychology seems to be a development of the late 20th century in all four countries.

The U.S. would seem distinctive in the academic and research base for clinical geropsychology: much of our Section is in academia and much of the impetus for the growth of the field has come from universities (including medical centers) and from the VA. Of course, it could hardly come from the National Health Service or a national initiative in dementia care, since we do not have those here. The sheer size of the U.S. (both population and geography) and the independent, private enterprise approach to health care, including the practice of clinical psychology as a kind of footnote make a broad-based national approach to clinical geropsychology essentially impossible and place decision making largely at the state, local, and individual levels. As we face the redesign of the U.S. approach to mental health service provision in general and the probable redesign of Medicare over the next decade in particular, we would do well to look for ideas and models of service and training abroad as well as in the U.S.

## MEMBER INFORMATION

**Name:** ________________________________________________

**APA Status (check one): Fellow _____ Member _____ Associate _____**

**APA Division Affiliations:** ________________________________________

**Primary Professional Position and Institutional Affiliation:**

________________________________________________________________

**Date of Birth:** _______________ **Highest Degree/Date:** ____________________

**(from) University/Major Field** ________________________________________

**Current Employment Status: Full Time _____ Part Time ____ Not Employed ____**

**Primary Work Setting: University (Academic Dept.) _____ Medical School _____**

**Mental Health Center _____ Other Hospital _____ Private Practice _____**

**Other** ________________________________________________

**Percentage of Time Spent In: Research _____ Clinical Service ______**

**Teaching _____ Clinical Training/Supervision _______**

**Administration _______ Other _________________**

**Other Psychological and Gerontological Organizations to Which You Belong:**

________________________________________________________________

**Primary Areas of Interest Within Geropsychology:**

________________________________________________________________

**Would you be interested in serving on Section Committees? Please rank the following in order of your preference (1 = most preferred. If you prefer not to do committee work, leave blank):**

_____ **Membership** _____ **Program**

_____ **Nominations/Elections** _____ **Ad Hoc Committees**

## APA Division 12, Section II (Clinical Geropsychology)

As many of you know, approximately 17% of the population will be over the age of 65 by the year 2000. Psychologists are responding to the needs of a growing older adult population by training professionals in the emerging field of clinical geropsychology. In 1993, the Clinical Geropsychology Section of Division 12 was created.

**What is Division 12, Section II?**

Clinical Geropsychology is a subspecialty of APA's Division 12 (Clinical Psychology). The members of Section II all share a common interest in clinical aging issues (e.g., intervention, psychopathology, diagnostic issues, legislation). The Section boasts a membership of over 300 individuals from numerous disciplines (e.g., Clinical, Counseling, Developmental, Health).

**Who can belong?**

Anyone with interests in aging issues. In order to join, you need to first become a student affiliate member of APA. The Section is particularly interested in increasing the number of graduate student members.

**Benefits of Membership:**

*Subscription to Section II newsletter (3 times/year)
*Annual Student Research Award and Travel Award Competition
*Compendium of Geropsychology Graduate Programs (predoctoral and postdoctoral)
*Access to Section web page and email chat group
*Partnership with Division 20 (Adult Development and Aging)

Further, there are exciting new professional opportunities for individuals pursuing study of aging populations. APA recently approved a proposal to recognize Clinical Geropsychology as a proficiency in professional psychology. From the very beginning, Section II has worked in conjunction with Division 20 and other APA interest groups to support and contribute to such a proposal.

**Cost?**

$5.00 annual fee.

**Annual Event:**

A Student Discussion Hour is held annually at APA in the Hospitality Suite for Division 12. This is a chance to meet and talk with Section II's leadership about issues in the developing field of clinical geropsychology.

**Contact Information:**

For student membership applications, questions, or suggestions, please contact the Student Liaison: Natalie Denburg, Ph.D., Neuropsychology Fellow, Department of Neurology, #2007 RCP, University of Iowa Hospitals and Clinics, 200 Hawkins Drive, Iowa City, IA 52242, (319) 356-2671. Please send all email inquiries to: natalie-denburg@uiowa.edu

**APA Division 12, Section II**
***Clinical Geropsychology***

# NEW MEMBER APPLICATION

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

**Name :** ______________________________

**Address:** ______________________________

______________________________

______________________________

**Phone:** ______________ **FAX:** ______________

***e-mail:** ______________

****All new members with e-mail addresses are automatically subscribed to the Division 12, Section 2 Clinical Geropsychology listserver (inernet network). If you would prefer NOT to be subscribed, please check here*** _______

| **Section II Membership Status (Circle one):** | | | |
|---|---|---|---|
| **Divisional** | **Affiliate** | **Associate** | **Student** |

**DUES**
**Divisional, Affiliate, Associate Dues are $10.00 (U.S.)**
**Student Dues are $5.00 (U.S.)**

**1998 Membership Dues$**_________

**Signature:**______________________________ **Date:** ____________

***Please make your check (in U.S. dollars) payable to:***
***APA Division 12, Section II***

**Mail this form, along with your check to:**

**Bernice A. Marcopulos, Ph.D.**
**Section II Membership Co-Chair**
**Neuropsychology Lab**
**Western State Hospital**
**Box 2500**
**Staunton, VA. 24402-250**

**Please complete the member information on the reverse side**

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