// Clinical Geropsychology News

Society of Geropsychology

APA Division 12, Section II Volume 15, Number 1

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Please contact Karyn Skultety at: karynskul@yahoo.com if you wish to comment on the contents of this Newsletter or wish to share ideas.

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*Published articles do not necessarily represent the official views of Section II, Division 12, or APA

President's Column

Suzanne Meeks, Ph.D.

I have uncharacteristically procrastinated in writing my inaugural President's Column, being somewhat at a loss for what to say and feeling some pressure to say something "of consequence." Then this week a member sent forth an inquiry, which landed in my email box on its way to an answer, about when the Society was founded (or 12-II, actually, since the "Society" technically is only two years old!), and what geropsychologists were doing before that. I didn't exactly know the answers to either of these questions, despite the fact that clinical geropsychology as an organized professional identity is about the same age as my career. The answer to the first question, for those of you who are curious, is 1993 or 1994, depending on how you define "founded."

THANK YOU FOR PAYING YOUR 2008 DUES!!
MANY MEMBERS HAVE ALREADY RENEWED!
JOIN THEM AND RENEW YOUR MEMBERSHIP NOW!!
Fill out the renewal application on the last page or go to https://webform.sfu.ca/cgi-bin/WebObjects/WebForm.woa/wa?gero.geropsyc.membership.payment

If we take 1993,--the year papers were signed--then we are ready to celebrate our 15th anniversary. I got to thinking about the history of this young field, and how important it is that we share this history with one another and with new people entering the field. Along those lines, watch the pages of this newsletter in future months for an article on the history of 12-II. Meanwhile, it occurred to me that recognition of this 15-year milestone would be an appropriate way to launch my "Presidential Initiative," which I am calling ***the branding of clinical geropsychology***. So Happy Birthday to us, along with a few questions to ponder.

Why *branding*? I understand from people who know about marketing that if you want people to know about something you have to sell, it needs to have a clear and salient *brand*. I believe that we have something important to sell, both in the traditional sense of services on the health care market and in the sense of dissemination of ideas and knowledge. Our brand is our professional identity as geropsychologists. There is an assumption that, in self-identifying as geropsychologists, we are differentiating ourselves from all the other psychologists in the world, and that folks who "buy" our "product" get some kind of "value added" by virtue of our specialization. Or, leaving aside the capitalist jargon, how do we communicate to the public what is special about our training and interests so that others will want to join, hire, be treated by, or take courses from us? The word "geropsychology" does not exactly roll off the tongue – how do we get people to use it, and to associate it with a particular group of individuals who have joined Section II of Division 12 of the APA?

I have a few answers that I would like to pursue during my year as President and beyond.

Here are some of mine:

- We need a snazzy new logo for our letterhead (what letterhead, you ask? The letterhead that we will develop with our snazzy new logo).
  Because we do not have funds to hire a graphic artist, we will have a contest among our members and friends for the design of this logo. More on that soon.
- We need to upgrade our website with our snazzy new logo, but more importantly, develop its potential to be a place to go for all kinds of useful information about geropsychology. Some of this information will be for public consumption, and some of it will be a "value added" benefit of being a Society member.
- We are the Society of Clinical Geropsychology, not just "12-II." 12-II is easier to say, but it doesn't brand us. Think about how to reconcile easy and explicit, when you're designing your logo contest entries.
- Our Mentoring Committee is working on a survey to help us understand what kind of mentoring experiences members have had, want, or need. Mentoring is a critical aspect of professional identity formation, and the results of this survey can be used as a basis for developing a formal mentoring program that can help share our history, identity, and knowledge with new generations.
- Thanks to the energy and commitment of our student representatives, we have started to encourage student involvement and interaction at professional meetings. We need to support and nurture these efforts.

These are just a few ways we can brand clinical geropsychology, either through the ongoing efforts and inspiration of others or through new initiatives. Send me your ideas – I'll bet they're even better!

Executive Board Meeting Summary: 1/31/08

Bradley Karlin, Ph.D.
Secretary

The meeting was held via telephone conference and was called to order by President Suzanne Meeks at 4:35p ET. In attendance were Suzanne Meeks, Forrest Scogin, Jon Rose, Brad Karlin, Rick Zweig, Deborah King, Amy Fiske, Ann Pearman, Sheryl Shigaki, Martha Crowther, and Deborah DiGilio (APA).

Welcome and Introductions – Suzanne Meeks

The current meeting was the first Board Meeting of the new calendar year. The meeting began with introductions of Board Members and Committee Chairs. The 2008 Executive Board consists of the following:

President: Suzanne Meeks (new)
Past President: Forrest Scogin (new)
President-Elect: Jon Rose (new)
Treasurer: Rick Zweig (new)
Secretary: Brad Karlin (ongoing)
Division 12 Representative: Deborah King (ongoing)

Secretary Report – Brad Karlin

Minutes from the October 24, 2007 Executive Board Meeting were approved. The minutes were previously distributed via e-mail.

Interdivisional Healthcare Committee – Margaret Norris and Cheryl Shigaki

Cheryl Shigaki provided the report of the APA Interdivisional Healthcare Committee. Cheryl reported that Margie will be attending the next meeting of the Committee, which will be largely related to Medicare reimbursement issues. Margie will provide a report to the Society following the meeting. The Board approved allowing up to $1000 in travel expenses for attendance at the 2008 APA Interdivisional Healthcare Committee meeting to Margie Norris since we will only have one representative this year.

Diversity Committee – Angela Lau

The Board discussed and agreed that it would be worthwhile to identify a co-chair of the Diversity Committee who could help with advancing the Committee's goals and projects. Angela Lau has expressed interest in remaining involved with the Committee. The Board discussed a couple of individuals who would likely be a good fit as co-chair of this committee and developed a plan to follow-up.

Continuing Education Committee – Dan Segal

Suzanne read the report submitted by Dan. A CE workshop proposal on assessment of suicide across the lifespan for the 2008 APA Convention was accepted.

Mentoring Committee – Amy Fiske

Suzanne read the report submitted by Amy. As previously reported, the report of the results of the Mentoring Committee survey have been delayed due to computer-related problems. The Committee is now exploring possibly having to readminister the survey.

Membership Report – Ann Pearman and Martha Crowther

Ann Pearman is the incoming Membership Chair, and Martha Crowther is outgoing Membership Chair. The Board again thanked Martha for her excellent service as Membership Chair.
The Society now has 109 paid members for 2008 – 88 regular members and 21 student members. 44 paid members are also members of Division 12.

An updated version of the Society's Membership Directory has been completed and will be posted on the Society's website.

Newsletter – Karyn Skultety

Suzanne read the report submitted by Karyn. The newsletter is being released on schedule. Brian Yochim, Ph.D. and Sherry Beaudreau, Ph.D. will be assuming responsibilities of the newsletter over the next year. The Board thanked Karyn in absentia for her excellent work as Newsletter Editor.

Division 12 Representative Report – Deborah King

APA Sections will continue to have a total of four program hours (3 substantive and 1 non-substantive) for the 2008 APA Convention.

Division 12 expects a modest surplus from the 2007 budget, representing significant improvement from previous years when the Division ended the year in deficit or just managed to break even. The Division will continue to operate with a conservative approach to spending in hopes of preventing future deficits.

The Division plans some changes to the nominations process for candidates for Division awards and offices. In the future, the Division will send a form to Section Representatives and Presidents requesting the names of individuals who have been identified and have agreed to run for each Division office as well as nominations for Division awards. The award winners were announced by the Division (see Deborah King's report for list of Division award winners).

The Division lost 154 members in the past year, reflecting a continuing trend across all APA Divisions. (There were 4459 members in 2006 and 4305 in 2007.) Nevertheless, there has been significant progress in recruiting student affiliate members. (There were 232 student affiliates in 2006 and 277 in 2007). The Committee is considering outreach to Directors of Clinical Training to create incentives for encouraging students to join the Division.

The Division 12 Committee on Diversity is pleased with the Sections' reports to the Board and the initiatives undertaken by some of the Sections. The Committee has recommended that Sections continue to report on their progress with regard to diversity issues at the midwinter meeting. The Committee made the following additional recommendations: (a) that the Division's mission statement reflect a commitment to diversity, (b) that the Division 12 APA Governance Committee Chair share with the Committee the call for nominations to APA Boards and Committees, (c) that the Board take into consideration the background and preparedness of nominees to address and promote diversity issues when making nominations, (d) that the Board revisit the inclusion of ethnic minorities on the slate for Council Representative, (e) that the "Final Report of the Committee on Diversity" be placed on the Division website and disseminated to all APA directorates, and (f) that the Board support a bylaws amendment that provides a voting seat on Council for each of the four National Ethnic Minority Psychological Associations.

The Division 12 Committee on Science and Practice has announced the development of a new website on "Research-Supported Psychological Treatments." There are section website editors for each class of mental disorders who are summarizing research on treatments according to a revised version of the Chambless et al. 1998 guidelines. Accordingly, treatments are now categorized according to whether they have "strong research support", "modest research support" and "controversial research support". Committee Chair David Klonsky is the overall managing editor of the site, though there is also a group of prominent consulting editors. The website includes a link inviting suggestions for additions and revisions. A draft of the Task Force on Research Supported Treatments "Report on Strengthening and Promoting Science in Psychology" has been completed. It is recommended that the Division: (a) sponsor at least one continuing education offering on the integration of the scientific method into everyday practice,(b) dedicate a portion of or supplement to the journal *Clinical Psychology: Science and Practice* disseminate clinically-relevant research to practitioners, (c) maintain a website on research-supported treatments, (d) maintain an updated, online list of evidence-based assessment instruments, (e) make efforts to collaborate on these issues with other Divisions containing large numbers of practicing clinicians, (f) develop a brief, user-friendly document to help consumers choose a psychologist, and

(g) encourage more research and practice augmenting evidence-based practice with ongoing quality improvement efforts and establish a new Task Force on Quality Improvement to accomplish this goal. The Division 12 Board approved these recommendations as well as financial support to continue the work of the task force.

The Division journal, *Clinical Psychology: Science and Practice,* now ranks 18th out of 36 social science journals in terms of impact factor. A motion was approved by the Division 12 Board to give 50% of the savings from online subscriptions to the new Section for Students and Early Career Psychologists. The Division 12 Board approved a recommendation from the Sections to support a "Section Showcase" during the Division Social Hour at the annual convention. The Showcase will feature the top two posters from students or early career psychologists chosen by each Section.

Division 29 and Division 12, Section 9, under the leadership of Norm Abeles, would like to create a process of giving a monetary award to the best paper on evidence-based approaches to working with ethnic minority elders. They have submitted a request for consideration by the Society Board to donate $200 to this award to support the winner's travel to the APA convention. The Society Board expressed support for this effort, which would support the Society's goals to promote attention to diversity issues in late life and further collaborations with other Sections and Divisions. Accordingly, the Board unanimously approved the following motion:
Resolved that the Society will provide $200 in 2008 to Division 29 and Division 12, Section 9 to support the award of best paper on evidence-based approaches to working with ethnic minority elders to be given at the 2008 APA Annual Convention.

Student Update – Caitlin Holley and Sarah Yarry

Suzanne read the report submitted by Caitlin and Sarah.

Two student-focused events were held at the 2007 GSA convention, both of which had excellent turnout – the "Careers in Geropsychology" symposium and a Student Social Hour following the symposium. Caitlin and Sarah encourage any suggestions for student events at the 2008 GSA convention.

Website Update – Steven David and Rachel Rodriguez

Suzanne read the update provided by Steven and Rachel. Plans are being developed to hire a web consultant to help with expanding and updating the "members-only" section of the Society website (www.geropsych.org).
The Board discussed some ideas for adding relevant research and related material, including articles of Society members, to the website.

Steven and Rachel are exploring updating the directory of graduate schools with clinical geropsychology training opportunities. Updates to the Directory of Psychology Internships with Geropsychology Training Opportunities and the Directory of Clinical Geropsychology Postdoctoral Fellowships are available for download on the Society's website.

APA Convention 2008 – Suzanne Meeks and Jon Rose

Suzanne and Jon provided the preliminary dates and times for major events at the 2008 APA Convention (Confirmation of dates/times closer to the Convention date is suggested):

- Symposium: Friday, 8/15/08, 8:00-9:50a
- Society Presidential Address: Friday, 8/15/08, 10:00-10:50a
- Kazdin Presidential Aging Symposium: Friday, 8/15/08, 11:00-12:50p
- CONA/CEMA/CDIP/CPO: A Symposium on Best Practices of Integrated Care: Opportunities and Challenges: Friday, 8/15/08, 1-1:50p
- CONA Anniversary Symposium: Saturday, 8/16/08, 2:00-2:50p
- M. Powell Lawton Award: Sunday, 8/17/08, 11:00-11:50a

Treasurer Report – Rick Zweig and Jon Rose
Rick Zweig begins his term as Treasurer. Jon Rose is outgoing Treasurer. Total anticipated income and expenses in the 2007 budget were $6,475.00 and $6,980.00, respectively. As of 12/31/07, actual income was $6,260.21, and actual expenses were $3,173.88. The expected loss for 2007 was offset by spending less than anticipated on travel, no spending for Presidential initiatives, accidental over-budgeting for the student paper award, and other savings. The overall "gain" for 2007 will be partly offset by unrealized expenses for 2007 (website expenses, award plaques, clerical support for membership directory) which will be paid in 2008.
The Society Board approved allowing up to $1000 in travel expenses for attendance at the 2008 APA Interdivisional Healthcare Committee meeting to Margie Norris since we will only have one representative this year. The Board also approved a resolution (per above) for a $200 award for research on evidence-based approaches to working with ethnic minority elders. Incoming treasurer Rick Zweig will look for other 2008 expense items that can be reduced to pay for the new award. Regarding our website, the board discussed the possibility of improving the "member's only" area to facilitate access by members, which may incur additional expenses in 2008; this will be explored further.

With $14,268.40 in savings and money market accounts, the Society is in a secure position to cover operating expenses over the next year despite any uncertainties of our Section's income and the economy. Please contact Rick Zweig (rzweig@aecom.yu.edu) for issues related to the financial status of our Section.

The Board again expressed appreciation for Jon Rose's excellent service as Treasurer of the Society over the past three years.

APA Office on Aging– Deborah DiGilio
A 2008 APA Convention CE Program is available from the APA Committee on Aging/Office on Aging.
Presentation topics include dementia detection and treatment, late-life depression and anxiety, behavioral health and older adults, professional practice issues, and epidemiology.

Fact sheets on integrated care are being developed following the release of the report of the APA Presidential Task Force on Integrative Healthcare for an Aging Population, "Blueprint for Change: Achieving Integrative Health Care for an Aging Population." Fact sheets are being prepared for providers, older adults, and training institutions.

APA Nominations – Suzanne Meeks and Deborah DiGilio
Nomination suggestions requested of the Society for APA offices have been provided to APA.

Journal Proposal – Suzanne Meeks
The Journal Proposal Committee (comprised of Suzanne, Forrest, Brad, and Barry) identified options for a Society-sponsored journal. Suzanne, Forrest, Brad, and Barry will convene a meeting to further discuss these options and follow-up with contacts, as necessary. The Board will continue discussion of the different options during future telephone Board Meetings.

National Guideline Clearinghouse – Forrest Scogin
The National Guideline Clearinghouse has extended an invitation to submit outcomes related to older adults from the APA Task Force on Evidence-Based Practice (2006) to the Clearinghouse. The Board unanimously supported this. There was also some discussion about adding these and related resources to the Society's website.

Presidential Initiative – Suzanne Meeks
Suzanne is developing her Presidential Initiative, which will focus on further developing an identity for and "branding" clinical geropsychology.

Next Board Meeting – Suzanne Meeks
The next telephone Board Meeting call was scheduled for March 24, 2008, 5:00p – 6:30p ET.

Meeting adjourned at 6:08p ET.

Society of Clinical Psychology, Division 12 - Board Meeting, Austin, Texas, 1/26-27/08

Deborah King, Ph.D.
Representative to Division 12

The following is an abbreviated summary of selected topics from the midwinter meeting.

Presidential Updates and Program Committee Announcements. *President Irving Weiner* discussed the operations and progress of the new Task Force on Education and Conference Planning. He also announced for *Program Chair Victor Molinari* the following addresses for the 2008 convention: Larry Beutler will be delivering an invited address entitled: "Why Science Matters to Clinicians Even if They Don't Know It." Irving Weiner's Presidential Address will be entitled: "The Glamour of Assessment Psychology." Sections will continue to have four total program hours (3 substantive, 1 non-substantive) in 2008. Section representatives underlined the importance of program time for Sections but Board members noted there are fewer hours to go around as new Sections are added.

Finance Committee Report. *Treasurer Bob Klepac* reported that the 2007 budget will be closed at the end of this month with a modest surplus, representing significant improvement from previous years when the Division ended the year in deficit or barely managed to break even. This is due in large part to interest on Division reserves, which may not be sustained in coming years depending on the economy. Therefore, the Division will continue to operate with a conservative approach to spending in hopes of preventing future deficits. There will be a joint conference call of the Finance and Executive Committees to discuss financial planning and investment strategies for the reserve funds.

Nominations Committee. *Past President Marsha Linehan* discussed the challenges of getting Division members to run for offices. She suggested that Sections be involved actively in submitting nominations for elections. In future years, the Division will send a form to Section Representatives and Presidents requesting names of individuals who agree to run for each Division office as well as nominations for awards.

Awards Committee. *Past President Marsha Linehan* announced these award winners:

- Award for Distinguished Scientific Contributions to Clinical Psychology: *C.R. Snyder*
- Florence Halpern Award for Distinguished Professional Contributions to Clinical Psychology: *Bruce Bongar*
- David Shakow Award for Outstanding Early Career Contributions to the Science and Practice of Clinical Psychology: *Samuel T. Gontkovsky*
- Samuel M. Turner Clinical Research Award for Distinguished Contributions to Applied Clinical Research in the Profession of Clinical Psychology: *Michael Perri*
- Theodore H. Blau Award for Outstanding Early Career Contributions to the Profession of Clinical Psychology: *Not awarded this year*
- American Psychological Foundation Theodore Millon Award in Personality Psychology: *Mark Lenzenwenger*
- Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology: *Lillian Comas-Diaz*
- Outstanding Clinical Educator Award for Excellence in Mentoring: *Leonard Handler*
- Lifetime Contribution Award for Distinguished Contribution to Diversity in Clinical Psychology Science and Practice: *Cheryl Boyce*

Membership Committee. *Membership Chair Barry Hong* reported the Division lost 154 members in the past year (4459 members in 2006; 4305 in 2007), reflecting a trend across APA Divisions. However, there has been significant progress in recruiting student members (232 students in 2006; 277 in 2007). The Committee is considering outreach to Directors of Clinical Training to create incentives for students to join.

Committee on Diversity. *Diversity Member-at-Large Asuncion Austria* noted that the Committee is pleased with the reports and diversity initiatives undertaken by some Sections.

The Committee asked that Sections report on progress with regard to diversity issues at the midwinter meeting. The Committee made the following recommendations: a) the Division's mission statement reflect a commitment to diversity, b) the Div12 APA Governance Committee Chair share with the Committee the call for nominations to APA Boards and Committees, c) the Board take into consideration the background and preparedness of nominees to address and promote diversity issues when making nominations, d) the Board revisit the inclusion of ethnic minorities on the slate for Council Representative, e) the "Final Report of the Committee on Diversity" be placed on the Division website and disseminated to all APA directorates, and f) the Board support a bylaws amendment that provides a voting seat on Council for each of the four National Ethnic Minority Psychological Associations.

Committee on Science and Practice. *Committee Chair David Klonsky* reported on the development of a new "Website on Research-Supported Psychological Treatments." There are section website editors for each class of mental disorders who are summarizing research on treatments according to a revised version of the Chambless et al. 1998 guidelines. Accordingly, treatments are now categorized according to whether they have "strong research support", "modest research support" or "controversial research support." David is the overall managing editor of the site although there is also a group of prominent consulting editors. The website will include a link for readers to provide suggestions for additions and revisions. The Division will announce the URL for the website once it is completed. *David Klonsky* also distributed and summarized the newly developed "Task Force Report on Strengthening and Promoting Science in Psychology". It was recommended that the Division do the following: a) sponsor at least one continuing education offering on the integration of the scientific method into everyday practice, b) dedicate a portion of a supplement to the journal *Clinical Psychology: Science and Practice* to disseminate clinically-relevant research to practitioners, c) maintain a website on research-supported treatments, d) maintain an updated, online list of evidence-based assessment instruments, e) make efforts to collaborate on these issues with other Divisions containing large numbers of practicing clinicians, f) develop a brief, user-friendly document to help consumers choose a psychologist, g) encourage research and practice augmenting evidence-based practice with ongoing quality improvement efforts and establish a Task Force on Quality Improvement to accomplish this. The Board approved these recommendations as well as financial support to continue the work of the task force.

Publications Committee. *Irving Weiner* reported for *Publications Chair Ed Craighead.* The contract with Blackwell Publishing is going well, although it was noted that Blackwell has been taken over by Wiley publishing and is now "Wiley Blackwell Publishing". The Division journal, *Clinical Psychology: Science and Practice,* now rates 18th out of 36 social science journals in terms of impact factor. The Board discussed the fact that the Division saves $9 for each individual who elects to receive online versus paper copies of the journal. A motion was approved to give 50% of the savings from online subscriptions to the new Section for Students and Early Career Psychologists.

Mission Statement. The Board approved a motion to send out the following to membership for approval: "The mission of the Society of Clinical Psychology is to encourage and support the integration of psychological science and practice in education, research, application, advocacy and public policy, attending to the importance of diversity."

Section News. The Board approved a recommendation from the Sections to support a "Section Showcase" during the Division Social Hour at the APA convention. The Showcase will feature the top two posters from students or early career psychologists chosen by each Section. In addition to providing a venue for this scholarly work, it is hoped that the Showcase will increase attendance at the Social Hour.

The next meeting will be held 9/12-9/14/2008 in Jacksonville, Florida.

Treasurer's Report

Rick Zweig, Ph.D.
Treasurer

*F*rom December 2007 through February 2008 we collected $3320.75 in dues and contributions, toward our budgeted goal of $5400 for the year. A $400 grant from APA Division 12 and a $550 grant toward last year's media infusion (ProfNet) program brought our total income to $4270.75 for this time period. We are now also realizing a small amount of additional income from interest on our Section's money market fund.

Through February 2008 our expenses have totaled $552, which has included newsletter and postal expenses as well as secretarial support to maintain our membership database. There are also unrealized expenses from 2007 that will be paid in 2008. Given our fiscally conservative stance in recent years and accumulated savings, we remain financially secure, even if we were to experience an unexpected disruption in income. Our collective hats are off to Jon Rose, president-elect of our section, for his very commendable work as treasurer of our section for the past three years.

OUR THANKS TO SECTION II CONTRIBUTORS!!

On behalf of the Board and members of Section II, we give our great thanks and appreciation to the following colleagues who generously made contributions to the Section!

Susan Cooley — **Rocco Marino**
DavidCoon — **James McKee**
Barry Edelstein — **Victor Molinari**
J. Kaci Fairchild — **Margaret Norris**
Paula Hartman-Stein — **Thomas Reid**
Bob Knight — **Manny Rich**
Nancy Leblanc-Savoie — **Richard Zweig**

APA Office on Aging and Committee on Aging Update

Deborah DiGilio
Director, APA Office on Aging

*F*or the past 18 months, I have had the privilege of providing staff support to the Presidential Task Force on Integrative Health Care for an Aging Population (IHAP) convened Dr. Sharon Stephens Brehm. Last month, the Task Force's product, Blueprint for Change: Achieving Integrative Health Care for an Aging Population was by the APA Council of Representatives. The Blueprint examines and makes recommendations for how psychologists can work with other healthcare professionals, individuals and families to ensure appropriate, effective, and integrated healthcare for older adults. CONA has agreed to continue the work of the IHAP Task Force. This year, in addition to broad dissemination of the Blueprint to health care and aging professionals, government agencies and policymakers, three fact sheets will be developed. They will target: 1) policymakers to make clear psychologists' involvement in and contributions to this expanding model of care, 2) graduate faculty and training directors to provide guidance to on how to shape and develop careers that would emphasize care for older adults in integrated settings, and 3) older adults and their families to provide information and skills to improve coordination of their care. If anyone (including student members) is interested in assisting with the development of the fact sheets, please let me know.

The Office on Aging also provides staff support to the ABA/APA Assessment of Capacity in Older Adults Project Workgroup, which is preparing its final draft of its third handbook, Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists. We hope this document will be available in time for the APA Convention. The previous handbooks have been very well received. Over 30,000 copies of Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers (2005) have been downloaded from the APA website.

The handbook has also been presented at National Association of Elder Law Attorneys, National Guardianship Association and National College of Probate Judges' meetings, as well as at numerous local CLE programs. Judicial Determination of Capacity of Older Adults in Guardianship Proceedings (2006) was the focus of the 2006 NCPJ conference and is accessed online over 1,500 times per month. As Jennifer Moye, PhD, Working Group member and editor of the Lawyers and Judges handbooks recently noted, 31 states now explicitly recognize psychologists as experts qualified to assess capacity under guardianship, and many states are moving to adopt procedures that call for more extensive clinical evaluation of older adults under guardianship proceedings. Massachusetts has just adopted a new medical certificate for guardianship based on the model form developed for the Working Group's judicial handbook. We are aware that a number of geropsychologists are involved in providing professional education to legal professionals in their community regarding capacity assessment of older adults. Of note, forms developed in the judicial handbook are available for states to use and modify according to jurisdictional needs. Psychologists may wish to work with state courts around these matters.

CONA welcomes its two new 2008 members, Chandra Mehrotra, PhD and Dolores Gallagher-Thompson, PhD. They join Peter Lichtenberg, PhD, ABPP (Chair), Merla Arnold, RN, PhD, Victor Molinari, PhD, ABPP and Michael Smyer, PhD.

CONA is planning special convention programming to celebrate its 10th Anniversary and that of the Office on Aging. Events include an all-day, preconvention continuing education program sponsored by CONA and the APA Office of Continuing Education to be held on Wednesday, August 13, 2008 entitled: "What Psychologists Should Know about Working with Older Adults." This program will increase the competencies of psychologists interested in working with older adults, their families, and their caregivers. It will draw upon the burgeoning psychological literature on the accurate psychological assessment and effective treatment of older adults as well as utilize the APA Guidelines for Psychological Practice with Older Adults, and the CE topics of greatest interest identified in the 2002 PP: RP article by Qualls, et. al. We have an esteemed group of presenters including: Drs. Rosemary Blieszner, Chandra Mehrotra, Peter Lichtenberg, Forrest Scogin, Victor Molinari, William Haley, Merla Arnold, and Margaret Norris. I will send a flyer to the 12-II list serve in April and ask that you distribute it widely to colleagues whom you think might be interested.

CONA will also convene a special 10th Anniversary Symposium, "Moving Psychology Forward in an Aging Society: Progress and Possibilities" which will feature CONA member, Michael Smyer, PhD. CONA is honored to have been asked by APA President, Dr. Alan Kazdin to plan a Presidential Symposium as part of his Psychology's Contribution to the Grand Challenges of Society Presidential Initiative. The symposium, "Responding to the Challenges of Aging: Lessons from Medicine, Psychology, and Law" was developed and will be chaired by past CONA-chair Rosemary Blieszner, PhD. Presenters include Robert Green, M.D., M.P.H., Sara Honn Qualls, PhD, Charles Sabatino, JD, and Michael Smyer, PhD as discussant. In addition, CONA chair and IHAP Task Force member, Peter Lichtenberg, PhD, ABPP, will chair a symposium, "Best Practices of Integrated Care: Opportunities and Challenges" with the Committees on Disability Issues in Psychology, Ethnic Minorities, and Psychology and AIDS. Finally, we are planning a celebratory gala in honor of this event! Stay tuned for more information as Convention time gets closer!!

All of the materials mentioned in this article, plus a variety of other resources, such as the recently updated Resource Guides on Older Adults and Insomnia and Aging and Human Sexuality, are available on the Office on Aging website: www.apa.org/pi/aging.

Interdivisional Healthcare Committee Report

Margie Norris, PhD
Cheryl Shigaki, PhD

The Interdivisional Healthcare Committee held its annual meeting at the APA convention on August 16, 2007. IHC representatives, Margie Norris and Cheryl Shigaki, attended the meeting. The following is a summary of this meeting.

Update on Psychological and Neuropsychological Testing Codes: Diane Pedulla provided an update on the revision of the CPT testing codes. She reported that the difficulties have occurred when billing for a psychologist's interpretation of test data and report when the same psychologist also uses (and bills for) a technician conducting test administration on the same day. A revision clarifies that a technician can be used to administer tests, but only a psychologist can bill for time required to complete professional interpretation of test results.

Update on International Classification of Functioning (ICF) Manual: Lynn Bufka has received feedback on the current draft of the ICF manual. Chapter 1 (mental functions) will be most relevant for members of the IHC to review, as it pertains generally to most psychologists. Depending on other areas of expertise (e.g., rehabilitation psychology), other chapter topics may be relevant. Lynn also described a specific plan she intends to utilize to solicit feedback from more reviewers. It was suggested that the IHC might benefit from a workshop training session on use of the ICF codes. By doing this, we would be better poised to talk to our colleagues regarding the ICF.

Report on Medicare Mental Health Equity Coalition: Margie Norris explained that the Medicare Mental Health Equity Coalition consists of about 35 healthcare organizations and advocacy organizations (e.g., American Psychiatric Association, American Psychological Association, Center for Medicare Advocacy). Its focus is on the discrepancy of co-pays for medical services (20%) versus mental health services (50%). Currently, there are 3 proposed laws that would change the 50% co-pay for mental health services to an equivalent 20% co-pay.

Update on Psychology Training and Medicare: Medicare has denied payment for services that are provided as part of training, when GME pays for such educational programs. Consequently, the issue of trainees administering tests and then billing for such time presents a problem. The group discussed the hypothesized economic outcome of pursuing GME funding more vehemently versus getting technicians/trainees reimbursed for services provided within training programs.

Update on H&B Code Reimbursement: Diane Pedulla reported that the latest data on H&B reimbursement comes from 2005; 2006 data are anticipated to come out soon. Reimbursement patterns across time suggest that a shift has occurred from reassessment to individual interventions. Larry Mullins indicated that six states are reimbursing H&B codes through Medicaid. Interestingly, one state reported that only their psychiatrists (rather than psychologists) are getting reimbursed for the codes. Issues surrounding reimbursement from the medical side versus the mental health carve-out section of insurance were also discussed.

Task Force on H&B Toolkit and Related Activities: Rodger Kessler created a Division 38 list serve for members to communicate more effectively regarding H&B code reimbursement. This effort has been used very effectively. There is significant interest in having a "tool kit," i.e. specific "canned" information to provide to hospital administration to assist them on submitting H&B codes for reimbursement.

Departure of Russ Newman: It was recently announced that Russ Newman will be leaving his role as the Executive Director of the Practice Directorate of APA. The Practice Directorate has grown through Newman's persuasion to involve a broader group of individuals (like the IHC).

Suzanne Johnson encouraged us to take an active role in determining Russ's replacement. Rob will draft a letter regarding the IHC, its perspective on relevant issues, and its priorities when identifying a replacement for Russ Newman. He will circulate this letter to IHC members for feedback.

Committee for Advancement of Professional Practice (CAPP) Update: Sandy Portnoy mentioned that some recent issues of CAPP discussion are particularly relevant to our group, such as revision of training for prescription privileges, pay for performance, and the model licensing act. Our input with regard to some issues that might be pertinent for them to discuss is welcomed.

Model Legislation for Prescriptive Authority: Suzanne Johnson presented two aspects of prescriptive authority, as discussed at APA Council meeting. One aspect centers around training, or what experiences a psychologist must complete at the post-doctoral level to be adequately trained on prescriptive authority. A second component is a model act of prescriptive authority. A new model act was proposed and used the term "medical psychologist" to refer to a psychologist with prescriptive authority. Divisions 38 and 22 have come together to express concern in using this term in the context of a model licensing act because historically, this term has been used more broadly and thus has not specifically referred to psychologists who prescribe medication.

Pay For Performance: Lynn Bufka reported that CAPP will provide some principles to Council and that the advisory group has been meeting on a regular basis. The plan is for the proposal to go on the cross-cutting agenda for the next APA Council meeting. Criteria for evaluating treatment guidelines are being suggested as a model approach, with details presented in a new document called, "Criteria for Evaluating Quality Improvement (QI) Programs." Problems discussed included possible violations of aspects of HIPAA standards and whether the program will remain voluntary. Physician colleagues are struggling with these same problems.

APA COMING SOON!!!

CONTINUING EDUCATION ANNOUNCEMENT

Daniel Segal
Chair of CE Committee

Amy Fiske, PhD and David Rudd, PhD will present a preconvention CE workshop titled "Assessment and Management of Suicide Risk across the Lifespan."

It will be held Wednesday, August 13 from 8 am to 4:00 pm. The workshop is sponsored by Division 20 and co-sponsored by 12/2.

DON'T MISS THE ANNUAL 12-II/DIVISION 20 DINNER AT APA 2008!!

Our 12-II/Div. 20 dinner will be held on Saturday, August 16, at SkipJack's seafood restaurant in Boston. The restaurant is walking distance from the Convention Center and hotels. Contact Jon Rose for more details and registration at Jonathon.Rose@va.gov

You must sign up by August 1st!

Public Policy: How Can We All Advocate for Clinical Geropsychology?

Donna Rasin-Waters, Ph.D.
Co-Chair Public Policy Committee
Div12 Federal Advocacy Coordinator

*O*ur section board has started to openly discuss the ways in which psychologists can advocate for our chosen field. Whether student member, early career or seasoned psychologist, probably the most effective way to advocate is to do so consistently and tirelessly, despite how busy we all tend to be. One of the greatest lessons I have learned in my role as Federal Advocacy Coordinator for Div12 is how persistent we need to be in our grassroots efforts for psychology on Capital Hill. Legislation can take years to pass. If we look at Mental Health Parity as an example, it has been a long and winding road for the past 10 years. Success is expected this year, once the differences between the Senate and House Mental Health Parity Bills are worked out in conference.

On another front, the APA Practice Organization has been advocating non-stop since 1996 on Medicare issues. Once again it has been a long and hard road with our most critical battles ahead of us. It is essential right now to sustain and grow reimbursement rates, as well as gain mental health parity for Medicare reimbursement. In addition, it is of utmost importance for all of us, whether researcher or practitioner, to understand that if we do not have a viable insurance reimbursement system for older adults we will have difficulty growing our profession.

So how do we get each other to persist, particularly when the battles can seem so endless that we want to tune out and stick our heads in the sand? Overall, I believe we have to recognize and take seriously that we have everything to lose if we do not work effectively on issues that involve our future as a profession. Medicare has lost ground in reimbursement rates for over a decade, with some small restorations won back instead of larger percentage decreases over the years from 1996-2006. Then in 2007 we sustained a 10% cut. This 10% cut to Medicare was made to offset increased payments the Centers for Medicare and Medicaid Services (CMS) made for Evaluation and Management codes after a 5 year review. While the cuts were not aimed at psychology, the impact was greater due to how psychology services are weighted more heavily toward work values in the reimbursement formula. This year Congress blocked another 10.1% annual cut that would have again impacted psychology services for 2008, but this block is only effective through June. Instead of the larger cut, reimbursement rates dropped another 1.8% in 2008 and in order to prevent the larger 10.1% cut from going into effect July 1st we must advocate through grassroots efforts. Other reimbursement changes for psychology will occur through 2010 due to a new practice expense methodology. Practice expense changes will continue with psychology services expected to lose 2% each year.

Please advocate for geropsychology by responding to the APA action alerts. It is easy to follow links from listserv notices I post concerning when and how to take action, to the Practice Organization site which allows one to personalize and send letters to Congress. Of note is that personalizing your letter to representatives increases the effectiveness of the letter by a huge percentage- from about 3% to 60-70%. This difference is due to how simple the internet has made letter writing to Congress. The staff in any representative's office will view a personalized letter as actually coming from a constituent that really knows and understands the issue. So take a moment to add a few lines to the APA letter by noting that you practice or conduct research with older adults and fully understand how cuts to Medicare for psychology will eventually translate into less access and fewer services for older persons. And when you grow weary or complacent regarding taking action, remember that if we want our field to grow and thrive we must work tirelessly to maintain insurance access for the older adults we get so much gratification from serving. We must often be the voices for the older persons we work with given how the stigma of mental health or illness and frailty may hinder their own ability to voice an opinion.

Profile On . . .
Jon Rose, Ph.D.

My interest in psychology arose from a part-time job when I was a senior at San Francisco State. I was hired to teach social skills to an autistic child, but he was actually a psychotic teen. The agency I worked for provided little supervision and the boy's parents were not interested in bringing him to a mental health provider, so I started reading psychology books in an effort to understand him. I took a class in abnormal psychology, but when I graduated I pursued brief careers in public administration and music. Three years later, I'd tired of playing sax in blues bars and looked into how I might prepare for graduate work in clinical psychology. I got a job as a nursing assistant at a subacute psychiatric facility and began studying for the GRE. This turned out to be the best job move of my life, because I met my wife, Susan, when she joined the hospital staff as an O.T, in 1980.

I was accepted to the Master's program in Clinical Psychology at San Francisco State in September 1980. It was a psychodynamic and developmental program that also offered a School Psychology track. The program was small and emphasized practical experience from the first semester. This was both exciting and terrifying. This was before the days of personal computers and cassette recorders, so preparation for supervision was very labor intensive. We had a remote reel-to-reel recording booth with a microphone in each treatment room. After every session I'd put on a headset and transcribe the session by hand.

One of my instructors and supervisors, Bill Littell, talked to us about the growing need for geropsychologists. Great job openings in clinical psychology were not plentiful in 1982, so the promise of a growing market was very appealing and I was happy to be accepted into the geropsych track at Northwestern's Clinical Psychology program in Chicago. The emphasis there on late-life personality development was a natural extension of my work at SFSU. Of course, most important life choices are multi-determined. At Northwestern, Dr. Gutmann said geropsychologists are attracted to the field by love or fear of aging.

I had enjoyed great relationships with all my grandparents, and my one remaining grandmother had helped type my thesis. My grandparents were all immigrants and I'd been fascinated by their experiences abroad and in finding their way in this country. When I began treating older adult clients, what really excited me were their stories. I'm still amazed that I can get paid to listen to personal stories, much as I enjoyed doing as a child with my grandparents.

As an undergraduate I'd majored in Liberal Studies, which was an interdisciplinary, thematic major. My theme was "Poverty and Social-Cultural Integration." This allowed me to take whatever classes I wanted, and to do independent research while at the Hebrew University of Jerusalem for my junior year. One attraction to Northwestern was the cross-cultural emphasis in David Gutmann's research. Another attraction was the strong neuropsychology training available outside of the older adult program. This provided a nice concrete balance to the abstract theory and delayed gratification of psychodynamic therapy.

The classes, workshops and supervised training at Northwestern prepared me well for a career in geropsychology. Unfortunately, I had a penchant for getting into the middle of faculty conflicts. That made my three years there tortuous, and I would not have finished were it not for the very strong support I had from my peers and my wife. Psychotherapy was also very helpful.

With the encouragement of David Gutmann and another Northwestern Older Adult Program faculty, Jerry Grunes, I joined GSA and presented a paper on my clinical work with an elderly caregiver at two of their conferences. There I met Sara Qualls, who was presenting her work on caregiving as a postdoc with Dolores Gallagher-Thompson and Larry Thompson at the Palo Alto VA. The same Dr. Littell who'd advised our class to think about a career in geropsychology had also recommended internship training at the Palo Alto VA. Sara encouraged me to apply and introduced me to Dolores, and I was accepted as a geropsychology intern the following year.

"Caregiving" was a new area of research back then, and few people even recognized the term.

Soon after being accepted for internship, I began talking to Dolores about collecting my dissertation data from subjects in a large caregiver intervention study she was conducting. I left Chicago at the earliest opportunity, assured I would have my data collected in the first half of internship. Three years later I'd learned how difficult it can be to recruit caregivers for research.

Despite the slow progress of my dissertation, internship at the Palo Alto VA was one of the happiest years of my life. I gained great breadth in clinical theory and practice. The warm, trusting and supportive environment created by staff helped me gain confidence in my work and made me a much better therapist. We had presentations from many famous and talented psychologists from around the world with exciting ideas. In Larry and Dolores' Older Adult Center, I participated in the true integration of research and practice. With the mentorship of Andy Futterman, who was doing a Fellowship there at the time, I started to really understand what all the numbers were doing in my statistical analyses, and I could make sense of the SPSS printout. Our intern class was close and supportive. Susan and I began the two-year restoration of a deteriorated 100-year-old house that we bought in a foreclosure auction, and our first child was born the week after internship, just as we'd planned five years earlier!

About half-way through internship I learned that the Caregiver Project psychologist would be leaving. I focused on learning all aspects of the job, and was happily hired right out of internship in 1986. The following year, our clinical coordinator, Steve Lovett, left to be the staff psychologist for a permanent demonstration project awarded to the VA Geriatric Research Education and Training Center (GRECC), called the Division on Vision and Aging (DVA). I was promoted to coordinator of the caregiver projects. This was a great job, with lots of responsibility balanced with a lot of recognition. I spoke to community groups, was interviewed on a radio talk show, and presented at many conferences. Larry and Dolores treated their staff and trainees like a second family and work was like a second home to me.

Another Northwestern professor, Nat Raskin, had taught me client-centered therapy and told me about the formation of the Association for the Development of the Person-Centered Approach (ADPCA). I became a founding member, but did not actively participate until I moved to California. I attended my first ADPCA meeting when it was held locally in Redwood City, and was elected to handle membership for an undetermined term. The ADPCA was anti-authority, and had no position titles at the time, but this position was later called Secretary when the organization incorporated years later. The job gave me the opportunity to meet many of Carl Rogers' former students, and the leading client-centered theorists, as well as many of our highly diverse members who were applying person-centered ideals to a variety of other fields including education, business, and dentistry. Working in a research environment with manualized treatments, I was not able to practice client-centered therapy at the VA, so I arranged to see private clients under the supervision of Arleen Wiltberger. This eventually developed into a Wednesday night private practice that I still maintain in San Mateo.

Eventually, I discovered I am not well-suited for the intense periods of hyperactivity required by a grant-dependent career. In 1990, with a second child, I needed more economic stability at a time when one of our largest grants had ended. Steve Lovett had been promoted to coordinator of DVA, and I continued my career path of taking Steve's old jobs. DVA was a home-based vision rehabilitation program for older adults. It was interdisciplinary, with vision/mobility therapists, optometrists, an audiologist and psychologists. We had our own professional training programs, and I was allowed to write my job description as a salaried staff psychologist. The staff at DVA was very committed to our mission of developing and implementing interventions to promote the independence of visually impaired older adults. Although we published little, we presented at professional conferences and the program was well regarded around the world. Our clients were diverse, ranging from former generals and executives to the homeless. I had the opportunity to work with patients where they lived, and learned a lot about the strengths and limits of interviews and tests in predicting actual behavior at home.

We trained to work with ethnic diversity, particularly to work with families that were not homogeneous in their acculturation. I was invited to the voluntary faculty of the Stanford Geriatric Education Center, which focused on training health care providers to work with diverse populations. I'd been interested in rehabilitation since volunteering as a counselor at Muscular Dystrophy camp while in high school and college. I am also married to an OT. I really enjoyed the inter-disciplinary team at DVA, and the opportunity it gave me to provide sensory and cognitive rehabilitation along with more traditional geropsychology.

I have been able to hold various leadership positions at the VA, helped start an on-site child care program, and I had a collateral assignment in our inpatient Geriatric Evaluation and Management Program, allowing me to practice my neuro-psychology skills and to provide intense daily therapy for very frail older adults. I was also recruited to help create an older adult track at the counseling department at SFSU. It was great fun to return to my alma matter, eat in the Student Union, and attend concerts before class. Who says you can never go home again? My specialty track was limited to two courses taught by me and two in the gerontology program, with students from both programs enrolled in all four classes. It was a challenge to find the right level and decide what to exclude from the three year full-time curriculum I'd been taught. Fortunately, the tenure-track faculty were very supportive, and the university offered free seminars in teaching. I've had to give up classroom teaching due to limited time, but I still enjoy working with students, interns and Fellows at the VA.

After eight wonderful years, Steve Lovett moved on. Unfortunately, we had a huge federal deficit in 1998 and the economy was in a downturn. VA Secretary Ken Kaiser decided to make VA a model of primary care while cutting the budget to pay down federal debt. This meant cutting specialty care programs. The GEM unit was closed, and I took Larry Thompson's place as psychologist in our geriatric primary care clinic. The VA was re-structured and DVA was no longer guaranteed funding from Washington. Our local management was replaced, and our Psychology Chief at the time refused to open the DVA coordinator job. Then a strange piece of protocol intervened. DVA was required to submit an annual report to Washington thru GRECC. The DVA staff met and asked me to take on Steve's former responsibilities and write the report as the unofficial program coordinator. I signed it with my proper title as Staff Psychologist. The new facility director sent it back to me for our director's signature. When I informed him that we had no director or coordinator, he changed my signature block to Program Director, and I continued to follow Steve Lovett's career path.

The American Federation of Government Employees helped me keep DVA running while other specialty programs continued to be closed. They introduced me to politics, and I joined the legislative action committee and went to Washington to get Congress on our side. I resigned as Editor-in-Chief of the Person-Centered Journal, and chaired a few union election committees. By the end of 2000, after three years of fighting the system to keep DVA funded, and doing three simultaneous full-time jobs at the VA, I was worn out. The VA Spinal Cord Injury Center needed a psychologist for their outpatient clinic. The Paralyzed Veterans of America are very organized, and there was intense pressure from Washington to fill the position. I was able to secure permanent funding for the remaining staff in exchange for transferring to another wonderful job. It has, however, challenged my professional identity. While a majority of our patients are elderly, some are as young as 17, and the average age is declining as the wars in Iraq and Afghanistan continue. I am beginning to feel like I am as much a rehabilitation psychologist as I am a geropsychologist.

About the same time as I moved to SCI, Barry Edelstein convinced me to run for Treasurer of 12/II, and I was surprised to win. Similar to my involvement with the ADPCA, I joined 12/II at its inception, but remained inactive for many years. Serving as Treasurer gave me the opportunity to give something in return to the many direct and indirect benefits of membership I've enjoyed. Being chosen as President-Elect is scary. Suzanne Meeks has been doing a great job mentoring me so-far, and hopefully I will be ready by January.

Consider This: Don't Forget about Sleep

Joseph M. Dzierzewski, M.S.
Christina S. McCrae, Ph.D., C.B.S.M.

Editor's Note: *I am pleased to feature one of our Society's 2007 Student Paper Award winners (and his mentor) in this edition of Consider This. The authors share with us a summary of the paper and their perspective on the important topic of sleep!*

*T*he patterns, durations, frequencies, and correlates of sleep in older adults are all well studied phenomena. In general, as an individual increases in age their sleep becomes lighter, shorter and more fragmented than when they were younger (Morgan, 2000). It has been found that older adults experience more frequent shifts from one sleep stage to another, more frequent intrasleep arousals (Bosselli, Parrino, Smerieri, & Terzano, 1998), and more, and longer, periods of alpha activity (indicative of 'wakefulness') during sleep (Webb, 1982) than do their younger counterparts.

One of the most prominent changes in sleep architecture associated with the aging process is the steady and drastic decrease in the amount of time spent in deep, slow-wave-sleep (Stages 3 and 4) (SWS; Prinz et al., 1982). The decrease in the amount of time spent in SWS in late-life means that older adults spend much more time in the light, non-restorative sleep Stages 1 and 2. These changes have led to the sleep of older adults being characterized as "structurally lighter" than that of younger adults. In fact, it has been found that older adults awaken more easily from sleep than younger adults (Zepelin, McDonald, & Zammit, 1984).

Whether these age-related changes in sleep are part of the "normal" aging process, or if they are the behavioral manifestations of an underlying pathology is debatable. A recent meta-analysis of the age-related sleep changes confirm that increased age is associated with increased wake time after sleep onset and sleep onset latency and decreased total sleep time (Floyd, Medler, Ager, & Janisse, 2000). In general, the functions of sleep have not yet been agreed upon but it is the consensus of the majority of sleep researchers that the above described changes in sleep reflect "normal ontogenetic change" (Morgan, 2000).

Insomnia, on the other hand, is among the most prevalent disorders of late-life. The *Diagnostic and Statistical Manual of Mental Disorders 4th Edition* (DSM-IV) defines insomnia as the difficulty initiating or maintaining sleep, or non-restorative sleep, for at least one month that causes significant distress (American Psychiatric Association, 1994). The prevalence of insomnia in older adults is not agreed upon. Epidemiological studies indicate that prevalence increases with increasing age (Ohayon, 1996). In an epidemiological community-based sample of over 5,000 older adults, the prevalence of insomnia was estimated at 65% (Newman, Enright, Manolio, Haponik, & Wahl, 1997), indicating the widespread nature of the disorder. Interestingly, recent epidemiological suggests that the bulk of late life sleep complaints and disorders are related to medical/psychiatric disorders rather than the result of age 'per se' (Vitiello, Moe, & Prinz, 2002). Furthermore, insomnia in older adults tends to be a chronic condition with the average span of the disorder lasting 7-12 years (McCrae et al., 2003).

Insomnia in late-life is not a solitary event; it is accompanied by many unwanted consequences and correlates. Individuals with insomnia have been shown to experience quality of life hindrances equivalent to the experience of congestive heart failure patients (Katz & McHorney, 2002). Other studies have reported deficits in cognitive and psychomotor functioning, including memory, concentration, attention, reasoning, problem solving, and reaction time (Harrison & Horne, 2000; Roth & Roehrs, 2003). Research examining the cognitive effects of insomnia in older adults have found:

(1) poor sleep to be associated with impaired overall cognitive functioning and decreased processing speed (Blackwell et al., 2006)

(2) individuals who sleep less and/or have more difficulty initiating and maintaining sleep perform cognitively worse than those whose sleep could be characterized as 'good' (Tworoger, Lee, Schernhammer, & Grodstein, 2006)

(3) insomnia symptoms are independent predictors of three year cognitive decline - independent of demographic, behavioral, and health factors (Cricco, Simonsick, & Foley, 2001).

Additionally, insomnia is often co-morbid with psychiatric (particularly mood and anxiety) and medical disorders. Estimates suggest that 30% to 50% of individuals with insomnia have an accompanying psychiatric disorder (Benca, 2001; Morgan, 1996). Insomnia has also been associated with the occurrence of coronary heart disease (Schwartz et al., 1999), chronic pain (Smith et al., 2000), and obesity (Vorona et al., 2005).

The negative impact of insomnia does not stop at significant personal hardship. Insomnia has significant national economic consequences. Insomnia has been associated with a significant increase in absenteeism due to health problems (twice as likely to miss work), lost productivity at work, increased rates of health care utilization, and automobile accidents (insomnia increases the risk of traffic accidents, accidents at home, and public accidents by 200% to 300%, and work-related accidents by 150%) (Benca, 2001; Hublin & Partinen, 2002; Katz & McHorney, 2002; Neubauer, 2004; Roth & Roehrs, 2003). The total economic burden of insomnia has been estimated to be between a staggering $77 and $100 billion per year (Hublin & Partinen, 2002; Stoller, 1994; Walsh & Engelhardt, 1999).

Clearly late-life insomnia has widespread negative consequences on cognitive, affective, and social functioning. However, late-life insomnia can be effectively treated! Cognitive-Behavioral Therapy for Insomnia (CBTi) has been shown to be a highly efficacious treatment for late-life sleep complaints. CBTi usually includes administration of sleep education, sleep hygiene instructions, stimulus control, relaxation training, cognitive restructuring, and sleep restriction. Recent reviews and meta-analyses indicate large to very large effects of treatment on remedying insomnia (Irwin, Cole, & Nicassio, 2006; Morin, Bootzin, Buysse, Edinger, Epsie, & Lichstein, 2006). Furthermore, these treatments have been manualized and can be delivered in 2 – 8, one hour treatment sessions.

Unfortunately, insomnia in older adults is under-diagnosed and under-treated.

One reason for this may be that many clinicians view insomnia as a symptom of another disorder, rather than a disorder itself. Following this line of reasoning, the sleep disturbance would be believed to dissipate as a function of treatment for the 'primary' disorder. However, to establish insomnia as secondary to another disorder is no easy task. One must determine that the sleep disturbance: (1) followed the onset of the 'primary' disorder, and (2) that fluctuations in the severity of the 'primary' disorder are followed by fluctuations in the sleep complaint (McCrae & Lichstein, 2001). Additionally, longitudinal studies investigating the development and course of mood disorders and sleep complaints in late-life are not widely available.

Even if the insomnia initially started in response to another disorder, it often 'takes on a life of its own' as over time the individual develops cognitive and/or behavioral patterns that serve to maintain poor sleep independent of the 'primary' disorder. For this reason, treatment of the 'primary' disorder frequently fails to produce improvements in sleep. Thus, rather than one disorder being seen as 'primary' and one being viewed as 'secondary', sleep experts at a recent NIH State-of-the-Science conference (2005) on the "Manifestations and Management of Chronic Insomnia in Adults" propose that the term, 'co-morbid' insomnia be used instead of the term, 'secondary' insomnia.

Interestingly, CBTi in individuals with mild depression has been shown to not only improve the sleep of these individuals, but it also resulted in a significant decrease in depressive symptoms (Taylor, Lichstein, Weinstock, Sanford, & Temple, 2006). Could it be that depressed mood may be a symptom of not sleeping well? The answer to that question is unclear. Preliminary results from a longitudinal study of a small sample of adults with depression found that complaints of worsening sleep actually preceded the re-occurrence of a depressive episode (Perlis, Giles, Buysse, Tu, & Kuofer, 1997). Whether or not insomnia is a symptom of another disorder or the primary cause of another disorder, results such as these suggest the need for a close monitoring of sleep in clinical settings.

Our goal in writing this opinion piece was simply to shed some much needed light on the topic of sleep and sleep disturbances in older adults. While it is very common for an older adult to complain of a sleep complaint, we do not believe it is as common for that complaint to be directly addressed in therapy. However, randomized controlled trials have continuously demonstrated the highly efficacious nature of CBTi in alleviating insomnia. In lieu of the evidence suggesting that insomnia 'secondary' to another disorder may not be alleviated by simply treating the 'primary' concern, and that treating the sleep disturbance of depressed individuals may provide some relief for the depression, it appears warranted to suggest careful monitoring and consideration of sleep in nearly all patients. Sleep may also play a role in cognitive/neuropsychological assessments. Chronic insomnia may create a situation where cognitive dysfunction is exaggerated.

In general, sleep disturbances are widespread in older adults. Greater clinical awareness of sleep disturbances and their negative impact is needed. However, it may take a re-conceptualization of the nature of sleep disturbances (i.e., insomnia in the context of another disorder is frequently 'comorbid' rather than 'secondary' in nature) for these concerns to be considered a priority. In order for a shift in conceptualization to occur, greater dissemination of the existing research demonstrating the importance of adequate sleep in later-life as well as future research exploring the mechanistic pathways underlying chronic 'comorbid' insomnia are needed.

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Student Voice

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*I*t's springtime! That means its time for beautiful weather, travel, playing outdoors, and community festivals. Yet, for many of us in graduate school these may all seem like mere distractions from the final exams and papers, clinical demands, thesis defenses, preliminary examinations, and other nagging deadlines that inevitably seem to hit this time of year. As we write this, we find ourselves faced yet again with the stress of managing a heavy spring workload and wanted to offer some handy tips that have helped us during times of stress:

Prioritize your do to list

If your to-do list is overwhelming, break it down. Prioritize the items based on due dates, relevance, and importance. Organizing your time based on smaller lists, such as tasks that need to be done today or this week, rather than this semester, can be less intimidating and can help you leave a reasonable amount of time to complete a project. Make sure you allocate your effort in a realistic manner, spending the bulk of your time on the projects that are most important to your academic success.

Get enough sleep, especially if you don't think you have the time!

Despite our knowledge that it is probably better to get a good night's sleep than to pull an all-nighter to finish that paper or cram for tomorrow's exam, we all do it. Getting enough sleep on a regular basis can been challenging during graduate school, but it can also make an immense difference in how efficient and productive we are able to be while awake. Getting enough sleep can improve your energy level, focus and concentration, and frustration tolerance, making it more likely that your work time will be fruitful.

Set limits for yourself, even if it means saying "no"!

When faced with great opportunities to be involved in another research project, coauthor a paper, give a talk, or volunteer your time in other ways, it can be tempting to always say yes. And why not? These are great ways to gain experience in areas of interest and build important networking connections. We should, however, be conscious of our stress levels and careful not to spread ourselves too thin. We have found that knowing our own limits and learning to say no, even when the offer sounds tempting, can often pay off more in the end.

Set aside time to relax, play, and exercise

These may seem like impossibilities during this time of year when there are more deadlines than days of the week, but setting aside time for you is a great way to de-stress. Some low-cost examples that we have found to be helpful in managing stress are yoga/meditation, taking a warm bath, walking outside on a nice day, and spending time with friends and family. To create balance in your professional and personal life, find a few minutes each day to indulge in whatever it is that makes you feel peaceful and rejuvenated.

Self Monitor

We all have idiosyncratic ways of "relieving stress" that probably don't work as well as we think. Procrastinating, consuming extra caffeine, and turning to junk food are all potential signs that we are stressed…and although these strategies may help in the short term, healthier and more adaptive stress-management strategies will be more beneficial in the long run. Be aware of your own stress warning signs and find better ways to cope.

Let's face it: stress and graduate school go hand in hand. Nevertheless, we hope these tips will help you have a happy and productive spring!

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