Clinical Geropsychology News

Society of Geropsychology

APA Division 12, Section II Volume 15, Number 2

INSIDE*

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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.

Not too long ago on the listserv there was an interesting series of posts about whether and when we should use the term "clinical geropsychologist," or "geropsychologist," to describe ourselves in professional communications. Some of the discussion was focused on credentialing and related legal issues, but I enjoyed the discussion because it speaks more broadly to the notion of professional identity, which of course relates to our purpose and identity as a society of professionals with common interests. Several of the contributors noted that the term "geropsychologist" is not widely understood by clients and others, so that it might not be particularly useful for identifying our expertise. Should it be?

WELCOME OUR NEW NEWSLETTER EDITORS: Brian Yochim & Sherry Beaudreau Drs. Yochim and Beaudreau are currently in the process of transitioning in as the new editors of the newsletter. They officially begin their role in 2009. They are both extremely talented and will bring much to the Clinical Geropsychology News!

What if "geropsychologist" were, to steal from former APA President Ronald Levant, a "household word"? Admittedly, it doesn't exactly roll off the tongue.

Recently the members of the committee exploring a Society of Clinical Geropsychology journal had a related discussion regarding what we would call our journal if we had one. Should the phrase "clinical geropsychology" be in the title? This led to a discussion of who would submit to the journal, and the recognition that many people who do work with older adults also have other professional identities, such as neuropsychology, health psychology, or rehabilitation psychology. We agreed that we would want a journal that was uniquely a *psychology* journal, with a focus on *clinical* or applied research, in contrast to the several multidisciplinary aging journals already in existence, and *Psychology and Aging*, which although psychological, is not exclusively applied or clinical. However, we would want to draw contributors and readers from beyond our rather small membership, and to recognize that there are many psychologists who call themselves something other than geropsychologist who in fact do work that we might categorize as clinical geropsychology. Wouldn't it be great if all those people *were* members of our Society?

Most of us probably have multiple professional identities. I am a professor (a researcher, a teacher, a supervisor, an administrator), a consultant, and a licensed psychologist. In some of those roles, I am also a clinical geropsychologist, in others I'm not. By my long-term membership in the Society of Clinical Geropsychology, however, I am affirming a common identity and mission with others who count among their many professional goals and interests the development, promotion, and application of psychological science for improving the mental and physical health of older adults. Let's beat the bushes for the many others out there who haven't yet joined us. And don't forget to pay your dues! The renewal form is on the last page of this newsletter!

Executive Board Meeting Summary: 3/24/08

Bradley Karlin, Ph.D.
Secretary

The meeting was held via telephone conference and was called to order by President Suzanne Meeks at 5:05p ET. In attendance were Suzanne Meeks, Brad Karlin, Jon Rose, Forrest Scogin, Deborah King, Ann Pearman, Rachel Rodriguez, Donna Rasin-Waters, and Deborah Digilio (APA).

Secretary Report – Brad Karlin

Minutes from the January 31, 2008 Executive Board Meeting were approved. The minutes were previously distributed via e-mail.

Interdivisional Healthcare Task Force – Margaret Norris and Cheryl Shigaki

Margie provided a brief report from her attendance at the recent in-person meeting of the Interdivisional Healthcare Task Force. At the Task Force meeting, there was some discussion that there has been some decrease in use of the Health and Behavior (H&B) Assessment and Intervention codes. APA is encouraging members to use the codes (which are to be used only when patients are receiving psychological services related to a physical health condition and not connected with a mental illness). A sample letter for private insurance companies has also been developed to encourage more favorable coverage policies for these codes in the private sector. Information about the H&B codes and the template letter will be made available on the Society's listserv and web site.

IHC Committee members acknowledged that many members have been on the IHC for over 3 years; some having been on since its inception in 1991. The committee welcomes members from other divisions and it is felt that the multidivisional composition of the IHC gives it clout in APA.

Diversity Committee – Angela Lau

Suzanne provided the report for the Diversity Committee. Suzanne spoke with Angela and developed plans for a more focused agenda for the Diversity Committee. This will initially include (1) identifying aging and diversity resources and linking to these resources from the Society's website; and (2) encouraging interest in diversity issues and mentorship with early career psychologists.

Mentoring Committee – Amy Fiske

Suzanne read the report of the Mentoring Committee submitted by Amy. The mentoring survey is being re-administered to Society members online. The survey includes items about members' mentoring experiences and practices.

Public Policy Committee – Donna Rasin-Waters and Peter Kanaris

Donna reported that there has been decreased activity on Prof Net. She encouraged members to develop media leads to stimulate interest among reporters' on geropsychology issues. The Public Policy Committee is happy to help Society members generate such leads.

Membership Report – Ann Pearman

The Board welcomed Ann to her first Board Meeting as Membership Chair. Ann reported that the Society a total of 170 paid members. There are 142 paid regular members, 70 of which are members of Division 12. There are 28 are paid student members, 12 of which are student members of Division 12.

The Society membership directory has been fully updated and is in the process of being distributed to the membership.

The Board has approved the option of a 3-year Society membership, which should help to simplify maintaining membership status. This option is targeted to take effect for the next membership year.

Division 12 Representative Report – Deborah King

APA is seeking nominations for members of an APA presidential task force on the future of psychological practice.

Conventions 2008 – Suzanne Meeks

A proposal has been submitted for a symposium/discussion of psychology internship training directors and representatives at the 2008 GSA. If accepted, the Society will sponsor an informal student social hour, similar to the successful student social hour held at last year's GSA convention.

Keeping with tradition, a joint Division 12, Section II-Division 20 dinner is planned for the APA convention in August.

Website Update – Rachel Rodriguez and Norm O'Rourke

Rachel reported that additional funding may be necessary for the website contractor to perform necessary updates, based on current rates. The Board discussed exploring other contractors who may have lower rates than the current contractor, who is based in Silicon Valley. A couple of Board Members stated they knew of website contractors that the Board may wish to consider.

Rachel reported she will have to step down as the Society's Website Coordinator due to other commitments. The Board stated it will look for others who may be interested in serving in this role. The Board thanked Rachel for her work.

Treasurer Report –Rick Zweig

Rick reported that income and expenses are thus far in line with projections and that financials are solid.

Office on Aging Update – Deborah DiGilio

The report of the APA Presidential Task Force on Integrative Health Care for an Aging Population report entitled, "Blueprint for Change: Achieving Integrated Health Care for an Aging Population," was adopted by the APA Council of Representatives.

The American Psychological Association (APA)/American Bar Association (ABA) handbook on capacity assessment for psychologists is nearing completion and is being planned for dissemination at the 2008 APA Convention. The handbook is part of the APA/ABA Capacity Assessment in Older Adults Project, which has previously developed a capacity assessment handbook for lawyers and another for judges, which has generated significant interest.

Current Issues – Suzanne Meeks

The Board discussed the importance of members' involvement in advocacy and discussed several methods for promoting advocacy by the Society, including developing programming related to advocacy at future conferences and providing research, information, and materials on effective advocacy strategies to members through the website and other mechanisms.

Suzanne, Forrest, Brad, and Barry are continuing to explore options for establishing a Society-sponsored journal and will be meeting again soon to discuss this further.

Presidential Initiative – Suzanne Meeks

Suzanne provided an overview of her presidential initiative to further the identity of the Society and the "branding" of clinical geropsychology, to include: (1) developing a consistent Society logo and letterhead; (2) enhancing the Society's website; (3) promoting recognition and activity of the Society; and (4) increasing involvement of early career psychologists. Suzanne will provide more information about her presidential initiative in the President's Column of the Society newsletter.

Next Board Meeting – Suzanne Meeting

The next telephone Board Meeting will be May 19, 5p ET.

Meeting adjourned at 6:31p ET.

Executive Board Meeting Summary: 5/19/08

Bradley Karlin, Ph.D.
Secretary

The meeting was held via telephone conference and was called to order by President Suzanne Meeks at 5:05p ET. In attendance were Suzanne Meeks, Jon Rose, Forrest Scogin, Brad Karlin, and Rick Zweig.

Secretary Report – Brad Karlin

The minutes from the March 24, 2008 Executive Board Meeting were approved. The minutes were previously distributed via e-mail.

Interdivisional Healthcare Task Force – Margaret Norris and Cheryl Shigaki

Suzanne read the report submitted by IHC Task Force members Margie and Sheryl. A draft of the Guidelines for Psychological Practice in Health Care Delivery Systems is expected in early June. The APA Committee on Professional Practice and Standards (COPPS) will be discussing the Guidelines at the APA convention and a public comment process will occur. The Society will also have an opportunity to review the Guidelines.

The IHC Task Force will be meeting at the APA Convention. The IHC Task Force is also trying to set up a meeting with Dr. Bray at the Convention. At the last IHC Task Force meeting, there was some discussion that there has been some decrease in use of the Health and Behavior (H&B) Assessment and Intervention codes. APA is encouraging members to use the codes (for use when patients are receiving psychological services related to a physical health condition and not connected with a mental illness). A sample letter for private insurance companies has also been developed to encourage more favorable coverage policies for these codes in the private sector. Information about the H&B codes and the template letter will be made available on the Society's listserv and website.

Education and Training Task Force Report – Erin Emery

Suzanne read the report submitted by Erin. The Education and Training Task Force has been focusing on competencies assessment, based on the Pike's Peak model, and has been interfacing with the Council of Professional Geropsychology Training Programs. The Task Force will distribute a draft to Society members for feedback.

Continuing Education Committee – Dan Segal

Dan is stepping down as Chair of the Continuing Education Committee. A new Chair will be appointed.

Mentoring Committee – Amy Fiske

Suzanne read the report of the Mentoring Committee submitted by Amy. The mentoring survey is about to be distributed. In addition, the Committee has been considering ideas for developing mentoring related content for the Society's website.

Awards and Recognition Committee – Bob Intrieri

Suzanne read the report of the Awards and Recognition Committee submitted by Bob. Bob is soliciting nominations for the mentorship and student awards. To date, there have been two nominations for the student award. Past applicants will be automatically considered.

Student Update – Caitlin Holley and Sarah Yarry

There have been a number of excellent nominations received for student representative, as Caitlin is ending her term. The nominations will be reviewed.

Website Update – Rachel Rodriguez

Laura Phillips will take over as website coordinator, as Rachel will be stepping down. Suzanne will explore with Laura developing the 3-year dues payment option for the website.

Treasurer Report –Rick Zweig

Rick reported that income and expenses are in line with projections and that financials remain strong.

Conventions 2008 – Suzanne Meeks

The Society Business Meeting at the APA Convention will be Saturday, August 16, 4-5p ET, in the Division 12 Hospitality Suite. There will also be a joint Division 12, Section II-Division 20 dinner on Saturday, August 16, beginning with a cash bar cocktail hour at the restaurant at 7:00pm.

CONA/Office on Aging Update – Deborah DiGilio

Debbie sent out a list of aging sessions to be held at the APA Convention. It can be accessed at: http://www.apa.org/pi/aging/2008_sessions_aging_ssues.pdf

The APA Committee on Aging (CONA) will have a 10th Anniversary symposium, "Moving Psychology Forward in an Aging Society: Progress and Possibilities," on Saturday, August 16th from 2:00-2:50p, Boston Convention Center, Room 257B. The 2008 CONA Award for the Advancement of Psychology and Aging will be presented to Greg Hinrichsen, Ph.D., at this event.

CONA is soliciting nominations for two new members, as Peter Lichtenberg and Victor Molinari are completing their terms.

Election Report – Forrest Scogin

Forrest is planning on holding the Society election in late June. The positions up for election this year are President-Elect and Secretary.

Presidential Initiative – Suzanne Meeks

As part of her efforts to promote the identity of the Society and the "branding" of clinical geropsychology, Suzanne recommended creating a new Society logo. She proposed holding a contest among the membership for the best logo, with an award of free membership going to the winner. This was approved by the Board. Suzanne said she also wants to soon turn to further developing the Society's website, as previously discussed among the Board.

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APA Office on Aging and Committee on Aging Update

Deborah DiGilio
Director, APA Office on Aging

The Office on Aging and Committee on Aging were formally established in 1998 at the urging of 1997 APA President Norman Abeles, PhD. To celebrate this 10th anniversary and developmental milestone, a number of events have been planned for the Convention:

- CONA 10th Anniversary Symposium, "Moving Psychology Forward in an Aging Society: Progress and Possibilities" will be held Saturday, August 16th from 2:00-2:50 pm, Boston Convention Center, Room 257B. Michael Smyer, PhD, a member of the original 1996-1997 Ad Hoc Committee on Issues of the Older Adult, and a current CONA member will present.
- At the CONA 10th Anniversary Symposium the 2008 CONA Award for the Advancement of Psychology will be presented to Gregory Hinrichsen, PhD for his strong, consistent leadership in the field of geropsychology..
- CONA CELEBRATION to be held Friday, August 15th from 6:30-9:00 pm in the Public Interest Directorate Suite at the Boston Marriott Copley Place Hotel (Look for signs in lobby for specific room number.) Stop by and have some champagne and refreshments!
- As part of President Kazdin's Grand Challenges Presidential Initiative, CONA has developed, "Responding to the Challenges of Aging: Lessons from Medicine, Psychology, and Law." This Presidential symposium will feature Charles P. Sabatino, JD, Director, ABA Commission on Law and Aging, Robert C. Green, M.D., M.P.H., Boston University Schools of Medicine and Public Health; Sara Honn Qualls, PhD, University of Colorado at Colorado Springs and Michael Smyer, PhD, Bucknell University, as discussant. Rosemary Blieszner, PhD, Virginia Polytechnic Institute and State University, will moderate. It will be held on August 15th from 11:00 am-12:50 pm, Boston Convention Center, Room 253B.
- CONA and the Office of Continuing Education will cosponsor an all-day, preconvention, continuing education workshop on August 13th. "What Psychologists Should Know about Working with Older Adults" will increase the competencies of psychologists interested in work with older adults.
- CONA is cosponsoring "Best Practices of Integrated Care: Opportunities and Challenges" which will highlight models of integrated care across social status, disability status, age, multicultural representation, and chronic disease.
- The Office on Aging will once again prepare its ***Sessions on Aging Issues*** convention program guide and inform individuals of its availability via the 12-II listserve.

Finally, over the past year, the ABA/APA Assessment of Capacity in Older Adults Working Group Working Group has been developing the third in a series of handbooks, *Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists*. Edited by Jennifer Moye, PhD and Stacey Wood, PhD, it will be available at Convention. Look for it at the Public Interest Directorate booth in the Convention Center.

Nomination and Elections Committee Report

Forrest Scogin, Ph.D.

The Nomination and Elections Committee (Forrest Scogin, Chair; Suzanne Meeks, Jon Rose, Members) developed two slates of candidates for spots on the Board of Directors. The candidates were Brad Karlin and David Powers for President-elect and Sherry Beaudreau and Karyn Skultety for Secretary.

The election was conducted electronically via a commercial service and unfolded smoothly. About 41% of the membership voted and David and Karyn were elected. They will assume office in January of 2009.

Public Policy Update

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

*P*sychology and particularly clinical geropsychology scored an enormous victory in June for Medicare recipients. The best and only way to hear the news is from the original source. Here is the reprint of the APA Practice Organization announcement!

Date: July 23, 2008
From: Marilyn Richmond, J.D., Assistant Executive Director for Government Relations, APA Practice Organization
Re: What the New Medicare Law Means for Your Practice

Thanks to your tireless advocacy, last week Congress successfully beat long odds and overrode the President's veto of the Medicare Improvements for Patients and Providers Act (MIPPA). The bill's enactment, and its inclusion of provisions of critical importance to psychology, is a compelling testament to the power of effective lobbying, grassroots mobilization and political giving. Now that implementation has begun, I wanted to provide you with further information on how the new Medicare law (Public Law 110-275) will affect Medicare payments to your practice and seniors' access to mental health services.

Payments for Psychotherapy

MIPPA increases payments for psychotherapy by five percent ($45 million more for these services) from July 1, 2008 through December 31, 2009 to partially offset cuts imposed in 2007. As you know, payment levels for psychotherapy and other psychological services suffered steep cuts in 2007 as a result of the Centers for Medicare and Medicaid Services' (CMS) most recent review of Medicare payment.

Every five years, CMS looks at services codes and determines whether they are overvalued or undervalued. After the decision was made to boost payment for "evaluation and management" (E/M) codes starting January 1, 2007, budget neutrality requirements forced a reduction in payment for all other codes. Among providers, psychologists were hardest hit by the reduction.

At the time of the reduction, the APA Practice Organization (APAPO) immediately began advocating for relief for members adversely affected by the cut, first by securing language in the House's Children's Health and Medicare Protection Act to restore Medicare funding for psychological services. The House passed the legislation in 2007. Since then, the APAPO has ensured that restoration language was included every time the House and Senate voted on Medicare legislation — throughout all six votes. Unfortunately, we faced strong pressures in the House and Senate to avoid language that could raise opposition. As a result, we had to compromise this year and drop our request for psychologist eligibility for reimbursement for E/M services. While we did not get all that we wanted, nevertheless the inclusion of the restoration provision marks a significant and unprecedented victory for psychology. Through APAPO advocacy, psychotherapy codes were the only codes that Congress provided relief for through this law. When Congress returns to Medicare issues in 2009, APAPO will keep up the fight to extend the restoration provision and provide psychologists with E/M eligibility.

As you know, in addition to the adjustments stemming from the five-year review, CMS also announced in 2007 changes in practice expense (PE) methodology for all Medicare providers phased in through 2010. These changes increased payment rates for some psychologist services and decreased the rate for others. On average, CMS projected that practice expense payments for psychologists would drop by 2% each year through 2010, and these reductions are still expected to be applied in 2009.

While we lobbied Congress for relief from the five-year review cut, we determined it was best to address the practice expense methodology change, which we view as flawed, at the regulatory level as it has produced mixed results on psychologists' payment rates for different services. We have joined with the AMA and other specialty societies, all of whom agree with our position, to provide CMS with new practice expense data from a massive survey project.

This survey is now underway and is expected to produce data for CMS to review in 2009. We believe CMS will reevaluate the expense component in a manner favorable to psychology.

Medicare Coinsurance Parity

Currently, Medicare beneficiaries are responsible for paying 50 percent of the approved amount for outpatient mental health services, but only 20 percent for other services. Under MIPPA, mental health services will enjoy the same 80-20 percent split in coinsurance by 2014. A phase-in to coinsurance parity for outpatient mental health services begins in 2010, when beneficiaries will pay 45 percent coinsurance; the figure drops to 40 percent in 2012, 35 percent in 2013 and 20 percent in 2014. This long-awaited end to the financial obstacle of discriminatory copayments will help seniors gain access to the quality mental health treatment they need and deserve. The provision of the new law is expected to cost $500 million over the next five years. The APAPO, a founding member of the Medicare Mental Health Equity Coalition, worked in tandem with Senators Olympia Snowe (R-ME) and John Kerry (D-MA) to advance the coinsurance parity issue and win this important victory for psychology.

Sustainable Growth Rate (SGR)

The SGR is part of a formula that determines each year if Medicare reimbursements will increase or decrease from the year before. For the last six years, the proposed reimbursement rate has dropped; every year Congress has taken action to stop the cut from taking effect. In December 2007, Congress delayed implementation of a 10.1 percent cut in 2008 Medicare payments from taking effect for six months, until July 1. MIPPA postpones this cut for an additional 18 months and provides a 1.1 percent payment update for 2009.

The SGR formula has created an untenable situation for Medicare patients, providers and the system as a whole, where every year we must collectively fight an automatic cut in Medicare payment rates. We will continue to press Congress for a permanent solution to equitably determine Medicare payments and keep fighting year after year for better reimbursement rates.

PQRI Bonus Payments

Since July 1, 2007, CMS has provided bonus payments of 1.5 percent to providers voluntarily reporting certain quality measurements under the Physician Quality Reporting Initiative (PQRI). Under MIPPA, PQRI bonus payments will increase to 2 percent in 2009 and 2010.

Rural and Veterans Mental Health

MIPPA uses an existing Medicare grant program to expand mental health services delivery in rural areas by authorizing an additional $50 million for mental health services under this program in 2009 and 2010. States that apply for available funds would be able to use the monies they receive to reimburse providers of mental health services. Although the relevant provision in the law highlights the needs of veterans who served in Iraq and Afghanistan, the services would be also available to other residents of rural areas.

Claims Processing

MIPPA applies its payments provisions retroactively to July 1, 2008, when the previous postponement of the SGR cut expired. Since Congress was considering the Medicare bill in June, the Centers for Medicare and Medicaid Services (CMS) had instructed its contractors to hold claims for Medicare services provided July 1, 2008 or later that were received for processing during the first 10 business days of the month. On July 16, one day after MIPPA was enacted, CMS announced that local contractors will need approximately 10 business days to incorporate the new payment rates into their systems. As a result, psychologists may wish to delay filing Medicare claims until August 1. If claims for services provided on or after July 1 are processed before the new rates are set, the payment to Medicare providers will reflect the cut that went into effect on July 1. Any claims paid at the lower rate will be reprocessed by local contractors at the higher rate once their systems have been updated.

Passage of MIPPA is a huge victory for psychology and will make a real difference in both payments to your practice and seniors' access to mental health services. The APA Practice Organization will keep up the fight in every legislative and regulatory avenue to ensure your services are fairly and adequately compensated.

Thanks again for all of your hard work!

Profile On . . .

Martha Storandt, Ph.D.

When I attended a meeting of the Gerontological Society for the first time in St. Petersburg, Florida, in 1967 I could find only one other clinical psychologist--Muriel Oberleder. Imagine my delight 6 years later when APA published its first of many books on aging--M. Powell Lawton and Carl Eisdorfer's edited volume, The Psychology of Adult Aging and Development--and I discovered a section entitled "The Clinical Psychology of Old Age." Although most of the authors of the four chapters were from disciplines other than psychology, at least those people were interested mental health and aging too. I was encouraged that Muriel and I were not totally alone.

About the same time I attended a session on "Training the Trainors" that Warner Schaie chaired at an annual meeting of either APA or GSA. He pointed out that we first needed to train the teachers if we were to build a work force that could address the needs of older people. We also needed a body of knowledge to teach. Both the teachers and the knowledge were sorely lacking with respect to the clinical psychology of aging.

At the time I was fortunate to be in a psychology department that had one of the few NIH training grants focused on the psychology of aging. Indeed, I had received my own doctoral training supported by that grant. Thus I had access to resources (i.e., funds for doctoral students). Now to find some who were interested in a) clinical psychology, b) aging, and c) teaching and research. They were few and far between. My first three clinical students to receive degrees, beginning in 1975, went into practice. It wasn't until 1983 that the first trainer graduated. Forrest Scogin subsequently built a very successful geropsychology program at the University of Alabama where another of my students, Becky Allen, joined the faculty subsequently.

In 1981 APA sponsored the first Older Boulder conference, which focused on training psychologists--not just clinical psychologists--all sorts of psychologists--to work with older adults.

It was a start. Indeed, APA has been marvelously supportive of the effort to build geropsychology, even if it has been an arduous task. At the second Older Boulder (actually in Colorado Springs) in 2006 it was heartening to see so many psychologists dedicated to training others to work with older people—a welcome change from St. Petersburg 40 years before.

Not only have we made progress with regard to providing personnel, we have made great strides in building a knowledge base about effective ways to address many of the mental health needs of people in later life. At the first Older Boulder I recall one eminent treatment researcher from a prestigious university saying that research on aging was "not intellectually interesting." Even a colleague from the clinical program in my own department was hesitant to include older people in her treatment studies for fear they would "mess up the results." Fortunately, many others disagreed with these pessimistic attitudes. Today a PsycINFO search using the key words treatment and older adults yields 2,141 hits. I cannot take much credit for that burgeoning literature; I have done little treatment research myself. My hat's off, however, to our colleagues who do. It demonstrates loud and clear that older adults don't "mess up" the results. Treatments work for them as well as they work for younger people.

One thing that has not changed a lot, however, is the number of graduate students applying for training in the clinical psychology of aging. Although the explosion of research on Alzheimer's disease attracted many budding neuropsychologists to the study of aging, those interested in other aspects of the clinical psychology of aging are still relatively rare. I suppose it takes a special kind of young person to value the challenges posed by the later portion of life; most focus on areas of study that are more familiar to them. This is one reason it is so important to continue and expand our efforts to provide training in geropsychology to midlife clinical psychologists who want to expand their expertise in this direction.

I mentioned the special emphasis on research on Alzheimer's disease that was spearheaded by the National Institute on Aging

beginning in the mid1980s. Some psychologists (as well as people in other disciplines) were not too happy about this focus; they thought it detracted from support for their own research interests. To the best of my knowledge, that wasn't true; Congress provided additional funds for this research effort. (Of course, I may be biased, given that much of my own work has been on this topic for the last 30 years.) This effort has paid off in terms of attracting many psychologists--both clinical and basic research--to the study of aging.

Perhaps more important, we have demonstrated that "senility" is not inevitable. I think the stereotype of inevitable cognitive decline in later life is one reason clinical psychologists have avoided geropsychology in the past. But now we know that, although many people do develop Alzheimer's, many people do not. They maintain their cognitive abilities until they die--some at a very old age. That's what we all want for ourselves. What is even more exciting now is the emphasis on finding a way to prevent this disease so we can allay the fear of experiencing it for everyone.

So we have a vaccine for Alzheimer's disease and people don't become demented and die. What then? There are other perils of late life waiting in the wings to ambush the unwary if dementia doesn't get you. Some are physical, some are social, and some are mental. Psychologists can help people sidestep many of these hazards if we put our minds to it. Consider the health problems that prevent older people from enjoying life. Many can be prevented with proper diet and exercise, but we psychologists have not yet figured out effective ways to motivate large numbers of people to follow that 30-minutes-a-day-5-days-a-week aerobic exercise program we all know is good for us. Instead we are experiencing an obesity epidemic that begins in childhood. I can remember one question Jack Botwinick used to ask on the final exam in the undergraduate course on the psychology of aging he taught. "What three things should you do if you want to have a long life?" The answers he was looking for were "eat right, exercise, and don't smoke." We've been highly successful in achieving the third but have failed abysmally on the first two.

I recognize that I have mainly talked about the field of geropsychology rather than what I do myself. I'm an academician. I teach and do research and avoid as many committee meetings as I can. I love the first two and hate the last. For years I taught our graduate seminars on assessment and treatment of older adults for the clinical students. That was fun and made me keep up with what was new. Graduate students expect you to assign readings that have recent publication dates. Anything over 5 years old you have to justify as a "classic." Now my younger colleagues, Brian Carpenter and Denise Head, have taken responsibility for these courses, so I'm rapidly becoming out of date. But thank goodness for computerized data bases like PsycINFO and Medline. In just a few minutes I can identify and download the PDFs of what look to be the best selection of most recent articles on a particular topic. It was a few years ago that I kept a work-study student busy tracking down journals and xeroxing articles for me in the library. Sometimes I even went to the library myself.

I also enjoy mentoring graduate students and watching them learn to do research themselves. We recently had the 50th anniversary celebration of our NIA-sponsored training grant (the one I mentioned earlier). Our program office doesn't think there are many, if any, others around that have been in business that long. It was great hearing about what former graduate students are doing now. One (Christina McCrae) has just learned that she had been awarded tenure at the University of Florida. It's times like that when I feel like we've come a long way in the last 40 years.

What is really fun nowadays is analyzing 30 years of data with all these sophisticated statistical packages we have on our desktop computers. I'm sure few of you view analyzing data as fun, but for me, it is. It's why I put up with the rest of the research process. I love seeing how things turn out. Sure, sometimes it's a bust. All you discover is that you've spent 3 years and tons of money on a dead end. But then a project turns out well, and it's all worth it. Remember, a variable reinforcement schedule is the most powerful way of all to increase the frequency of a behavior.

Consider This: Cognitive Errors, Symptom Severity, and Response to CBT in Older Adults with Generalized Anxiety Disorder

Editor's Note: I am pleased to feature one of our Society's 2007 Student Paper Award winners, Donald Caudle (and his co-authors) in this edition of Consider This. The authors share with us a summary of the paper!

Donald D. Caudle, MA[1,2]; Ashley S. Roseman, Ph.D.[3,4,8]; Julie Loebach Wetherell, PhD[5,6]; Howard M. Rhoades, PhD[2]; J.G. Beck, PhD[7]; Mark E. Kunik, MD, MPH[3,4,8]; A. Lynn Snow, PhD[9]; Nancy L. Wilson, MA, MSW[3,4,8]; Melinda A. Stanley, PhD[3,4,8]

[1]University of Houston; [2]University of Texas Health Sciences Center at Houston;
[3]Houston Center for Quality of Care & Utilization Services; [4]Michael E. DeBakey Veterans Affairs Medical Center; [5]University of California, San Diego; [6]Veterans Affairs San Diego Health Care System; [7]University at Buffalo-SUNY; [8]Baylor College of Medicine; [9]University of Alabama

Abstract

This project investigated whether performance on Mini-Mental Status Examination (MMSE) domains could predict baseline anxiety/depression and outcome following cognitive-behavioral therapy (CBT) when established predictors were controlled. Baseline anxiety/depression was investigated in 208 older adults (> 54 years) diagnosed with generalized anxiety disorder (GAD). Participants who committed an error in Working Memory exhibited increased severity in anxiety/depression at baseline. Predictors of treatment response were investigated in a subsample of 65 participants who completed CBT. Patients with an error in Orientation exhibited decreased treatment response at 6-month follow-up when established predictors were controlled. The MMSE is widely used to exclude participants whose scores suggest dementia; however, our results suggest cognitive errors in MMSE domains may be useful in the study of symptom presentation and treatment outcome for patients with anxiety.

Introduction

Anxiety disorders are prevalent among older adults, with estimates ranging up to 10.2%, and GAD the most frequently identified at 7.3%; however, treatment of this group remains difficult. Although medication is often considered as the first course of treatment for older individuals, several risks are associated with the use of anxiolytics and antidepressants, and older adults may prefer nonpharmacological treatment options. While CBT is efficacious in older adults with GAD, response rates are lower than for younger adults. Very few studies have attempted to explain the decreased response of late-life anxiety to CBT, though it has been postulated that this decreased responsivity may be due to cognitive dysfunction (CD).

Wetherell et al. (2005) pooled elderly subjects (n=65) from three independent randomized CBT trials for GAD and established three predictors of response to CBT: severity of GAD symptoms, homework adherence, and psychiatric comorbidity. They found no relationship between CBT response and CD as measured by MMSE Total Score, which may be due to reduced sensitivity of the MMSE Total Score. Factor analysis of the MMSE has revealed 5 distinct, though related, domains: Orientation (to both time and place); Attention (immediate recall of three items), Working Memory (serial 7s or spelling "world" backward); Delayed Recall (delayed recall of three words); and Language and Praxis (naming, following commands, and construction). In contrast to the Total Score, individual MMSE domains may increase sensitivity for predicting outcome (Small et al., 2000).

The current project expands upon the work of Wetherell et al. (2005) by examining the relationship between CD, anxiety and depression symptomatology, and response to CBT in the same pooled treatment sample and larger baseline sample. The current project uses MMSE domain scores to investigate: 1) The relationship between CD and anxiety/depression symptomatology at baseline, and 2) The relationship between CD and response to CBT, while controlling for previously established predictors (severity of symptoms, homework adherence, and psychiatric comorbidity).

Methodology

Participants:

The baseline sample consisted of 208 older adults with GAD who participated in one of three independently conducted treatment outcome studies in Houston, Texas (n=50 and 84) and Los Angeles (n=75), California. Exclusion criteria varied slightly by study but included age (under 55 or 60 years) and MMSE scores below 23, 24, or 25 points. Subjects were also excluded if they presented with a history of mania or psychosis, current participation in psychotherapy, or current alcohol or other substance abuse. [See Wetherell et al., (2005) for a thorough description of recruitment.] Participants in the treatment sample (n=65) were patients from the larger baseline sample (n=208) who were randomly assigned to CBT and completed treatment. Other participants in the baseline sample were assigned to control conditions.

Measures:

Cognitive functioning was measured with the MMSE, a widely used measure of cognitive functioning useful for screening and excluding patients with suspected cognitive impairment. This measure is comprised of 23 items, with scores ranging from 0 to 30. A cutoff score of 24 is commonly used to indicate cognitive impairment. As mentioned, factor analysis has indicated the presence of five distinct, but related domains: Orientation, Attention, Working memory, Delayed Recall, and Language/Praxis.

Several instruments were used as measures of anxiety symptoms. The Anxiety Disorders Interview Schedule (ADIS-R or ADIS-IV) was used as a measure of GAD severity, with severity ratings ranging from 0 (no distress/disablement) to 8 (very severe distress and disablement). The Penn State Worry Questionnaire (PSWQ) is a frequently used 16-item measure designed to assess the severity of pathological worry, independent of content. The Hamilton Rating Scale for Anxiety (HAMA) is a 14-item measure of clinician-rated anxiety. Each item is defined by a series of symptoms and rated on a five-point scale, from 0 (not present) to 4 (severe). All measures of anxiety symptoms were determined to have sufficient psychometric properties for inclusion in this study.

Measures of depressive symptoms included the Beck Depression Inventory (BDI) and the Hamilton Depression Rating Scale (HAMD). The BDI is a 21-item self-report rating scale that assesses characteristic attitudes and symptoms associated with depression. Each item is rated on a four-point Likert scale. The HAMD is a 21-item clinician-administered symptom rating scale for depression. All measures were determined to have adequate psychometric properties.

Procedure:

Participants were recruited largely from the community for participation in clinical trials of CBT for anxiety. The ADIS-R/ADIS-IV interviews were administered to establish diagnostic criteria. Participants with a principal or coprincipal diagnosis of GAD according to DSM-III-R or DSM-IV criteria were included in the baseline sample. All measures (MMSE, HAMA, HAMD, PSWQ, and BDI) were administered at baseline. Participants were then randomly assigned to either CBT or a comparison group. Components of CBT were similar across the three studies, with treatment administered in a group format over 12 to 15 sessions. For a detailed description of the treatment intervention, refer to Wetherell et al. (2005). Only those who completed CBT were considered as participants here, and assessments were repeated at posttreatment and 6-month follow-up.

Treatment outcome was operationally defined as the mean reliable change index (RCI) across the anxiety outcome variables (ADIS GAD severity, PSWQ, and HAMA). Statistically significant change was indicated by RCI values > 1.96. Due to the restricted range of MMSE scores and lack of distribution across domains, group membership was defined according to performance on each MMSE domain such that scores were dichotomized to reflect the presence or absence of at least one error. Hierarchical regression was used to assess the effect of MMSE domain performance in predicting mean RCI at posttreatment and six-month follow-up, over and above the variables previously found to significantly predict response to treatment in this sample (GAD severity at baseline, homework completion, and psychiatric comorbidity).

Results

Participants in the baseline sample were female, white, and well-educated. Approximately half had one or more comorbid disorders, with the most common being depression, social phobia, and specific phobia. Because one Houston study sample had a greater proportion of patients with a depressive disorder, and owing to methodological differences across the 3 studies, study sample was included as a covariate in all baseline and treatment analyses.

There were no differences in MMSE scores across the three studies, either for the baseline or treatment groups. Mean MMSE scores in the baseline and treatment samples were 28.5 (SD1.34) and 28.7 (SD=1.09), respectively.

MMSE domains were uncorrelated in both baseline and treatment samples (all r in range: -0.21 to 0.13; all $p > 0.09$). Aside from a greater proportion of participants in the baseline sample with errors in the Language/Praxis domain, there were no differences between the baseline and treatment samples in the pattern of MMSE errors. The Attention domain was removed from subsequent analyses due to the lack of variability.

Anxiety and depression symptomatology of participants who committed at least one error on each MMSE domain was compared with that of participants who committed no errors. MANCOVA indicated a significant effect for Working Memory, and follow-up ANCOVA analyses determined that those who committed an error in Working Memory exhibited higher levels of anxiety (GAD Severity) and depression (HAMD, BDI) at baseline.

The proportion of participants in the treatment sample, regardless of cognitive status, with a mean RCI >1.96 was 53.85% (n=35) at posttreatment and 67.19% (n=43) at six-month follow-up. At posttreatment, performance on MMSE domains did not contribute to prediction of CBT response, over and above the already established predictors. However, at six-month follow-up, the overall model was significant, with performance on the MMSE domains accounting for an additional 8% of total variance. In terms of individual significance of MMSE domains, Orientation was the only domain that was significant in predicting mean RCI. Those who committed no errors in Orientation showed greater improvement to CBT (mean RCI=2.91) than those who committed at least one error (mean RCI=1.99). There was a statistically significant difference in terms of those with/without an error in Orientation who remained treatment responders at six-month follow-up, suggesting that subtle cognitive dysfunction at baseline may predict poorer maintenance of treatment gains following CBT.

Baseline Anxiety and Depression Symptomatology by Performance on MMSE Working Memory Domain

	No Errors (n=158) Mean (SD)	Errors (n=48) Mean (SD)	F (df)	*P*
GAD Severity	5.08 (0.85)	5.48 (0.97)	7.20 (1, 204)	.01
PSWQ	61.63 (10.02)	63.27 (10.01)	2.32 (1, 198)	.13
HAMA	17.97 (7.04)	20.82 (5.44)	2.74 (1, 199)	.10
HAMD	14.88 (6.92)	19.13 (7.36)	6.16 (1, 202)	.01
BDI	15.78 (7.27)	19.54 (7.22)	9.98 (1, 194)	.01

Prediction of RCI at 6-month Follow-up

	R2	F	*p**	B	SE	t	*p**
(1) Model w/Only Already Established Predictors (Wetherell et al., 2005)	40%	7.77	<.0001				
(2) Model 1 + MMSE Domains	48%	5.50	<.0001				
GAD Severity				.37	.20	3.44	.001
Homework Adherence				.41	.01	3.88	.001
Comorbidity				.25	.39	2.38	.02
Orientation				.24	.43	2.30	.03
Working Memory				.19	.52	1.68	.10
Delayed Recall				.08	.40	.77	.44
Language/Praxis				.03	.56	.28	.78

Discussion

The Working Memory domain of the MMSE was significantly related to severity of both anxiety and depression at baseline. This relationship may reflect increased concentration difficulties that are often a presenting symptom for GAD and depression. Performance on the MMSE Orientation domain was significantly related to CBT outcome at six-month follow-up. Patients who committed at least one cognitive error in orientation to time or place experienced a poorer response to CBT at follow-up in comparison with their peers who committed no errors. Orientation may play a central role in treatment outcome given that it is one of the most frequently reported symptoms of brain disease (Lezak et al., 2004) and perhaps one of the most sensitive domains in predicting future onset of brain disease (Small et al., 2000). As such, cognitive errors in the Orientation domain may reflect the presence of an underlying preclinical dementing process in some elderly patients with late-life anxiety that is not yet detectable by other measures, but nevertheless exerts a deleterious effect on treatment gains. To our knowledge, this is the first study to demonstrate that cognitive errors on MMSE domains can be used to predict differential presentation of anxiety and depressive symptoms and response to CBT.

Future research will need to replicate and extend these findings and further examine the role of executive dysfunction using a more comprehensive assessment of CD with either multiple measures or a multidimensional instrument such as the Dementia Rating Scales–2 (DRS-2; Mattis, Jurica, & Leitten, 2001). Improved understanding of the relationships between subtle deficits in cognitive functioning and symptom presentation/response to treatment will likely support treatment development or refinement of established CBT approaches for older adults who present with cognitive dysfunction and GAD.

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Student Voice: Making the Most of Your Summer

Sarah Yarry, M.A.
Student Representative

*I*t's summertime and we've made it safely through another year of graduate school! Summer is a time when responsibilities for graduate students change and we begin to look ahead to the next year. Here are some suggestions to help you make the most of summer, and meet your personal goals:

1. Get ahead on a publication or thesis. Academic departments are typically more laid back in the summer, so it is a good time to work on a publication that has been sitting on your desk for a while, or to put in some time on your thesis. An added benefit of working on your thesis over the summer is that committee members may have more flexible schedules due to reduced teaching loads. If you are planning to work intensively on your independent research, just be sure to check if your committee members will be out of town!

2. Seek out an additional clinical experience. Since formal clinical experiences do not always last the entire calendar year, summer provides a few months when you can create your own supplemental clinical experience. Have you always wanted to work in a particular setting or with a certain population? The summer provides an excellent opportunity to contact specific sites or supervisors about training. Networking is an essential part of getting the training you want, so during the summer, start looking for ways to round out your clinical experiences.

3. Attend a conference. Conferences are a fantastic way to learn more about a specific area of interest or do to some of that networking you've heard so much about. In particular, APA will be held in Boston this year, assuring some great training in cutting edge research and clinical practice set against the beautiful city backdrop. Division 12, Section II will be holding a social hour for students on Saturday, August 16 at 5:30 at Clery's (113 Dartmouth St.) so come out to meet other students and professionals in clinical geropsychology!

4. Do some non-required reading. In order to round out your academic knowledge, pick up a book on a topic you always wanted to know more about but not had time to explore. This will enhance your overall training as a clinical geropsychologist, and maybe even give you an idea for a project. I should point out that reading is always more productive when done by a pool, bringing me to my final way to get ahead during the summer…

5. Relax! The importance of self-care cannot be overemphasized. Sometimes the stresses of graduate school can be overwhelming, but they are more manageable if you reward yourself with a nice break over the summer. A break does not have to involve an elaborate European back-packing trip (although it has been known to happen), but can be anything that will help you unwind, like an evening stroll or a movie on the couch. Graduate school is a marathon, not a sprint, so be sure to pace yourself throughout your graduate school years to protect against burnout.

It is my hope that these tidbits of advice will be helpful in making the most of the summer months. As always, feel free to contact me (sarah.yarry@case.edu) or my fellow representative Caitlin Holley (c.holley@louisville.edu) with questions about upcoming division activities, or if you're interested in becoming more involved. Whatever you choose to do with your summer, though, I hope you have a great one.

Editor's Note: Correction

In the last newsletter, we ran a list of the 2008 Society officers, committee members and representatives. In this list, we incorrectly listed the members of the Interdivisional Healthcare Committee and omitted Margaret Norris. Here is Margie's corrected listing as a representative:

Margaret Norris, PhD, 7607 Eastmark Drive, Suite 117, College Station, TX, 77840.
Office: (979) -255-2281, Fax: (979)-690-6703.
E-mail: MARGIENORRIS@hotmail.com

We apologize for the error and thank Dr. Norris for her hard work on the committee!

SUMMARY OF MAY BOARD MEETING (Continued from Page 5)

Old Business – All

The Board discussed amending the composition of the Awards and Recognition Committee to a standing committee that could allow greater divsersity and inclusion of early and mid-career psychologists in the process, while retaining a veteran member of the Society (such as a past president) as part of the Committee. There was agreement among the Board to pursue this change, which will require an amendment of the Bylaws. Revised language will be sent to the Board for vote by e-mail.

Suzanne will convene a workgroup to implement the 3 years dues option.

Suzanne, Brad, Forrest, and Barry will meet in mid-June to discuss next steps for developing a Society-sponsored journal.

Next Board Meeting – Suzanne Meeks

The next Board Meeting will be August 16, 10-12p ET. This will be held as an in-person meeting at the APA Convention.

Meeting adjourned at 6:25p ET.

THE SOCIETY OF CLINICAL GEROPSYCHOLOGY 2008 APA EVENT SCHEDULE

Wednesday, August 13th

CE Workshop: Assessment and Management of Suicide Risk Across the Life Span
Time: 8am - 3:50pm
Location: Westin Boston Waterfront Hotel, Lobby Level, Hancock Room
Enrollment Fee: Member--Advance $210, On-site $245, Nonmember--Advance $245, On-site $315
CE Credits: 7 hours. Limited enrollment.

Friday, August 15th

Symposium (Co-Sponsor: Div.44): Psychotherapy with Lesbian, Gay, Bisexual, and Transgender Older Adults
Time: 8am - 9:50am
Location: Boston Convention and Exhibition Center, Meeting Room 156B

Presidential Address (Suzanne Meeks, PhD): 12-II is You (and Me): A Salute to Our Accomplishments.
Time: 10am -10:50am
Building: Boston Marriott Copley Place Hotel, Fourth Floor, Provincetown Room

Saturday, August 16th

12-II Board Meeting
Time: 10am - 12pm
Location: Division 12 Hospitality Suite

12-II Business Meeting
Time: 4pm - 5pm
Location:Division 12 Hospitality Suite

Sunday, August 17th

M. Powell Lawton Award for Distinguished Contributions to Clinical Geropsychology
Time: 11am -11:50am
Location: Boston Convention and Exhibition Center, Meeting Level 1, Meeting Rooms 102A and B

Division 20-12-II 2008 Annual Dinner

SkipJack's
Boston, MA
Saturday, August 16, 2008
7:00 p.m. cash bar open
8:00 p.m. dinner

Reservation Form

Your Name: _____

Membership: ☐ **Div 20** ☐ **Div 12-II** ☐ **Both** ☐ **Neither**

Please select from the following entrees (if reserving for more than one person, indicate number):

Please indicate the number of people attending in each category:

_____ D20 and D12II members/spouses/partners -- $60

_____ Student -- $30 (regardless of membership status)

_____ Non-member of D20 or D12II -- $70 (yet another incentive to join!)

Total enclosed (*Make checks out to the Society of Clinical Geropsychology*): $_____

For planning purposes, please indicate menu preferences below (choose 1 in each category):

Enter number of people	**First Course:**	Enter # of people	**Dessert:**
	Clam Chowder		Chocolate Bundt Cake
	Balsamic Salad		Sorbet
	Caesar Salad		
Main Course:			
	Baked stuffed lobster		
	Gingered sea bass		
	Fried seafood platter		
	Marinated steak tips		Vegetarian Option
	Wasabi crusted salmon		

Send check to:
Jon Rose, Ph.D.
SCI Clinic, VA Palo Alto HCS
3801 Miranda Ave (128)
Palo Alto, CA 94304

DEADLINE FOR RESERVATIONS HAS BEEN EXTENDED TO AUGUST 12!!
Please e-mail Jon Rose (Jonathon.Rose@va.gov) prior to August 12th if you want to reserve a spot. Inform him of the number attending, your menu choices for each attendee and confirm that your check is in the mail. You must contact Jon prior to August 12th, so reserve your spot today!!!

APA Division 12, Section II: The Society of Clinical Geropsychology
2008 MEMBERSHIP DUES FORM

Name (Print)	**Degree**	**Membership Status** (Please check one) **____Renewal ____New Member**

APA Member No. (Required) _____
(You must be a member of APA to join Section II. Student applicants must have their application endorsed by a faculty advisor who is an APA member)

APA Membership Status (Please check one)
___Fellow ___Member ___Associate ___Emeritus (retired member of APA) ___Student Member (graduate, internship, postdoc)

Street Address

City	**State**	**Zip Code**
Phone ( )	**Fax ( )**	

E-mail _____
(Note: E-mail is crucial for our records, and therefore strongly encouraged)

____ CHECK HERE TO OPT OUT OF THE LISTSERV

Are you a member of Division 12 (The Society of Clinical Psychology)?	**___Yes**	**___Yes** (as a student)	**___No**

Please list other Divisions you are affiliated with:

Special Interests within Geropsychology

What is your PRIMARY emphasis as a Geropsychologist? (Define primary as 51% or greater)
____Clinical practice ____Research ____Teaching ____Administration

PAYMENT OF DUES (USD) **$25.00 for Members, $10.00 for Students, Emeritus members are dues exempt**	**$ _____**
B. Added Contribution to Section II (donations are strictly voluntary, but greatly appreciated!)	**$ _____**
C. Total Amount Enclosed (Please make your check in U.S. dollars payable to APA Division 12, Section II)	**$ _____**
Signature	**Date**

If Student, Faculty endorser (print)

Faculty signature	**Date**

You can pay via the web:
https://webform.sfu.ca/cgi-bin/WebObjects/WebForm.woa/wa?gero.geropsyc.membership.payment

***Or* mail this form, along with your check payable to "APA Division 12, Section II" to Jon Rose** (treasurer):

Jon Rose, PhD; VA Palo Alto Health Care System; 3801 Miranda Avenue, #128; Palo Alto, CA 94304
E-mail: Jonathon.Rose@VA.Gov; Phone (650) 493-5000 ext. 64334

____ CHECK HERE TO BE INCLUDED IN THE MEMBERSHIP DIRECTORY