

# Clinical Geropsychology News

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## Presidential Address

### *Racial/ethnic diversity in family caregiving: Implications for clinical geropsychology*

**William Haley, Ph.D., Department of Gerontology, University of South Florida**

With the limited space available, I want briefly to review the work that I have done with my students and colleagues over the past 10 years focused on comparisons of White and African-American family caregivers of older adults with Alzheimer's disease and other dementias. Obviously I will have to skip over some of the finer points of this work; if you are interested in reprints, feel free to email me at [whaley@chuma1.cas.usf.edu](mailto:whaley@chuma1.cas.usf.edu). I do not have sufficient space to summarize the excellent work of many other scholars who have done work on African-American caregivers, or more broadly on race, ethnicity, and caregiving; if you are interested in learning more about these related areas there are several outstanding reviews (Aranda & Knight, B.G., 1997; Connell & Gibson, 1997; Janevic & Connell, 2001; Yeo & Gallagher-Thompson, 1996) that have summarized the broader field.

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### Some background on the project.

Besides reviewing our research findings, I want to say a bit about how I got interested in this topic, and some of the issues that we confronted in conducting the research. I had gotten interested in family caregiving and dementia early in my career, and published several articles on caregiving. My interest in

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**Division 12/Section II Officer Elections Results**

Submitted By: Greg Hinrichsen, PhD.

- ◆ President-Elect (2002): *Victor Molinari, Ph.D.*
- ◆ Treasurer (2002-2004): *Margaret P. Norris, Ph.D.*
- ◆ By-Laws Amendment to make Public Policy Committee a Standing Committee: *Approved*

**Public Policy Committee: Update On Recent Developments**

Margaret P. Norris, Ph.D., Public Policy Committee Chair

As Chair of the Public Policy Committee, I would like to update the Section II membership on many recent developments:

- ◆ Now headed by Thomas Scully, HCFA has been renamed Centers for Medicare and Medicaid Services (CMMS).
- ◆ APA has written a response to CMMS on the OIG report "Medicare Payments for Psychiatric Services in Nursing Homes." Many thanks to Diane Pedulla for doing the leg work on this response! I have a copy of this letter if you are interested in seeing it.
- ◆ AARP announced that they no longer would be able to host the Coalition on Mental Health and Aging meetings. Fortunately, Debby DiGilio, Aging Issues Officer of CONA, offered the services of APA to host these meetings. Many thanks to Debby for showing this leadership and we look forward to a close and fresh collaboration with the Coalition!
- ◆ CMMS announced the formation of "health-sector workgroups," which will meet to improve communications between CMMS and providers. APA Practice Directorate members are expected to attend the first meeting, which has recently been re-scheduled to October 26<sup>th</sup>. We are hopeful this forum will provide an opportunity for the psychology profession to have a greater voice in CMMS regulatory matters.
- ◆ An announcement is expected in November on the fees that will be paid for the new health and behavior CPT procedure codes.
- ◆ There is good news on the progress of the Mental Health Equitable Treatment Act of 2001. The Senate Health, Education, Labor, and Pensions Committee approved it by a 21-0 vote! This bill would replace the 1996 federal parity law, which expires the end of September. This current law prohibits discriminatory annual and lifetime dollar limits for treatments of mental illness. The current updated bill would go further in abating mental illness discrimination by prohibiting caps on the number of treatment sessions and barring higher deductibles or co-payments for mental health care. Coverage for mental health services and medical services would have to be equal. These proposed changes

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**Division 12, Section II Student Research Award Winner:****Sherry A. Beaudreau, M.A.****Age Differences in Storytelling: Inhibitory Deficits versus Pragmatic Change**

The current debate in the cognitive aging literature is whether age differences in language production reflect inhibitory deficits or, alternatively, if older adults select a more verbose style of speech when interacting with others with the goal of increasing social interaction. Hasher and Zacks (1988) proposed a general underlying age-associated deficit in the ability to inhibit irrelevant information, especially holding focus during conversation, the theory of inhibitory deficits. Burke (1997), however, proposed the pragmatic change hypothesis suggesting that verbosity is a practical skill used by older speakers to elicit increased social interaction. The purpose of this study was to determine if older adults use a different strategy than younger adults in some conditions but not in others during storytelling as predicted by the theory of pragmatic change. Specifically, older adults should tell lengthier stories when given the opportunity to do so. Further, these stories should be judged to be of superior quality.

Old and young participants were recruited from the volunteer research pool at Washington University. Three pictures and three personally relevant stories of negative, neutral, and positive valence were used as storytelling stimuli. All participants gave informed consent and were randomly assigned to either a terse (2 min) or a long (10 min) condition. Forty-eight young and 48 old participants were asked to "Tell about... You will have 2 min (10 min) to tell your story". A linguistic program (SLIWC second-version, 1999) was used to calculate the number of words and to analyze the percentage of words in the following categories: affective, cognitive, sensory and perceptual processes, social, first person, and fillers. Then, 5 older and 5 younger different participants rated the narratives in terms of overall quality, off-topic, interest, clarity and richness in detail. Each of the five ratings was on a 5-point Likert scale ranging from 1 (not at all) to 5 (very much so).

We found no age differences in total words,  $F(1, 93) = 0.84, p > .05$ ; or the Age x Length interaction,  $F(1, 93) = 0.07, p > .05$ . Significant main effects for storyteller age were found for sensory and perceptual words,  $F(1, 92) = 10.55, p < .01$ , social words,  $F(1, 92) = 4.08, p < .05$ , first person words,  $F(1, 92) = 5.24, p < .05$ , and filler words,  $F(1, 92) = 53.64, p < .001$ . Specifically, older adults used more sensory, social, and first person words. Young adults used more fillers.

Although significant interactions with age were detected on the dependent variables of percentage of social, filler, and first person words, none of these simple effects tests were significant ( $p > .05$ ). There were no age differences in any of the ratings of the stories from the long condition. The quality of the stories told by younger narrators in the short condition were rated as significantly better than the stories told by the older adults (2.62 vs. 2.53). These stories were also judged to be significantly more interesting (2.52 vs. 2.32) and richer in detail (2.56 vs. 2.43). The correlations between the subjective ratings of the stories and the types of words (e.g., affective, cognitive) used in the story were very modest. They ranged from -.20 to .17. Similarly, the correlations among the types of words used were minimal ranging from -.19 to .27.

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## **A Powell Lawton Memorial**

Gregory A. Hinrichsen, Ph.D., Past Section II President

A memorial service for Powell Lawton was held on March 15, 2001 at the Abington Friends Meeting House. The service, one of two held in the Philadelphia area, was organized by his friends and colleagues from the Philadelphia Geriatric Center. Attendees sat in straight back benches in this sparsely decorated place where Quakers have met for over 100 years. In the tradition of the Society of Friends, attendees were asked to share their thoughts about Powell. People sat quietly in their pews until someone spoke. Following a recollection there were a few moments or a few minutes of silence. Then another would stand, share thoughts, feelings, stories. The simplicity of the service seemed so appropriate for the direct, unpretentious manner of Powell Lawton.

The substance of the remarks by those of us who knew him mirrored comments that have been made on listserves, in the Division 12, Section II and Division 20 newsletters, and in informal conversations. Powell was a person of enormous intellectual and creative talent that emanated from a person who consistently evidenced personal modesty and deep respect for others. A note from former Philadelphia Geriatric Center colleague, Elaine Brody, was read at the service. It said that in the Jewish tradition it is believed that despite so much evil in the world, God does not destroy it because of the presence of a handful of righteous people. Elaine Brody said that Powell was among that handful.

Powell's wife Fay shared a powerful and loving memory of her husband, the life long Quaker. She said that as he was dying he cried out "take me to the sacred place." The memorial service closed simply as the conveners clasped each other's hands in friendship in a way that reminded me how so many people felt that their hands had been clasped in friendship by Powell Lawton.

## **The World Trade Center Attack: A View From New York City**

Gregory A. Hinrichsen, Ph.D., Past Section II President

The attacks on the World Trade Center and Pentagon have deeply shocked Americans everywhere. For residents of New York the destruction of the World Trade Center is a deeply personal, painfully poignant loss. As a resident of lower Manhattan, I stood on the street with my neighbors watching the twin towers burn. And then they were gone. The towers were such a prominent part of the New York City metropolitan skyline that many, many people were first hand witnesses to this overwhelming sight. An older patient told me that he watched the towers being built from his living room window in Brooklyn in the early 1970's and then watched them collapse through the same window. As I write this article, smoke continues to rise from the hole in the skyline that was once the Trade Center.

The social and psychological impact of these events on New York and the nation will be revealed in the coming months and years. The North Shore-Long Island Jewish Health System, of which my employer, Hillside Hospital, is a part, responded immediately. On Tuesday of the

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**The Student Voice****Merla Arnold, R.N., Ph.D.**

We are just coming back from the San Francisco 2001 APA conference. It was a great time of learning, connecting and reconnecting. Sherry Beaudreau, our most recent winner of the Section II Student Research Award, was appointed Student Representative. She is already hard at work to meet the needs of the student membership. Welcome Sherry!

We would like to hear about and announce the accomplishments of other 12/2 student members. Let us know what you've been up to. While many are beginning a new academic year, it may be that thinking "what next" is far from your minds. Maybe not. Either way, it is not too soon to consider the following recommendations of one former 12/2 student member:

***Seeking a Post-Doc in Geropsychology*****Frederick J. Kier, Ph.D.**

As a former geropsychology post doctoral fellow, and a current staff member at a site that offers post-doctoral fellowships in geropsychology, I am often asked by interns and graduate students for advice about applying for post-docs, as well as how to make the most of one's fellowship experience. I will very briefly touch upon what I feel are the most critical points.

Many of the things one can do to improve the chances of getting a post-doc are often done years before the application. If you are planning a career in geropsychology, plan for a post-doc and plan far ahead of time. Expand your experiences in geropsychology as you move through your graduate program, including practicum, research, and course work. With all else being equal, an applicant whose only experience in working with the older adult is one internship rotation may be at a disadvantage when competing with another postdoctoral applicant with a history of experiences in the field. Another plus could be your dissertation, if it focuses on a geropsychological topic. The recommendation to begin early gaining experience with the older adult rests partly on the notion that many fellowship sites use this history to assess the extent of your interest in working with older adults and to gauge whether or not you might make a career out of it.

This isn't to say internship is not important. Picking an internship site that either has a geropsychology specialization, a large number of rotations working with older adults, or a site that has geropsychology post-docs will help you when applying for a post-doc. These sites will likely have more intensive experiences in geropsychology and have faculty members knowledgeable about the field and those in it. These faculty members are also more likely to know more about post-doc opportunities and the application process. Another thing to keep in mind is that some sites tend to take their own interns for the post-doc positions. While nothing is guaranteed, if a site has a history of taking their own interns, it may be worth looking into applying there for internship.

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## **Profile On: Claren Sheck-Boehler, Ph.D. Career Opportunities in Long-Term Care**

**I** am an early-career clinical psychologist providing psychology services at three extended care facilities in the Toledo, Ohio area. I am also the mother of three daughters: 13 months, 4 years, and 7 years. I received my Ph.D. from the University of Georgia in 1994, when I was 8 months pregnant. Like many graduates, I was faced with the challenge of starting my family and career at the same time. Establishing my career in long-term care has allowed me to do both.

My affinity for the elderly began in childhood. I was fortunate to spend time with older relatives and remember fondly my 80-year-old Aunt Alice living with my family for a year. During my training at the University of Georgia I specialized in behavioral medicine and developed an interest in gerontology. I was fortunate to work with Bill Haley and Dan Marsen during my internship at the University of Alabama at Birmingham. They encouraged my interest in clinical work and research with the elderly. While in Birmingham, I received training in inpatient and outpatient geriatric settings as well as geriatric neuropsychology and rehabilitation psychology. By the time I graduated, I knew I wanted to pursue a career in geropsychology.

Originally I planned to start my career in a hospital setting where I would have access to clinical work, research, and teaching opportunities. However, I found I wanted to spend as much time as possible with my baby and decided traditional full-time postdoctoral training was not for me. I found a part-time position with a company providing rehabilitation and psychological services to area long-term care facilities. This first job provided me the opportunity to work part time in a medical setting, become familiar with clinical and payment issues unique to long-term care, and complete my postdoctorate requirements.

In 1999, due to changes in Medicare funding for psychology and rehabilitation services, the company I worked for discontinued its psychology services program. I found myself a newly licensed psychologist with two small children going into business for myself. I continued to want to work part time in order to enjoy my children's early years. To make the prospect financially feasible I decided to do my own billing and was able to attend workshops and hire a consultant to train me in this area. Today I am the consulting psychologist at two local extended-care facilities and share services at a third with two colleagues. I spend two days working outside the home and another half day a week doing billing, etc, from my home office. Being self-employed has given me greater flexibility to accommodate child sick days and extracurricular activities, has increased my revenue, and has simplified my pursuit of research and teaching experiences in these settings.

Regardless of whether you work for yourself or a company, employment in long-term care provides opportunities for professional growth both in and beyond clinical work. Long-term care settings offer the early-career psychologist exposure to a wide variety of presenting problems. Pain management, rehabilitation issues, neuropsychological screening and assessment, and grief work are frequent referral issues as well as the full range of inpatient and outpatient psychological disorders. Collaboration with medical, rehabilitation, pharmacology,

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**Posting of Internships and Postdoctoral Training in Geropsychology**

Merla Arnold, R.N., Ph.D.

Many are beginning to think about applying for Internships and obtaining a Post Doctoral experience. To facilitate your search, APA's Division 12, Section II *Clinical Geropsychology* website posts training opportunities for students interested in clinical geropsychology. Included in that list are clinical psychology internships and clinically focused postdoctoral fellowship opportunities.

◆ To find this listing go to: [http://bama.ua.edu/~appgero/apa12\\_2/training/trainmain.html](http://bama.ua.edu/~appgero/apa12_2/training/trainmain.html)

Please feel free to contact me should you have any questions or comments:

Merla Arnold, R.N., Ph.D.

12/2 Student Representative

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**Presidential Address, continued from page 1**

race/ethnicity was inspired by my clinical work. While I was in the psychology department at the University of Alabama at Birmingham (UAB), I got interested in this area through my work at the VA Medical Center. I was spending one day per week seeing patients, consulting with the geriatric medicine team, and training psychology interns. For the first time during my training and career, I began to work with increasing numbers of minority patients and families. In particular, I began to see African-American caregivers who sometimes had reactions to caregiving that seemed very different from what I had encountered in White families. A common experience I encountered was that African-American caregivers brought their relative in with a complaint of cognitive impairment only when the patient had severe impairment, but the caregiver described the memory loss as mild. Another frequent clinical observation was that African-American caregivers showed very little psychological distress, and willingly took on caregiving even when the caregivers were more distant relatives (nieces, grand-daughters), or had been estranged from a parent for many years. At this point (the late 1980s) there was very little empirical research on racial/ethnic diversity and caregiving, and no easy prospects for recruiting significant numbers of minority caregivers. I surveyed Alzheimer's Association groups in the state of Alabama (which was about 25% African-American) and found that less than 2% of their members were African-American. In the Memory Disorders Clinic at UAB, less than 10% of our patients were African-American, compared to about 50% of the Birmingham population.

Under the leadership of a neurologist, Dr. Lindy Harrell, UAB successfully competed for an Alzheimer's Disease Center grant from NIA, and I led an Education Core that made its primary emphasis the education and recruitment of African-American patients and families to the UAB Center. We were also funded for a Program Project grant from NIA, which included a study I directed on comparing White and African-American caregivers. With these resources we

hired some very dedicated and skilled staff who conducted community outreach at health fairs, churches, radio stations, and other settings. Dr. Constance West (at the time an undergraduate, now a Ph.D. clinical psychologist) deserves special recognition for her ability to connect with the African-American community, to build trust, and to recruit patients and caregivers to the UAB Center and our project. I have some very special memories of these efforts, including being welcomed into several large and historically important African-American churches where Constance and I addressed the congregation or worked booths at health fairs. Dr. Lindy Harrell also deserves enormous credit for making a number of efforts to make the Center accommodating to African-American patients and families. This included offering patient evaluations without costs to minority families, and making clinic staff attuned to flexibility in seeing families at times other than their precise clinic appointment schedules. After several years of this effort, more than 20% of the new patients in the AD Center were African-American, and we were able to recruit a significant sample of African-American patients and families to our project.

#### **The UAB Family Caregiver Research Project.**

Funded through a Program Project grant, "Alzheimer's Disease: A Multidisciplinary Approach," with Dr. Harrell and Dr. Mike Wyss as overall PIs, this study was funded from 1990-95, with additional funding from 1996-2001. The project continued after my departure to the University of South Florida in 1995 under the leadership of Dr. Kathy Goode and subsequently Dr. David Roth. We recruited 123 White caregivers, and 74 African-American families caring for patients who had similar diagnoses, ages, and levels of impairment. All patients were seen at the UAB clinic, and thus were very well characterized. We also recruited samples of 141 White and 77 African-American noncaregivers who were similar to the caregivers (within race) on demographic variables. The inclusion of noncaregivers has proven very important as we have some ability to distinguish which differences found between White and African-American caregivers are specific to caregiving, versus more general differences by race/ethnicity. We conducted initial assessments of a comprehensive set of variables, including patient impairments, and caregiver/noncaregiver mental and physical health, stressful life events, ways of coping, appraisals, and social supports. We kept in close touch with all study participants by phone so that we could track any changes in patient or caregiver status, such as deaths, moves, or institutionalization. We conducted annual reassessments of participants, plus special assessments in the event of patient death or institutionalization. Thus, we have a large, rich, and complex data set with information on longitudinal stress and coping in White and African-American caregivers and noncaregivers. I will briefly summarize some of our major findings.

#### **Major cross-sectional findings.**

One of our key goals was to assess whether White and African-American caregivers showed differences in indicators of well-being, including psychological, social, and health variables, in comparison with non-caregivers. We found (Haley et al., 1995) that White caregivers had significantly higher depression scores than White noncaregivers or African-American caregivers or noncaregivers. A similar pattern emerged for measures of life satisfaction. Across a number of measures of psychological distress, we found no evidence that African-American caregivers showed greater psychological distress than noncaregivers, suggesting a resilience to this stress. African-American caregivers did have worse self-rated health than White caregivers, but the same pattern of poorer health for African-Americans held



for noncaregivers. This demonstrated the importance of including noncaregiving comparison groups; without the noncaregivers, we might have misinterpreted the difference between caregivers as due to a differential health vulnerability of African-American families to the stress of caregiving. Finally, contrary to a sizeable qualitative literature, we found that White and African-American caregivers and noncaregivers did not generally differ on measures of social support. African-American caregivers also did not have more people helping them provide care for the relative with dementia.

In another paper focused on explaining individual differences (Haley et al., 1996) we applied structural equation modeling to a stress process model of caregiving, with major variables including caregiving stressors; potential mediators of social support, appraisal, and coping; and outcomes of caregiver depression and life satisfaction. While the results are complex, we found that the differences in depression by race were mediated by caregiver appraisals and coping, while social support was not a mediator. African-American caregivers rated caregiving stressors, including managing self-care and behavioral problems, as less upsetting than did White caregivers, and African-American caregivers also reported higher self-efficacy in managing these problems. The results suggested that any resilience in coping with caregiving in African-Americans might be due to internal coping resources rather than to advantages in social support. We speculated that African-American caregivers might have more prior experience with adversity, and greater expectation that caregiving would occur as a natural transition instead of an unexpected stressor, compared with White families. We also wrote that caregiving may serve as more of a disruption to the life course for White families, who often reported that plans for retirement or travel had been disrupted by the dementia caregiving responsibilities.

#### **Major longitudinal findings.**

In an initial longitudinal paper (Goode et al., 1998) we examined the prediction of longitudinal changes in caregiver adaptation using factors from the stress process model. Caregivers were re-assessed at a one year follow up, and we computed difference scores assessing changes in patient impairments, caregiver appraisals, coping, social support, and well-being (depression, life satisfaction, and health). In summary, we found that, despite considerable worsening of dementia symptoms in patients over time, changes in caregiver well-being were not directly related to patient decline; rather, caregiver well-being was associated with changes in caregiver appraisals, coping, and social supports, or baseline values of these variables.

In a recently published paper (Roth et al., 2001) we examined changes in depression, life satisfaction, and health over a two year interval in White and African-American caregivers and noncaregivers, using latent growth models. (I should note that Dr. David Roth of UAB deserves all the credit for our use of complex statistical models in all of this work, so please send questions about these issues to him!) Our African-American and White noncaregivers showed stable levels on all three dependent variables over the two year period, increasing our confidence that any time effects found were related to caregiving stress. We found that White caregivers showed stable, high levels of depression over the two year period, and that African-American caregivers showed low, stable levels of depression. On life satisfaction, African-American caregivers showed stable levels, but White caregivers showed worsening life satisfaction over time. On physical health symptoms, both White and African-American caregivers showed increased symptoms over time. Thus, African-American caregivers showed remarkable

resilience to worsening caregiving stressors over time, but this stress appeared to take its toll on both groups of caregivers in terms of physical health. Since few studies have looked at racial differences in caregiver health over time, our group is discussing the possibility of using physiological indicators of health status in a subsequent longitudinal study of this issue.

#### **Caregiving and end of life issues.**

Alzheimer's disease and other dementias are increasingly recognized as major causes of death. We have explored potential differences between White and African-American caregivers in attitudes and reactions to death in several publications. Dr. Becky Allen-Burge conducted a study using vignettes about end of life scenarios with the caregiving sample (Allen-Burge and Haley, 1997) and found that African-American families were significantly less likely than White families to state that they would withhold certain types of heroic life-sustaining treatments for a relative with dementia. In a subsequent study (Owen et al., in press) of caregivers whose relative died during the project, we found that African-American caregivers were actually less likely than White caregivers to have made a decision to withhold life-sustaining medical treatment prior to the patient's death. We also found racial differences in certain emotional aspects of grief and reaction to death; African-American caregivers rated feelings of relief lower, and feelings of loss higher, than White caregivers. African-American caregivers were also lower on several indicators of anticipatory grieving.

We are completing an additional manuscript examining long-term psychological, social, and health consequences of the death of the dementia patient. Our preliminary analyses suggest that both White and African-American caregivers show similar responses, including improvements in social engagement and life satisfaction, but depression that remains quite high in White caregivers even at a year after the death.

#### **Implications for intervention.**

One of the goals of conducting naturalistic studies of stress and coping is to provide information useful for clinical interventions. Fortunately, research on race, ethnicity, and caregiving has proven useful in stimulating intervention research focused on evaluation of whether caregiver interventions are useful for diverse caregivers. The Resources for Enhancing Alzheimer Caregivers Health (REACH) project, funded by NIA and NINR since 1995, includes six geographically diverse sites and a Coordinating Center focused on evaluating caregiver interventions for White, African-American, and Hispanic caregivers. I have been involved in REACH through Dr. Lou Burgio, PI of the Alabama site, and have worked with Dr. Dolores Gallagher-Thompson to co-chair the REACH Ethnicity Work Group. We have written several papers outlining practical suggestions for working with diverse caregivers (Gallagher-Thompson et al., 2000, 2001). In summary, caregiver interventions should be designed with an eye toward considering cultural issues; printed materials and examples used should include both diverse caregivers and reflect situations that may be encountered by minority families. Interventionists should understand cultural issues and may need to accommodate to differing communication styles and norms about promptness or family roles. Particularly with Hispanic caregivers, great care should be given to proper and sensitive translation and use of language.

#### **Final comments.**

Because the recruitment of racial/ethnic minority older adults for research studies, or within many clinical settings, requires extraordinary effort and thoughtful attention to a myriad of details, most research in clinical geropsychology has focused on White older adults. Increased

attention to racial/ethnic diversity is not only a necessity occasioned by pressures from NIH and increased demographic growth of minority elders; it can be an interesting and inspiring focus. For a close-up view of caregiving through the eyes of an African-American caregiver, I urge you to consider reading Lela Knox Shanks' 1999 book, "Your name is Hughes Hannibal Shanks." This is a joyful and illuminating telling of Ms. Shanks' journey through caregiving, from its initial phases through bereavement. I will not give away the story, but guarantee that after reading it you will have an increased appreciation of how prior experience with adversity, optimism, faith, and determination can help make the potentially overwhelming stress of dementia caregiving bearable and even an opportunity for growth and satisfaction. Of particular note is that she reports receiving more hope and help from her psychologist than from other health care providers she encountered during this long caregiving career. Geropsychology has a great deal to offer to diverse older adults and their families, and we can learn much from greater attention to diversity issues that will make us more effective clinicians.

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#### Public Policy Committee: Update, continued from page 2

would not apply to treatment for chemical dependency or substance abuse. It would also not apply to employers who do not offer coverage for mental health care or employers who have 25 or fewer employees. (An interesting question is whether it would apply to Medicare beneficiaries!)

Despite strong support from the Senate as indicated by 50 Senate co-sponsors for the bill, it will face some opposition and attempts to water down the impact as it makes its way through Congress. The costs of the bill are estimated to be minimal, 1% or \$1.32 per enrollee per month. However, Republican Judd Gregg (New Hampshire) plans to propose an amendment that would exempt employers if the benefits would increase costs by more than 1%. Republican Bill Frist (Tennessee) would like to limit parity to "biologically based illnesses." Nevertheless, the committee's unanimous passing of this bill bodes well for eliminating some of the existing discrimination policies that still exist for insurance coverage of mental health treatments. The Public Policy Committee will continue to keep you apprised of this and other bills and alert members to letter-writing campaigns.

- ◆ Learn if your Medicare carrier is revising LMRPs pertaining to mental health coverage. On the web, go to [www.draftlmp.net](http://www.draftlmp.net), click on "draft policies" and highlight your carrier.
- ◆ Finally, we want to welcome Brian Kaskie as a new member of the Public Policy Committee. Brian is an Assistant Professor at the University of Iowa and comes to us with a strong background and research interest in public policy matters. With regrets, Lynn Northrup has decided she must resign from the committee in order to prioritize her responsibilities. Best wishes, Lynn, for you and your new baby!

#### 12/2 Student Award Winner: Age Differences in Storytelling, continued from page 3

The pattern of results does not support the theory of pragmatic change. Older adults did not use a greater number of total words or a greater percentage of words in meaningful categories compared with young adults in the long condition. Furthermore, older adults were not rated at



telling stories of better overall quality, or that were more off-topic, interesting, clear, or rich in detail than those told by young adults in the long condition.

These results also do not support the theory of inhibitory deficits. Old adults were similar to young adults in total number of words and on the five subjective ratings (overall quality, interest). General slowing may explain why young adults were rated as telling stories of better quality, interest and detail than old adults in the short condition. Because we found that, overall, old and young storytellers were commensurate with regard to the quality of stories based on objective and subjective measures, it is possible that off-topic verbosity is a sign of pathological and not normal aging.

#### **The World Trade Center Attack: A View From New York City, continued from page 4**

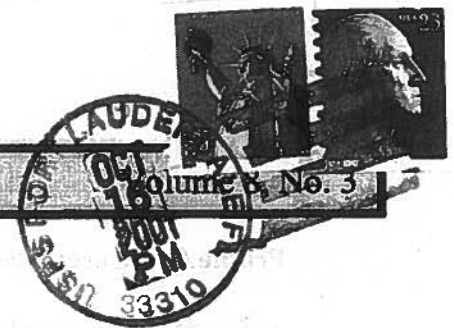
attack, we prepared to care for the wounded. As we now know, few survived the attack. A crisis hotline was established to provide support, information, and resources. Support groups for individuals affected by the attack were established at Hillside Hospital. Our psychology staff has played a prominent role in these efforts. Hillside Hospital staff volunteered to provide ongoing mental health services at a support center that was established by the Port Authority near Kennedy Airport. The Port Authority owned and had a large number of employees in the World Trade Center. Hospital staff members have also volunteered to provide mental health services at the New York City Family Assistance Center located on the Hudson River in a converted pier.

I have met with survivors of the attack and families of missing persons who now we know are likely dead. Survivors tell of the remarkably orderly evacuation of the Trade Center and how they helped each other make the long trip down several thousand stairs while firefighters resolutely made their way up the same stairs. Some survivors were in the Trade Center during the 1993 bombing and contended with the practical and emotional aftermath of that trauma. One woman with whom I spoke said she had PTSD symptoms for several years after the 1993 bombing. The September 11 attack was everything that she had feared. Survivors spoke of the personal items that they left behind: a favorite pair of shoes, a picture of their family, a wedding album. They seemed surprised by their concern about these objects which are small but tangible representations of the enormity of a loss that cannot currently be fathomed. They spoke of friends at the Trade Center who survived and those who did not. They wondered whether people they casually knew who also worked at the Trade Center were still alive -- the guy who ran the newsstand, the woman who served food at the cafeteria, or the janitor. Family members of the missing shifted between mental scenarios in which their loved one was still alive ("Perhaps he was in the basement and is alive in an air pocket," "Perhaps she is in a coma in the hospital,") to flashes of realization that none of the missing likely survived. When entertaining the plausibility that the loved one was dead, they bargained for a fragment of a body that could be linked by DNA analysis to the missing. For some, the experience of the tragic events of the Trade Center was sharpened by problems that predated the attack -- a conflicted relationship with the missing person, a not so loving and supportive family, financial problems, a pending divorce.

Needless to say, the emotional toll on those of us who have spoken with survivors and with families has been considerable. I spoke with a Muslim man clutching a copy of the Koran who wept while he told me he simply couldn't tell his wife that their son was dead. When he left the pain and shock on my face was so visible that one of the clergy passing by my work station at







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