Clinical Geropsychology News

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Presidential Address

An Interpersonal Perspective on Late Life Depression

Gregory A. Hinrichsen, Ph.D.

The interpersonal ramifications of depression in younger persons have been the focus of theory and research for at least three decades. However, little attention has been paid to how depression in older adults is influenced by and, in turn, affects their social relationships. This presentation summarizes research conducted by my colleagues and me on family issues in late life depression. It also describes our experience with conducting Interpersonal Psychotherapy of Depression (IPT) with depressed older adults.

Does Depression Affect Social Relationships? Early work by Weissman and colleagues (Weissman & Paykel, 1974) documented that serious depression in younger women impaired their ability to function in social roles, including those of wife, parent, homemaker, and worker. Even after the episode of depression ended, these women continued to have socially relevant problems. Of particular note was continuing problems in their marriages. Other work mirrors Weissman's research. In a report from a large collaborative study of mood disorders, Coryell and colleagues reported that the longer-term psychosocial consequences of affective disorders were "surprisingly severe, enduring, and pervasive" (Coryell, et al., 1993 p. 723). Quite simply, depression damages social relationships.

Coyne (1976) provided a theoretical window into the dynamics of depression in a classic article. He suggested that the interpersonal dynamics of depression lend themselves to a destructive downward spiral between depressed persons and significant others. He posited that the depressed person engages the significant other (typically the spouse) into efforts to help. These efforts often don't have their intended effect as they are rejected by the depressed person. The spouse may grow increasingly frustrated with the depressed partner. The depressed person experiences the spouse's frustration or anger as rejection and grows more hopeless. The spouse then feels guilty and redoubles efforts to help, which only leads to more frustration for both parties. Eventually

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Inside this Issue:

Division 12, Section II Election Results

Antonette Zeiss, Ph.D., Past-President

I am pleased to announce the results of the recent Section II election. We had an excellent slate of candidates and a high rate of ballot return, at about 42% (yes, that is high compared to other professional organizations). Winners of the election are:

- President-elect: **Sara Honn Qualls**
- Division 12 Representative: **Dolores Gallagher-Thompson**

Warmest congratulations to both of them; they will be excellent additions to the Executive Board. I also thank the other candidates, Steve Rapp for President and Deborah King for Division 12 Representative, who have shown service to the Section and also would have done an excellent job. And thanks to all of you who voted; it's great to see the level of involvement in this Section.

Editor's Comments: Editorship Changes

Suzanne Norman, Ph.D. & Michelle (Shelley) Gagnon, Psy.D.

Greetings to all! As some of you know, this is a transitional time for the editorial staff of the newsletter. After four years I am passing the editorship on to Shelley Gagnon (Shelley's comments follow below). I would like to thank Alex Troster who preceded me as 12/2 newsletter editor for the opportunity to contribute. I would also like to thank past presidents Bob Knight, Steve Zarit, Toni Zeiss and our current president Greg Hinrichsen for making my job easy and fun. I have enjoyed the opportunity to network with colleagues around the country who are interested in older adults. When I accepted the editorial position I had no clinical geropsychology colleagues at work and being involved in 12/2 gave me valuable support. I will remain involved in 12/2 as the continuing education liaison. Vic Molinari, Peter Lichtenberg & I have begun to plan a day-long program of CE offerings focusing on clinical geropsychologists in long-term care setting to be offered before the APA Conference next August in San Francisco. More information will be available once our plans are finalized. Now please join me in welcoming the new newsletter editor for 12/2 Shelley Gagnon.

First, I'd like to thank Suzanne Norman for her guidance and patience as I assume the role of editor of 12/2's newsletter. It will be a challenge to follow in her footsteps, but I feel enthusiastic about this endeavor. Further, I'd like to thank Greg Hinrichsen and 12/2 board members for allowing me this opportunity to become a more active member of 12/2 and contribute to the ongoing work of this Section. I am looking forward to interacting with other members and gaining valuable relationships with colleagues who also share my commitment to better serving the growing older adult population.

I will introduce myself briefly to 12/2 members. I recently completed my postdoctoral residency at the Philadelphia Geriatric Center, and subsequently worked at PGC as the Project Director on a research study investigating how trauma survivors (Holocaust) fare in long-term care settings (the preliminary results of this study should be forthcoming in 2001). I am now the Director of the Geriatric Institute (GI) at Nova Southeastern University. GI is composed of both a residential treatment facility consisting of 44 beds and a day treatment program for older adults with serious mental illness. The residential program, which is based on a psychosocial rehabilitation model, is rather unique in that we offer our residential clients a whole spectrum of on-site care, including psychiatric and medical visits, 24-hour nursing care, individual and group therapy, structured social activities, and transition back to community planning. Further, GI serves as a training site for doctoral students and interns who are interested in working with older adults. I believe that the work we do at GI allows many elders, many of whom have lived with serious mental illness for decades, to get effective treatment while preventing (re)institutionalization and/or further psychiatric decline.

As for the newsletter, I'd like to encourage 12/2 members to e-mail or call me with ideas and suggests for upcoming topics, articles, columns, etc. Also, please send articles for the clinical geropsychology exchange. I plan to work in MS Word, so submit articles, etc., in either Word (as an attachment) or pasted directly onto your e-mail (I'll clean it up). Again, I look forward to an interesting and rewarding run as editor. I can be reached by any of the following means:

mgagnon123@aol.com
4800 North State Road 7, Ste 102
Lauderdale Lakes, FL 33319
(954) 485-2827

A Profile of Division 12, Section II Members

Frederick J. Kier, Ph.D., Geropsychology Fellow, Houston VA Medical Center
Victor Molinari, Ph.D., Director, Geropsychology, Houston VA Medical Center

As most of you know, your Division 12, Section II membership renewal/dues notice includes a brief "demographic" questionnaire on the back. This information assists Section officers in developing efficient Section operations and gathering opinions and suggestions for the Section. We wanted to first thank those who completed this form, and to share some of the information we collected.

First, 146 people responded, at least in part. Eighty-seven respondents identified themselves as members of APA, twenty-four said that they were APA fellows, four held associate status, and 22 were student members. The vast majority of respondents held Ph.D.'s (118) and were employed full time (115).

As for work settings, 40 worked in university academic departments, 37 in private practice, 17 in university medical schools, 17 in VA hospitals, 15 in other hospital settings, with 18 in other settings and 3 retirees. In terms of time spent in various activities, the average percentage of time spent in clinical activities was highest (49%), followed by research (19%), administration (12%), teaching (9%), supervision (8%), and other (3%).

Of the Section services, the newsletter was deemed to be the most useful, with an average rating of roughly 4 (on a 1 to 5 scale). The other services (e-mail network, directory, and APA program) all fell between 3 and 4 on the rating, suggesting that most members felt that these services provided by the Section were useful.

However, one of the most interesting things that we found was that a great many Section members were unaware of the e-mail network. Sixteen respondents stated that they had not heard of the network. This suggests that the Section needs to get the word out: In order to enroll in the email network, please contact Barry Edelstein at BEDELSTE@wvu.edu.

Somewhat encouraging was the high number of respondents who expressed a willingness to serve on Section committees (42), with half (21) wanting to serve on either the program or ad hoc committees. The membership committee has 11 members expressing an interest. Fewer members appear willing to serve on the nomination/election committee (5). If you said you are willing to serve on a Section II committee, do not be surprised if you are contacted soon by a committee chairperson.

Comments and suggestions varied. Many focused on Medicare reimbursement, and this would appear to be an issue that the Section should focus more attention upon. One suggestion, to make "a list of the journals in the field with an indication of the specific content which might be found in each," is another excellent idea. Some student members wanted more student based activities sponsored by the Section. All comments and suggestions have been forwarded to Section officers for consideration.

Lastly, we noticed that the renewal form was not "user-friendly" and/or clear in some areas. We are working to improve it for next year so that we can better facilitate communication between the executive board and members.

Overall, the results suggest that Section II is very diverse in terms of the work setting and activities of its members. This diversity is likely the Section's greatest strength as many members from different backgrounds join together to promote knowledge of aging and care for older adults.

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 meets three times a year. Our most recent meeting was June 3-4 in Washington, D.C. 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. Some of the issues discussed at the June meeting, and on the agenda for our upcoming October meeting, include:

Membership and Changes in the Sections: Sections I and V (Child Clinical and Pediatrics) left Division 12 and became new APA Divisions as of January 1, 2000. Because of this and other trends (including fewer junior level psychologists joining Division 12), there has been a great deal of concern about potential loss of members. Figures presented at the Board meeting

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Task Force Progress Report: Summer 2000

George Niederehe, Ph.D.

Michael Duffy represented the Interdivisional Task Force on Qualifications for Practice in Clinical and Applied Geropsychology, Section II and Division 20, at a June meeting of the Board of Directors of the APA College of Professional Psychology. He presented results from the 1999 survey of practicing psychologists' interests in continuing education and a possible proficiency certificate in Clinical Geropsychology, and discussed with the Board the various factors the College is considering with respect to certification in this area. Though there has been no formal word from the College about whether they might move to develop such a certificate, indications were that the Board viewed the case for a geropsychology certificate as strong but its financial feasibility as still quite questionable. Given that the College does not have a standing budget for developing new certificates, there was some discussion of whether any third-party "sponsor" organization might be found to help underwrite the costs of developing a proficiency exam and administering the certification process that would be required.

The Task Force's revised document "Training Guidelines for Practice in Clinical Psychology" was re-reviewed by the APA Board of Directors in June, and sent on to the Council of Representatives with a recommendation that it be approved as posing no undue risk to APA or its members. Nonetheless, a number of practitioner concerns surfaced during the Council deliberations in August, and final action was deferred. In the meanwhile, the Guidelines have been distributed to APA committees, boards, divisions and state associations to allow their submission of additional comments, due by December 1. Following that, a special workgroup will consider the comments, and make recommendations to the Task Force about any further revisions that may be advised before the Council again takes up consideration of the Guidelines. Members interested in supporting approval of the Guidelines can be of most help by working to assure that any APA groups in which they have membership, particularly divisions or state associations, submit positive comments on the Guidelines to the appropriate staff contact at APA (Sarah Jordan) by December 1. The Guidelines document is posted on both the Section II and Division 20 websites.

Update: Coalition on Mental Health and Aging

Deb Cotter, Ph.D. & Weldon Bagwell, Ph.D.

The National Coalition on Mental Health and Aging (NCMHA) welcomed new members, including the Older Adult Consumer Mental Health Alliance and the Gerontological Society of America (GSA). The Coalition praised GSA for adopting a policy statement that requires GSA to maintain its membership in the Coalition on Mental Health and Aging to ensure that GSA staff participates in Coalition meetings and activities. The Coalition, which now represents over 50 Federal agencies and National organizations, urges other organizations to follow GSA's lead.

On June 11, the Coalition sent a letter to Health and Human Services Secretary Donna Shalala on how Medicare and Medicaid can better serve older persons with mental health problems. The six-page letter has apparently made its way through the Health Care Finance Administration (HCFA) and the Coalition plans to follow up with a meeting or series of meetings with HCFA officials. There was considerable discussion about HCFA's treatment of mental health, particularly the agency's communications, or lack there of, with state mental health authorities/agencies and officials. Coalition members look forward to meeting with HCFA in this regard.

NCMHA is developing a brochure based on the report of the November 15, 1999 Special Conference of the NCMHA that will be used for educational and advocacy efforts. It was thought that a one page briefing sheet could best present the outcome of that conference for educational and advocacy efforts. A three-page summary with a list of "Observations/Solutions" was distributed.

Coalition members briefly discussed coalition-building efforts. AARP has funded three grants to develop mental health and aging groups at the state and local level. NCMHA hopes to have fifty such groups. NCMHA currently meets three times a year with coalition members. Some members expressed interest in developing a web site for the Coalition.

The American Society on Aging and the National Council on Aging (ASA-NCOA) will hold a joint conference in New Orleans from March 8-11, 2001. Draft copies of the agenda were circulated. The joint conference will enable local,

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Clinical Geropsychology in Medical Settings: Prevention, Assessment, Intervention and Training

Suzanne Norman, Ph.D. (Editor)

What follows is a brief synopsis of the 12/2 symposium on clinical geropsychology in medical settings presented at APA in August. The symposium explored research, assessment, intervention, and training opportunities for clinical geropsychologists in medical settings.

The Role of Geropsychologists in Health Promotion Research and Practice

Sara Wilcox, Ph.D.

The projected increase in older adults coupled with age-associated increases in disease and disability will pose major economic, social, and public health challenges to our society. Negative health behaviors play a major role in chronic disease and disability, and more widespread adoption of health behaviors could help ease these burdens. For example, a recent study found that 82% of coronary events in women could be attributed to dietary factors, exercise, smoking, overweight, and alcohol use (Stampfer et al., 2000). Most (88%) older adults visit their physician in a given year, providing a window of opportunity for reaching older adults and delivering health promotion messages. Clinical geropsychologists bring a number of strengths to health promotion and prevention research and practice in medical care settings, including an understanding of aging in relation to cognition, mental health, and other factors; a view of aging as a time for continued growth and opportunities; training in behavior change theories and principles; training in effective communication skills; and training in assessment. Practitioners and researchers in this area are also encouraged to integrate public health perspectives into one's practice and to gain a greater working knowledge of health, disease, and health promotion. Research and practice topics that could benefit from the involvement of clinical geropsychologists include practitioner health behavior counseling; psychosocial factors related to the adoption of and adherence to health behaviors; patient-practitioner communication in relation to health behaviors; and the tailoring of educational materials and interventions to be age-appropriate and age-relevant. Age-tailoring requires an appreciation of factors such as caregiving, widowhood, health issues, transportation, and life experiences as they may impact attitudes, beliefs, and behaviors (e.g., the historical exclusion of women from sport and exercise may impact current attitudes toward exercise). Finally, clinical geropsychologists are encouraged to prepare for the changing demographic profile of older adults that will result in an older and more ethnically diverse aged population.

Assessment of Older Adults in Medical Settings

Peter A. Lichtenberg, Ph.D., ABPP

There are several core principles of assessment to remember when assessing cognition in older adults:

Principle 1: Age and functioning are not linearly related in clinical settings. In medical settings, for example, cases of dementia may be almost as common in younger-old (60-79 years) as older-old patients. This is generally due to the fact that hospitalized younger-old patients represent some of the most impaired individuals in their age group whereas older-old hospitalized individuals reflect the characteristics of the community at large.

Principle 2: Comorbidity in clinical settings must be recognized. Delirium and dementia, as well as depression and dementia are frequently found together. In the past clinical gerontologists have too often attempted to differentially diagnose depression vs. dementia or delirium vs. dementia rather than assess for the coexistence of these disorders. Comorbidity is also reflected in the fact that frailty issues, the existence of dysfunction across many systems, plays a more prominent role in functioning than does principal diagnosis. In a recent study (Mast, MacNeill & Lichtenberg, 1999 Journal of Gerontology: Medical Sciences) rates of dementia and depression were identical for hospitalized patients with stroke or lower extremity fracture.

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The Student Voice

Martha Crowther, Ph.D., Prior Student Liaison-Clinical Geropsychology

As I embark on a new journey as an assistant professor at the University of Alabama, I was invited to write a column discussing the path that led me to my current focus in clinical geropsychology. My interest in older adults is the culmination of fondness for old people and my diverse research and clinical background. I grew up around a lot of older adults and I have always had a very positive view of aging. Professionally, my clinical and research interests have merged – largely focused on understanding the relationship between the health and behavior of older adults. Specifically, the effects of stress and coping behavior on health outcomes of African American elderly apart from the other confounding variables and changes associated with normal aging and the impact of spirituality on the health and well-being of older adults.

Early on, I recognized the power of research while serving as a research assistant in the psychology department at U.C. Berkeley. Upon completion of my undergraduate degree, I worked full time as a research assistant at U.C. San Francisco on a project funded by the National Institute on Drug Abuse. The job stimulated my interest in problems affecting drug abusers and their families. This interest led me to volunteer working with a support group at San Francisco General Hospital. The participants were primary caretakers of their grandchildren who were secondary victims of drug abuse. This experience reinforced my observation that there is a relationship between health and behavior.

After working for a year, I decided to obtain a MPH with a concentration in epidemiology at Yale University. I wanted to learn the methodological skills necessary to study the relationship between health and behavior. My thesis from Yale, which examined the correlates of cognitive impairment in White and Hispanic community dwelling elderly further, stimulated my interest in the association between health and behavior. It also sparked my interests in doing research with older adults.

After completing my MPH, I decided that it was time to integrate my previous experiences and pursued a Ph.D. in clinical psychology with a focus in health psychology. I changed my focus from examining relationships at the population level to an individual one. My dissertation was on the nature, impact, and consequences of full-time caregiving among African American grandparents. This population, which I had worked with much earlier, became a central focus of my research and clinical work. I concluded my training at the Palo Alto Veteran's Hospital in their clinical geropsychology program. It was a great opportunity for me to once again combine my training and apply it specifically to older adults.

I received funding during my graduate training that I would like to mention in case any of you are interested in pursuing external funding. During graduate school I received awards from The American Psychological Association Minority Fellowship in Ethnic Minority Gerontology and Gerontological Society of America Minority Pre-doctoral leadership Development Award. In terms of dissertation support, I received the Duke Long term Career Development award and a National Institute of Aging Minority Dissertation Award.

I hope what I have demonstrated to you and what I realized myself as I was writing this column, all of our experiences are valuable and you do not have to travel a straight line to end up at the correct destination. Good luck with your graduate school training and if I can assist you please feel free to send me an e-mail at crowther@bama.ua.edu.

Treatment of Generalized Anxiety Disorder in Older Adults

Student award winner at APA for Division 12, Section II

Julie Loebach Wetherell, M.A., University of Southern California

Advisor: Margaret Gatz, Ph.D.

Although anxiety disorders, like most psychological conditions, are less common among older adults than among younger people, epidemiological evidence suggests that anxiety is a major problem in late life, and its consequences are potentially serious. Few investigations, however, have examined the psychological treatment of anxiety in older adults. The current study compared group cognitive-behavioral therapy (CBT) to a discussion group (DG) and a wait list control condition (WL) among 75 older adults with generalized anxiety disorder (GAD) on measures of anxiety, worry, depression, and quality of life.

Participants were recruited through hospital-affiliated health education programs, senior centers, and the media. The sample was 80% female and 77% Caucasian, with an mean age of 67.1 years (SD = 8.2) and an average of 14.5 years of education (SD = 2.2). Mean duration of GAD was 29.4 years (SD = 28.7). Participants had an average of 6.8 medical conditions (SD = 4.4), and 52% had a comorbid psychiatric diagnosis. Forty percent were taking psychotropic medications, and 88% had previously experienced either psychological or pharmacological treatment.

Participants were randomly assigned to 12 weekly sessions of CBT (n=26) or DG (n=26) or a 12 week waiting period (n=23). The program was advertised as "worry reduction classes," and both active conditions were designed to resemble psychoeducation programs rather than traditional psychotherapy or a support group. CBT consisted of progressive muscle relaxation, cognitive restructuring, and worry exposure using a manual based on one published Craske, Barlow, and O'Leary (1992). The DG condition consisted of a series of 12 worry-provoking topics for older adults, including memory problems, health concerns, and loss of independence. Each session, a photograph or brief reading assignment was used to stimulate discussion on the assigned topic. The manual included a list of questions for each topic as well as general directions for leading a group discussion. Four doctoral students in clinical psychology led the groups, three of whom had specialized training in therapy with older adults. They were supervised by Michelle Craske, Ph.D. for CBT and Margaret Gatz, Ph.D. and Cynthia Pearson, Ph.D. for DG.

The conditions did not differ on any demographic or outcome variable, and CBT and DG participants did not differ in their assessment of the credibility of the treatment rationale or their expectations for improvement. The overall attrition rate at 12 weeks was 20%, with eight individuals dropping out of CBT (31%), five from DG (19%), and two from WL (9%). Collection of six-month follow-up data is currently in progress.

CBT participants improved relative to the waiting list on five of 10 study measures, with a trend toward superior performance on a sixth. Within-group comparisons revealed that CBT participants showed at least a trend toward improvement on eight measures, whereas WL did not result in any significant gains. CBT showed transfer effects on depressive symptoms and quality of life as well as effects on anxiety and worry, suggesting that the benefits of treatment were multidimensional.

DG participants improved relative to WL on only two measures of anxiety and worry, and CBT performed significantly better than DG on two measures of worry and quality of life. The median effect size for CBT was .67, compared to .28 for DG and .05 for WL.

Results suggest that CBT with relaxation training, cognitive restructuring, and exposure is superior to a waiting list and may be superior to a credible nondirective group intervention for generalized anxiety in older adults. Gains in both conditions were modest when compared with younger GAD samples, but participants may have been unusually treatment resistant by virtue of their long history of anxiety, lack of response to concurrent pharmacological and previous psychological and pharmacological treatment, and coexisting medical conditions. Limitations of the study include the small and relatively homogeneous participant pool. Yet given the prevalence of anxiety in the older population, the limitations associated with pharmacological treatment, and the lack of adequate data on psychological interventions, the current study makes an important contribution to the treatment outcome literature on anxiety in older adults.

Acknowledgments

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there is withdrawal by the spouse from the depressed individual. Experimental data have, in fact, documented that depressed persons evidence verbal and nonverbal social behaviors that tend to elicit hostility and rejection from others. Other work has found that there are maladaptive interactional patterns between members of a couple in which one member is depressed (Keitner, Miller, Epstein, & Bishop, 1986).

Do Social Relationships Affect the Onset and Course of Depression? In an influential study conducted in England, Brown and Harris (1978) found that stressful life circumstances increased women's vulnerability to depression but that an intimate relationship was protective against depression. In summarizing findings from the Epidemiologic Catchment Area Study, Weissman (1987) noted that there was a strong association between marital problems and major depression. Similarly, Hooley and colleagues (Hooley, Orley, & Teasdale, 1986) found "expressed emotion" in partners of depressed person (EE; which essentially indexes criticism by a family member toward a psychiatrically ill relative) was tied to much higher rates of depressive relapse.

How Have Social Factors Been Tied to Late Life Depression? As part of a National Institute's of Health Consensus Conference on late life depression, George (1994) summarized research evidence on social aspects of depression and found that late-life social problems, including deficits in social integration and social support, were associated with poorer

emotional well-being and depressive symptoms. On the whole, however, there has been only a handful of studies that have investigated interpersonal aspects of late life depressive disorders. In one of the earliest studies, Liptzin (Liptzin, Grob & Eisen, 1988) reported that during a psychiatric hospitalization, family members of elderly persons with dementia or depression were comparably burdened. Six months later, however, relatives of depressed elderly were more burdened than those of elderly with dementia, a finding that supports the notion that negative interpersonal fallout from depression may endure beyond the resolution of the depressive episode. Some have suggested that depression may be "contagious" within intimate relationships. Recent evidence supports this view. In a study of depressive symptoms in older couples in which one member evidenced depression, depressive symptoms increased the likelihood that the other member of the coupled dyad would him or herself experience depressive symptoms (Tower & Kasl, 1996).

Studies of Interpersonal Aspects of Late Life Depression at Hillside Hospital: Over the years, my colleagues and I have conducted several studies of family issues in late life depression. Interest in this topic was generated by my own clinical observation that family members of depressed older clients were often quite stressed by responsibilities for care of a depressed older patient and uncertain how they could best be of help to the relative. Using different conceptual frameworks and methodologies, we have conducted three studies on the interpersonal aspects of late life depression.

Study 1. Supported by a grant from the National Institute of Mental Health, we longitudinally studied stress and coping in 150 spouse and adult child caregivers of older adults hospitalized with major depressive disorder. Findings have been reported in a series of papers (Hinrichsen, 1991; Hinrichsen, 1992; Hinrichsen, Hernandez, & Pollack, 1992; Hinrichsen & Hernandez, 1993; Zweig & Hinrichsen, 1993).

Study 1A. As part of Study 1 we also conducted a longitudinal investigation of a brief measure (the Five Minute Speech Sample) of expressed emotion in 54 spouse and adult child family members (Hinrichsen & Pollack, 1997).

Study 2. Using an object relations framework, 50 adult sons and daughters caring for a mother hospitalized with major depressive disorder were cross-sectionally studied (Hernandez, Hinrichsen, & Lapidus, 1998).

Study 3. In recently completed work, my colleague Leslie Adelstein and I conducted a longitudinal study of expressed emotion using the Camberwell Family Interview in 46 spouse and adult child family members of older adults hospitalized for major depressive disorder.

I will summarize some salient findings from Studies 1, 1A, and 3 that, I believe, make the case for psychotherapeutically addressing interpersonal issues in late life depression.

What do Family Members Find Most Difficult and Rewarding in Caring for a Depressed Older Adult? In Study 1, we asked family members what was most difficult and most rewarding about caring for the depressed older person. The most frequently mentioned problem reported by family members was interpersonal stresses associated with care of the depressed older person (e.g., attempts to motivate or reason with the older patient were frustrating, efforts to help seemed useless or inadequate, efforts to help were rejected by the patient). Two of the other most frequently reported problem areas included practical difficulties (e.g., competing responsibilities, contending with the health care system, increasing dependency of the patient on the family member) and emotional stresses experienced by the family member (e.g., physical or emotional well-being was damaged, guilt, anger). These open-ended reports were consistent with studies of younger person in that they underscored the interpersonal and emotional toll of living with or providing care to a depressed person.

Although at first glance it would be hard to understand how care for a depressed older adult might be rewarding, responses from family members were interesting. Although a smaller percentage of family members reported rewarding aspects of care than reported difficulties, some indicated that the episode of depression actually improved the relationship with the older patient. Other family members felt better about themselves because of the care they provided because, for example, they took satisfaction in discovering that they possessed the strength or capacity to deal with a very challenging situation.

What is the Emotional Well-Being of Family Members of Depressed Older Adults? Fairly high levels of emotional distress were evident. In Study 1, 44% of family members reported moderate to severe burden. Levels of burden were, in fact, comparable to those we found in another study we have conducted with 152 dementia caregivers. In Study 3, 26.1% of family members scored in the "mild-moderate depression" range of the Beck Depression Inventory and 6.5% evidenced "moderate - severe depression." A troubling finding from Study 3 was that 43.5% of family members had evidence of at least one past episode of major depressive disorder themselves. This finding underscores the potential emotional vulnerability of this group of family members to the stresses of care for a depressed older adult.

Is Family Members' Coping Tied to their Own Adjustment? In Study 1, we used a stress and coping paradigm to understand how the family members' response to the stress of caring for a depressed older person was tied to their own emotional adjustment. We used a widely used and broad measure of coping as well as a specific measure of how family members managed problems specific to the patient's depressive illness. To our surprise, none of the coping and patient

management strategies was related to better emotional well-being of the family member. In fact, 4 out of 6 of the coping and patient management strategies were cross-sectionally related to poorer emotional well-being. The result seemed consistent with Coyne's (1974) contention that the interpersonal dynamics of depression are complex and mutually frustrating to both patient and family member.

What Factors Predict Patient Failure to Recover from Major Depression Over One Year? In all of our studies, we used structured psychiatric interviews to characterize the older patient's psychiatric symptoms and, in the longitudinal studies, used a procedure for characterizing the course of major depression over one year. In Study 1, we examined the power of three domains of variables to predict whether the older patient recovered from the episode of major depression: Patient demographic variables, patient clinical variables, and family member psychosocial variables. Only family member psychosocial variables were tied to patient recovery. Family members who evidenced more psychiatric symptoms, reported more difficulties in caring for the older patient, and who had poorer health had older relatives who were less likely to recover from the depressive episode. Results generally supported the proposition that interpersonal factors influence the course of an episode of depression.

What Factors Predict Patient Suicide Over One Year? In Study 1, we found that out of the 126 older patients whom we were able to follow for one year, 11 (8.7%) made a suicide attempt. We were interested in ascertaining whether variables from each of the three domains noted above could predict whether a suicide attempt was made. Variables from each of the domains predicted a later suicide attempt. These included: 1. Patient demographic variables: Higher social class, 2. Patient clinical: Suicidal tendencies at hospitalization, attempted suicide in current episode, and past suicide attempt, and 3. Family member psychosocial: Higher burden (trend), more psychiatric symptoms, more reported relationship strain, and more reported difficulties in patient care. Findings were consistent with previous studies that have found that past suicidal behavior is a predictor of a subsequent attempt. Findings also underscore the influence of interpersonal factors on the course of depression.

What is the Role of Family Member Expressed Emotion (EE) and the Course of Depression? As noted, we were able to study expressed emotion (EE) in a subset of study participants (Study 1A). EE indexes critical and/or hostile remarks made by a family member about a psychiatrically impaired relative or who evidence emotional overinvolvement with the patient. This information is gleaned from a semi-structured interview, the Camberwell Family Interview. Family members are then dichotomized as "High" or "Low" EE. Psychiatric patients residing with High EE family members have been found to have much higher rates of psychiatric relapse than patients residing with Low EE family members (Koenigsberg & Handley, 1986). The explanation is that living in an interpersonally taxing environment creates stress in already stress-prone individuals.

We were interested in examining EE in our Study 1 sample of relatives of depressed elderly. However, it was not feasible to conduct the Camberwell Family Interview in the context of our existing study because of the considerable time it would take to conduct the Camberwell Family Interview. We chose, instead, to utilize a brief measure of EE, the Five Minute Speech Sample (FMSS). The FMSS is a five minute statement by the family member of their perceived relationship with the depressed older person. The content of the taped statement is coded and the family member characterized as High or Low EE.

In Study 1A, forty percent of family members were classified as High EE. This rate was higher than in other studies that have used the FMSS. For example, in a group of spouse caregivers of elderly patients with dementia, 21% were classified as High EE (Vitaliano, Becker, Russo, Magna-Amato, & Maiuro, 1988-1989). EE status in the combined group of spouse and adult children in Study 1A was unrelated to recovery or relapse. However, there was an interaction between EE and relationship to the patient (e.g., spouse or adult child) on 1-year clinical outcomes. Consistent with past studies among adult children caring for older patients, High EE status predicted higher rates of patient relapse and lower rates of recovery from depression than Low EE. In contrast, among spouses there was an association between high EE and lower rates of relapse as well as higher rates of recovery. Findings suggest that the impact of EE-related behavior may have different meaning and impact on depression depending on the type of relationship. It is possible that for older couples the emotional impact of EE-related behaviors on the patient may be softened when filtered through a long history of shared intimacies and resolution of interpersonal conflicts with the spouse. In contrast, expression of critical remarks by adult children may be especially painful for older adults and challenge existing assumptions about their relationship.

An Examination of EE Using the Camberwell Family Interview: What Does it Measure? As noted, in Study 1A we did not use the Camberwell Family Interview method for assessing EE because of the considerable time the interview takes to conduct. In addition, conducting the Camberwell Family Interview and scoring it require extensive training. In Study 3, however, we were able to use the Camberwell Family Interview.

Although EE has demonstrated a consistent and empirically robust association with psychiatric outcomes, it remains to be determined what it actually measures. In recent years, an attributional framework has been used to explain why some family members evidence EE-related attitudes toward the patient (i.e., family members who blame the patient for the psychiatric illness are more likely to be classified as High EE). Our suspicion was that EE overlaps with many of the constructs that have been examined in the gerontology caregiver research.

In cross-sectional findings from Study 3 that have just been analyzed, we examined to what extent selected gerontology caregiver constructs were associated with family member EE status.

First, it is important to note that in Study 3, in which we used the Camberwell Family Interview, the rate of High EE in this sample was much higher than in Study 1A, which used the FMSS method (i.e., 71.7% vs. 40%). Although it is documented the FMSS method underestimates rates of High EE compared with the Camberwell Family Interview, the discrepancy was striking. This suggests that the vast majority of family members of depressed older people evidence attitudes that have been tied strongly to relapse in younger psychiatric patient (and, in Study 1A, in a more complicated fashion to depression outcomes in older adults.)

As in other analyses, we looked at different domains of variables. High EE was unrelated to patient demographic characteristics, patient clinical characteristics, and family member demographic characteristics. Notably, most family member psychosocial variables were significantly associated with High EE. High EE was negatively associated with the family member's general social integration, communal orientation to social relationships, affectual solidarity with the patient, and a positive past relationship with the patient. High EE was positively associated with the family member's history of major depression, high levels of burden, and more attributions about depression that blame the patient. One implication is that individuals with a preexisting better relationship with the patient as well as to the larger social world are able to better contend with the significant stresses often tied to a depressive episode. It also appears that many constructs used in gerontology caregiver research that have been associated with better (or worse) capacity to contend with caregiving stresses are significantly linked with High EE. We have previously argued (Hinrichsen & Hernandez, 1992) that there is a need for a better dialogue among researchers from the many academic disciplines to develop common language and constructs to describe the dynamics of helping processes across a spectrum of human problems, age groups, and relationship types.

What's a Geropsychologist To Do? Interpersonal Psychotherapy for Depression: The genesis of my original interest in studying family issues in late life depression was clinical work with older people and their families. Results from our research and from others underscored the important role of interpersonal factors in life depression. One psychotherapy that explicitly focuses on interpersonal issues within the context of depression is Interpersonal Psychotherapy for Depression (IPT).

IPT was developed by Klerman, Weissman and associates (Klerman, Weissman, Rounsaville, & Chevron, 1984) to treat major depressive disorder. IPT is a time-limited psychotherapy that was originally manualized for a collaborative treatment study of depression in the 1970's. In younger adults, it has been found to be effective in acute and continuation/maintenance studies of depression alone or in combination with antidepressant medication. It has been adapted for other depressive disorders and other psychiatric disorders. It has been identified by Division 12's Task Force on Empirically Supported Treatments as a psychological intervention for which there is evidence of its efficacy. An increasing body of evidence supports its usefulness in the acute (Sloane, Staples & Schneider, 1985) and continuation treatment of major depression in older adults (Reynolds et al., 1999). It has also been found effective in the treatment of depressive symptoms in medically ill older adults (Mossey, Knot, Higgins, & Talerico, 1996). IPT is conducted in three phases of treatment with a focus in one or two of four problem areas: role transition (significant change in life circumstances), dispute (conflict with a significant other), grief (complicated bereavement), and social skills deficits (individuals who lack skills to get or keep people in their social worlds.)

At our institution, my colleagues and I have used IPT in the treatment of major depressive disorder and adjustment disorder in older adults. Alone or in combination with antidepressant medication, we have found clinically that 80% of older adults who have been treated with IPT evidence significant reductions in depressive symptoms (Hinrichsen, 1999). IPT is congruent with general recommendations for doing psychotherapy with older adults and most of our patients find its time-limited, problem-focused format appealing.

Conclusions. Care for a depressed older adult is emotionally stressful and interpersonally complex. It may be especially difficult for family members who have preexisting emotional vulnerabilities an historically problematic relationship with the older patient, or who are not socially well-integrated. Consistent with research on families of younger psychiatric patients, family factors influence the course of depression as well as risk for suicide.

Clinically, interpersonal issues need to be addressed. These issues are often evident at initial intake when the family member is present. If the clinician suspects problems, both the patient and family member should be asked about them. For

example, Jill Hooley and her colleagues found that depressed patients who affirmatively replied to the simple question, "Is your spouse critical of you?" had much higher rates of relapse from depression than other patients. Family members who are struggling with concerns related to care for a depressed older adult need education on depression and its treatment, some practical recommendations on how to deal with issues that arise, an understanding of where there may be limits on what they can do to help the older person, and a recommendation that they need time away from the older depressed person to engage in pleasurable activities. For the depressed older adult with interpersonal problems, Interpersonal Psychotherapy is recommended. Whatever therapeutic modality is used, however, if the older person has interpersonal problems they need to be addressed since their ongoing presence may make recovery more difficult or relapse into depression more likely.

Division 12 Update, continued from page 3

suggest that the number of Members and Fellows in Division 12 peaked at 4912 in 1995, and has declined to about 4300 in 2000. The good news, though, is that we have not experienced the massive loss of membership over the past year that was feared with the loss of two sections. Apparently, many Section I and V members have retained Division 12 membership. There have been corresponding declines in other membership categories, including students and new members. Declining memberships and other factors threaten to produce a budget deficit of $20,000 to $30,000 for the Division.

One strategy discussed to increase membership is to add additional sections. In addition to the addition of Section VII (Emergencies and Crises) last year, an additional section (VIII), the Association of Medical School Psychologists, is now fully operational. The Division 12 Board will be discussing several new possibilities for sections during the October meeting, including Clinical Psychology in the Schools and VA Psychologists.

Leadership: Dr. Ed Craighead's term as President of Division 12 ends during the year 2000, and Dr. Karen Calhoun will become President in 2001. Dr. Larry Beutler will be President-elect in 2001 and then President during 2002.

Relationship to APA Directorates: During the June meeting, we were able to meet with the Directors of the APA Education, Practice, Science, and Public Interest Directorates. Several important trends were discussed. Dr. Cynthia Belar, Director of the Education Directorate, suggested that APA may move to change its recommendation on the minimum level of training for practice, and by implication, licensure. The requirement would be to require two years of clinical training, one of which must be the internship. Current APA recommendations are that independent practice require two years of clinical training, one of which should be postdoctoral. Essentially this would encourage licensure directly after internship. Of course states are free to institute whatever standards they wish. Dr. Russ Newman spoke about initiatives in the Practice Directorate. The Practice Directorate wants to press for increased emphasis on quality of health care to counterbalance current emphasis of competition only around cost issues. When asked about Medicare issues, he stated that the Practice Directorate intends to hire a second full-time attorney to expand the Directorate's efforts in this area. The Division 12 Board hopes to meet with the Directorate leadership every year in order to allow us to keep our concerns at the forefront of APA leadership.

Division 12 priorities: We spent an afternoon brainstorming about future directions for the Division. The scientist-practitioner model was confirmed as a core value of the Division, with breadth of content including diverse populations served by clinical psychology. We discussed the importance of providing more member services and value of membership beyond the existing journals. One way to increase the number of new Division 12 members would be to target training faculty in clinical training programs and internships.

Final thoughts: I have repeatedly urged Section II members to join Division 12. This becomes even more important as the Division is facing declining membership. Section II is actually one of the largest and most active sections within Division 12. I know that most Section II members have a strong affinity with Division 20—I do as well—but I encourage everyone to consider membership or even Fellow status within Division 12.

Update: Coalition on Mental Health and Aging, continued from page 4

state, and national coalition representatives to meet and discuss such issues as mental health and primary care, mental health and substance abuse, state and local practices, as well as public policy and advocacy. ASA and NCOA are still accepting agenda items: http://www.ncoa.org/asa_ncoa_conference.html.

Alixe McNeill mentioned NCOA's "Promising Practices" on Meeting Substance Abuse & Mental Health Needs of Older Adults. This is a joint initiative of NCOA and the Substance Abuse and Mental Health Services Administration. This initiative plans to highlight promising practices for senior centers and other elder services as role models of programs and partnerships that offer successful educational, prevention, screening and referral services.

Christine de Vries reported on the recent American Association for Geriatric Psychiatry's Consensus Conference on Providing Optimal Mental Health Services in Long-term Care Settings. A consensus statement will be forthcoming. The conference focused on current research, practices and policies, with the aim of providing integrated services for older adults and support of research, training and Medicare reimbursement issues.

Clinical Geropsychology in Medical Settings: Prevention, Assessment, Intervention and Training, continued from page 5

Principle 3: Normal and pathological conditions must be distinguished. I am an advocate that an empirical approach be used. Cognitive assessment must utilize performance-based instruments that can be reliably administered and scored. Cognitive assessment is dependent on the availability of good normative data sets. There has been an explosion of excellent resources in this regard over the past 10 years. Gerontologists must remember to closely match the normative data set with their individual examinee on the basis of age, education, ethnicity and gender.
Principle 4: Utilize brief assessments: Cognitive assessments or geriatric neuropsychological assessments have often taken 4-8 hours to complete. There are several drawbacks to this approach to assessment including loss of rapport with the patient, patient fatigue, and reimbursement problems. In addition, there are several 45 minute- 2 hour batteries that have demonstrated good reliability and validity.
Principle 5: Emphasize cognitive strengths, weaknesses and treatment recommendations in assessment. It is increasingly important that cognitive assessment be used to guide treatment and care management plans, in addition to its usage in the diagnostic process. Treatment recommendations (e.g.. implications for independent living, driving, competency, how to structure leisure time) should be based upon empirically supported findings.
Principle 6: Multiple methods of assessment are optimal. In cognitive assessment, self-report of cognitive abilities, performance-based psychometric test results, and the comparison of self-report with performance based results are valuable. Awareness of deficit (or of strengths) is very important in terms of both diagnostic statements and treatment planning.

Treating Depression in Older Primary Care patients with Psychotherapy

Patricia A. Arean, Ph.D.

Depression in older primary care patients is a significant public health problem. Depression in this population is related to increased health care cost, morbidity and mortality. Most research has focused on treating depression in this population with antidepressant medication only, despite the fact that more than 30% of older adults prefer to be treatment with psychotherapy alone, and an additional 25% prefer a combination of treatment. Most recently there have been a few studies that have looked at the effectiveness of CBT in treating late-life depression in older primary care patients. Currently, three multi-site trials are looking at the utility of psychotherapy as part of a primary care treatment package for depression. This paper reported the results of a longitudinal trial of CBT in low-income patients.
Methods: 70 primary care patients over the age of 60 were randomly assigned to receive CBT, Clinical Case Management (CCM) or the combination of CBT and CCM. All patients met criteria for either Major Depression or Dysthymia, nearly 60% were minority, and all were referred from primary care physicians. Patients were followed for 18 months, and outcomes of interest were symptom severity, quality of life, functioning and use of other services.
Results: Our results indicate that patients who received a combination of CBT and CCM had superior outcomes at 6, 12 and 18 months in terms of symptom severity, role functioning, quality of life, and linkage to community services. Patient with co-morbid anxiety or trauma had worse outcomes over all. Conclusions: Often depression treatments for primary care elderly may need to be augmented with additional services in order for treatment gains to be persistent. The results from this

study were discussed in the context of the ongoing research on psychotherapy as a treatment for depression in older primary care patients with psychotherapy.

Training Clinical Geropsychologists to Work in Medical Settings

Suzanne Norman, Ph.D.

Acutely distressed older adults under-utilize mental health services. Based on a survey of the general health sector serving the elderly, only 56% of older adults with mental disorders used the mental health system with the remainder using primary care providers (Gatz & Smyer, 1992). Unfortunately primary care physicians are less likely to identify the mental health needs of older adults and provide appropriate referrals (Gatz, Karel, & Wolkenstein, 1991; Rapp, Parisi, Walsh & Wallace, 1988). Psychologists working with primary care physicians could provide assessment and interventions aimed at improving both the mental and physical health of older patients. However, there are few psychologists proficient in clinical geropsychology to provide appropriate services. It was estimated that by the year 2000 the projected need for psychologists trained to work with older adults would be 7,495 professionals working full-time. As of 1991 just over 700 psychologists in clinical practice spent at least half of their time working with older adults and their families. Yet only one quarter of those serving older adults had specialized training in clinical geropsychology. Further, only 10% of clinical or counseling psychology doctoral programs offer a concentration focusing on issues and treatment of older adults (Gatz & Finkel, 1995; Gatz, Karel, & Wolkenstein, 1991; Smyer, 1989). Clearly opportunities exist for clinical geropsychologists to work with older medical patients. This presentation focused on addressing two primary questions. First, what do clinical geropsychologists need to know to work effectively in a medical setting? Second, how can we teach this to our students? Models for educating students through graduate course work and clinical experiences were introduced including: Parham et al. (Eds.) 1990. Psychology of Health. In ACCESS: Aging Curriculum Content for Education in the Social-Behavioral Sciences; D. Frazer (1995). The medical issues in geropsychology training and practice, in Knight et al. (Eds.) Mental Health Services for Older Adults; a curriculum focusing on health issues in geropsychology developed by S. Norman. Resource materials and suggestions for activities to enrich the students' experience and provide exposure to other health care professionals were discussed.

Announcement: Position Opening

Nationally recognized senior living and health center in suburban Cleveland, Ohio, seeks a director for its research center. Menorah Park Center for Senior Living has been in existence over 90 years, and is comprised of a campus with multiple programs, including: 350+ beds of skilled nursing care, 90+ units of assisted living, 220+ units of independent living, adult day care, in-patient and out-patient rehabilitation services, an aquatic therapy center, and community outreach services such as home health care. Established in 1986 through a grant from the Cleveland Foundation, our Myers Research Institute has an excellent track record of external funding. Both applied and global geriatric-centered issues have been emphasized in the past. Qualifications for the Director's position should include a doctoral degree in social, behavioral, or health sciences, a proven record of research and publications in peer-reviewed journals, success in acquisition of peer-reviewed grant funds, experience in applied gerontology and a commitment to long-term healthcare. Highly competitive salary with comprehensive benefits. Please forward resume/vita, including references to: Jamie Herbst, Director of Human Resources, Menorah Park Center for Senior Living, 27100 Cedar Road, Beachwood, OH 44122, www.menorahpark.org, menhr@core.com, (216) 831-6500, EOE

Did you know....

- If you need to **change your address** for the newsletter, please contact Barry Edelstein, Ph.D. at e-mail: u21b4@wvnet.edu or by phone: (304) 293-2001, Ext. 661.
- Stay connected with your colleagues in clinical geropsychology by joining our **e-mail network**. Simply send an e-mail to Barry Edelstein at u21b4@wvnet.edu (Be sure to include your name, e-mail address, and express your interest in joining the 12/2 e-mail network).
- Division 12, Section 2 has a **website**. Check in out at http://bama.ua.edu/~appgero/apadiv12.htm.
- Encourage your colleagues and students to **join Division 12, Section II**. Contact Michele Karel, Ph.D., Psychology Service, 3-5-C, Brockton VAMC, 940 Belmont Street, Brockton, MA 02301; e-mail: Michele.Karel@med.va.gov; or phone: (508) 583-4500, ext. 3725 regarding membership.

Call for Award Nominations

Shelley Gagnon, Psy.D. (Editor)

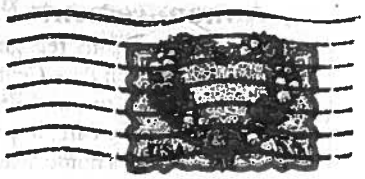
The Board of the Trustees of the American Psychological Foundation (APF) is announcing its call for nominations for the ***APF 2001 Gold Medal Awards*** and the ***Distinguished Teaching in Psychology Award***. All nomination/application materials are due by **December 1, 2000**.

APF Gold Medal Awards, which recognizes life achievement in and enduring contributions to psychology, are limited to psychologists **age 65 years and older** who reside in North America. Awards are conferred in the following four categories: Science of Psychology, Application of Psychology, Public Interest, and Practice of Psychology. Awards include a gold medal, $2,000 to be donated to the charity of the winner's choice, and a 2-night/3-day expenses paid trip to the 2001 APA convention in San Francisco.

To nominate a psychologist, include a nomination statement for a specific award category that traces the individual's lifetime cumulative record of contribution, and the nominee's current vita and bibliography. Letters of support for the nomination are also welcome. The chief nominator should collect all materials and forward them in one package to: Gold Medal Awards Coordinator, American Psychological Foundation, 750 First Street, NE Washington, DC, 20002-4242; Phone: (202) 336-5814; foundation@apa.org.

The ***APF 2001 Distinguished Teaching in Psychology Award*** recognizes a career contribution to the teaching of psychology. Requirements include: evidence of influence as a teacher of students who become psychologists, research on teaching, development of effective teaching methods and/or materials, development of innovative curricula and courses, exemplary performance as a classroom teacher, training of teachers of psychology, teaching of advanced research methods and practice in psychology and/or administrative facilitation of teaching. Awards include a plaque, $2,000 check, and a 2-night/3-day expenses paid trip to the 2001 APA convention in San Francisco.

APF provides nomination forms. Nominations should include the form, statement of how the nominee fulfills the award criteria, and the nominee's current vita and bibliography. Letters of support for the nomination are also welcome. The chief nominator should collect all materials and forward them in one package. Requests for nomination forms and completed nomination packets should be sent to: APF Teaching Award Coordinator, 750 First Street, NE Washington, DC, 20002-4242.



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

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