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President's Comments

Interdisciplinary Health Care for Older Adults as a Model for the Future of Health Care

Antonette Zeiss, Ph.D.

I had the great pleasure of presenting the Presidential Address for Section II at APA in August. I was asked to provide a brief overview of the talk for this newsletter, and that effort follows these introductory remarks. Many of us also discussed the idea that it would be worthwhile to attempt to publish full versions of the Presidential addresses, every year, in the Division 12 journal, *Clinical Psychology: Science and Practice*. I do plan to prepare a complete version to submit to that journal, and I hope that former and future Presidents of Section II will do likewise. In the meantime, if any Section members would like a full copy of the text of my talk, feel free to be in touch with me at tmz@icon.palo-alto.med.va.gov.

I examined three inter-related points in this talk: First, since the mental health problems of older adults are often interwoven inextricably with other changes in health and function, the best care for older adults is offered by Interdisciplinary teams, comprised of representatives of multiple professions working collaboratively to plan, implement, and evaluate the outcomes of health care. Second, the Interdisciplinary team model of care is becoming the standard for care throughout the health care system, not just for older adults. Third, as teams become the standard of care, Clinical Geropsychologists are poised to become leaders in teaching about their benefits and challenges, because of the experience we have in using this model and making it work. I attempted to address these issues by 1) examining some lessons learned from care of older adults, 2) laying out basic principles of interprofessional team work, 3) pointing out signs of this model of care's increasing importance, and 4) suggesting an agenda for Section II members and other conference attendees to enhance their abilities to work effectively in interprofessional settings and to share their understanding of such work with others.

I began by claiming that the mental health problems of older adults are often interwoven with other changes in health and function. There are many ways to explore that assertion. Rather than doing an exhaustive literature review, I will present examples of such relationships from some of my own research in two different areas: depression in older adults and sexual dysfunction in older adults. In recently published work with my mentor, Peter Lewinsohn, and colleagues at the Oregon Research Institute (Zeiss et al., 1996), we examined the relationships among physical disease, functional impairment, and the onset of depression in community dwelling older adults. Considerable prior research has demonstrated a statistical relationship at single points in time between the presence of physical illness and depression in older adults. The meaning of this relationship, however, has not been clear. Is disease a risk factor for depression (the most common interpretation)? Or is depression a risk factor for becoming or remaining physically ill (as others argue)? And if illness is a risk factor for depression, what is the causal agent in that relationship? (continued on p. 6)

APA David Shakow Early Career Award: Treating Depression in Disadvantaged Elderly

Patricia A. Areán, Ph.D., University of California, San Francisco

Depression in low-income people over the age of 65 is a disabling and costly illness. Researchers estimate that 7% of older, disadvantaged patients meet criteria for Major Depression and 18% meet criteria for Dysthymia (Koenig and Blazer, 1992; Areán & Miranda, 1995; Finch, Ramsey & Katona, 1992). These disorders are important to treat in older adults because they are highly related to increased disability, pain, suicidality, placement in long-term care facilities and hospitalization, which leads to poor quality of life (Murphey, 1988; Harris et al., 1988). Depression is also a costly illness. Direct medical costs of depressed patients are approximately 50 % higher than non-depressed controls matched for age, gender and severity of medical problems (Callahan et al 1992, Simon et al 1995, Unützer et al 1997). These costs are not only due to mental health utilization, but are due to increases in every component of health care costs including primary care visits and laboratory, emergency and inpatient utilization (Simon et al 1995). In a study of 2,558 older adults, specialty mental health care and substance abuse treatment accounted for only about 1 % of total health care costs (Unützer et al 1997). Because of the debilitating and costly consequences of depression in this population, treatments for low income and elderly primary care patients in under served communities is important to explore (NIH, 1992).

Few research initiatives have specifically looked at the role psychosocial interventions play in the treatment of depression in disadvantaged elderly. The lack of research is surprising given that this population must deal with their medical illnesses, the stressors of poverty, the complications of having to deal with public sector settings, and a host of other psychosocial problems. Declining socioeconomic status, the loss of loved ones and social support, and illness can all impact on self-esteem and coping abilities (Butler et al., 1991; Ruegg et al., 1988). Hughs, Blazer, & George (1988) point out that a relationship between age and number of life stressors exists in that older adults were more likely to experience psychosocial stressors than younger adults and that this is directly related to increased stress and depression. Krause (1987) has shown that financial strain is related to stress and depression in older adults and Koenig and Blazer (1992) point out that those patients with the least favorable prognosis are those who are unemployed. Whether such stressors precipitate depression may be determined by the person's ability to cope with these problems (Lazarus, 1991). In fact recent research has found that depressed older adults show deficits in coping skills—deficiencies that may impair ability to cope with the stressors related to depression, aging, and poverty (Fry, 1989; Schein, Arean, Joseph, Perri, and Nezu, 1990). When the changes associated with aging are coupled with the stressors of chronic illnesses and poverty, depression can be even more devastating. Therefore, somatic therapy may not be enough to help these people in coping with daily problems. Successful treatment may require modification of those psychological factors that are etiologically related to depression in late life and depression in medically ill elderly. Moreover, as Steiner et al. (1991) point out, psychotherapy has other advantages, such as the lack of potentially dangerous side effects, and the coping skills which are taught, can be used after therapy ends. Moreover, clinical case management services may enhance the utility of either somatic or psychosocial interventions, giving the older, disadvantaged patient a chance to work with social services to address their basic needs while concurrently working on their depression in therapy.

The purpose of the study described briefly here is to explore the relative impact two psychosocial interventions have on the treatment of depression in older, disadvantaged elderly. In this study, 71 older adults, with incomes lower than 20,000 dollars a year, were identified through the primary care sector and randomized to receive either cognitive-behavioral therapy (CBT), clinical case management (CCM), or the combination of both interventions. In this ongoing study, participants are assessed for depression, quality of life, disability, life satisfaction and activity level every 6 months for 2 years. Presented here are data from the immediate post treatment and 6 month evaluation periods for depression, role functioning and social activity. Data on one year and 18 month outcomes are still being collected.

According to the analysis thus far, utilization of psychosocial interventions has a significant impact on depression outcomes, but only slight impact on quality of life and activity outcomes. Treatment effects for depression as measured by the Hamilton Depression Rating Scale show highly significant decreases in depressive symptoms for the CBT only group immediately at treatment end, but most people relapse within 6 months of treatment end. (continued on p.10)

Section II Honors Abeles and Niederehe

Steve Zarit, Ph.D.

The first Section II Distinguished Achievement Awards were presented to Norman Abeles and George Niederehe during the Section's Business Meeting at APA in Boston. This award recognizes significant contributions to the Section and the field of Clinical Geropsychology.

Dr. Abeles, who is a former Secretary of Section II and Past President of APA, was honored for his efforts to make aging part of the agenda at APA. As President of APA, Dr. Abeles organized a mini-convention focused on the psychology of aging. His efforts as President also led to the establishment of the Committee on Aging at APA. Dr. Abeles is on the faculty in Psychology at Michigan State University.

Dr. Niederehe, who is a former President of Section II, was honored for his work to establish Clinical Geropsychology as an approved proficiency. Building on momentum from a clinical training conference held in 1992, Dr. Niederehe headed a joint task force of Section II and Division 20 which developed recommendations for training in Clinical Geropsychology. These efforts led to creation of a proposal for a proficiency, which was subsequently approved by APA Council. Dr. Niederehe is in charge of the Psychosocial Treatment grants program at the Adult/Geriatric Treatment and Prevention Research Branch, National Institute of Mental Health.

The Distinguished Achievement Award is presented by a committee of past Presidents of Section II. Bob Knight chaired the committee this past year. Also serving were Mick Smyer and Steve Zarit.

Division 12, Section II Symposium: The Business of Clinical Geropsychology

Deborah W. Frazer, Ph.D., Moderator

Five panelists shared their perspectives on the challenges of a career providing psychological services to older adults. Joseph M. Casciani, Ph.D., President of Senior Psychology Services (a large, multi-state provider of psychological services in long-term care), opened with an introduction to the complexity of working within Medicare and Medicaid reimbursement. Melinda Fitting, Ph.D., President of Comprehensive Geriatric Services (a medium-size company providing psychological services, training and education services in long-term care), talked about changes in the regulatory environment within the last six months, including PPS, OBRA, and the new Clinical Indicators. She commented on the opportunities afforded by the growth in Assisted Living and geriatric care management. Donna Rasin-Waters, Ph.D., President of Independent Practitioners in Geropsychology (a support service for psychologists who choose to provide services through an individual or small group practice rather than a company), talked about the financial and lifestyle advantages to maintaining an independent practice. Paula Hartman-Stein, Ph.D. President of the Center for Healthy Aging (a company that provides more outpatient than nursing-home based practice), discussed a variety of opportunities for practice that included forensic, care management, and other outpatient-oriented work. Finally, Patricia A. Parmelee, Vice-President for Outcomes at Genesis ElderCare, discussed the interface between measurement of general outcomes through the MDS and Clinical Indicators, and psychological interventions. Each panelist provided practical suggestions for working in the field. The participants and the audience agreed that another session would be extremely useful, designed as a roundtable discussion with more chance for audience participation.

Clinical Geropsychology Exchange- Research Update

Benjamin T. Mast M.A., Susan E. MacNeill, Ph.D. & Peter A. Lichtenberg, Ph.D., ABPP
Wayne State University, Detroit, MI

(Editor's note: Benjamin Mast was our 1999 APA student award winner and a summary of his paper entitled, "Can cognitive effects of stroke be detected within dementia: A mimic model" will appear in the February newsletter. Congratulations Ben!)

Stroke and lower extremity fracture are two of the most common primary rehabilitation diagnoses among older adults. In separate lines of research both of these conditions have demonstrated substantial rates of comorbidity with geropsychological problems such as dementia and depression (Tatemichi, et al, 1994; Robinson, Kusbos, Starr, Rao, & Price, 1984; Johansson & Skoog, 1996; Billig, Ahmed, Kenmore, Amaral, Shakhshiri, 1986). However, in spite of this research evidence, no direct comparisons of the prevalence rates of stroke and lower extremity fracture have been made. As a result, it is still commonly assumed that a geriatric stroke patient is more likely to present with dementia and/or depression than is a geriatric patient who has a primary diagnosis other than stroke (e.g., lower extremity fracture). This is most likely due to obvious differences in the nature of the injuries involved (neurological vs. peripheral injury).

It is our contention that all older adults admitted for medical rehabilitation, regardless of diagnosis, may be at risk for such geriatric problems such as dementia and depression. The risk for these geropsychological problems may be increased by the presence of co-morbid medical illnesses among geriatric patients. Most older adults seen in primary care clinics suffer from at least one chronic medical illness, and it is estimated that over 60 percent of older medical patients suffer from multiple chronic medical illnesses (Stewart, et al., 1989; Cambell, et al., 1994). Chronic medical illnesses such as diabetes, cardiac disease and lung disease have been associated with cognitive deficits, longer lengths of stay, greater physical disability, and generally poorer outcomes following rehabilitation. In addition, many of the co-morbid conditions experienced by older adults have some degree of multi-system involvement, influencing most major organs such as the brain, heart, and kidneys. Therefore, although stroke and lower extremity fractures are central aspects of disabling conditions among older medical patients, they are accompanied by similar multi-system influences. We contend that dementia and depression are part of this constellation of co-morbid conditions, and as such, can be considered to be as important as the primary medical diagnoses. On this basis, we hypothesized that the rates of dementia and depression will not differ between stroke and lower extremity fracture patient groups.

One hundred and ninety-eight lower extremity fracture patients and 101 stroke patients were administered the Normative Studies Research Project test battery which included the following measures: The Logical memory subtests of the Wechsler Memory Scale-Revised, Fuld Object Memory Evaluation, Mattis Dementia Rating Scale, Boston Naming Test, Visual Form Discrimination Test, Hooper Visual Organization Test, and the Geriatric Depression Scale (GDS).

The prevalence rates of dementia were examined among both stroke and lower extremity fracture patients. Following the procedures utilized in the Nun Study (Snowdon, et. al., 1997), patients were determined to have dementia if they (1) scored in the impaired range on at least one measure of memory, (2) scored in the impaired range on any additional domain of cognitive functioning (attention, language, visuospatial), and (3) had at least one impairment in activities of daily living. The prevalence of depression was examined among demented and non-demented stroke and lower extremity fracture patients as well. Overall, there were no significant differences in the prevalence rates of dementia between these two groups. Among all patients who had complete GDS scores, there were no significant differences in the prevalence of depression. Among demented patients there were no significant differences in the prevalence of depression.

Despite admission to rehabilitation for different diagnoses (neurological vs. peripheral injury), no significant differences were observed between these two diagnostic groups in their rates of dementia or depression. In our conceptualization, whether the individual has suffered a stroke or lower extremity fracture becomes less important because both are characterized by considerable medical co-morbidity as well as substantial rates of dementia and depression. For the purposes of medical rehabilitation it is important to recognize these co-morbid conditions early so that treatment and discharge planning can focus on the constellation of symptoms rather than solely upon primary diagnosis. Given that past research has shown that both depression and dementia adversely affect rehabilitation outcomes, it is important to recognize and address them early within the rehabilitation stay.

Division 12 Update

William E. Haley, Ph.D., Section II Representative to Division 12 Board

The Division 12 (Society of Clinical Psychology) Board of Directors met in Denver, Colorado October 2nd and 3rd. The site is important for Division 12 because of the historical significance of visiting the home of the conference that spurred the development of the scientist-practitioner model of clinical psychology 50 years ago. Boulder is also noteworthy because it is the home of Dr. Ed Craighead, the Division President for the year 2000. Since our last Section II newsletter, the Board also met in Halifax, Nova Scotia over the summer.

Division 12 is the primary voice for the scientist-practitioner model of clinical psychology within APA, and is a strong and supportive ally for clinical geropsychology. The health of the Division is important to the future of our section. Several important issues have been discussed at the recent meetings that are of note for Section II members:

Changes in the Sections: Sections I and V (Child Clinical and Pediatrics) are officially ending their status as Sections of Division 12 and becoming new APA Divisions as of January 1, 2000. Because these have been the largest Sections, there is great uncertainty about what this will mean for membership figures for Division 12, and for allocation of program hours for the convention. The worst case scenario for the Division is that all of these former Section members fail to renew their Division 12 memberships. Even without such a catastrophic loss, there will certainly be some drop-off in membership of the Division. Thus we are facing a potential loss in revenues, program hours at the convention, and APA Council Representatives.

We have a new Section (VII), Emergencies and Crises, that is now fully operational. An additional Section (VIII), the Association of Medical School Psychologists, is making efforts to become an official Section by January 2000. There was discussion at the Boulder meeting of approaching other groups of clinical psychologists that might be interested in affiliation with the Division.

Budget issues: During the Boulder meeting, the Board approved a balanced budget of \$408,500 for the year 2000. However, the projections for this budget were, even more than usual, conducted with a certain amount of guesswork. A dues increase has helped pull us out of several years of deficit spending, but because dues comprise over half of our projected Division income, our projections on membership are vital to actually producing a balanced budget. If large numbers of former Section I and V members fail to retain the Division 12 memberships, we could be faced with a major shortfall. On the other hand, if a greater than expected percentage of these individuals retain their memberships, we could have a surplus. The Division journal, *Clinical Psychology: Science and Practice*, has been very successful in becoming a respected scholarly publication, but is not currently the financial success for the Division that it could be. There was a great deal of discussion about ways to promote the journal and to resolve problems we are having with the publisher, Oxford Press, in providing sufficient advertising and customer service.

Leadership: Dr. Tom Ollendick will hand the presidential gavel to Dr. Ed Craighead during the year 2000, and Dr. Karen Calhoun will become President-elect. There was a great deal of discussion at both Board meetings about the importance of assuring gender and ethnic diversity in Division 12 officers and Council Representatives. Historically, few female and ethnic minority psychologists have been elected to Council or to Division offices unless special slates assuring such diversity are arranged by the Nominations and Elections Committee and approved by the Board. Recent Division Presidents have been very active in appointing women and minorities to committees and task forces, but White males have largely filled major offices determined by election. After a great deal of discussion we decided not to establish specific quotas to ensure diversity, but approved a procedure which makes it likely that underrepresented groups will be presented on special election slates when diversity is lacking.

Division awards: The Division currently has four major awards, two of which recognize senior level psychologists, and two of which honor early career contributions. There was consensus that the format for honoring these individuals should be revised in order to remove the rush that was apparent during the 1999 session at APA, and to increase the number attending the award ceremonies.

Relationship with other organizations: Division 12 monitors and/or maintains close relationships with a virtual alphabet soup of organizations including BPA, CEMA, CAPP, ACP, and APAGS. During recent meetings there has been a great deal of discussion given to Division 12's relationship with the Academy of Clinical Psychology, which administers the ABPP examination, including a proposal to cosponsor Division 12 Postdoctoral Institutes with this group. (Continued on p. 10)

UPDATE from CONA and APA Aging Office

Weldon Bagwell

APA's Office on Aging is working on a new web based resource guide on the topic of Sexuality and Aging that will be introduced by Toni Zeiss. It will include listings of current journal articles, books, videos, and organizations on this important subject. Look for it soon at: <http://www.apa.org/pi/aging/homepage.html> which is APA's Aging Office homepage. Committee on Aging (CONA) member, Margaret Gatz, PhD, will participate and be the discussant at the Nov 15, 1999, National Coalition on Mental Health and Aging Conference. This meeting will consider the 1995 White House Conference on Aging resolution on mental health and aging in light of current issues and best practices. The special meeting of the coalition is being held in recognition of the UN International Year of Older Persons.

President's comments (continued from p. 1)

Based on experience working with older adults, I hypothesized that impairment in independent function, such as loss of ability for self-care, recreational activities, mobility, hearing or vision, would be the actual risk factor for depression. Older adults are more likely to lose function when they have physical illness, accounting for the observed relationship between disease and depression. However, we argued that illness in the absence of impairment should not be a risk factor for depression.

We tested these hypotheses in a sample of 680 older adults who were not depressed when initially interviewed and who were followed over a period up to four years. Four groups were differentiated: healthy, without impairment of function; physical ill without impairment of function; healthy, with loss of function; physically ill, with loss of function.

Survival curve analysis revealed that functional impairment carried the day in predicting depression. The two groups who had lost some aspects of independent function were significantly more likely to develop an episode of major depressive disorder. The two groups without functional impairment developed the lowest rates of depression. In addition, loss of function had an incremental relationship to the likelihood of becoming depressed: the greater the level of impairment, the higher the likelihood of becoming depressed. There was no such relationship for number of diagnosed illnesses. However, a minority of all of the older adults in this study never became depressed, even when faced with physical disease and loss of function. For instance, in the most at risk group, those who had loss of function without current disease, over 70% never became depressed during the follow-up period. These findings fit repeated research demonstrations that adults who live to old age are particularly hardy people, with a lower incidence of onset of new depression than almost any other age group.

Another strand is also emerging from the Oregon Research Institute data set. We are exploring a conceptually different issue – one usually called the “continuity hypothesis” of depression. This question explores whether diagnosable depression is best thought of as falling on a continuum with limited depressive symptoms or whether it represents a categorically distinct category, as using the diagnostic approach of DSM-IV directs us.

To approach this question we used the full sample (N = 1,005) from which the earlier set of adults not depressed at initial interview were selected. For this research, we divided this sample into five groups: one group meeting criteria for Major Depressive Disorder and four subgroups of those not meeting criteria; the four subgroups are based on the level of depressive symptoms reported on the CES-D: low (0-5), slight (6-10), moderate (11-15), and high (16 or greater). The sample was also divided into five groups based on the number of clinical symptoms reported during a diagnostic interview: 0, one, two or three, four, and those meeting full MDD diagnostic criteria.

Data on a broad spectrum of measures covering psychological and social functioning: major and minor stressors, social support and social interaction, life satisfaction, pleasant activities, self-esteem, social skills, coping skills, cognitive functioning, behavior problems, and emotional reliance on others were examined in relation to the five groups. Note that in this study, we are still interested in how the mental health problems of older adults are interwoven with other changes in health and function, but this time we are looking at psychosocial health and function, not physical health and function.

Discriminant function analysis was used to examine the relationships between psychosocial variables and depression status using the five groups described above. One significant discriminant function was extracted, accounting for 87% of the

President's comments (continued from previous page)

variance among the groups based on CES-D scores and 88% of the variance based on diagnostic symptoms. To test the continuity hypothesis, we examined mean scores on the discriminant function for each of the five groups. The significant discriminant function tells us that the groups differ in some way, but the important question is whether older adults diagnosed with depression differ dramatically from older adults in all the other groups, or whether there is a continuous, gradual increase in discriminant function scores, with no meaningful break point when comparing diagnosed individuals with others.

The data support the continuity hypothesis fairly clearly. There is a gradual, continuous and very statistically significant increase in discriminant function score across the five groups. This is true when examining the CES-D criterion or the groups based on symptoms (full data can be reviewed in a forthcoming publication, Lewinsohn et al., in press).

While emphasis was on testing the continuity hypothesis, the data just as clearly bear witness to the assertion that older adults who are depressed also carry a diversity of other problems in psychosocial functioning. In addition, the more depressed the older adult, the more other problems are also present, suggesting that those individuals who do end up seeking help may need more than what psychotherapy alone can offer. Specifically, they may need the complex, interwoven services of an Interdisciplinary team.

So far so good, but there is one caveat, and it's related to another of my opening assertions: the Interdisciplinary team model of care is becoming the standard for care throughout the health care system, not just for older adults. The caveat – in this study, we also examined two other samples, one of adolescents and the other of mid-life adults. We found exactly the same patterns in both those samples: first, continuity across a range of increasing depressive symptoms; second, a single discriminant function emerging that included all the psychosocial function measures. Put simply, the mental health problems of adolescents and younger adults seem to be interwoven with other changes in health and function too – and they may need Interdisciplinary team care just as much as older adults do.

A final example of interrelationships among problems in older adults is based on much simpler research we have conducted for about 15 years on sexual problems in older adults, in the context of an Interdisciplinary clinic at VA Palo Alto, the Andrology Clinic. Our typical patients are older adults (although we see the full adult age spectrum); they are usually male; and they usually present with erection problems (and often other sexual problems as well).

In the literature on erection problems, it is common to see statements of the following type: "We used to think that most erection problems were caused by psychological factors, but now we know that most erection problems are a result of medical causes." The statement is usually offered by a physician and I have never seen it paired with supportive data. We have collected data on the causes we can identify in our patients, based on the results of a medical history and physical exam, lab tests of endocrine function, nocturnal erection testing, and a semi-structured psychosocial interview examining emotional and interpersonal issues. We have reviewed data on multiple occasions, with a total sample now approaching 2,000 patients.

Among our clearest results is a finding replicated in each data review: 80% of our patients report medical problems that would be sufficient to cause the presenting problem with erections – just like the popular claim. However, it is also true that 80% of our patients have psychosocial problems that would be sufficient to cause the presenting erection problem. Thus, if we functioned solely as a psychosocial clinic, we would be convinced that the primary etiology of erection problems is emotional and interpersonal difficulties. If we functioned solely as a medical clinic, we would be equally convinced that the primary etiology of erection problems is medical illness and/or medications. Since we function as an Interdisciplinary clinic, we understand that both things can be true at once, and that we will serve our patients best by not sorting them into "psychogenic" vs. "biogenic" causation, but instead by recognizing the full range of problems they have and designing treatment that is responsive to all their concerns.

And, just as with my last example, this is not only true for older adults. It may be more likely that an older adult will develop medical problems that contribute to sexual dysfunction, but any patient, presenting at any age, with a sexual concern may be best served by receiving assessment and treatment from an Interdisciplinary team. And we who are Clinical Geropsychologists know how to do that.

In fact, our knowledge is embedded in the Standards for Proficiency in Clinical Geropsychology, which recognizes the importance of coordinated care with the following: "Interdisciplinary team approaches and, even in the private practice setting, coordination of services are key ingredients in the care of elderly patients. . . Clinical geropsychologists must be knowledgeable about the services available from other disciplines, educate others as to skills and role of the geropsychologist, and continually show an ability to collaborate effectively with other professionals."

A lot of meaning is packed in those few words. To say that a group of health care providers is a "team" says very

President's comments (continued from previous page)

little. A group that is a team shares a common work-place and set of patients, but teams differ on many dimensions (Zeiss & Steffen, 1998). To clarify, I will briefly contrast two kinds of teams: Interdisciplinary vs. multidisciplinary.

Interdisciplinary teams are composed of members from more than one profession, making a breadth of resources available to patients. Interdisciplinary teams work collaboratively. On an Interdisciplinary team, the group as a whole takes responsibility for program effectiveness and team function. Leadership functions are shared among members; all team members are assumed to be colleagues; and there is no hierarchical team organization.

Individual team members work out overall strategies for assessment and share information to generate a conceptualization of the relationships among biological, psychological, and social aspects of the case. This approach goes by the awkward but useful title, the "biopsychosocial" model. That conceptualization is used to formulate shared team goals and to plan how team members will work together. Team members implement the plan, either individually or collaboratively as necessary, and evaluate progress. Those evaluations become new assessment data, which are brought back to the team to revise goals or strategies for reaching them. This process is repeated as often as necessary until goals are achieved.

Role maps are helpful for understanding the contributions of each team member. In such maps, an oval appears for each profession on the team, indicating the skills and responsibilities of that profession in providing care for patients served by the team; each oval overlaps with others. Within each discipline's oval are listed the components of their role. In the unique, non-overlapping part of each oval appear clinical responsibilities assumed only by that discipline. In areas of overlap, clinical responsibilities appear that either discipline might perform or that two team members might perform as co-therapists. There might also be areas where three ovals overlap. In those intersections appear tasks which several team members might perform; for example, on some teams, Nursing, Medicine, or Psychology might all perform cognitive screening. Team role maps provide several kinds of information. They delineate services patients could receive from the team; they clarify what each discipline will provide to the team; they clarify opportunities for conjoint efforts or, in a poorly-functioning team, sources of conflict known as "turf battles;" and they suggest which disciplines may have the most difficulty speaking each other's language.

For contrast, consider how a Multidisciplinary team functions; the term Multidisciplinary is often used as if it were synonymous with Interdisciplinary, but they differ in crucial ways. A multidisciplinary team also has members from more than one discipline, but here each discipline does its own assessment, generates its own treatment plan, implements the plan, evaluates progress, and refines the plan based on its own evaluation. Team members share information with each other, but there is no attempt to generate or implement a common plan.

Multidisciplinary teams are hierarchically organized: there is a designated program "Chief", who is usually the highest-ranking professional (commonly an M.D.). That leader is responsible to oversee the program, chair meetings, resolve conflicts, and allocate case load - whether they have the requisite skills or not. Other team members feel responsible only for the clinical work of their own discipline; unlike Interdisciplinary team members, they need not share a sense of responsibility for program function and team effectiveness.

When used in appropriate settings, well-functioning Interdisciplinary Teams provide cost-effective care. First, Interdisciplinary teams generate more comprehensive and creative interventions, since the ideas and knowledge of a group can be brought to bear, and team members can stimulate each other's ideas. Second, problems don't fall through the cracks. Third, Interdisciplinary teams reduce duplication of services compared to Multidisciplinary teams. Fourth, team members do not provide conflicting information or interventions to the patient. Finally, Interdisciplinary teams can reduce institutional costs, because they increase staff morale and reduce staff turnover.

While there is a need for more research to examine each of the elements of this argument, the evidence available does support the cost-effectiveness of the Interdisciplinary team approach. I was actually delighted in preparing this talk to discover a growing, solid body of evidence supporting the effectiveness of interdisciplinary team care - much greater than just 2 years ago when I gave a previous version of this talk. Full references and information are available in the longer report.

Interdisciplinary teams have been the standard of care for geriatric settings since the early 1980s. They also have been used in pediatric care, rehabilitation, and some mental health settings, especially inpatient programs. In the 1990s, this model of care began to expand dramatically, and one of my basic contentions is that it is becoming a common standard of care, as the review of recent literature on team care outcomes also suggests. Clinical Geropsychologists are in a special position to take a leading role in offering guidance about this system of health care and how to make it work.

In the United States, this shift has occurred most dramatically in the movement to primary care. Primary care has

President's comments (continued from previous page)

been conceptualized as intrinsically Interdisciplinary in nature. APA recognized this, and recently produced a task force document to underscore the importance of this shift for the future of psychology training: that document is titled, "Interprofessional Health Care Service in Primary Care Settings: Implications for the Education and Training of Psychologists."

There also has been a growing international awareness of the role of Interdisciplinary care. A Select Committee of the Council of Europe recommended "the provision of joint professional education as a means of improving teamwork in cancer care. . ." (Jones, 1992). The European Health Committee has funded a review of Interdisciplinary training of health care staff in member states, and Interdisciplinary training modules are available in countries throughout Europe. Other countries around the world are using Interdisciplinary health care concepts; a literature review of who is publishing about model programs or research outcomes using teams included references from Belgium, Brazil, Canada, China (Hong Kong), England, Finland, France, Germany, Greece, Ireland, Israel, Italy, Netherlands, Norway, Romania, Scotland, South Africa, Sweden, Switzerland, and the United States.

The growing importance of the Interdisciplinary care model is recognized and embedded in the 1995 report of the Pew Health Professions Commission. This group has the mission of assisting policy makers and educational institutions to produce health care workers who meet the changing needs of the American health care system. The 1995 report provided a sweeping overview of fundamental changes in American health care. Elements related to team care are expressed strongly in this report.

The Department of Veterans Affairs plays a role in the training of over half of all health care professionals in the United States. In the early 1990s, VA's model of care shifted from tertiary hospital care to primary care offered through Interdisciplinary settings. A large portion of VA's training budget was re-allocated in 1993 to the PRIME program, which funds a full spectrum of health care providers in Interdisciplinary primary care settings. More recently, a VA task force re-examined all funding for associated health professional training. That task force generated a proposal, in which there is a clear commitment that ALL VA training of associated health professionals should be guided by an Interdisciplinary model. The proposed trainee allocation methodology includes two principles that are key in this context: education should reflect clinical practice realities, and training programs should demonstrate Interdisciplinary strategies and collaboration. Working out implementation of this proposal is still occurring, but eventually, every request for VA funding for psychology interns, social work interns, etc. is likely to need to be supported by a plan describing the nature and extent of Interdisciplinary training to be provided.

At the start of this talk, I argued that the Interdisciplinary team model of care is becoming the standard of care not only for older adults, but throughout the health care system, and I have presented evidence to support that contention. However, I also know that many parts of the health care system are having difficulty trying to make this real. Twenty years ago, there was more talk than action in geriatric settings, too; now interdisciplinary care is commonly implemented, often extremely effectively, in geriatric programs. In the process of getting from the point of seeing what needed to be done to actually knowing how to do it, we have learned a lot. I want to turn now, briefly, to recommendations for how Clinical Geropsychologists could share what we have learned along the way and help other parts of the health care system develop expertise for interdisciplinary work.

If you work in an organized health care setting, you are probably observing colleagues trying to deal with the shift to Interdisciplinary care. I urge you to be leaders in that process. Let your colleagues know about skills you have that can help in team development and improved collaborative process - for example, providing assertion training to help all team members express themselves effectively; training in conflict resolution; or training in problem-solving skills applied to a group setting. Tell people about your experiences with teams and ways you have found to solve problems and promote commitment to a collaborative model.

Academic programs in psychology are not changing fast enough to prepare therapists and researchers for the transformed world of health care. Too often, psychology's educational models are grounded in single discipline care and an outdated assumption that the health care system will be made up of tertiary care hospitals and private practice offices. The Pew Commission recommendations should be implemented by academic leaders by including these components in all clinical and counseling graduate training. Clinical Geropsychologists are the faculty most likely to have already implemented such concepts in their curricula, syllabi, and practicum experiences. I hope you will have even more impact on your colleagues in Psychology Departments, so that these concepts become fundamental to clinical training across the life-span. I assure you it

President's comments (continued from previous page)

would make it much easier for your students when they arrive at internship sites, whether they are working with older adults or with other parts of the age spectrum.

In addition, research opportunities in Interdisciplinary care abound. While a wonderfully expanding set of data support Interdisciplinary teams, major questions remain to be explored. What are the best methods for developing productive teams? How do we assess the level of coordination in team care? Which patients benefit the most from Interdisciplinary care? What are the components of care that are basic and essential to positive outcomes? These are questions for which Clinical Geropsychologists may have an edge in hypothesis formulation, research design, and knowing which treatment approaches are best included in the team repertoire.

As our Standards for Proficiency recognize, Clinical Geropsychologists in private practice seek to develop Interdisciplinary linkages that function as "virtual teams," in which there can be coordinated attention to the various aspects of the biopsychosocial model. Those in this role can be leaders in showing other private practitioners how to develop such collaborative interactions, thus encouraging coordination of the services clients receive in formerly disconnected parts of the health care network.

The best summary of the Interdisciplinary team philosophy is one I heard years ago "People support what they help create". Interdisciplinary teams come about through the efforts of health care professionals who challenge each other, learn from each other, and rely on each other. Interdisciplinary teams depend on the wise and creative integration of diverse viewpoints. Sometimes those are complementary, but sometimes they are conflicting. Teams must value diversity, remain cohesive when viewpoints conflict, and negotiate agreement to which all team members are committed.

I heard some other wise advice even earlier than I learned that "people support what they help create." One of my graduate school faculty told me, "Students try to be special by being smart, but there are lots of smart students. The ones who really matter are the ones who are generous with their smartness." I would like to pass that on and invite all of us who are Clinical Geropsychologists to be generous right now with our smartness about interdisciplinary team work. There are a lot of struggling health care providers out there who could use it.

APA Early Career Award (continued from p. 2)

However, if patients received CCM, either alone or combination, change in depression was more gradual over time, but persistent and significant at 6 months. The effects of psychosocial treatment on role-functioning and social activity are not significantly evident at post or 6 month assessments, but trends for positive changes in all treatment arms is clear.

In summary, preliminary data from this study suggests that older, disadvantaged adults clearly benefit from psychosocial treatment, but the greatest benefit is related to access to case management services. The impact of case management services makes sense when one considers the life circumstances of low-income elderly. Case management allows people in this economic group to first focus on their immediate needs. Once these problems are taken care of, the patient is less distracted by their socioeconomic problems and can spend more energy on learning mood management skills. It is likely that the lack of effect for treatment on outcomes other than depression is due to the short assessment period, rather than lack of impact. Long term findings may be more promising.

Division 12 report (continued from p. 5)

This type of issue can get enormously complex, given the financial issues and even potential legal issues related to liability with cosponsorship.

Final comments: I urge all eligible members of Section II to become members of Division 12 (information is available at the Division web site, through the APA site). In addition, Section members who have made significant contributions to the field of clinical geropsychology should consider becoming Fellows of Division 12—either as Old Fellows (after attaining Fellow status through another Division), or as new Fellows. Check to be sure that your institutional library has a subscription to Clinical Psychology: Science and Practice! I will provide my next report after our January 2000 meeting in Charleston, South Carolina.

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 listserv (internet 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

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

Section II Program for APA Convention in Washington, D.C.

William E. Haley, Ph.D.

Section II has 5 hours of program time, 2 of which are devoted to our Presidential Address and Business meeting. If you have any ideas concerning special symposia or invited addresses that the Section should sponsor, please contact me at whaley@chumal.cas.usf.edu. Most presentations by Section members will be handled via the Divisional review process, but if you feel that there are some sessions of special interest to Section members, let me know as soon as possible.

Did you know...

- ◆ 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.
- ◆ Stay connected with your colleagues in clinical geropsychology by joining our e-mail network. Any member of Division 12, Section 2 may join the e-mail network by simply sending a note (including your name, e-mail address, and expressing your interest in joining the 12/2 e-mail network) to Barry Edelstein at u21b4@wvnm.wvnet.edu.
- ◆ Thanks to Rebecca Allen-Burge, Ph.D., Division 12, Section 2 has a web-site. Check it out at <http://bama.ua.edu/~appgero/apadiv12.htm>.

Clinical Geropsychology News
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