Clinical Geropsychology News

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President's Comments:

Improving End-of-Life Care: Roles for Clinical Geropsychologists

William E. Haley, Ph.D.

Throughout my career in clinical geropsychology, I have found that the expertise of geropsychologists can prove extremely valuable in diverse settings. Most of my own training and experience has involved settings that are fairly familiar to most geropsychologists: outpatient mental health, nursing home consultation, and work as a geropsychologist as part of inpatient and outpatient interdisciplinary teams in medical settings. Geropsychologists have proven their skills in these areas, and research has demonstrated that psychosocial interventions in these settings are effective.

One additional area that may provide increasing opportunities for clinical geropsychologists in the future is greater involvement in end-of-life care. Psychologists have already made important contributions in the study of death, dying, palliative care, and bereavement, including not only basic scholarship but also work relevant to assessment and intervention of dying patients and their families (e.g., see Edelstein, Kalish, Drozdick, & McKee, 2001; Lawton, 2001; Rando, 2000; Stroebe, Hansson, Stoebe, & Schut, 2001). However, the recent "Report from the APA Working Group on Assisted Suicide and End-of-Life Decisions" (See http://www.apa.org/pi/aseolf.html), submitted to APA in May 2000, is rather sobering in its conclusions about where psychologists stand in terms of

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Inside this Issue:

REMINDER!

Inserted in this issue are forms for:

♦**Renewal of Division 12, Section II Membership**

♦**Application for new members**

Division 12/Section II Officer Elections

Division 12/Section II will be electing individuals to serve in the following offices:

- **President:** the person elected President will serve as President-elect from January - December, 2002 and as President from January - December, 2003.
- **Treasurer:** the person elected Treasurer will serve a 3-year term beginning January, 2002.

* Voting members will receive ballots in June. The following are statements from the candidates.

Statements from Candidates for Office of President

Victor Molinari, Ph.D.

After completing my Ph.D. in clinical psychology at Memphis State University in 1979, I did a 2-year post-doctoral fellowship in geriatric psychology at the Texas Research Institute of Mental Sciences. I have spent my entire professional career in geropsychology. I was a staff psychologist at an outpatient geropsychiatric clinic at a community mental health center before becoming employed at the Houston Veterans Affairs Medical Center (HVAMC). As the HVAMC director of geropsychology, I function as the psychologist on the geropsychiatric inpatient unit and the major preceptor for the geropsychology fellowship program. I have recently been appointed the HVAMC Acting Psychology Director of Training and am also a Clinical Associate Professor in the Department of Psychiatry and Behavioral Sciences, Baylor College of Medicine. I am the current coordinator for the Psychologists in Long Term Care, and the Treasurer for Section II. I edited "Professional Psychology in Long Term Care" (2000, New York: Hatherleigh Press), and have also published articles on reminiscence, ethical issues, and personality disorders in older adults.

I have thoroughly enjoyed my tenure as Treasurer of Section II, which has allowed me to participate in the Executive board meetings for the last 3 years with an outstanding group of cutting-edge professionals. I hope to serve Section II as President to further the development of geropsychology as a proficiency, and to advocate for improved reimbursement rates, increased research, and enhanced training for psychological interventions in long-term care settings.

Paula E. Hartman-Stein, Ph.D.

Division 12, Section II is a unique group in organized psychology that combines the expertise and interests of academicians as well as practitioners who struggle with the regulations of Medicare and managed care. Members of this division have a similar ultimate goal: to improve the quality of lives of older adults and make a living doing so by direct service, teaching, or research. I have been a member since the Section was organized and feel "at home" here.

My primary work is as a private practitioner in northeast Ohio at the Center for Healthy Aging. In the last 8 years I have been able to play a role in advocacy and education. In 1993 I was one of 7 psychologists who worked with a team of Harvard economists studying the "work value" of psychology that influenced reimbursement under the Medicare system. For over two years I have been writing about geropsychology practice issues for the National Psychologist. Last year I visited Capitol Hill and

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Program for Division 12/Section II (Clinical Geropsychology) Annual APA Convention, San Francisco, August 2001

Sara Honn Qualls, Ph.D.

Friday 8/24 11:00-11:50am:
* Section II Presidential Address, William E Haley, Ph.D., University of South Florida,
"Racial/Ethnic Diversity in Family Caregiving: Implications for Clinical Geropsychology".

Friday 8/24, 12:00-12:50pm:
* Section II Business Meeting, William E. Haley, Ph.D., President, presiding.

Friday 8/24, 3-3:50pm:
Invited Address, Mark D'Esposito, M.D., University of California-Berkeley,
"Isolating the Neural Mechanisms of Age-Related Changes in Working Memory using Functional MRI"

Saturday 8/25, 9-10:50am:
Symposium: *"The Family Context of Decision Making about Older Adults"*
*Sara Honn Qualls, Ph.D., University of Colorado at Colorado Springs, Chair
Participants:
Lawrence Fisher, Ph.D., University of California, San Francisco
"The Family and Disease Management in Latino and European-American Patients with Type 2 Diabetes"
Morton A. Lieberman, Ph.D., University of California, San Francisco,
"Multi-generational Families and Dementia"
Karen A. Roberto, Ph.D., Virginia Polytechnic Institute and State University,
"Making Health Care Decisions: Elders' Wishes or Family Beliefs"
Discussant:
Sara Honn Qualls, Ph.D., University of Colorado at Colorado Springs

Tuesday, 8/28, 11-11:50am:
Invited Address, Lou Burgio, Ph.D., University of Alabama-Tuscaloosa,
"Psychosocial Interventions for Behavioral Complications of Dementia in Nursing Homes"

Other Division 12 Activities by Section II members

Sat., 8/25, 5-5:50pm: Division 12 Social Hour

Mon., 8/27, 9-10:50am:
Symposium: *"Geropsychology for Clinical Graduate Students - Models of Training,"*
*Helen M. DeVries, Ph.D., Chair (includes several members of Section II)

Mon., 8/27, 3-4:50pm:
Symposium: *"Dementia Caregiving Interventions - The Impact of Gender, Ethnicity, and Sexuality"*,
*Dolores Gallagher-Thompson, Ph.D., Chair

Geropsychology Workshops

*Watch APA and Div. 12 publications for enrollment information!

Wed., 8/22, 9am-5pm - Women and Stress:
"Empirically Supported Interventions to Reduce Stress in the Lives of Middle-Aged and Older Women"
Participants include: Patricia Arean, Ann Steffen, Toni Zeiss, Dolores Gallagher-Thompson
7 CE units offered through the Professional Development Institute of Div 12.

Sat., 8/25, 9am-5pm:
"Professional Psychology in Long Term Care," San Francisco Hilton, Franciscan B.
* Victor Molinari, Ph.D., Organizer

Presenters & topics :

9-10:30:	What psychologists need to know to set up a LTC practice (Margie Norris)
10:30-12:00:	Psychological assessment in LTC for the experienced practitioner (Peter Lichtenberg)
1-2:30:	Psychological intervention with LTC residents & administrators (Joe Casciani)
2:30-4:00:	A methodology for addressing ethical issues in LTC (Martin Zehr)
4-4:30:	Q&A

Hospitality Suite Events

*These dates and times are tentative, pending final assignment by Division 12

Fri. 1-2:30pm: Interdivisional Task Force on Practice in Geropsychology

Sun. 7:30-9:30am: Section II Student Breakfast (Section II Board hosting)

Sun., 9:30am-12:30pm: Section II Board Meeting

Mon., 8:30-10:30am: Geriatric Neuropsychology Interest Group meeting

Mon., 10:30am-noon: Clinical Geropsychology in Medical Settings Interest Group meeting

Social Event - Section 2 Members Come Join the Fun!:

Friday 7pm: Cliff House, Dinner in Ben Butler Room, $40.10 (including tax and gratuity but not cash bar) with choice of 4 entrees. Ocean view, private dining room, long-established restaurant on the Pacific coast side of San Francisco (too far to walk, transportation required). Come join your colleagues for a beautiful, top quality evening! You must sign up ahead by contacting Sara Qualls at squalls@mail.uccs.edu or 719-262-4151.

Summary of a Presentation to the Committee on Aging: *Breaking Down Barriers to Medicare Coverage for Mental Health Services*

Deborah DiGilio, MPH
Aging Issues Officer, Public Interest Directorate, APA

Leslie Fried of the American Bar Association (ABA) Commission on the Legal Problems of the Elderly spoke at the March 2001 meeting of APA's Committee on Aging (CONA). Her presentation, *Breaking Down Barriers to Medicare Coverage for Mental Health Services*, focused on the Medicare Advocacy Project, which is a joint project of the ABA and Alzheimer's Association. Those involved with the Project believe that the most significant barrier to coverage of mental health services for Medicare beneficiaries with dementia is the Local Medical Review Policies (LMRP) established by the insurance carriers that process Medicare claims for HCFA.

HCFA defines Local Medical Review Policy as "an administrative and educational tool to assist providers, physicians, and suppliers in submitting correct claims for payment." The major goal of these local policies is to prevent overutilization of clinical services paid by HCFA. Over 8,000 such policies exist for medical services, items and procedures, including Psychiatry and Psychological Services. An LMRP includes a description of the service, specific procedure codes, and, for each of these procedures, a list of covered and non-covered diagnostic codes. They vary nationally by insurance carrier. However, most LMRPs on Psychiatry and Psychology Services restrict payment for services to individuals with dementia.

Until recently, the contract medical director of each insurance carrier and the Carrier Advisory Committee developed LMRPs. Limited review was provided by HCFA and little or no provider and public input was secured. This began to change in 1999 when a concerted effort was launched in Connecticut to counter United Health Care's proposed Psychiatry and Psychology Services LMRP that would automatically prohibit payment for psychiatric services including psychotherapy as well as physical, occupational and speech therapy for dementia patients. A coalition of mental health providers including psychologist Paula Hartman-Stein, with the assistance of the Medicare Advocacy Project, successfully advocated for the consideration of evidence-based clinical practice guidelines in development of the policy. One result of this intervention is that services are not automatically excluded for dementia patients in Connecticut.

In November 2000, HCFA issued a program memorandum to its Intermediaries/Carriers instructing contractors "to establish an open and public process for the development of LMRPs. The development process parallels the national coverage determination development process, providing more notice and opportunity for providers, physicians, suppliers and other interested parties to have input into the policies." These rules took effect January 1, 2001.

CONA believes that this new development process provides psychologists with an important opportunity to follow the lead of Connecticut and become active participants in the establishment of appropriate and evidence-based LMRPs for Psychiatry and Psychology Services.

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Profile On: *Nanette Kramer, Ph.D.*

Nursing Home Consultant, Researcher, and Professor

Contrary to the label on my ID card at one of the nursing homes where I work, I am not a fungus specialist (phycologist) but rather a practicing geropsychologist of twenty years. I believe my original interest in aging may have been sparked by the fact that my parents were relatively older than the parents of my friends. But what really cinched it for me was a brief encounter I had when I was a college undergraduate volunteering as a "friendly visitor" in a nursing home. As I saw it, my mission there was to cheer up poor old lonely people. When I saw a wizened-looking female resident, sitting alone in a wheelchair, seeming to be staring off into space, I made my move, saying something like, "Hi, I'm Nan, and I'm here to chat with you." Slowly and deliberately, she turned her face toward mine, and looking at me like I was a speck of dirt, spat out, "I don't know you and I don't want to know you."

While, at the time, this encounter made me think that I might do better exploring a career in botany (fungi?), the more I thought about what had happened, the more I felt challenged to make sense of discrepancies between my preconceptions and the realities of aging. Looking back, I realize now that this encounter was just one of a number of experiences I have had in which older people helped me stretch my mind. As I see it, one of the greatest perks of working as a psychologist with older clients is the continuous stream of surprises and discoveries inherent to the work.

Following graduate school at the University of Southern California, I returned to my home and family in New York. My first professional job was at Bellevue Hospital, where I was part of a multidisciplinary geriatric outpatient team. This team was very grass-roots oriented, often ferreting out community-dwelling older people who had become isolated and convincing them to let us help them. Many of the older people I met through this job were incredibly hardy and self-sufficient, despite very limited resources. Over the ten years I worked there, only three of the patients I knew died and most found ways to stay in their homes despite encroaching illnesses. These statistics were certainly at odds with my assumptions about growing old and gave me an enlightened perspective on the range of possibilities for ways to age.

At the same time that I began working at Bellevue, I also began teaching courses on aging at Teachers College, Columbia University. Teaching has been a wonderful motivator for keeping up on professional literature that I might otherwise have let slide. Teaching courses on aging has also given me a window into the minds and motivations of young people who are in the process of deciding on career paths. Being steeped in geropsychology, I was surprised by the number of students who had never known anyone over 60, never known anyone seriously ill or anyone who had died. Not surprisingly, these were the students who tended to never have thought about a career in gerontology. On the other hand, students who had had encounters with older people were much more likely to have interest in working with older people as part of their career. Given the wave of older people expected to sweep the country over the next few decades, these observations made me realize the importance of providing young people with exposure to the elderly.

The next turn in my career came about ten years ago when Medicare began to pay for psychological services and I began working as a consultant in nursing and adult homes. I have now worked with hundreds of nursing home residents, mostly between the ages of 60-105 but some as young

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The Student Voice

A Cure for Fear of Heights: Defending the Dissertation

Getting from there to here - one person's experience; one person's opinion.

Merla Arnold, M.Phil.

Completing the dissertation is a long distance run (or walk, depending on your temperament). I often found it useful to think of the moral of the Tortoise and the Hare story; slow and steady wins the race. Try to get and keep your interests front and center throughout the doctoral studies process. With each class project or assignment, think of ways to examine your interests. For example, in a social psychology course, I was expected to research a social phenomena and present it to the class. I searched the literature on attachment styles (attachment is a major interest area of mine) with a focus on social relationships to meet the class objective. I built upon the material over subsequent years. In another class, we were to complete an extensive literature review on a construct of our choosing. There, I focused on the death anxiety literature. By the end of that class, I had the core of Chapters I and II.

One trick is to find your passion. Follow your instincts and examine your area(s) of interest from as many different angles as you can. The final research project, the dissertation, is a way to integrate and extend your thinking about your constructs of interest. For example, try thinking about how your interest(s) can link with the greater psychology community. This can be an effective way of answering the "so what?" question about your research proposal. In my case, when I linked my work with geropsychology training and career issues, the "implications" argument unfolded readily.

Another great piece of advice was offered by the Program Director. I was told to "develop a project that will help you graduate." I was strongly encouraged to be practical. For me, that meant careful consideration of the population to examine. As I started to think about training implications, it occurred to me that, while I am interested in working with older adults, I'm not locked in to using the older adult as the study population. I surveyed graduate psychology students' interest in working with older adults after graduation; looking at the influence of attachment style and death anxiety. Paradoxically, while the literature search for the dissertation expanded necessarily beyond my two original constructs of interest, the research questions became more focused, more specific.

As you work with Professors and Teaching Assistants, try imagining how it might be working with that person on your dissertation project (my regression analysis TA acted as my first-line data consultant). What role can that person play? What is their expertise? Ask, "how can I learn from that person's talents?" If you think you would like to work with someone, join that person's research team. The research team is a great place to get guided practice in formulating research ideas, designing projects, implementing them, analyzing data, doing write-ups, and creating an opportunity to present the work to the professional community.

I had sage advice as I anticipated the oral defense of my dissertation. I was told by my academic mentor, "Consider the experience as one where you move from student to colleague." The defense is an opportunity to reiterate: (1) why this study, (2) what was done, (3) generally, what was found and, (4) so what. After that's laid out, typically the committee members ask questions, give their impressions, and offer critiques. The questions can be clarifying and/or challenging. There may be questions that ask

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CLINICAL GEROPSYCHOLOGY (Division 12, Section II)
is calling for submissions for the
CLINICAL GEROPSYCHOLOGY STUDENT RESEARCH AWARD

Graduate and post-doctoral students may submit a completed project relevant to clinical geropsychology by **June 22, 2001** to me via email at: Antonette.Zeiss@med.va.gov or by mail to :

Antonette M. Zeiss, Ph.D.
VA Palo Alto Health Care System (116B)
3801 Miranda Ave.
Palo Alto, CA 94304

The award ($250 and a plaque) will be presented at the 2001 APA meeting in San Francisco during the Section II business meeting; the winner also will be invited to appear at the Division 12 awards ceremony. Submissions will be accepted from student members of Section II and from the students of members of Section II. Manuscripts should be at least 10-15 pages of text, plus tables and references. Manuscripts which are being presented as posters or in symposia at APA will be accepted and are encouraged; please let us know if the manuscript you submit is being presented. Announcement of the award will be made by **July 6, 2001**.

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contributions and status in this area of care. This outstanding report, which is available in its entirety online, was developed by a group of distinguished psychologists, including Section II member Dolores Gallagher-Thompson. Included in the conclusions of this report is the statement: "Although some psychologists have made important contributions to the field, there is little evidence that the discipline of psychology as a whole has considered end-of-life issues to be an important area that deserves substantial professional time and attention." This report also notes evidence that other professions do not generally see psychologists as central to end-of-life decision making and care; for example, the Institute of Medicine report on improving end-of-life care (Field & Cassel, 1997) does not include psychologists in lists of valuable team members for palliative care programs.

Due in large part to the recommendations of this Working Group, APA has funded an ongoing effort, the Ad-hoc Committee on End-of-Life Issues. This committee has an ambitious mandate that includes working to increase the visibility of psychology in the end-of-life arena, developing and promoting clinical roles for psychologists in end-of-life care, and developing and promoting research, education, training, and policy roles for psychologists. Dr. Judith Stillion Chairs the Ad-hoc Committee, and I am a member. Several Section II members are members of the Advisory Panel for this Committee.

Over the past 5 years I have been working as a consultant with LifePath Hospice, a large nonprofit hospice based in Tampa, Florida. My involvement in hospice has opened my eyes to the contributions that psychologists could make to improve palliative care, hospice care, and bereavement services. Nearly 360,000 Medicare patients used hospice services in 1998, about 20% of all Medicare beneficiaries who died that year (General Accounting Office, 2000). According to this GAO report, average length of stay in hospice has been steadily declining, and 1998 figures show a median length of stay of only 19 days. As is described in the APA Working Group Report, psychologists could make

many contributions to areas such as assessment and treatment of hospice patients and families, and research aimed at development of empirically based practice in end-of-life care. One overarching need is for research that addresses factors that are contributing to delayed referrals to hospice, and educational programs that might serve to foster earlier entry into hospice and increased length of stay. In my own experience in working with hospice, we have collaborated with hospice staff to introduce standardized, psychometrically sound assessment instruments into clinical practice. For example, hospice patients and family caregivers are now administered short forms of the CES-D and SF-36 as part of the intake assessment. Also, we have done research with bereaved hospice caregivers attempting to identify risk factors for their chronic depression after caregiving has ended. Our preliminary results indicate that caregivers who had poor health and high levels of depression while caregiving are at risk for chronic depression several years after the death of the hospice patient. We have also collaborated with hospice physicians to identify factors that predict survival after admission to hospice as a means to improve decision-making about eligibility for hospice services.

In a recent query of the Section II listserve, only a small number of geropsychologists reported that they had experience in working with hospices to provide clinical care. One of the major barriers to such involvement in clinical care to hospice patients and families is that hospices receive a Medicare per diem payment that includes all medical and psychosocial care for the patient and family; thus, in most cases, psychologists cannot bill Medicare for services delivered to a hospice patient who is receiving the Medicare hospice benefit. However, there are some circumstances in which hospices might be able to make more referrals to psychologists, such as when bereaved individuals need more intensive psychotherapy services than hospice can provide. A number of geropsychologists working in VA settings, where Medicare is not a factor, have had very successful experiences as members of hospice teams.

As I continue to work on APA's Ad Hoc Committee on End-of-Life Issues, I will welcome ideas from members of Section II about how clinical geropsychologists can become more involved in end-of-life research, education, and clinical care. For example, if any Section II members have ongoing research, educational, or clinical activities focused on end-of-life care, please let me know (whaley@chuma1.cas.usf.edu) so that I can forward this information to the Committee, and possibly involve you in our Advisory Panel or in the programs that we hope to develop. This is an area where geropsychologists have unique expertise and experience, and I think that our efforts may be increasingly important to APA as a priority area.

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Division 12/Section II Officer Elections, *continued from page 2*

presented information to lawmakers on behalf of passage of the Older Americans Act. Currently I hold adjunct faculty positions at two universities, conduct on-line seminars on geropsychology topics, and write for academic journals. In 1998 I edited *Innovative Behavioral Healthcare for Older Adults: A Guidebook for changing times*.

The group, Psychologists in Long Term Care, afforded me an opportunity for leadership. I served on the steering committee and became part of the team that wrote the standards for psychological services in long-term care facilities. I am also a member of the APA Task Force on qualifications for practice in clinical geropsychology.

I am honored to accept the nomination of my colleagues for President-elect for Division 12, Section II. My vision for the section is ambitious. If elected, I will strive to make it a more supportive forum for clinicians and academics that fosters brainstorming of innovative practice approaches, works cooperatively with psychologists in other branches of APA, educates professionals, and advocates for change with lawmakers. If elected, I would strive to involve more clinicians to be active in the division. I believe I am uniquely qualified because of my 20 years of experience in clinical private practice as well as recent advocacy efforts on a national level. I hope you will consider supporting me for President-elect.

Statements from Candidates for Office of Treasurer

Margaret (Margie) Norris, Ph.D.

I am an active member of three major geropsychology organizations. I have served as Treasurer of Psychologists In Long-Term Care (PLTC) since 1999, Co-Convener of the Mental Health Practice and Aging Interest Group of GSA from 1999-2001, and Chair of the Public Policy Committee for Section 12(II) since 1997. My term as Treasurer for PLTC ends this year, so I am prepared to assume similar responsibilities for Section 12(II). My work as Treasurer has been rewarding. This work allows me to become familiar with the membership. I am often the initial contact person for members joining or renewing the organization. In performing the treasury duties of Section 12(II), I will maintain close attention to the solvency of our organization, offer suggestions for prudent ways to use our financial resources, and strive to productively contribute as a member of the executive board.

I received my doctoral degree in 1990 from the Department of Health and Clinical Psychology at the University of Florida. I am currently an Associate Professor at Texas A&M University and maintain a geropsychology private practice. Blending science, teaching, and service has been the pinnacle of my

professional aspirations. I have always believed that this range of activities sparked my interest in becoming involved in professional organizations. I will do my best to serve my colleagues through leadership that incorporates the science and service of geropsychology.

Suzanne Ogland-Hand, Ph.D.

After receiving my PhD in clinical psychology from Fuller Graduate School of Psychology (Pasadena, CA) in 1993, and completing an Interdisciplinary Team Training Program (ITTP) internship at the Palo Alto VA Medical Center, I completed a one year geropsychology post-doctoral fellowship at the Palo Alto VA. Following two years as a geropsychologist at the Nursing Home Care Unit at the Knoxville VAMC in Iowa, I moved to Pine Rest, a non-profit psychiatric facility in Grand Rapids, Michigan. As the Chief of Psychological Services on the Older Adult Inpatient Unit at Pine Rest, I led the development of a Behavioral Intensive Care Service; this program serves geropsychiatric inpatients with behavioral disturbances secondary to dementia. Currently, in addition to doing outpatient evaluation and treatment, I work as a geriatric consultant providing program development for non-profit organizations. I also have been the Assistant Training Director of Pine Rest's Internship program and, throughout my career as a geropsychologist, have been involved in supervision and training.
I value contributing to organizations that make a difference. For example, I have enjoyed serving as secretary to Psychologists in Long-Term Care (PLTC) for the past 6 years. In my experience, Section II is the critical advocate for professional geropsychology. I have benefited from the education, policy discussions, and collegiality that Section II provides. I would welcome the opportunity to collaborate with the continued growth and professional contributions of Section II.

Summary of a Presentation to the Committee on Aging, *continued from page 5*

What you can do:

- Check the web site, www.draftlmrp.net regularly. It is here you will the find draft policies that are up for revision listed by insurance carrier ("contractor") for your state/region. If there is a draft LMRP up for review, dates for written comments and open meetings will be listed. **Currently, there are draft LMRPs for Indiana and Kentucky (AdminiStar Federal carrier) up for review through 6/13/01.**
- Educate carrier medical directors on mental health issues including evidenced-based clinical practice guidelines.
- Mobilize existing professional networks for action.
- Submit written comments and attend open meetings on draft LMRPs.
- Read the National Psychologist January/February 2001 article by Paula Hartman-Stein to learn more about Connecticut's success story.
- Call the Medicare Advocacy Project for information and technical support/assistance on Medicare. The Project is also interested in hearing from you about Medicare problems, including denial notices and reimbursement problems (especially related to the new DSM-IV code 294.11 - dementia with behavioral problems). Contact Leslie Fried at: friedl@staff.abanet.org or (202)662-8684.

Profile On: *Nanette Kramer, Ph.D.*, *continued from page 6*

as 25. Initially, I was concerned that the nursing home atmosphere might not be conducive to conducting effective psychotherapy. Over the years, however, I came to see that practicing in the nursing home setting can offer several advantages over practicing in a private office. First, rather than my relying solely on clients' self-reports and on the dynamics between clients and myself, I have also benefited by being able to observe clients directly as they engage in their real lives outside of psychotherapy. Second, the nursing home setting has provided me with access to many more secondary sources of information about my clients (e.g., charts, staff feedback, information provided by other residents, family contacts) than would be available to me if I saw clients in a private office. Based on my own as well as colleagues' experiences, I can attest that many nursing home residents make excellent psychotherapy candidates. While in part their responsiveness may be attributable to generalized loneliness, they are frequently aware of and troubled by their problems and welcome the opportunity to work on them with someone who takes them seriously.

Working in nursing homes has made me acutely aware of the inappropriateness of the term "rest home" to describe the true nature of these facilities. On the contrary, I am often struck by the high rate of emotionally charged situations and the level of intensity present in the nursing home atmosphere relative to the world outside. Because of the concentrated nature of life here, these situations often have a negative impact not only on the parties directly involved but on others as well. In many of these instances, I believe that psychologists are uniquely equipped to help not only those who live in this environment but also those who work in and visit it to manage many of the stresses they face. To date, however, most of us who work in nursing homes are paid only to provide direct psychotherapy services to residents. Hopefully, we will be able to convince those who are the most likely payment sources (insurance companies and nursing homes) of the ultimate cost-effectiveness of expanding the use of our services, e.g., to develop behavior management training programs for staff, to conduct stress management training for staff and to design programs to improve communication between family and staff.

Another component of my career has been my collaboration in a series of research studies examining the roles and reactions of nursing assistants who work with nursing home residents with dementia. Not only do nursing assistants spend more time with residents than do any other staff or family, but also their work necessitates a more intimate level of involvement than humans typically engage in with one another. The more I have come to realize how many psychological challenges nursing assistants face in their work and how little is known about their perspectives, the more I feel that there is a great deal to be learned from them.

In the initial phase of our research, nursing assistants were reluctant to speak openly to members of the research team and tended to underreport negative aspects of their work. But gradually, as we learned better how to gain their trust (e.g., conducting semi-structured interviews rather than using close-ended questionnaires, obtaining coverage for them on their units while they volunteered their time with us, watching them provide care and asking them to explain what they were doing and why, seeking their advice for new nursing assistants), they began to share their personal feelings, experiences, insights and suggestions. In one study in which we interviewed nursing assistants directly, we learned that they often know more than they are credited with knowing, that their knowledge goes beyond what they learn

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APA Division 12, Section II:
Clinical Geropsychology
NEW MEMBER APPLICATION

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

Name: _____ **Degree:** _____

Address: _____

_____

_____

Phone: _____ **Fax:** _____

E-mail: _____

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

APA Membership Status:

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

What is your APA membership status? Please check one:

___Fellow ___Member ___Associate ___Emeritus (retired member of APA)

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Divisional and Affiliate Member Dues are $15.00 (U.S.), Student Dues are $5.00 (U.S.)

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Michele J. Karel, Ph.D., Section II Membership Chair
Psychology Service, 3-5-C
Brockton VAMC
940 Belmont Street
Brockton, MA 02301

Questions? Call Michele at (508) 583-4500 X3725, or e-mail at Michele.Karel@med.va.gov

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Clinical Geropsychology
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Victor Molinari, Ph.D.
HVAMC
Psychology Service 116B
2002 Holcombe Boulevard
Houston, TX 77030

Profile On: *Nanette Kramer, Ph.D.*, *continued from page 12*

in basic training and in-service classes, and that they possess valuable knowledge to impart to others as well as strong emotional reactions to aspects of the work, reactions which need to find expression. In this study, the nursing assistants offered so many suggestions for working with persons with dementia and their suggestions were so much more psychologically sophisticated than those typically found in training materials for nursing assistants (see Kramer and Smith, 2000, for a review of training materials for nursing assistants), we decided to put them together into a manual (Kramer, Smith, Dabney and Yang-Lewis, 1997). This manual was written largely in the words of the nursing assistants and was accompanied by photos of them engaging with residents. Follow-up studies have explored the role of peer-oriented training for nursing assistants and also the training of nursing assistants in specialized music and touch techniques to be used with profoundly demented individuals.

Looking back, I only wish I had a chance to thank that woman I met so many years ago in the nursing home who spurned my offer of help. She set me on a path that enhanced my life immeasurably. But then again, she probably wouldn't accept my thanks anyway.

References

Kramer, N. & Smith, M. (2000). Training nursing assistants to care for nursing home residents with dementia. In V. Molinari (Ed.), Professional Psychology in Long Term Care. NY: Hatherleigh Press.

Kramer, N., Smith, M., Dabney, J. & Yang-Lewis, T. (1997). Speaking from experience: Nursing assistants share their knowledge of dementia care. Brooklyn, NY: Cobble Hill Health Center.

The Student Voice, *continued from page 7*

you to extend your thinking beyond the scope of the project. These kinds of questions can serve to spark other committee members' participation. Remember, a lively discussion is a good thing.

Well, by now you may be wondering about the link between fear of heights and the oral defense. While I was waiting for the committee members to decide what my next step was to be (i.e., did I pass and, if so, what revisions were necessary?), I was standing by the stairway railing, three floors up. I looked down and was reminded of a scene out of a Hitchcock movie. I noticed that I was absent of my familiar fear of falling. I remember thinking, "I'm not afraid of heights anymore." Soon after this, my sponsor came out of the conference with her hand outstretched and said, "Congratulations Doctor!"

♦♦

If you have comments, questions or ideas for a future STUDENT VOICE column, please contact:
Merla Arnold, M. Phil, 12/II Student Liaison at ma159@columbia.edu

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