Clinical Geropsychology News

Society of Clinical Geropsychology

APA Division 12, Section II Volume 19, Issue 3

November 9, 2012

INSIDE*

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Please contact Erin Woodhead at Erin.Woodhead@sjsu.edu or Kaci Fairchild at JenniferKaci.Fairchild@va.gov if you wish to comment on the contents of this Newsletter.

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

President's Column

By Erin Emery, PhD

Typically, the President's column in the Fall newsletter is a re-cap of the highlights of the APA Presidential Address for those who were not able to attend. I'd like to follow that tradition, and make a **request of members to have a voice in our next steps**.

In 2005, Barry Edelstein created the 12/II Education Task Force as part of his 12/II presidential initiative. The task force was appointed to identify gaps in geropsychology training with the intent of eventually filling those gaps. Barry, Nancy Pachana, Candy Konnert, Erin Woodhead and I began this endeavor by surveying training directors about available geropsychology training opportunities in their programs. Our international sample of 93 training directors (46 USA, 25 Australia, 22 Canada) reported interest in expanding aging courses and placements, but identified recruitment of staff geropsychologists and finding appropriate older adult placement opportunities as barriers (Pachana et al., 2010). The 15% response rate in the US was notable, despite multiple personal requests for participation to training directors.

In 2010, members of the Education Task Force received a research award from the Council of Professional Geropsychology Training Programs (CoPGTP) to conduct a survey of psychology graduate students about their geropsychology training experiences in comparison to their self-rated geropsychology competencies. Preliminary data from this international survey of 764 graduate students (376 USA; 139 Australia; 25 New Zealand; 224 Canada) shows that increased exposure to older adults in practica was related to higher anticipation of working with older adults in the future. Further, increased coursework, practicum, and geropsychology faculty were associated with greater geropsychology competency. PLEASE COME HEAR MORE ABOUT THIS DATA AND OTHER TRAINING ISSUES AT GSA! Friday, November 16, 2012, 5:00 PM - 6:30 PM Room 12 (San Diego Convention Center).

At the APA convention in 2011, attendees were invited to participate in a conversation about training trends in the US and internationally, with focus on needed next steps in geropsychology education. Out of that conversation came a call for broader access to available training opportunities that were scattered across the internet and publishing world, along with development of more webinars by geropsychology experts, and a need for developing an online version of the Pikes Peak Competencies (see www.copgtp.org). It became clear that collaboration of the geropsychology organizations would be key in the development of such an endeavor. Thus, as my 12/II presidential initiative, I brought together representatives of Divisions 12/II and 20, CoPGTP, Psychologists in Long Term Care (PLTC), and CONA to develop what has become GeroCentral.org. By now, you are likely aware that this is an APA-funded (CODAPAR interdivisional grant) website that will bring together the available geropsychology training and professional development resources in one internet clearinghouse to maximize organizational effectiveness, increase access to geropsychology training, and collaboratively create new tools to increase the effectiveness of existing resources, including the first in a series of geropsychology webinars.

GeroCentral.org will have a **Clinician & Researcher Toolbox** with assessment and intervention resources; **Science & Policy** section with critical articles by competency and information about national and local policies impacting older adults and geropsychologists; an online version of the **Pike's Peak Competencies** with options to save responses over time; and a **Training** section with information about geropsychology training programs from the graduate through post-licensure levels, including continuing education and mentoring programs. The website is currently under construction, and will be coming to a computer near you in **March, 2013**.

I believe that the history of this endeavor is important to understanding not only the amount of time that the journey has taken, but also the process of making change in training. Alongside this process has of course been the 2006 National Conference on Training in Professional Geropsychology (and the history of Older Boulder conferences upon which it was based), development of the Pikes Peak competencies tool, the identification of geropsychology as a specialty, and current efforts toward developing geropsychology board certification. This is a very exciting time in geropsychology, and a critical time for growth of our specialty as the boomers enter later life and health care reform (in whatever direction it goes next) is upon us.

Request for member voice: As we assemble resources for launch of GeroCentral.org, we recognize that we don't have a representative from every area of geropsychology expertise on the committee. Thus, if you have resources (lists of key articles, books, measures, manuals, webinars, geropsychology websites to link to, etc) that are important to include in this clearinghouse, it would be incredibly helpful if you would send them to gerocentral@gmail.com. We will not be posting actual resources that are protected by copyright, except to link to PubMed or the publisher. All resources are welcomed, and we will include them as they fit with the organization of the site. Thank you for your participation!

It has been a pleasure serving as the President of the Society of Clinical Geropsychology, and I look forward to continued participation with the board as Dr. Amy Fiske takes the reins in January.

Pachana, N.A., Emery, E.E., Konnert, C., Woodhead, E., & Edelstein, B. (2010). Geropsychology Content in Clinical Training Programs: A Comparison of Australian, Canadian and US Data. *International Psychogeriatrics*. doi:10.1017/S1041610210000803

GeroCentral

COMING MARCH 2013
TO A COMPUTER NEAR YOU

Comments from the Editors: Kaci and Erin

Welcome to the Fall edition of the 12/II Newsletter! There are a few pieces in the current issue that we would like to highlight:

- As GSA Convention is right around the corner, we have included a guide to Geropsychology-relevant posters, presentations, and events as an attachment to the newsletter email. This was assembled by the Mental Health and Aging Special Interest Group of the GSA.
- We are continuing our efforts to profile members by including *Where Are They Now*, which was introduced in the last newsletter (Summer 2012). With the help of the Membership Committee, we also included a special feature on *The Way We Are*, which profiles the activities and demographics of our current membership. We would love to hear of any ideas that you may have for future special features.
- We are committed to increasing member content. Is there someone you would like to profile? Have you had an interesting clinical case or project that you would like to spotlight? Please contact us and we'll work with you on your ideas for submission.
- 12/II is recruiting for a new Chair of the Awards and Recognition Committee. This person is involved in organizing 12/II's three annual awards: the M. Powell Lawton Award, the Distinguished Clinical Mentorship Award, and the Student Research Paper Award. If you're interested, please contact Erin Emery at Erin_Emery@rush.edu. Speaking of awards, check out page 13for photos of award recipients for 2012! Start thinking of people you'd like to nominate for 2013 – nominations are welcome from any member! Email your nomination ideas to Erin_Emery@rush.edu.

Where Are They Now?

As a new feature in the newsletter, the editors decided to contact prior winners of the 12/II Student Research Award to ask them a few questions about what they're up to now. The first installment of this new column was introduced in the Spring 2012 newsletter. For the second installment, we profiled Ben Mast (received award in 1999) and Julie Wetherell (received award in 2000). Here we publish the abstract from their award winning work, and follow-up with questions about their current activities.

Benjamin Mast, Ph.D.
Associate Professor & Vice Chair of the Department of Psychological & Brain Sciences
Associate Clinical Professor of Family & Geriatric Medicine
University of Louisville

Mast, B.T., MacNeill, S. E., & Lichtenberg, P. (2002). A MIMIC model approach to research in geriatric neuropsychology: The case of vascular dementia. *Aging, Neuropsychology, and Cognition, 9(1),* 21-37.

The goal of the current study is to demonstrate a new methodology that can be used in neuropsychological research concerning differential diagnosis research. The multiple indicators, multiple causes (MIMIC) model is a latent variable methodology which can examine group differences on individual tests while controlling group differences in global cognitive impairment. As a demonstration, neuropsychological data from 217 dementia patients were incorporated into a MIMIC model to examine the influence of cerebrovascular disease (CVD) upon (1) dimensions of global cognitive impairment and (2) upon individual tests after controlling for global impairment. The presence of CVD in dementia (i.e., vascular dementia [VaD]) was not significantly related to dimensions of global impairment. In addition, the presence of CVD within dementia did not significantly contribute to impairment on 9 out of 10 neuropsychological tests/subscales examined after controlling global cognitive impairment. These results are discussed in the context of current vascular dementia research, and are focused primarily upon the MIMIC model methodology and suggestions for its use in future research.

Interview Questions for Dr. Mast

Q: How did you get interested in the field of aging?

After I graduated from Calvin College I took a job working at an Alzheimer's day center. I spent all day, nearly every day working with people who had Alzheimer's disease and other dementias. I was struck by the tremendous need these people were experiencing and the profound effects the disease had on these individuals and their families. These experiences were very influential in my decision to pursue clinical geropsychology and they continue to motivate me in my current work.

Q: What are your key responsibilities at your current job?

I am currently an Associate Professor and Vice Chair in the Department of Psychological & Brain Sciences at the University of Louisville. My time is split between teaching graduate courses, mentoring doctoral students, research, and administration. I am also an Associate Clinical Professor in the Department of Geriatric Medicine and involved in the assessment of people with suspected cognitive impairment and dementia (and also supervise doctoral students who play a key role in these assessments as part of their training).

Q: What has been your most memorable experience in gerontology and aging research?

I'm thankful to have had many great experiences in the field of geropsychology over the past 10 years or so. I've had fantastic students over the years, and seeing them graduate with PhD's and launch into successful careers in geropsychology has consistently been one of the highlights of my career thus far.

Q: Why is it important for students to join 12/II?

12/II provides a great opportunity for students to become involved in the field of clinical geropsychology and provides a unique opportunity to get connected with the leaders in our field.

Q: Do you have any tips for emerging geropsychologists?

Find an area of research and practice that you are passionate about and pursue it. Find a good mentor who cares about and is committed to your career development.

Q: Tell us about your most recent activities.

I recently published a book on the assessment of people with dementia (Whole Person Dementia Assessment, 2011, Health Professions Press). This book integrates neuropsychological testing with person centered principles, which are two very different approaches to understanding people with dementia. I had

wanted to write this book for quite some time and in some ways links back to those early experiences I had working in the Alzheimer's day center (see above).

Q: Have you had an important mentor in your career? If so, how did it make a difference?

I had an outstanding mentor in Peter Lichtenberg. Peter's mentoring has had a tremendous and lasting impact on my career. He provided opportunity, equipped and trained me, invested in and supported me. Peter always believed in me, often times more than I believed in myself and my own ability.

Julie Wetherell, PhD
Psychologist, VA San Diego
Associate Professor in Residence, University of California San Diego

Wetherell, J.L., Gatz, M., & Craske, M.G. (2003). Treatment of generalized anxiety disorder in older adults. *Journal of Consulting and Clinical Psychology, 71(1)*, 31-40.

Older adults with generalized anxiety disorder (GAD; N = 75; M age = 67.1 years) were randomly assigned to cognitive-behavioral therapy (CBT), a discussion group (DG) organized around worry-provoking topics, or a waiting period. Participants in both active conditions improved relative to the waiting list. Although CBT participants improved on more measures than DG participants, the authors found only I significant difference immediately after treatment and no differences at 6-month follow-up. Effect sizes were smaller than in younger samples, but CBT showed large effects and DG showed medium-sized effects Overall, results indicate that brief treatment of late-life GAD is beneficial, but they provide only limited support for the superiority of CBT to a credible comparison intervention.

Interview Questions for Dr. Wetherell

Q: Why did you become a 12/II member and how did 12/II assist you with your professional development?

I define myself as a clinical geropsychologist. 12/II has helped me (and continues to help me) by making connections with new collaborators and new ideas.

Q: How did you get interested in the field of aging?

My first aging-related job was as a Research Associate for Pat Arean at UCSF. While collecting data for one of her studies, I heard the most fascinating stories - for example, from a woman who had come to California during WWII to build aircraft (a real life Rosie the Riveter!) and a man who had been arrested for drinking out of the "whites only" drinking fountain in Baltimore in the era of Jim Crow. It was like history coming to life. I was also inspired by the seriousness of the problems older people face: illness, disability, loss. You just have to respect their struggles and their strengths. And Pat is a wonderful mentor. She had collected some data on anxiety from a sample of patients in one of her studies and told me, "You might want to take a look at this. Very few people are interested in anxiety in older adults." That sparked my interest and launched my career.

Q: What are your key responsibilities at your current job?

I have a joint appointment at the San Diego VA and the UCSD Psychiatry Department. In this position, I wear many hats. As a clinician, I direct Behavioral Medicine services in the VA's Home-Based Primary Care program, which means I conduct assessments and psychotherapy in the homes of older adults with serious medical illness. I teach. Currently I mentor three graduate students in the San Diego State

University/UCSD Joint Doctoral Program in Clinical Psychology, I supervise a VA postdoctoral fellow who works with me in HBPC, I co-lead a weekly seminar with first year medical students (an innovative program in which they pair physicians in non-mental health disciplines with mental health providers to emphasize the role of psychology and behavioral health in medicine), and I supervise three psychiatry residents who are learning cognitive-behavioral therapy. I spend most of my time doing research. Right now I direct three randomized controlled trials: a comparison of Acceptance and Commitment Therapy for chronic pain delivered in person vs. via telemedicine; a test of an intervention integrating exposure therapy for anxiety and exercise for older adults with excessive fear of falling; and a comparison of Mindfulness-Based Stress Reduction and health education for older adults with depression or anxiety and cognitive concerns. And I'm the mother of 2 boys, one of whom turns 7 on Sunday (November 18).

Q: What has been your most memorable experience in gerontology and aging research?

I loved every minute of graduate school at the University of Southern California, working with Margy Gatz. She is the most amazing mentor I have ever encountered. In addition to being brilliant, she is so generous, in terms of providing resources and allowing students to follow their own paths. In my own work with students, I spend a lot of time thinking, "What would Margy do?" My peers were incredible as well; it was a wonderful experience to work with and learn from people like Chandra Reynolds, Susan Charles, Julia Kasl-Godley, and Amy Fiske. I count myself very fortunate to have had such excellent training.

Q: Why is it important for students to join 12/II?

The mental health and aging community is very nurturing. I don't know whether it's because certain kinds of people are attracted to working with older adults, or because working with older adults gives us a sense of the importance of building a legacy, or because we see how great the need is for new people to join us in this important work. For whatever reason, the people involved in 12/II are some of the most supportive folks in the field, always willing to help junior colleagues find their niche.

Q: Do you have any tips for emerging geropsychologists?

Try as many different experiences as you can - research, teaching, clinical work - in as many different settings as you can - long-term care, primary care and specialty medical settings, inpatient units, home care - with as many different populations as you can - Veterans, dementia patients, caregivers, older adults from different ethnic backgrounds. Meet as many people in the field as you can. Stay open to new opportunities and possibilities. Follow your heart.

Q: Tell us about your most recent activities.

See above.

Q: Have you had an important mentor in your career? If so, how did it make a difference?

See above.

ABPP Update

Submitted by Douglas Lane, Ph.D., ABPP and Victor Molinari, Ph.D., ABPP

The ABPP process is moving ahead. Just recently the ABPP geropsychology committee heard that our application has been approved at the initial level by ABPP, and that we need to defend it before the executive board in December. As before, we have had to strike a balance between setting minimal criteria to take the ABPP-geropsychology examination at a level reflecting our enhanced training opportunities in the geropsychology field, while being inclusive of those who went to graduate school at a time when fewer

geropsychology specific training options were available. If we get approved at the ABPP executive meeting, our next step will be to finalize the details of the oral examination by describing the particular behavioral anchors for the geropsychology specific competencies which we plan to evaluate. If all goes well, individuals will begin to be examined at the APA and GSA meetings next year.

Society of Clinical Geropsychology on Facebook

Submitted by Norm O'Rourke, Ph.D., R.Psych., Division 12, Section II Treasurer and Eddy Elmer, MA
Simon Fraser University, Burnaby (BC) Canada

Earlier this year, 12/II set up a Facebook page and, to date, we have 92 'Likes.' Our goal is to hit 100 likes before year end. If you're a Facebook person, please consider 'Liking' us at http://www.facebook.com/ClinicalGeropsychology.

We want to ask, however, what members think our presence in social media should be. We have thus far avoided duplicating listserv postings, with the exception of job advertisements (our statistics indicate that job postings are being forwarded onto others more commonly than our other postings). Maybe our Facebook page could also be a vehicle to inform others about significant publications we and our students have published, recommended texts, or conference notices germane to geropsychology.

Thus far, only Eddy and I have been posting content to the Facebook page; members (and others) haven't been able to post advertisements or ad hominem editorials. Would members prefer that we change this policy (i.e., allow others to post, too)?

Below is a link to a very brief questionnaire asking your opinions about 12/II on social media. It should take only a few minutes of your time: https://www.sfu.ca/agingresearch/APA12II. We would appreciate any feedback you can provide.

The Student Voice

Submitted by Annie Mueller, MA
12/II Student Representative

Hello from beautiful Colorado Springs! My name is Annie Mueller, and I am elated to have been selected as the new junior student representative for Division 12/II. I have been passionate about the field of geropsychology since 2007, when I participated in a Research Experience for Undergraduates program at the University of South Florida. Under the mentorship of Dr. Victor Molinari, I designed and implemented a reminiscence group intervention for a group of older women in an assisted living facility. This project opened my eyes to some of the issues older adults in long-term care face, and the necessity for clinical geropsychologists in these settings. Around the same time, my grandfather developed dementia, which was my first personal experience in recognizing the clear need for geropsychologists. These experiences led me to my doctoral education at the University of Colorado at Colorado Springs (UCCS), where I am currently a 5th year doctoral candidate.

My research interests are focused on aging and mental health, with a specific focus on late-life anxiety assessment. Mentored by Dr. Daniel L. Segal, my doctoral dissertation is examining the psychometric properties of the Geriatric Anxiety Scale, a new measure of anxiety for use with older adults. My project will examine the psychometric properties of the scale in three samples, and use statistical analyses from both classical test theory and item response theory. In regards to clinical work, I have gained experience in a variety of settings and contexts in which older adults and their families receive mental healthcare. I especially enjoy working in integrated care, and ultimately envision myself providing clinical services and conducting research in such settings. Overall, my doctoral education thus far has provided me with a wealth of experience in both research and practice in clinical geropsychology, and I am excited to continue my work in the field.

I have enjoyed being involved with Division 12/II since beginning my doctoral program in 2008. I especially appreciate the genuine warmth and sincerity of our division members, as well as our ability to laugh and have fun (anyone recall the interview with Dr. Cameronkowsky at APA in Washington, DC?). Our organization is an invaluable resource for the field, and I feel fortunate to have chosen a career path in which I can work alongside so many inspiring and passionate individuals. I view the emphases on mentorship, peer collaboration, and student involvement as major strengths of Division 12/II, and am greatly looking forward to contributing to our organization as student representative.

As always, please contact either Jay or myself with any suggestions or ideas in regards to maximizing the student experience in Division 12/II. Co-representative Jay Gregg and I are planning a student social for the GSA conference in San Diego, and we hope to see you there!

Annie Mueller: amuelle2@uccs.edu
Jay Gregg: jgregg@mail.wvu.edu
Click to go to our Facebook Group

Special Feature

Newsletter Editor Comment: In going through the old newsletters, we noticed a piece written by George Niederehe, PhD, in Vol. 1, Number 2, in which he profiled the demographics and activities of our membership in 1994. In thinking about new content for the newsletter, we asked the Membership Committee to update this information. You may have recently completed a membership survey, which informed this piece. Thanks to the Membership Committee for providing this information! We have included the original article from 1994 as a point of reference to see how we have changed. -Kaci & Erin

They Way We Are: Membership Facts and Figures (1994)

Submitted by George Niederehe

The Section 2 membership has grown to 260, up 33 members since January. We now have 139 Divisional, 98 Affiliate, 1 Associate, and 22 Student members. The following summary is meant to enhance our sense of collective identity by roughly sketching some of our group characteristics. Information is based mainly on that which we provided on application/dues forms (with varying amounts of missing data from item to item).

Overall, we number 147 men, 113 women. We include 48 APA Fellows, and 34 ABPP diplomates (28 Clinical, 6 in other specialties). Nonstudent members are mostly PhDs (222) or PsyDs (8), but include 8

individuals with EdD, MD, DMin, or masters-level degrees. About half of our Student Members have masters or doctoral degrees.

We tend to be a mid-career group. Our average nonstudent member received his/her degree around 1976. About 13% of us graduated during the 1940s or 50s, 13% in the 60s, 29% in the 70s, 37% in the 80s, and 9% in the 1990s. Ages within this group range from 29 to 84, with a median of 48 years (and few of us beyond our 60s). Student Members' ages range from 24 to 57.

We hail from 39 states, the District of Columbia, Puerto Rico, and 3 other countries (Brazil, Canada, Germany; n=6). As you might expect, a large portion of us come from populous states, with 8 states accounting for 60% of the members: California (35), New York (33), Florida and Pennsylvania (each 18), Texas (15), Maryland (14), Illinois (12), and Massachusetts (11). By regions, 19% of members reside in New York/New England, 17% in the Mid-Atlantic region, 23% across the South. 18% in the Midwest, and 21% in the Western region (Mountain/West Coast States, plus Hawaii).

We received our degrees from 110 different universities (on average, 2 members per school). By number of graduates, members' top 9 Alma Maters are: U. of Southern California (13); U of Chicago and NYU (8 each); Columbia, Duke, and Northwestern (6 each); Harvard, U of Washington, and West Virginia U (5 each). Six schools produced 4 members each (Case Western, Florida, Indiana, Nebraska, Pittsburg, UCLA).

About 64% of us graduated from clinical psychology, 10% from developmental psychology/human development, 10% from counseling psychology, 6% from educational school psychology, 3% from experimental psychology, 4% from miscellaneous other subdisciplines (social, personality, professional) and 4 % from general psychology or psychology (unspecified) programs. Five percent mentioned graduating from a program with an aging or lifespan emphasis.

By comparison, the **major fields in which we currently function professionally** (as specified in the APA Membership Directory) are as follows: clinical psychology (for 70% of us); geropsychology (7%); medical/health psychology or behavioral medicine (5%); developmental psychology (5%); counseling psychology (4%); clinical neuropsychology (3%); psychotherapy (1%); community psychology (1%); experimental or applied experimental psychology (1%); and six other subfield designations (3%). **Eighty-nine percent of us are employed full-time**; 10% part-time; and only 1% not employed. The primary site of employment was characterized as private practice for 28%, university academic departments for 24%, university medical schools for 16%, other hospital settings for 20%, mental health centers for 4%, and "other" for 8%. We also reported **what percentages of our professional time are spent in various types of activities**. On average, across all nonstudent members, 48% of our time went into clinical work, 17% into research, 11% into administration, 10% into teaching, and 2% into "other" functions. These time distributions varied markedly by job context, however. For example, time in clinical work ranged from 78% for those in private practice to 12% for those in university academic departments; the averages for all categories except the latter were at least 33%. Only those of us who are university employees (whether in academic departments or in medical schools) average one-third or more of our time in research. Only if employed in academic departments (where the average is 31%) do we spend more than the overall group mean of 10% time in teaching; in all other employment settings we average 7% or less in this activity.

As already mentioned, **139 (53%) of us are members of Division 12. In addition, we tend to participate in many other unites within APA**, with at least one of us holding membership in 44 of the 47 other APA Divisions. The most common of these affiliations is with Division 20 (Adult development and Aging), in which 62% of us are members. Sizeable portions of us belong also to Division 40 (Clinical Neuropsychology, 17%), Division 38 (Health Psychology, 14%), Division 42 (Independent Practice, 14%),

Division 29 (Psychotherapy, 13%), Division 18 (Public Service, 6%), Division 35 (Psychology of Women, 6%), Division 22 (Rehabilitation Psychology, 5%), Division 17 (Counseling Psychology, 5%), and Division 1 (General), 13 (Consulting), and 27 (Community Psychology), each 4%.

We also belong to a broad array of other gerontological and psychological organizations outside APA. Among nonstudent members, the most commonly mentioned aging-related affiliations are with Gerontological Society of America (43%), American Society on Aging (11%), Psychologists in Long Term Care (7%), International Psychogeriatric Association (3%), and sundry state and local gerontological societies. In addition to state psychological associations (31%), the most commonly mentioned psychological organizations include the International Neuropsychological Society (10%), Association for the Advancement of Behavior Therapy (9%), American Psychological Society (8%), National Academy of Neuropsychology (7%), and Society for Behavioral Medicine (5%). Because of missing data, these rated of organizational affiliation are almost certainly underestimates.

We manifest a plethora of specific interest areas within geropsychology. Far and away, our greatest expressed interest is in psychological intervention(s), including various psychotherapies and other techniques (mentioned by 38%); this rate expands to 47% if certain related but broader themes in clinical care are included (e.g., rehabilitation, and dementia care). Next most commonly mentioned (by about 20% each) were generic interest such as assessment/diagnosis, neuropsychology, dementia(s), and affective disorders/depression. We also frequently mentioned as interests additional aspects of psychopathology (14%), cognition/memory (12%), services organization/delivery (9%), caregiving/family support (9%), families/marital relationships (8%), long-term care/nursing homes (8%), training issues (8%), health maintenance/promotion (7%), personality and social/interpersonal processes (6%), stress and coping (6%), and medical issues (5%). Interests repeatedly reported but at lower rates (2-4%) included consultation, gender/women's issues, positive mental health/wellness, work and retirement, death and dying, minorities and other special populations, adaptation and phases or patterns of developmental change, loss and grief, psychopharmacology, and additional specific topics.

When asked to recommend **major goals or priorities for section 2**, only about half of us made specific suggestions. Among those responding, about 30% suggested that the Section assume a public advocacy/public education role as regards aging and related public policy and professional issues; included were numerous mentions of attempting to influence Medicare reimbursement or health care reform, and increasing elders' access to services. Next most frequent (at about 25% each) were three themes, suggesting that Section 2 should: a) facilitate and help promote research generally (e.g., through lobbying for funding) or particular data collection efforts; b) maintain a focus on clinical practice and service delivery issues; and c) be involved in continuing education for its members. Also frequent were responses recommending a focus on professional issues (e.g., standards, credentialing, specialization; ca, 20%), or concentration on the Section's role in networking and developing ways to facilitate communication among members (also 20%). Training issues at the graduate school level or phrased generically (i.e., not specified as CE) constituted another common them (13%), including mentoring and attention to student needs. In fact, if pooled together with the comments on CE, training overall might constitute a model category among suggestions. Also recommended were the development of interorganizational and intra-APA linkages (11%), facilitation of more program time at the APA convention or more publication space devoted to members' interests (9%), and miscellaneous other themes.

As a section we obviously have many things to do and many common interests to draw us into greater communication with each other. We're also poised to handle our communications with increasing technological sophistication: according to the membership listings, 57% of us can be reached through a fax number, and 21% through an e-mail address.

The Way We Are (2012)

Submitted by the Membership Committee: Rebecca Allen & Morgan Eichorst

As our numbers keep rising and our membership continues to diversify in interests, it becomes critical to pause and take stock of what we have and still want to accomplish as a Division. With hopes that this information provides some insight about the current state and future direction of 12-II, here are the numbers.

As of October 2012, APA Division 12-II stands strong with 274 active members. Of those, 211 are full members and 63 are student members. Approximately 61% of the Division's full members and 85% of its student members are also members of Division 12.

Of our full members, most have a Ph.D (84%) with approximately 14% reporting a Psy.D. and 1.5% reporting some other type of advanced degree.

Our membership is diverse. We come from 39 different US States with the most represented states being California (44 members) and New York (33 members). We are also international. Our membership hails from Canada, Australia, Ireland, Switzerland, Austria, Sweden, and the Netherlands.

According to our October 2012 survey conducted by Morgan K. Eichorst, student representative to the membership committee, the interests of the 12-II remain varied. Including both full and student members, approximately 79% of 12-II members are currently in or graduated from a clinical psychology program (12.8% from counseling psychology, 3.5% from developmental, and 1.2% from each of the following: human factors, experimental psychology, general psychology, and counselor education). Of our full members, the majority spend their time doing clinical work (43%) while 26.7% of our members spend their time mostly in research, 15% in administration, 8.3% in teaching, and 6.7% in clinical training/supervision.

The membership committee analyzed themes from full and student members regarding the goals, perceived benefits and future visions for 12-II. Regarding goals and future visions, three major themes were found. 1) providing information, training, and networking opportunities to members in 12-II; 2) promoting geropsychology as a field (i.e., ABPP) and advocating for issues important to geropsychology; and 3) a new website! One member phrased it well when s/he said: "[we should be] building a two-way street between research and practice." Regarding the primary benefits of being a member of 12-II, two main themes emerged: 1) networking and resources available to members; and 2) communications via the Listserv and newsletter. One member expressed that being a part of 12-II gave her/him a sense of "professional identity."

Regarding major interests of our members, the majority (19%) report a main interest in interventions. Long-term care comes in at a close second with 15.5% of members. In descending order, the remainder of interests of 12-II members include: affective disorders (9.5%), neuropsychology (6%), dementias, (6%), psychopathology (6%), caregiving (4.8%), health maintenance (4.8%), medical issues (4.8%), death and dying (4.8%), service delivery/utilization (3.6%), family/marital units (2.4%), work and retirement (2.4%), with 1.2% of membership reporting their main interest in assessment/diagnosis, social/interpersonal processes, stress and coping, positive mental health/wellness, minorities/special populations, and loss/grief.

12/II Student Research Award

Congratulations to Lindsay Gerolimatos, MA, from West Virginia University for her paper, "Predictors of Health Anxiety among Older and Young Adults" which won 12/II's 2012 Student Research Award (see below for photo from APA). Here we publish the abstract from Lindsay's paper and encourage you to read the full paper in *International Psychogeriatrics*:

Gerolimatos, L. A., & Edelstein, B. A. (2012). Predictors of health anxiety among older and young adults. *International Psychogeriatrics, 24*, 1998-2008. doi: 10.1017/S1041610212001329

Background: Many older adults have at least one chronic disease and experience greater health problems than young adults. However, little is known about factors other than health that account for health anxiety (HA) among older adults. The overall objective of the present study was to develop a better understanding of HA among older and young adults.

Methods: We examined how anxiety-related constructs (anxiety sensitivity, intolerance of uncertainty, anxiety control, and emotion regulation) predict two core components of HA described in the cognitive-behavioral model of HA (illness likelihood and negative consequences) in older and young adults. We also examined the extent to which the predictor variables differentially account for HA in both age groups. Older and young adult participants completed several self-report surveys.

Results: Young adults reported higher levels of HA than older adults. Anxiety sensitivity and reappraisal predicted illness likelihood for older and young adults. Intolerance of uncertainty predicted negative consequences in both age groups. Anxiety sensitivity predicted negative consequences for older adults only. Anxiety control did not predict illness likelihood or negative consequences for either age group.

Conclusions: Results suggest that anxiety sensitivity and intolerance of uncertainty may predispose older and young adults to HA, which is influenced by reappraisal. Implications for the cognitive-behavioral model of HA in both age groups are discussed.

Announcements and Member News

This section of the newsletter highlights announcements relevant to the membership and the accomplishments of the Section's members. If you have received any local or national awards, or want to let the Section know about recently accepted publications, or recently published books, please email updates to Erin Woodhead (Erin.Woodhead@sjsu.edu) and Kaci Fairchild (JenniferKaci.Fairchild@va.gov).

Announcements

The "Older Adult Full Service Partnership (FSP) Tool Kit for Cultural Relevance" has been completed by *Janet Anderson Yang, Ph.D.,* Clinical Director of Heritage Clinic, a division of the Center for Aging Resources as the Principal Writer, in partnership with the California Institute for Mental Health (CiMH), Katherine Eliott, PhD, MPH, CiMH consultant and the FSP Advisory Committee. It is located on the CiMH website at http://www.cimh.org/Learning/Publications-DVD/Toolkits.aspx.

Member News

Awards and Recognitions

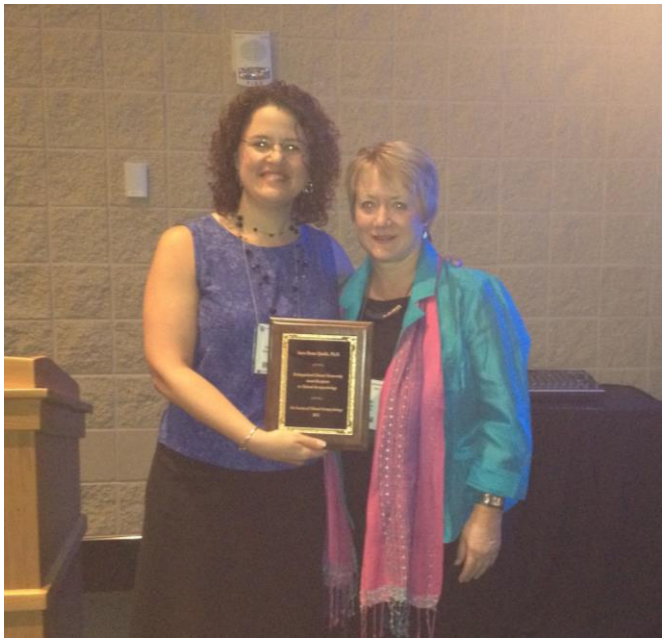
Amy Rosett was recently presented with an award for Distinguished Service to the Los Angeles County Psychological Association (LACPA). Dr. Rosett has been active in the LACPA for several years and has served in a variety of ways including being Secretary from 2007-2008; Membership Chair from 2007-2009; and President in 2010. She currently serves on the Board of Directors as the Networking Committee Chair. Another of the many ways Dr. Rosett has contributed to the LACPA was to add a Special Interest Group in Geropsychology.

Robert Maiden, Professor of Psychology and Director of Alfred University's Gerontology Program in the College of Liberal Arts and Sciences, received the 2012 Walter M. Beattie, Jr. Award from the State Society on Aging of New York (SSA). This award, which is SSA's most prestigious, was based on Dr. Maiden's outstanding contribution to the work of SSA and for commitment to its goals.

At the recent APA convention, 12/II presented awards for Distinguished Contributions to Clinical Geropsychology, Distinguished Clinical Mentorship, and the Student Paper Award. We also welcomed two new board members to the group: Brian Yochim as President Elect and Michele Karel as Division 12 representative. Congratulations! In planning for next year's awards, please be thinking of individuals that you would like to nominate for these awards! Don't delay – send your nomination ideas to Erin_Emery@rush.edu.

Bob G. Knight received the Division 12, Section II (Clinical Geropsychology) M. Powell Lawton Award for Distinguished Contributions to Clinical Geropsychology. Dr. Knight is the Merle H. Bensinger Professor of Gerontology and Professor of Psychology at the USC Davis School of Gerontology/Andrus Gerontology Center. He also serves as director of the Tingstad Older Adult Counseling Center and is the Editor of the Journal of Gerontology: Psychological Sciences. The M. Powell Lawton Award recognizes significant contributions to gerontology through innovation in gerontological treatment, practice or service, prevention, amelioration of symptoms or barriers. This award honours those who exemplify the outstanding professional and personal qualities of M. Powell Lawton.

Sara Qualls received the Division 12, Section II (Clinical Geropsychology) Distinguished Clinical Mentorship Award. Dr. Qualls is Professor of Psychology and Kraemer Family Professor of Aging Studies at the University of Colorado at Colorado Springs where she also serves as Director of the Gerontology Center. The Distinguished Clinical Mentorship Award recognizes those clinical geropsychologists who have played significant roles in the clinical supervision of psychology trainees who work with older adults. This award also recognizes those who have mentored trainees interested in a career in clinical geropsychology.



And, welcome to new Board Members **Michele Karel**, (Division 12 Representative) and **Brian Yochim** (President Elect)!

Dr. Karel serves as the Mental Health Program Coordinator for the Home-Based Primary Care Program at VA Office of Mental Health Services as well as an Associate Professor of Psychology in the Department of Psychiatry at Harvard Medical School.

Dr. Yochim is a Clinical Neuropsychologist at the Sierra Pacific Mental Illness Research, Education, and Clinical Center at the VA Palo Alto Health Care System. He is also a Clinical Assistant Professor (affiliated) of Psychiatry and Behavioral Sciences at Stanford University School of Medicine.

Recent Member Publications

Barbera, E. F. (2012). *The Savvy Resident's Guide: Everything You Wanted to Know About Your Nursing Home But Were Afraid To Ask*. Psychology Insights Press.

Camp, C. J. (2012). *Hiding the stranger in the mirror: A detective's manual for solving problems associated with Alzheimer's Disease and related disorders*. Solon, OH: Center for Applied Research in Dementia.

Fairchild, J. K., Friedman, L., Rosen, A., & Yesavage, J. (in press). Who Maintains Benefit from Cognitive Training? Use of Signal Detection Methods to Identify Long-Term Treatment Responders. *International Psychogeriatrics.*

Jason, L.A., & **Glenwick, D.S.** (Eds.) (2012). *Methodological approaches to community-based research.* Washington, DC: American Psychological Association.

Rasin-Waters, D. & Abel, V. (2012). Neuropsychological Program Development: Integration and Innovation. S. S. Bush (Ed.), *Neuropsychological Practice with Veterans.* Springer Publishing Co.

Rose, J. (2012). Lessons for spinal cord injury rehabilitation taken from adult developmental psychology: 2011 Essie Morgan Lecture. *The Journal of Spinal Cord Medicine, 35(2),* 133-139.

Russo, A.C., Bush, S.S., & **Rasin-Waters, D**. (2012). Ethical neuropsychological practice with older adults: Professional competence as the foundation. In L.D. Ravdin & H.L. Katzen (Eds.), *Clinical Handbook on the Neuropsychology of Aging and Dementia*. New York: Springer Science.

Russo, A.C., **Rasin-Waters, D**., & Bush, S.S.(2012). Ethical considerations in the neuropsychological assessment of older adults. In L.D. Ravdin & H.L. Katzen (Eds.), *Clinical Handbook on the Neuropsychology of Aging and Dementia*. New York: Springer Science.

Yochim, B., Mueller, A., & Segal, D. (in press). Late life anxiety is associated with decreased memory and executive functioning in community dwelling older adults. *Journal of Anxiety Disorders*.

Committee Updates

Interdivisional Healthcare Committee (IHC) Update

Submitted by Margie Norris, Representative for Division 12/II

IHC August 2012 meeting: Abbreviated Minutes

1. The Affordable Care Act (ACA): Overview, State-based implementation of Health Care Reform, and Prospective IHC Action Steps

An APA staff member has been assigned to track the ACA activities of each State. Benefits of "APA Communities," a new online resource – it will serve as a clearinghouse for ACA-related information to assist psychologists advocating for psychology-based health care reform initiatives across the 50 states.

Barry Nierenberg discussed his involvement in the Practice Directorate's State Implementation of Health Reform Committee. Barry underscored the challenges faced by psychology advocacy groups across the States. Government administrators and physicians, in general, do not comprehend what professional psychology brings to the table. Key question: How can we communicate effectively that psychologists are health providers with expertise in management of chronic illnesses (e.g., diabetes, obesity, and stroke), not DSM-focused, mental health practitioners? Barry also noted professional psychology has limited visibility to the general public and policy makers. He emphasized the importance of increasing the profile of psychologists in the healthcare reform arena.

APA's priorities in facilitating the inclusion of psychologists in ACA were discussed. The Practice Directorate and the State Healthcare Reform Committee have targeted four or five states which have shown high involvement in health care reform, particularly implementation of health insurance exchanges, to

implement intensive advocacy efforts. Two key issues need to be addressed in fostering the effectiveness of state-based advocacy campaigns: (1) What are the Medicaid regulations that prevent psychologists from participating fully in Medicaid?

(2) Which psychological services are likely to be reimbursed?

The importance of H&B Medicaid reimbursement to solidify the role of psychologists in ACA at the state level was also underscored. There are currently 11 states in which H&B codes are turned on (i.e., reimbursement of entire 96150-96155 CPT Series), and another 11 states where they are partially turned on. At the State Leadership conference in February 2012, APA charged leaders to focus their efforts in expanding H&B reimbursement. We need an advisory group of people with boots on the ground. Especially in states that are real activist states.

Barry has been asked to play a pivotal role in supporting the activities of State advocates. He and reps from APA Practice Directorate requested the IHC develop fact sheets, 1-2 pages, on the contributions of psychologists in treating chronic illnesses (obesity, diabetes management, and chronic pain).

As States develop plans to expand Medicaid coverage, there will be more need for IHC to help APA cover the topics and policy issues relevant at the interface of healthcare and psychology.

ACTION STEP: IHC members will write four Fact Sheets (2 pages each) on key topics relevant to Psychology's role in states' implementation of the ACA. Randy and Lynn will provide feedback on these documents and help to guide future iterations of this initiative.

2. Pediatric Medicaid Reimbursement and APAGS Initiatives

Not much relevant here for 12-II.

3. Obesity and Biopsychosocial Practice Guidelines

It was noted that psychology has lost the recent battle for who gets funding for obesity treatment. CMS has limited reimbursement for obesity treatment to physicians, PAs and nurse practitioners. Furthermore, H&B codes have specific exclusions for weight loss intervention, so there is no alternative avenue there. APA Practice Directorate reps responded that despite current reimbursement difficulties, obesity guideline development is going forward. They asked for the involvement of IHC in scoping the questions that will drive the evidence review. They reported that the guidelines will take at least two years to write – "hopefully the reimbursement problems will be addressed by then." APA is no longer working on changing Medicare/Mac policies. Medicaid reimbursement is a priority. We need to focus where State plans are being developed for expansion of Medicaid.

4. Amendment of APA's Model legislation for Prescriptive Authority:

Proposed Action Steps

Dan Bruns provided draft language for change in APA policy related to the use of the term, medical psychology, by Louisiana and other prescribing psychologists, eschewal of medical board oversight of licensed prescribing psychologists, and prohibition of funding for proposed prescriptive privileges legislation advocating the use of the term, medical psychology, and/or regulatory oversight by state medical boards. It

was noted that CAPP is not going to give financial support to prescriptive authority lobbying efforts that include restriction of the term, medical psychologist. Procedural paths the IHC could take were outlined if the IHC wants to push for APA to develop more explicit policies.

Education Committee Update

Submitted by Erin Woodhead and Erin Emery

The Education Committee of the Society of Clinical Geropsychology has completed data collection for a survey of students' geropsychology training experiences in the USA, Canada, Australia and New Zealand. The project was funded by an award from the Council of Professional Geropsychology Training Programs. The goal of the project was to assess training opportunities and student competencies in geropsychology and determine the factors that influence students to pursue or not pursue a career in geropsychology. We are currently working on a manuscript and will present preliminary findings at a GSA symposium entitled *Increasing the Geriatric Health Workforce Across Disciplines and Levels of Training*. The symposium includes results from our study as well as studies done by our international colleagues on increasing aging training among undergraduates and nursing students. The symposium is scheduled for Friday November 16th from 5:00pm-6:30pm in Room 12 of the San Diego Convention Center.

APA Office on Aging and Committee on Aging Update

Submitted by Deborah DiGili, MPH, Director, APA Office on Aging

Institute of Medicine (IOM) Study: The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands? - On September 19th, Drs. Nida Corry and Diane Elmore of the Public Interest Government Relations Office, in partnership with the American Association for Geriatric Psychiatry and the National Association of Social Workers, planned a very well attended briefing on Capitol Hill, to highlight the IOM report, *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* Dr. Michael Hoge, a member of the IOM panel presented on behalf of psychology. A video recording of the briefing and slides are available at: http://www.apa.org/about/gr/issues/aging/mental-health-workforce.aspx. Efforts are underway to promote its education and training recommendations within psychology. A conference call of individuals representing all levels of geropsychology training to strategize, including 12-II President Erin Emery, PhD, will occur the first week of November.

Update of the APA Guidelines for Psychological Practice with Older Adults - These 2003 guidelines were developed by the Interdivisional Task Force on Practice in Clinical Geropsychology convened by Divisions 20 and 12-II and were set to expire in 2013. A CONA, Division 12-Section II and Division 20 effort is underway to update the Guidelines. The members of the *Guidelines for Psychological Practice with Older Adults Revision Working Group* are: Gregory Hinrichsen, PhD (Chair), Adam Brickman, PhD, Barry Edelstein, PhD, Kimberly Hiroto, PhD, Tammi Vacha-Haase, PhD, and Richard Zweig, PhD. The group has had multiple conference calls and one meeting in October. A draft will be available for public comment early in 2013.

The Survey of Professional Geropsychology Training and Experiences: Wave 2 - Last year, the Office on Aging and the Education Directorate, in collaboration with Drs. Sara Qualls and Daniel Segal and with the support of Divisions 12-II and 20, CoPGTP, and the APA Center for Workforce Studies, jointly administering a survey of APA members regarding practice patterns, education and interest in training in professional geropsychology in 2011. Findings were shared with the IOM Workforce panel and by Dan Segal, PhD at the APA 2012 Convention Symposium on the Geriatric Mental Health Workforce. Development of a second wave of the survey of licensed psychologists (including those who are *not* APA

members) is now underway. Members of the Survey Working Group are: Sara Qualls, PhD (Chair), Michele Karel, PhD, Jennifer Moye, PhD, Daniel Segal, PhD and Yvette Tazeau, PhD.

Committee on Aging - This year, CONA focused its efforts on its five strategic issues: (1) The Psychology Workforce to Serve Older Adults (2) The Science of Aging to Inform Practice, Policy and Public Education (3) Integrated Health Care (4) Age and Diversity and (5) Advocacy. A few of CONA efforts this year:

- Conducted a successful aging research mentoring workshop, *Speed Mentoring for Budding Geropsychology and Neuropsychology Careers* in collaboration with Division 20 and Division 40 and for the fifth year, the CE workshop, *What Psychologists Should Know about Working with Older Adults*.
- Participates in the development of *GeroCentral*, and in ongoing discussions with CoPGTP to encourage training opportunities for post-licensure psychologists.
- Provided input on the *Guidelines and Principles for Accreditation* requesting the infusion of aging into doctoral level training in clinical psychology.
- Regularly meet with the Practice Directorate to encourage Medicare and Medicaid policies that enhance the availability and reimbursement of services to older adults. CONA provided vignettes that portray examples of clinical work that are not reimbursed by Medicare for use in advocacy efforts to include psychologists in the Medicare definition of "physician" and for advocacy efforts to include psychologists in Transitional Care Management reimbursement.
- Provided evidence supporting psychotherapy as a front line intervention for older adults that was then included in the *APA Recognition of Psychotherapy Effectiveness* resolution.
- Updated the 1997 publication, *Elder Abuse: In Search of Solutions*, a brochure for consumers.
- Works to ensure the inclusion of age as an essential component of diversity and the increasing diversity of the aging population in all APA efforts
- Nominated psychologists with expertise in aging to national advisory panels and working groups such as the Advisory Council on Alzheimer's Research, Care and Services and to APA Boards, Committees, Task Forces and Working Groups.

The 2012 Committee on Aging members are: Neil Charness, PhD (chair), Adam Brickman, PhD, Kelly O'Shea Carney, PhD, CMC, Manfred Diehl, PhD, Jennifer Moye, PhD and Karen Roberto, PhD. Drs. Charness and Brickman will be rotating off CONA in December. New members are announced by the APA Board of Directors in mid-December.

For more information about activities and products, visit the Office on Aging website. As always, please direct your ideas and questions to me at ddigilio@apa.org.

Public Policy Committee Update

Submitted by Margie Norris, PhD, Committee Co-Chair

POSSIBLE UNDERPAYMENT OF PSYCHOTHERAPY CODES

The Public Policy Committee, now the combined PPC for 12/II and PLTC, has learned more about a possible error made by CMS for the past several years regarding the fees paid for psychotherapy services provided to non-skilled nursing home patients. Dr. Eric Garfinkel, our colleague in New York, has conducted extensive research into a fee discrepancy that warrants further investigation and efforts toward possible rectification.

The CMS fee schedule sets different rates for many services provided to patients in non-facility versus facility settings, coded as Place of Service (POS) 32 versus 31, respectively. The facility fee is in effect

when Medicare Part A is paying for the nursing home to provide rehabilitation and other skilled services. In almost every case, non-facility fees are higher than facility fees because Medicare views facility fees as partially covered by the Part A payment for patients' care to the skilled nursing home.

Psychotherapy services provided in nursing homes are primarily procedure codes 90816 and 90818. Prior to 2003, the non-facility fees were higher than the facility fees, as would be expected. Then, in 2002, the facility fees and non-facility fees became equivalent. In 2011, the non-facility fees became *lower* than the facility fees, which is the opposite of the principle that Medicare Part A is not paying facility fees. It is possible that the lowered non-facility fees was an error.

A second possible error in fees occurred in 2011. Congress prescribed a 8% across the board Part B reduction in fees, which was to be gradually implemented as a 2% annual cut for 4 years. However, for new codes, the 8% reduction was implemented immediately. The non-facility fees for 90816 and 90818 took an immediate 8% reduction in 2011 although these were clearly not new codes.

It is difficult to estimate the total losses to mental health providers, but certainly it surpasses many *million* dollars.

On October 26th, various members of PLTC held a conference call with Paul Rudolf, M.D. Dr. Rudolf is an attorney with Arnold and Porter, LLC a Washington D.C. law firm. He has significant experience in Medicare legal, regulatory and policy issues. Dr. Rudolf previously served as Medicare Director for Trailblazers and was a medical officer at CMS for 5 years where he led policy development for the physician fee schedule. Dr. Rudolf's in-depth experience with coding and reimbursement for Medicare is a tremendous asset to our effort in this matter.

As a result of the conference call, it was decided that we should pursue a rigorous investigation of how and when the errors were made, which providers may be possibly impacted by incorrect payments, and whether any recourses are available. Dr. Rudolf estimates this first phase of investigation will cost approximately $5,000 in legal fees, and take 2-3 weeks. Then, based on the results, we will collectively decide (along with any other impacted professional organizations) about aggressively pursuing recoupment of the funds through meetings with CMS officials. This second phase, of course, will incur higher legal fess. If this effort develops, other professional associations will be approached to contribute to the cost and effort for this second phase.

PLTC is a 501(c)6 incorporated organization. There are no limitations to gathering money for advocacy, which is why we incorporated as this entity. Also, as an independent organization, PLTC has the autonomy needed to take quick and unencumbered actions. (Unfortunately, APA Practice Directorate has stated it is unable to participate in this endeavor at this time; although they offered invaluable support by recommending Dr. Rudolf.) The PLTC Board and the PLTC -12/II Public Policy Committee are recommending that we collect from our members the money to fund the initial investigation. In the event that more funds are raised than are necessary for the initial phase, the additional monies can be used to fund the second phase. If no further legal work is recommended, the membership can collectively decide on holding these funds in PLTC reserves or proportionately refund the monies to the contributors.

The hopeful outcome is that Medicare could reverse these errors and make restitution to all providers impacted by this mistake. This outcome is not possible without the expertise of attorneys who are positioned to research the source of the errors and then take the matter to CMS for rectification.

If you are interested in making a contribution toward this effort, please send your contribution to Alan Duretz, PLTC Treasurer, with checks payable to PLTC. Please note that the donation is for the non-facility fee effort. You may also make your donation through PLTC's PayPal account. If you do not have a PayPal account, but would like to pay using PayPal, simply send an e-mail to Alan and he will send you a link to do that.

Alan's email and cell #: aduretz.pltc@gmail.com; (954) 684.5895
Mailing address: Phybill, Inc., 1727 Banks Rd., Margate, FL 33063

Did You Know…

- That the Society has two Facebook pages?
  - One is for all members: https://www.facebook.com/#!/ClinicalGeropsychology
  - The second is for student members: https://www.facebook.com/groups/53793187809/
- That you can spotlight members with a newsletter submission? If you're interested in doing this, email the newsletter editors!
- That you can receive listserv messages in a daily digest form? Go to http://listserv.wvu.edu/archives/wvuger-l.html and click on "Join or Leave WVUGER-L" to manage your listserv settings.
- That you should encourage your colleagues and students to join the Society? Please distribute the membership form on the next page to encourage others to join!

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Past President: David Powers
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APA Division 12, Section II: The Society of Clinical Geropsychology
2012 MEMBERSHIP DUES FORM
RENEW ONLINE AT: http://www.geropsychology.org/membership-application

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

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(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)

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

Please list other Divisions and Societies you are affiliated with:

Please list your 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) – Please check one of the following boxes: ☐ **$25 for 1-year membership** ☐ **$75 for 3-year membership** ☐ **$10 for 1-year student membership** ☐ **Emeritus members are dues exempt**	**$ _____**
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**

Faculty endorser (if joining as student)	**Faculty Signature**	**Date**

Mail this form, along with your check payable to "APA Division 12, Section II" to Norm O'Rourke, Ph.D. , Faculty of Arts and Social Sciences, – Saywell Hall Rm #10322, Simon Fraser University, 8888 University Drive, Burnaby, BC Canada V5A 1S6

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